

New York State/ New York City Mental Health- Criminal Justice Panel **Report and Recommendations**

to

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and

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I. Executive Summary

In the wake of several recent, highly publicized violent incidents involving individuals with mental illness, officials in New York State (NYS) and New York City (NYC) convened a panel to examine these cases, consider opinions of experts and recommend actions to improve services and promote the safety of all New Yorkers.

The NYS/NYC Mental Health and Criminal Justice Panel (Panel) was convened by NYS Deputy Secretary for Health and Human Services Dennis Whalen and NYC Deputy Mayor for Health and Human Services Linda Gibbs. The Panel was co-chaired by NYS Office of Mental Health Commissioner Michael Hogan, NYS Division of Criminal Justice Services Commissioner Denise O'Donnell, NYC Deputy Mayor Linda Gibbs and NYC Criminal Justice Coordinator John Feinblatt. Members of the Panel included top State and City officials in mental health, addiction, criminal justice and adolescent services.¹

The Panel's work was informed by a review of several cases in NYC involving individuals with serious mental illnesses who engaged in violent behavior and encountered law enforcement and the criminal justice system, as well as a broader assessment of how New York's mental health and justice systems respond to adults and adolescents with serious mental illness. The Panel also consulted with national experts in mental health and violence.

The Panel focused on opportunities to improve services for the subset of individuals with serious mental illness who are at risk of poor treatment outcomes, violence, and involvement with the justice system. This targeted focus is supported by an extensive body of research indicating that the vast majority of those with mental illness are not violent, and that mental illness is not a major driver of violent crime—in fact, studies show that individuals with mental illness are far more likely to be victims of violence than the general population.^{2,3} Research does suggest, however, that the risk of violence is significantly increased among individuals who do not receive adequate mental health care,^{4,5} and considerably more so among those individuals with co-occurring mental health and substance use disorders.^{6,7} Individuals with serious mental ill-

Notes

- 1 See Appendix A for Panel's membership list.
- 2 JA Pandiani, SM Banks, BB Carroll. *Crime Victims and Criminal Offenders Among Adults With Serious Mental Illness*. *Psychiatric Services*, Nov. 2007; Vol. 58(11): pp. 1483-1485.
- 3 J Monahan, John. *Mental Disorder and Violent Behavior: Perceptions and Evidence*. *The American Psychologist*, 1992; 47(4), 511.
- 4 Monahan J, Steadman HJ, Silver E, et al: *Rethinking Risk Assessment*. New York, Oxford University Press, 2001.
- 5 EF Torrey, J Stanley, J Monahan, and HJ Steadman. *The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After Its Initial Publication*. *Psychiatric Services*, Feb. 2007; Vol. 59(2): pp. 147-152.
- 6 HJ Steadman, EP Mulvey, J Monahan, et al. *Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*. *Archives of General Psychiatry*, 1998; Vol. 55: pp. 393-401.
- 7 JW Swanson, MS Swartz, SM Essock, et al. *The social-environmental context of violent behavior in persons treated for severe mental illness*. *Am J Public Health* 2002;92:1523-1531.

ness who engage in effective mental health treatment, though, have considerably lower rates of violence than those who do not.^{8,9}

In its examination, the Panel recognized a variety of challenges that individuals with mental illness commonly face; perhaps most apparent is the difficulty of securing safe and affordable housing. Efforts are currently underway to address this and other challenges, but such issues were not the specific focus of the Panel's work.

Panel Findings

Panel members identified many ways in which both the mental health and criminal justice systems could improve their ability to help adults and adolescents with serious mental illnesses. The challenges fall into four broad categories: (1) Poor coordination, fragmented oversight and lack of accountability in the mental health system; (2) Inconsistencies in the quality of care within the mental health treatment system; (3) Limited capacity to share information within and between the mental health and criminal and juvenile justice systems; and (4) Insufficient training, supports and tools to identify and engage justice-involved individuals with mental illnesses. Following are specific recommendations within each of these categories. While designed to respond specifically to NYC incidents and its system of care, the Panel believes that the report's conclusions have broader statewide application.

■ 1. Poor coordination in the mental health treatment system

Recommendations:

- ◆ **Establish Care Monitoring Teams for high-need adults** - The NYS Office of Mental Health (OMH) and the NYC Department of Health and Mental Hygiene (DOHMH) should jointly establish and administer Mental Health Care Monitoring Teams (CMTs) in NYC that are directly responsible for monitoring the care of high-need individuals and the high-intensity programs (such as assertive community treatment and intensive case management) that serve them, to help improve treatment and services.
- ◆ **Create a database to track the mental health care provided to high-need adults** - OMH and DOHMH should create a database accessible to both agencies of encounters of high-need in-

Notes

8 Ibid Monahan et al. 2001

9 Ibid Torrey et al. 2007

dividuals in the public mental health system to enable the CMTs to track care patterns so that interruptions in care or escalating need for services are better identified and addressed.

- ◆ **Implement Family Care Coordinators for justice-involved youth** - Every adolescent with Serious emotional disturbance (SED)¹⁰ in the juvenile justice system should be assigned a Family Care Coordinator, until the youth is discharged, to help families navigate the juvenile justice, mental health and other systems and facilitate information sharing among providers and families.
- ◆ **Improve OCFS discharge planning and aftercare services** - Discharge planning should begin within 30 days of admission to a NYS Office of Children and Family Services (OCFS) facility and should engage the youth, family members and community providers. In addition, adolescents should be assigned community service workers to facilitate discharge planning and aftercare, in collaboration with Family Care Coordinators.
- ◆ **Implement recommendations of the OMH/OASAS Task Force on Co-Occurring Disorders** - OMH and the NYS Office of Alcoholism and Substance Abuse Services (OASAS) are overseeing implementation of recommendations from a 2007 Task Force on Co-Occurring Disorders that was convened to make improvements in the care for this population. The Panel supports the Task Force recommendations, which include the issuance of guidelines that call for screening for both mental health and substance use disorders in all clinics that treat these disorders, training for screening and use of evidence-based treatments and reimbursement for evidence-based integrated treatments.¹¹

■ 2. Inconsistencies in quality of care

■ Recommendations:

- ◆ **Conduct critical incident reviews** - The State should enact legislation to authorize OMH to collaborate with local governments and appropriate State and local agencies to conduct regular, timely reviews of critical incidents involving the care of individuals with mental illnesses. These system-level reviews should aim to reduce care errors and improve safety.
- ◆ **Issue standards of care for mental health clinics** - OMH should issue standards of care - including guidelines for assessing risk of violence to self or others - for mental health

Notes

¹⁰ An adolescent with SED must have a psychiatric diagnosis along with an impaired level of functioning due to the emotional disturbance. A full definition of SED is available at http://www.omh.state.ny.us/omhweb/rfp/2008childrens_community_residences?appendix_c.html

¹¹ See Appendix C for more information.

clinics serving adults. These standards should also provide guidance on the initial evaluation, ongoing risk assessment and changing treatment plans when an individual's mental health deteriorates. OMH and DOHMH should incorporate these standards into licensing and programmatic reviews.

- ◆ **Implement systemic improvements to Assisted Outpatient Treatment (AOT)** - DOHMH should conduct outreach to hospitals to improve the rate of appropriate referrals to AOT, clarify and standardize AOT enrollment and renewal criteria, and establish an independent clinical review of decisions to not accept or renew AOT orders.

■ 3. Limited capacity to share information

■ Recommendations:

- ◆ **Pilot a program for sharing information between the criminal justice and mental health treatment systems** - NYS and NYC should pilot an effort to identify persons with serious mental illness who have become involved in the justice system. This information would be shared, with appropriate consent, to facilitate diversion to treatment-based alternatives.
- ◆ **Increase information available to the NYPD** - The NYC Police Department (NYPD) should establish database flags for locations that might trigger dispatch of the specially trained Emergency Service Unit, including locations that have been the subject of prior “emotionally disturbed person” (“EDP”) calls and housing with supports for individuals with mental illness.
- ◆ **Enable information to follow adolescents through transition points in the juvenile justice system** - OCFS and the NYC Departments of Probation (DOP) and Juvenile Justice (DJJ) should establish policies to seek consent from parents or guardians to share otherwise confidential information, such as the results of health and mental health screening and assessments, to help determine how to best meet the service needs of adolescents as they move through detention, placement, and aftercare.
- ◆ **Increase monitoring of individuals deemed not responsible for criminal conduct due to mental illness** - DCJS should provide OMH and the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) with real-time notification of arrests of individuals who are determined to be not responsible for criminal conduct due to “mental disease or defect” and are in the community subject to court-ordered conditions.¹²

Notes

12 NYS Criminal Procedure Law § 330.20

4. Insufficient training and supports in the criminal and juvenile justice systems

Recommendations:

- ◆ **Pilot a NYC alternative-to-detention program** - NYC should pilot a new alternative-to-detention (ATD) program with a special mental health track, designed to provide assessment, case management, supervision, and community-based treatment to defendants with mental illnesses who might otherwise be detained while their cases are moving through court and who do not pose a high risk of recidivism or flight.¹³
- ◆ **Create a dedicated mental health unit at the NYC Department of Probation (DOP)** - NYC DOP should create a dedicated mental health unit of probation officers with reduced caseloads, who would establish relationships with probationers' mental health providers and assist probationers in receiving appropriate services.
- ◆ **Include validated mental health screening in pre-sentence investigations** - Pre-sentence investigations conducted by NYC DOP should include a brief, validated mental health screen, to allow DOP to alert judges about defendants who may need a deeper clinical assessment and may benefit from treatment-based alternatives or special probation conditions.
- ◆ **Introduce mental health screening in Criminal Court for individuals sentenced to community-based sanctions** - NYC should introduce mental health screening in the Bronx Criminal Court, to identify individuals sentenced to brief community-based programs who may benefit from mental health assessments, intensive engagement, and voluntary case management as an alternative to the original court mandate.
- ◆ **Expand new mental health courts and alternatives-to-incarceration** - NYS should expand the number of mental health courts throughout the State and NYC should expand the number of alternative-to-incarceration programs that link offenders to court-monitored mental health treatment as an alternative to traditional case processing.¹⁴
- ◆ **Improve training for 911 call takers and dispatchers** - NYS should create and refer to the NYS 911 Board a training protocol for 911 dispatchers to elicit information about whether a person involved in an incident has a history of mental illness.
- ◆ **Continue on-going review of best practices for dealing with “EDP” incidents in NYPD’s training curriculum** - NYC’s Project LINK-an ongoing NYPD and DOHMH

Notes

¹³ An alternative to detention (ATD) program provides community supervision of a defendant during the period when his/her case is moving through the court. An alternative to incarceration (ATI) program provides a community-based sentencing option for judges, in lieu of a jail or prison sentence.

¹⁴ See Appendix D for more information on mental health courts in NYS.

effort that includes mental health professionals, consumers, and researchers-should continue to review NYPD's training curriculum to ensure it reflects current best practices in law enforcement training for dealing with "EDP" incidents.

- ◆ **Sponsor a Statewide Mental Health-Law Enforcement Summit** - NYS should sponsor a Mental Health-Law Enforcement Summit to enhance the relationships between law enforcement and the mental health community. Action Plans will be developed in cooperation with the local mental health authority; the Division of Criminal Justice Services (DCJS) will follow up to assist in implementation.
- ◆ **Enhance clinical interventions for youth with SED in DJJ or OCFS custody** - DJJ and OCFS should incorporate clinical interventions into its systems through several initiatives, including expansion of DJJ's Collaborative Family Initiative to provide community-based treatment options in lieu of further detention and/or State placement, and OCFS administration of a Voice-Diagnostic Interview Schedule for Children (V-DISC) and a trauma assessment upon a youth's entry into care.

The recommendations presented in this report can improve mental health services and criminal justice interactions for individuals with mental illnesses and enhance the safety of these individuals and the public. However, it is important to recognize that even a perfect system would not be able to predict and prevent every violent incident involving a person with mental illness, and individuals may legally refuse care offered to them. Even with improved information sharing, there are substantial limitations to the data that exists and that can be shared, including reporting lags, data quality issues, information that is unavailable on individuals who are not served by public systems of care, and confidentiality concerns

In spite of these limitations, the Panel is confident that with the implementation of the recommendations presented in this report, and the ongoing collaboration between State and City officials and the involvement of the community, both public safety and the quality of care for individuals with mental illnesses can be improved.

Recommendations grouped by system

Adult Mental Health Treatment System

- Create Mental Health Care Monitoring Teams to oversee high need adults and high intensity providers
- Create database of high need adults in the public mental health care system to better track services.
- Conduct critical incident reviews of incidents involving the care of individuals with mental illnesses.
- Issue clinical standards of care for adult outpatient mental health clinics.
- Implement systemic improvements to AOT to improve outreach, standardize enrollment/renewal, and review decisions not to renew orders.
- Implement measures to better identify and enhance care for individuals with co-occurring mental health & substance abuse disorders.

Adolescent System of Care

- Create Family Care Coordinators for justice-involved youth, to assist families in navigating mental health system.
- Improve OCFS discharge planning and aftercare services.
- Ensure information follows adolescents through transition points in the juvenile justice system.
- Enhance clinical interventions for seriously emotionally disturbed (SED) youth in DJJ or OCFS custody.

Adult Criminal Justice System

- Pilot a program for sharing information between the criminal justice and mental health treatment systems.
- Increase information available to NYPD dispatch to allow for more specialized responses for incidents involving individuals who may have a mental illness.
- Pilot a NYC alternative-to-detention program to allow eligible individuals to be supervised within the community while receiving treatment and services.
- Create a dedicated mental health unit at the NYC Department of Probation (DOP) to assist eligible probationers in receiving appropriate mental health treatment services. Introduce brief mental health screening in pre-sentence investigations.
- Introduce post-arraignment mental health screening in the Bronx Criminal Court to identify and link appropriate individuals.
- Expand new mental health courts and alternatives-to-incarceration programs providing court monitored mental health treatment.
- Improved training for 911 call takers and dispatchers to better elicit information about whether an incident involves a person with mental illness.
- Incorporate best practices into NYPD's training curriculum for dealing with incidents involving "emotionally disturbed persons."
- Sponsor a Statewide Mental Health-Law Enforcement Summit to enhance relationships between police and mental health professionals.

II. Introduction

In the wake of several recent, highly publicized violent incidents involving individuals with mental illness, officials in New York State (NYS) and New York City (NYC) convened a panel to examine these cases, consider opinions of experts and recommend actions to improve services and promote the safety of all New Yorkers.

The NYS/NYC Mental Health and Criminal Justice Panel (Panel) was convened by NYS Deputy Secretary for Health and Human Services Dennis Whalen and NYC Deputy Mayor for Health and Human Services Linda Gibbs. The Panel was co-chaired by NYS Office of Mental Health Commissioner Michael Hogan, NYS Division of Criminal Justice Services Commissioner Denise O'Donnell, NYC Deputy Mayor Linda Gibbs and NYC Criminal Justice Coordinator John Feinblatt. The Adolescent workgroup was co-chaired by NYS Office of Children and Family Services Commissioner Gladys Carrión and NYC Family Services Coordinator Ronald Richter. Members of the Panel included top State and City officials in mental health, addiction, criminal justice and adolescent services.¹⁵

The Panel's work was informed by a review of cases involving individuals with serious mental illnesses and violent behavior, some of which involved engagement with law enforcement officials, as well as a broader assessment of how New York's mental health and justice systems respond to adults and adolescents with serious mental illnesses. The Panel also consulted with national experts in mental health, violence, and the interaction between individuals with mental illness and the criminal justice system.

The Panel focused on opportunities to improve services for the subset of individuals with serious mental illness who are at risk of poor treatment outcomes, involvement with the justice system, and potential acts of violence. The Panel noted that the vast majority of individuals with mental illnesses are not violent,¹⁶ that mental illness is not a major driver of violent crime,¹⁷ and that people with mental health needs are far more likely to be victims than perpetrators of violence.¹⁸ At the same time, research does suggest that the risk of violence is significantly increased among individuals with co-occurring mental health and substance use disorders, especially for those who do not receive coordinated, high quality treatment. Providing effective mental health care for these individuals is critical, as it may significantly mitigate the risk of violence. Research demonstrates that individuals with mental illness engaged in regular treatment are no more likely to commit acts of violence than the general population, and are

Notes

15 See Appendix A for Panel membership list.

16 Ibid Monahan 1992

17 Ibid Swanson, et al. 2002; Ibid Steadman 1998

18 Ibid Pandiani et al. 2007

considerably less likely to commit violent acts than those who could benefit from and are not engaged in appropriate mental health treatment.¹⁹

This report, which reflects collaboration between State and City officials, summarizes the Panel's findings and recommendations. Through ongoing collaboration, and the involvement of the community, the Panel believes that essential improvements in the engagement and care of people with mental illnesses can be achieved, thereby benefiting the safety and well-being of both these individuals and the community.

Notes

¹⁹ Ibid Monahan et al. 2001; Ibid Torrey et al. 2007

III. Background on New York State’s Mental Health and Criminal Justice Systems

Mental illness is prevalent and often untreated or poorly treated. In the United States, 50% of individuals will experience a mental disorder some time in their lifetime,²⁰ and more than 20% will be affected annually²¹; 3-5% of adults and children will have a mental illness severe enough to cause major disability. Yet fewer than half of the people who experience a mental illness will receive care, according to recent studies, and only half of the care by mental health specialists and far less of the mental health treatment in the general health system is clinically adequate. Delays in receiving care are also common - the average age of onset for a mental disorder is 14 years, while the average lag from first symptoms to receiving care is 9 years.²²

Individuals with mental illness in NYS face challenges that are similar to, and sometimes more profound than, those found elsewhere in the United States. While dedicated clinicians and programs provide high quality care to hundreds of thousands of New Yorkers with mental illness every year, NYS’ mental health system is exceptionally large, and it is therefore quite difficult to track and facilitate access to quality care for those most in need. Families provide much of the needed support for relatives with mental illness, yet they frequently struggle in isolation from other caregivers.

To live successfully in the community, individuals with serious mental illnesses, with or without involvement with the criminal justice system, need effective treatment for their illnesses and a range of recovery-based services. For many individuals, effective counseling and/or medication provided in clinics can be sufficient. For individuals with more complex conditions, greater disability and multiple challenges, well-coordinated care that knits the pieces together is essential. In addition to counseling and medication treatment, this care may include housing (with or without supervision), rehabilitation and employment supports, careful monitoring, and well-charted “hand-offs” if hospitalization is necessary.

Furthermore, people with mental and substance use disorders cannot recover and lead productive lives in the community without safe and reliable housing, and employment or other meaningful social roles. Yet finding suitable housing is particularly difficult because of New

Notes

20 RC Kessler, PA Berglund, O Demler, R Jin, EE Walters EE. *Lifetime prevalence and age of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R)*. Archives of General Psychiatry. 2005; Vol. 62: pp. 593-602.

21 PS Wang, M Lane, M Olfson, HA Pincus, KB Wells, RC Kessler. *Twelve-Month Use of Mental Health Services in the United States Results From the National Co morbidity Survey Replication*. Archives of General Psychiatry. 2005; Vol. 62: pp. 629-640.

22 Ibid Kessler et al. 2005

York's high housing costs coupled with large numbers of low-income people with disabilities and numerous obstacles to competitive employment.

New York's law enforcement, courts and corrections agencies also struggle to meet the needs of the tens of thousands of adults with serious mental illness who touch the City and State criminal justice systems each year. Similarly, the juvenile justice system has focused increasing attention in recent years on the high incidence of mental disorders - including serious emotional disturbance (SED) - among justice-involved youth.

The following sections provide background on how the mental health system in New York is configured and how the criminal and juvenile justice systems interface with and respond to individuals with mental illness.

A. New York State's Mental Health System

The NYS Office of Mental Health (OMH) funds, licenses and operates a statewide system of care for people with mental illness, especially adults with serious mental illness and children with SED - those individuals with the most difficult and complex conditions.

In NYC, the Department of Health and Mental Hygiene (DOHMH) also administers this safety net. DOHMH is responsible for, among other things, planning and contracting for mental health services; its responsibilities also include directing and operating the Assisted Outpatient Treatment (AOT) program and administering a system to facilitate the removal of individuals with mental illness under an AOT order who may be a danger to themselves or others to emergency rooms for evaluation for hospital admission.

The public mental health system in New York State includes OMH, DOHMH and other local government units, licensed and unlicensed programs, inpatient hospital and outpatient and community-based agencies that serve more than 600,000 New Yorkers annually. Multiple State, City and county agencies share responsibility for those individuals receiving services and the 2500+ community-based mental health programs and providers of rehabilitative services and housing who care for them. OMH also operates the nation's largest network of state-operated inpatient facilities for children, adults and forensic clients.

Like other states, but to a greater degree, NYS has turned to Medicaid to finance mental health care, and the Medicaid program is now the State's largest payer of mental health services. While the State benefits from this approach by securing federal financial support for mental health services, using Medicaid funding to this degree has its drawbacks, including the fact that many people do not qualify for the program and essential services such as employment and housing are not covered.

B. NYS' Assisted Outpatient Treatment (AOT) and Inpatient Commitment Laws

In 1999, NYS enacted legislation that authorizes courts to order AOT for certain individuals with mental illness who are unlikely to survive safely in the community without supervision.²³ Commonly referred to as “Kendra’s Law,” the AOT program focuses on individuals whose non-adherence to treatment has resulted in repeated hospitalization or has led to threats or acts of violence, and who would likely deteriorate without AOT. Passage of the AOT statute was accompanied by significant funds to expand case management and other services for individuals on AOT.

An AOT order is issued by a court and requires an individual to engage in outpatient treatment with an assigned provider - such as case management services, a clinic, or assertive community treatment (ACT) - that provides a variety of treatments such as individual or group therapy, substance abuse treatment, and medication monitoring. Local counties and NYC have the responsibility for seeking court approval for AOT orders and monitoring the services provided. A court may renew an AOT order and may determine the length of renewal. AOT teams may choose not to petition for renewal of an order if the person’s condition is improved-or if the person is considered not to be benefiting from AOT. Even after an order has ended, a person can still receive services from the team of professionals originally assigned to the individual, but the AOT program would not monitor either the services or the individual.

AOT has proven to be effective for many people who receive these services.²⁴ OMH has engaged an independent research team to evaluate the program, which should help clarify whether its effectiveness is attributable to better access to services for individuals on an AOT order or to the mandatory nature of the services; that report is due in April 2009.

With respect to non-emergency involuntary inpatient commitment, NYS has one of the broadest involuntary commitment laws in the United States.²⁵ While many states require that there be a finding of “imminent” or “immediate” danger to self or others in order to involuntarily commit an individual to a psychiatric hospital, NYS’ standard for non-emergency, involuntary hospitalizations does not require a finding of “imminent” or “immediate” danger.

C. New York State’s Criminal and Juvenile Justice Systems

Each year, thousands of people with serious mental illness touch the State and City criminal justice systems. While the inmate census in NYS correctional facilities has remained stable over the

Notes

23 NYS Mental Hygiene Law (MHL) §9.60

24 NYS Office of Mental Health (March 2005). *Kendra’s law: Final report on the status of assisted outpatient treatment*. New York: Office of Mental Health.

25 NYS Mental Hygiene Law (MHL) §9.27

past three years at approximately 63,000 inmates, the percentage of inmates diagnosed with mental health needs has increased by 15% in that same period. Approximately 8,500 inmates, or 13.5% of the State's inmate population, receive mental health services every day.

In NYC, a study of individuals arrested in Brooklyn found that 18% had a serious mental illness²⁶ and, according to DOHMH, on any given day there are roughly 2,500 individuals with mental health problems in the City's jails. Of these, approximately 800 are housed in dedicated mental observation units. NYC police, who respond to 4.5 million calls annually, receive nearly 90,000 calls every year regarding an "emotionally disturbed person" ("EDP") - though only approximately 1% of these calls lead to an arrest.

Studies indicate that youth in the juvenile justice system are more likely to be diagnosed with SED (20%) than youth in the general population (9-13%).²⁷ The NYS Office of Children and Family Services (OCFS) found that in 2003, 53% of young people entering placement facilities needed mental health services, and the NYC Department of Juvenile Justice (DJJ) reported that 67% of detained youth received mental health services in 2007.

NYC and NYS law enforcement, courts and corrections agencies struggle to meet the needs of these individuals. Over the past decade, NYS' criminal justice system, in collaboration with the Office of Court Administration, has developed an increasing network of mental health courts²⁸ and alternative-to-incarceration programs that link offenders to court-monitored mental health treatment, often in lieu of jail or prison; and NYS has more than doubled its corrections-based mental health staff. Similarly, City and State officials have responded in recent years to the high incidence of mental disorders among youth in the juvenile justice system with new programs, services, and supports.

Police agencies throughout the State, too, recognize the need to train officers to respond appropriately to individuals deemed to be "EDPs." The State has mandated a 14-hour mental health training curriculum for new police recruits around the state. This has been supplemented by increasing amounts of in-service training for veteran officers and specialized training for officers who respond to "EDP" calls, including use of the Crisis Intervention Team (CIT) model.

Notes

26 N Broner, SS Lamon, DW Mayrl, and MG Karopkin. *Arrested adults awaiting arraignment: Mental health, substance abuse, and criminal justice characteristics and needs*. Fordham Urban Law Journal. 2003: Vol. 30(2), pp. 663-721.

27 J Cocozza and K. Skowyra. *Youth with Mental Health Disorders: Issues and Emerging Responses*. Office of Juvenile Justice and Delinquency Prevention Journal. 2000; 7(1): pp. 3-13, available at www.ncmhjj.com/pdfs/publications/Youth_with_Mental_Health_Disorders.pdf.; J Koppelman. *Mental health and juvenile justice: Moving toward more effective systems of care*. 2005; Washington, DC: National Health Policy Forum.

28 See Appendix D.

IV. Findings and Recommendations

As noted previously, in developing its findings and recommendations, Panel members reviewed several cases involving high-need adults with serious mental illnesses and adolescents with serious emotional disturbance (SED) who came into contact with the criminal and juvenile justice systems.²⁹ The members of the Panel also called upon their own expertise and experience to conduct a broad assessment of the mental health and justice systems, and obtained input from national experts about the state of the art in mental health treatment, risk assessment and the intersection of mental health and criminal justice.

National experts with whom the Panel consulted point to research indicating that people with mental illness receiving appropriate care commit violent acts at a rate slightly below that of the general population and account for a very small proportion of serious crimes.³⁰

The research also suggests, however, that violence among people with serious mental illness who abuse alcohol or drugs is a real risk, and that this risk is compounded if they fail to get treatment or receive inadequate care.^{31,32} Thus, the Panel concluded that the best way to improve outcomes and safety is to take concrete steps to provide people enrolled in care with appropriate, coordinated services.

Panel members identified many ways in which both the mental health and criminal justice systems could improve their ability to help adults and adolescents with serious mental illnesses. The challenges, which were identified through the case reviews and the Panel's broader assessment of the mental health and criminal justice system, fall into four broad categories: (1) Inconsistencies in quality of care within the mental health treatment system; (2) Poor coordination, fragmented oversight and lack of accountability in the mental health system; (3) Limited capacity to share information within and between the mental health and criminal or juvenile justice systems; and (4) Insufficient training, supports, and tools to identify and engage individuals with mental illnesses in the criminal justice and juvenile justice systems.

Specifically, the cases examined by the Panel revealed poor accountability and weak integration or communication among mental health, substance abuse and correctional services, even in instances where individuals were assigned the highest intensity community-based services, such as ACT (Assertive Community Treatment) - a proven community-based intensive treatment for those with complex needs and difficulty engaging in traditional treatment. Further-

Notes

²⁹ To comply with State and federal laws regulating the disclosure of personal health information, this Report does not include identifying information about any particular case.

³⁰ Ibid Monahan 1992

³¹ Ibid Monahan 2001

³² Ibid Torrey 2007.

more, individuals routinely accessed inpatient and emergency department hospital care, highly limited and expensive resources, rather than community-based services.

Though families are often critical sources of information, important aides in coordinating and overseeing care, and vital supports in the demanding work of recovery and treatment, the cases revealed that family members were not effectively engaged in the treatment process.

Limited capacity to share information within and between the mental health and criminal and juvenile systems was also evident in the cases the Panel reviewed. Information sharing may have helped both clinicians and criminal justice professionals make more informed and better decisions. The Panel's review also included police training and the need for police to have access to information that can help them respond more effectively to encounters with individuals with serious mental illness. The Panel also noted that the criminal justice system as a whole has limited ability to identify individuals who might benefit from mental health treatment and services as an alternative to traditional criminal justice processing.

The cases revealed problems and challenges common to many individuals with mental illnesses, including lack of safe and affordable housing and difficulty securing employment or other meaningful social roles. In discussing these broader challenges and their impact on the cases reviewed, the Panel recognized many efforts currently underway to address these issues, though these issues were not the focus of the Panel's work.

Instead, the Panel focused on core problems in the mental health and criminal and juvenile justice systems regarding the care and treatment of people with complex and serious mental health needs. Because the Panel focused on areas where there was room for improvement, this report does not detail the extent to which thousands of mental health and criminal justice professionals are dedicated to ensuring both public safety and the well being of individuals with mental illness.

Finding: Poor coordination, fragmented oversight and lack of accountability in the mental health treatment system

In the cases it examined, the Panel saw tragic outcomes resulting from fragmented care and a failure to detect and respond to signs of inadequate care, deterioration in mental health, and increasing signs of potential violence.

Coordination between service providers is a critical component of effective treatment, yet the Panel noted that mental health providers often act in parallel, rather than in concert. Further, individuals who need high-intensity services do not always have a care provider who is primarily responsible and accountable for all aspects of the individual's care and with whom the in-

dividual is in regular communication. Such a provider takes action when care is failing or when the individual shows signs of clinical deterioration or disengagement from care.

The Panel also noted that individuals with co-occurring substance use and mental illness lack access to and information about treatment for co-occurring substance use and mental illness, and too few providers offer coordinated, evidenced-based integrated care for these conditions, severely limiting an individual's capacity to recover.

The Panel observed that care is often provided to individuals by multiple agencies, and that these agencies too often do not effectively communicate with other treating agencies, hospitals or involved families. In such cases, care is often poorly coordinated and information gaps often inhibit the ability to provide needed services effectively. In addition, there are overlapping responsibilities and a lack of accountability for monitoring either the individuals receiving intensive services or the providers that treat them.

The same lack of communication, coordination and accountability is evident in the care provided to adolescents with SED in the juvenile justice system, especially when youth transition in and out of the system. Care providers do not routinely communicate with one another and review each others' records so that the youth's treatment plan reflects prior treatment successes or failures. Often, there is also inadequate coordination among the NYC Department of Probation (DOP), the Department of Juvenile Justice (DJJ), and OCFS, and even within OCFS facilities, as well as with community-based aftercare providers. Furthermore, the Panel reviewed evidence that suggested that families with children in the juvenile justice system are not consistently engaged in their child's care, including in the creation and realization of treatment and discharge plans. Finally, discharge plans for those aging out of the OCFS system do not always provide for consistent aftercare services that are essential for successful re-entry into families and the community.

Recommendations

Establish Care Monitoring Teams for high-intensity treatment providers

OMH and DOHMH should jointly establish and administer Mental Health Care Monitoring Teams (CMTs) in NYC, potentially at the borough level, to be directly accountable for monitoring the care of high-need individuals and the programs that serve them, such as ACT and ICM. Although the primary responsibility for coordinating care and communicating with different treatment providers and families should rest with an individual's primary provider and other providers on the team (as detailed in the Standards of Care section below), the CMTs would play an important role in facilitating coordinated care and improving services. Finally, because problems with engagement and retention of people with serious mental illness at times may relate to problems with how the client is approached rather than to how much a provider is trying, OMH should explore peer based approaches and efforts that encompass goals that may

be more primary to consumers such as assistance with housing and entitlements and recovery oriented treatment plans.

Create a database to track the mental health care provided to high-need adults

CMTs should have a database of information concerning the care provided to high-need individuals in the public mental health system, initially populated with existing data - including Medicaid claims, with Federal approval - to monitor the care provided to high-need individuals and high-intensity programs. This monitoring would increase the likelihood that interruptions in care or escalating need for care are identified and addressed. This database could also assist in improving service delivery to those in emergency or crisis situations and to inform decisions made by mental health professionals that evaluate or treat individuals. Finally, the database can help individuals receive proper treatment once they come into contact with the criminal justice system (see recommendations for an information sharing pilot in the following section).

Implement Family Care Coordinators for justice-involved youth

Adolescents with SED in the juvenile justice system should be assigned a Family Care Coordinator, an individual with first-hand experience with the child or adolescent mental health system, who would follow that youth from entrance into the justice system until the youth is discharged. The Coordinator would help families navigate the juvenile justice, mental health and other service systems; facilitate information sharing among providers and families; and arrange for family case conferences that assist youth and their families in getting care and support, especially during transitions. Coordinators would use their own experiences negotiating the mental health system and other systems to empower families to advocate for their own needs. The Coordinator would also arrange “circles of support” - facilitated meetings where individuals who share similar challenges gather to provide mutual support - for families of youth with SED who are in the custody of DJJ or OCFS.

Improve OCFS discharge planning and aftercare services

Discharge planning should begin within 30 days of admission to an OCFS facility and should engage the youth, family members, and community providers. In addition, adolescents should be assigned community service workers to facilitate discharge planning and aftercare, in collaboration with Family Care Coordinators.

As youths are discharged from OCFS-provided services, referrals should be made (and confirmed) to specific community-based mental health services such as waiver programs, outpatient clinics, day treatment programs, and intensive mental health programs. Community

service workers and Family Care Coordinators should connect youth approaching age 18 to appropriate adult mental health services. In addition, AOT petitions should be initiated for youth who are 18 or older who do not voluntarily engage in treatment and who meet AOT eligibility criteria.

Implement recommendations of the OMH/OASAS Task Force on Co-Occurring Disorders

OMH and the NYS Office of Alcoholism and Substance Abuse Services (OASAS) are overseeing implementation of recommendations from a 2007 Task Force on Co-Occurring Disorders that was convened to make improvements in the care for this population. The Panel supports the Task Force recommendations as important steps to expand access to integrated treatment for co-occurring mental health and substance use disorders. The recommendations include the issuance of OMH/OASAS advisory guidelines that call for screening for both mental health and substance use disorders in all clinics that treat these disorders; training in screening and evidence-based treatments to community-based providers; outreach to mental health and substance use treatment providers to help them understand the regulatory opportunities for providing integrated co-occurring disorder care; reimbursement for evidence based integrated treatment; and the promotion of local innovation in the treatment of co-occurring disorders.³³

Finding: Inconsistencies in quality of care within the mental health treatment system

In reviewing the cases, the Panel noted that while individuals with a serious mental illness were often enrolled in clinic-based mental health care, treatment providers did not consistently follow widely accepted, but not explicitly stated, standards of clinical care that describe quality care for recipients and their families. For example, good clinical practice and a body of literature on mental health and substance use treatment stress the need for thorough and timely psychiatric, substance use and medical evaluations. Good clinical practice also calls for assessing an individual's degree of dangerousness to self or others, engaging family and significant others as key partners and supports, and responding appropriately when individuals disengage from their established treatment plans, including medication. In addition, quality care is dependent on appropriate caseloads and supervision, especially of inexperienced professional staff.

With respect to AOT, the Panel reviewed evidence that suggests that individuals on AOT often do quite well while they are engaged in services, but access to and discharge from AOT is not sufficiently standardized or reviewed. For example, the Panel noted during the case reviews that while some individuals receive court-ordered services the individual and the provider are both

Notes

³³ See Appendix C for more information on the Task Force and its recommendations

engaged in the treatment process. However, when the order is allowed to expire, there are failures to provide follow-up care, resulting in lapses in care.

In the course of its work, the Panel also recognized the value of reviewing representative incidents and “near misses” to identify failures in the provision of care as well as quality improvement steps that can be taken to mitigate future incidents. Yet New York has no protocol for conducting regular, system-level reviews of critical incidents with information from multiple city and state agencies and community providers concerning individuals with mental illnesses for quality assurance purposes.

Recommendations

Conduct critical incident reviews

NYS should enact legislation to establish a protocol, similar to that employed by OCFS Child Fatality Review Teams, which will allow OMH officials to collaborate with local governments to conduct timely reviews of critical incidents involving the care of individuals with serious mental illnesses. These case-specific, system-level reviews should aim to reduce care errors and improve the safety of the public as well as individuals who need mental health care. This critical incident review process will serve as an ongoing quality assurance mechanism.³⁴

Issue and monitor the use of standards of care for mental health clinics

OMH, in consultation with DOHMH, should develop, issue, conduct training on and monitor the use of standards of care for all licensed adult mental health clinics. The standards should be drawn from a body of clinical knowledge, training and professional publications and address issues such as initial evaluation, coordination with case management and other services, ongoing risk assessment, and changing treatment plans when an individual’s mental health deteriorates or he or she is not engaged in care. The standards should also provide clear guidance about appropriate caseload levels and communication with other providers, families and other caregivers. These elements of quality care are more explicitly described for other mental health services but not for clinics, where most people receive care and where staff members are positioned to identify and intervene earlier in the course of treatment with high-need individuals.

Because quality care for individuals with serious mental illness involves a thorough understanding of and focused response for the management of identified risk factors, a critical component of the Standards of Care for individuals with mental illness is conducting initial and ongoing risk assessments. Risk assessment is a sequential process that begins with obtaining

Notes

34 Optional: See Appendix ___ for draft legislation

information from the individual and collateral sources regarding any history of violent thoughts or behavior and includes identification of factors such as the presence of a co-occurring substance use disorder that increases risk. An assessment and recognition of the factors that influence risk should be used to guide the development of an individualized plan, prepared jointly by the clinician and the individual. After treatment begins, risk assessments should be performed at various junctures in the treatment process, including discharge from treatment or when there are indications that the treatment plan is failing.

To monitor that these standards are implemented in the course of treatment, OMH and DOHMH should incorporate a review of adherence to the standards into licensing and programmatic reviews. The Panel notes that previously planned increases in reimbursement for clinic care could be introduced to coincide with the issuance of these standards.

Implement systemic improvements to AOT

The Panel chose not to recommend any statutory changes to AOT while the program is being examined, although some improvements can be made in advance of the study's release, specifically regarding AOT renewals. The Panel recommends that DOHMH continue its increased effort to conduct outreach to hospitals to improve the rate of appropriate referrals, clarify and standardize AOT enrollment and renewal criteria, and establish an independent clinical review of decisions not to accept or renew AOT orders. OMH and DOHMH should work collaboratively with the Office of Court Administration regarding judicial assignments for AOT cases and to provide training to those involved with individuals on AOT.

Finding: Limited capacity to share information within and between the mental health and criminal and juvenile justice systems

The Panel reviewed evidence that suggests that information related to an individual's treatment often is not transmitted, shared, or made available between care providers, leading to poor care coordination and lack of continuity of care. For example, critical information is often not shared during transitions (e.g., from hospital to clinic) or between providers treating the same person. Similarly, important treatment and educational records do not typically follow adolescents through the juvenile justice system and when youths transition into and out of that system. The Panel also noted that clinicians in the emergency departments often lack prior treatment records that would help them to make accurate diagnoses and determine appropriate treatments. Complicating matters further, available mental health data is not organized in a way that enables effective oversight and receipt of needed care.

Pursuant to the Standards of Care outlined previously, important aspects of individuals' previous treatment as well as relevant information from families can and should be transmitted be-

tween clinical programs treating the same individual - especially hospitals, emergency departments, and community-based mental health and substance use treatment programs - to the fullest extent allowable by law. Yet the Panel noted that consumers, providers, and families are often unsure about what can be appropriately disclosed to facilitate the provision of good care.

The Panel noted that emergency 911 call takers statewide do not generally elicit information about whether mental illness is relevant to a 911 call. This information could be used to determine when to deploy specialized resources, such as NYPD's Emergency Service Unit, which has been specifically trained to respond to such calls.

More fundamentally, the Panel discovered that there is very limited capacity to share information between the mental health and criminal justice systems, even when information could help ensure continuity of care and help justice officials determine when an individual may be appropriate for a treatment-based alternative. In practice, this has been difficult primarily for three reasons:

- ◆ Privacy laws intended to safeguard personal health information effectively prohibit disclosure to entities other than treatment providers, absent an individual's consent to disclose such information.
- ◆ The criminal justice system lacks a sufficient number of built-in mechanisms to routinely screen for mental illness and elicit defendants' consent for the sharing of relevant mental health information.
- ◆ Criminal justice and mental health data systems lack the ability to facilitate the cross sharing of information, regardless of whether that information is publicly available or made available through consent.

In its exploration of this issue, the Panel considered recommending statutory changes to permit limited mental health information sharing with the criminal justice system without the consent of the involved individual. Such legislation would recognize that the criminal justice system can serve as a critical gateway into treatment, since it is often a point of contact for individuals whose mental health is deteriorating because of inadequate, or lack of, treatment.

Several concerns were raised about this option, however, including that information sharing could potentially stigmatize individuals with mental illness and lead to punitive criminal justice system responses, raise privacy concerns, significantly alter current practice, and require consultation with and possible approval from the Federal government (as it relates to appropriate uses of Medicaid data). The State would also have to consult extensively with mental health and criminal justice advocates to draft such legislation.

Given the divergent views on this issue, and as an alternative to recommending statutory changes at this time, the Panel recommends that New York City pursue several pilot projects (detailed in this and the following section), designed to identify individuals with mental illnesses

in the criminal justice system who might be diverted from the criminal justice system into long-term services. The results of these programs should be closely monitored to determine if the information-sharing gap can be bridged without statutory changes.

Recommendations

Pilot a program for sharing information between the criminal justice and mental health treatment systems

NYS and NYC should pilot an effort to identify individuals with serious mental illness who have become involved in the justice system in order to determine whether they may be appropriate for mental health treatment-based alternatives. Specifically, as part of the CMT's responsibilities (discussed previously), a member of the team would notify community mental health providers and case managers that an individual has been arrested-facilitating continuity of care, including jail-based treatment and discharge planning. The CMT liaison would also facilitate eliciting consent to share otherwise confidential information about mental health history and status with criminal justice professionals for purposes of considering diversion to treatment-based alternatives.

Increase information available to the NYPD

The NYPD should establish flags within its 911 database for locations that might trigger the dispatch of the specially trained Emergency Service Unit, including locations that have been the subject of prior "EDP" calls and locations of housing with supports for individuals with mental illness.

Include information sharing protocols in the standard of care guidelines

The standards of care that the Panel recommended previously should include clear guidance for providers regarding appropriate and effective communication with other service providers, families and other caregivers.

Enable information follows adolescents through transition points in the juvenile justice system

NYC DOP, DJJ and OCFS should establish policies to seek consent from parents to share otherwise confidential information - such as the results of mental health screening and assessment - to help determine how best to meet the service needs of adolescents as they move through detention, placement, and aftercare.

Increase monitoring of individuals determined to be not responsible for criminal conduct due to “mental disease or defect”

Every year, approximately 30 individuals across NYS are determined to be not responsible for criminal conduct due to “mental disease or defect” and are committed to the custody, or subject to the jurisdiction, of either OMH or the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD).³⁵ DCJS should provide these agencies with real-time notification of arrests of such individuals who are in the community and subject to Court Orders of Conditions.

Finding: Insufficient training, supports and tools to identify and engage individuals with mental illnesses in the criminal and juvenile justice systems

As discussed in the previous section, court officials have limited tools with which to access information that could help them assess whether a defendant has a mental illness. This information can help justice professionals determine whether a defendant is an appropriate candidate for a short voluntary treatment program, an alternative-to-detention or -incarceration program, or specialized services while under probation supervision. The Panel also noted that access to such treatment-based programs and services is expanding but still limited in some areas.

The Panel discovered that emergency call takers and dispatchers are not trained to routinely elicit information about whether mental illness is relevant to a 911 call. This may result in police officers failing to notify and activate specialized mental health care response teams. Even when such information is available, the Panel found that police departments throughout the state do not have clear protocols about how best to respond to EDP calls or link these individuals to treatment.

Recommendations

Pilot a NYC alternative-to-detention program

NYC should pilot a new alternative-to-detention (ATD) program with a special mental health track, designed to provide assessment, case management, supervision, and community-based treatment. The ATD program should target defendants who are likely to be detained in jail while their case is pending and who do not pose a high risk of either recidivism or flight. Such a program will also assist judges in making appropriate sentencing decisions by helping them assess whether an individual is an appropriate candidate for a treatment-based alternative in lieu of a jail or prison sentence. Piloting this program on a smaller scale will allow NYC to determine whether participation in a court-monitored community supervision program can reduce the frequency of arrest among offenders who have a mental illness.

Create a dedicated mental health unit within the NYC Department of Probation (DOP)

NYC DOP should create a dedicated mental health unit of probation officers with reduced caseloads who would establish relationships with their probationers' mental health providers, assist probationers in receiving appropriate services, and provide closer supervision. These officers should receive special training in handling high risk, seriously mentally ill probationers. To ensure that this unit has ongoing support, DOHMH should establish an official liaison to DOP, to assist and advise probation officers about the most appropriate community treatment settings for their probationers, provide ongoing trainings, and serve as a point of reference for questions about the mental health care and substance abuse treatment systems.

Include validated mental health screening in pre-sentence investigations

Pre-sentence investigations conducted by NYC DOP should include a brief, validated mental health screen, to allow DOP to alert judges about defendants who may need a deeper clinical assessment and may benefit from treatment-based alternatives or special probation conditions. The screen should be piloted in the Bronx to test its efficacy in identifying offenders with mental illness and promoting linkages to treatment.

Introduce mental health screening in Criminal Court for individuals sentenced to community-based sanctions

NYC should expand post-arraignment mental health screening in the Bronx Criminal Court to identify appropriate individuals, sentenced to brief community-based programs, for mental health assessments, intensive engagement, and voluntary case management as an alternative to the original court mandate. This pilot would help evaluate whether brief mandatory engagement efforts promote longer-term participation in mental health services.

Expand new mental health courts and alternatives-to-incarceration

The State should open mental health courts in seven additional counties during the coming year. NYS and NYC should also expand the number of alternative-to-incarceration programs that link offenders to court-monitored mental health treatment as an alternative to traditional case processing.³⁶

Notes

³⁶ See Appendix D for more information on mental health courts in NYS.

Improve training for 911 call takers and dispatchers

NYS should create and refer to the NYS 911 Board, which is responsible for promulgating 911 standards, a training protocol for 911 dispatchers to elicit information about whether a person involved in an incident has a history of mental illness.

Sponsor a Statewide Mental Health-Law Enforcement Summit

NYS should sponsor a Mental Health-Law Enforcement Summit to enhance the relationships between law enforcement and the mental health community statewide. Through the assistance of a facilitator, each participating jurisdiction should provide a preliminary Action Plan at the close of the summit, developed together by law enforcement and the local mental health authority [A1] in each respective jurisdiction. DCJS along with the facilitator will follow up with the jurisdictions to assist in the implementations of these Action Plans.

Continue on-going review of best practices for dealing with “EDP” incidents in NYPD’s training curriculum

NYC’s Project LINK—an ongoing NYPD and DOHMH effort that includes mental health professionals, consumers, advocates and researchers—should continue to review NYPD’s training curriculum so that it reflects current best practices in law enforcement training for dealing with “EDP” incidents.

Enhance clinical interventions for youth with SED in DJJ or OCFS custody

DJJ and OCFS should incorporate clinical interventions into its systems through several steps, including 1) expansion of DJJ’s Collaborative Family Initiative to provide community-based treatment options in lieu of further detention and/or placement with the State; 2) OCFS administration of a Voice-Diagnostic Interview Schedule for Children (V-DISC) and a trauma assessment instrument upon a youth’s entry into care; 3) the use of evidence or consensus-based treatments at OCFS facilities; and 4) a three-year OCFS phase in of the Sanctuary model, which provides a safe and therapeutic environment for youth and staff.

V. Conclusion

The recommendations presented in this report can improve mental health services and criminal justice interactions for individuals with mental illnesses, especially for high-need populations, and enhance the safety of these individuals and the public. However, it is important to recognize that even a perfect system would not be able to predict or prevent every violent incident involving a person with mental illness. Even with improved information sharing, there are substantial limitations to the data that exists and that can be shared. For example, there are confidentiality concerns, reporting lags, data quality issues, and limited information on individuals who are not served by public systems of care. Furthermore, even with accurate and timely information, the tools and existing services for intervention are often limited. A significant number of people with serious mental illness may refuse - and have a right to refuse - high-intensity community-based services. In spite of these limitations, the Panel is confident that with the implementation of the recommendations presented in the report, and the ongoing collaboration between State and City officials and the involvement of the community, public safety and the quality of care for persons with mental illnesses can be improved.

APPENDIX A: Panel Membership

Co-Chairs:

John Feinblatt, NYC Criminal Justice Coordinator

Linda Gibbs, NYC Deputy Mayor for Health & Human Services

Michael F. Hogan, Ph.D., Commissioner, NYS Office of Mental Health

Denise O'Donnell, Commissioner, NYS Division of Criminal Justice Services

Adolescent Workgroup Co-Chairs:

Gladys Carrión, Commissioner, NYS Office of Children and Family Services

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Panel and Workgroup Members:

Karen Friedman Agnifilo, General Counsel, Office of NYC Criminal Justice Coordinator

Nina Aledort, Assistant Commissioner for Program Services, NYC Department of Juvenile Justice

Anita Appel, L.C.S.W., Director, NYC Field Office, NYS Office of Mental Health

Joseph Baker, Assistant Deputy Secretary for Health and Human Services, Office of the NYS Governor

Scott Bloom, Director of School Mental Health Services for Office of School Health, NYC Department of Health and Mental Hygiene

Joyce Burrell, Deputy Commissioner, NYS Office of Children and Family Services

Chelsea Chaffee, Legislative Counsel, Office of NYC Criminal Justice Coordinator

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Rima Cohen, Director of Health and Social Services, Office of the NYC Mayor

Vaughn Crandall, Special Assistant, NYC Department of Probation and NYC Department of Correction

Colonel James L. Harney, Deputy Superintendent, New York Division of State Police

Myla Harrison, M.D., M.P.H., Assistant Commissioner for Child and Adolescent Services, Division of Mental Hygiene, NYC Department of Health and Mental Hygiene

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Rochelle Macer, Director of Mental Health, Policy and Planning in Office

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Robert Myers, Ph.D., Senior Deputy Commissioner, Director of Division of Adult Services, NYS Office of Mental Health

Pedro Perez, First Deputy Superintendent, NYS Police

Wendy Perlmutter, Deputy Family Services Coordinator, Office of the NYC Mayor

David A. Rosin, M.D., Executive Deputy Commissioner for Mental Hygiene Services, NYC Department of Health and Mental Hygiene

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Michael Seereiter, Program Director for Mental Hygiene Services, Office of the NYS Governor

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Michele Sviridoff, Deputy Coordinator for Research and Policy, Office of the NYC Criminal Justice Coordinator

Susan Thaler, Director of Children's Services, NYC Field Office, NYS Office of Mental Health

Erika Tullberg, Assistant Commissioner for Office of Clinical Policy, NYC Administration for Children's Services

Previn Warren, Advisor on Criminal Justice and Economic Opportunity, Office of NYC Mayor

Linda Wernikoff, Executive Director, Office of Special Education Initiatives, NYC Department of Education

Bernard Wilson, Manager of Shared Services Programs, NYS Division of Probation and Correctional Alternatives

APPENDIX B: Community Mental Health Incident Review Process

As noted in the report, the Panel recommends the creation of a collaborative, multi-agency quality review process to examine system-level problems in care. The broad delegations of authority given to the Commissioner of Mental Health under the Mental Hygiene Law could be invoked to establish his authority to convene such a group with other State and City agencies.

In addition, the State should pursue legislation to allow the Commissioner to establish multi-agency review panels to perform detailed, retrospective reviews of serious incidents or “near misses” that merit attention and may provide opportunities to prevent similar incidents from occurring in the future as well as opportunities to improve the care of people with mental illness in NYS. The Child Fatality Review Team statute in the Social Services Law may be a useful model that can be adapted to such an incident review. Following is a description of the two levels of reviews.

1. System-Level Review Process

Under current law, OMH should establish a collaborative process that includes State and City (or county) officials to review aggregate, systems-level data and make recommendations for actions that can be taken to improve the public mental health care system. Such a process should include consideration of the unique issues that arise when such individuals interact with the criminal justice system. The goals of this collaborative process will be to identify problems or gaps in service delivery systems and to identify needed systems changes to further improve individual and public safety.

The process should focus on improving the delivery and continuity of mental health care in the community, rather than on identifying deviations by a particular provider or individual from proper and accepted practices. However, if quality problems of particular programs are identified by the reviews, OMH is authorized under current law to take actions regarding the licensure of a particular provider and/or to refer the issue to other responsible parties to investigate and to take appropriate action.

2. Incident Review Process

NYS should seek passage of legislation that would establish a process to permit the Commissioner of the NYS Office of Mental Health (or designee) to convene an appropriate group of State and local officials, including those from mental health, criminal justice and other agencies, to review the circumstances and services surrounding a serious incident in the community involving a person with mental illness. Exercise of this convening authority would be prompted by events meeting certain pre-established criteria, such as when a person with a serious mental illness is harmed or causes harm to others, or becomes involved in a violent incident. Safeguards should be included to protect individual privacy and medical confidentiality, while at the same time enabling all parties to discuss the incident candidly and without fear that their discussions will become public and subject to discovery as part of court proceedings.

Such a statute should identify specific entities that would be authorized to be convened, but should indicate that the specific composition of a particular review would depend on the nature of the incident to be reviewed, including the location of the incident and the pertinent entities. There should be no permanent member except the Commissioner (or designee) as the convening authority, and participants should be selected to participate in the review of any given incident.

The intent of such incident reviews would be to identify problems or gaps in service delivery systems that could be addressed by corrective action. If quality problems concerning particular programs or individuals are identified based on such a review, OMH should refer the issue identified to the responsible parties to investigate and take appropriate action. In addition, if the review of a particular incident identifies non-performance by a particular organization or entity, the Commissioner (or designee) should have the ability to make such a finding and to call on the entity to take corrective action. This function underlines the importance of the ensuring the confidentiality and protecting from discovery the proceedings of this review process.

APPENDIX C: Co-Occurring Disorders

On June 29, 2007, Commissioners Michael Hogan (OMH) and Karen Carpenter-Palumbo (OASAS) convened a statewide Task Force charged with examining the ambulatory system of care overseen by OMH and OASAS and providing meaningful, measurable, and actionable recommendations that could be implemented in a timely manner to improve the care of people with co-occurring disorders.

In any given year, 2.5 million adults in the United States have a co-occurring serious mental illness and substance abuse disorder. The Table below presents the rate of co-occurring disorders for individuals served in the OMH and OASAS systems in 2003. Because OMH and OASAS programs have not been required to report or record more than one diagnosis per individual, the rates identified in the Table are presumed to reflect a significant under-estimate. Importantly, this Table also does not reflect the number of individuals with co-occurring disorders who are not seen in either service system - a number that the Task Force presumes is significant. Notably, 50 percent of individuals with co-occurring serious mental illness and substance use disorders receive no care; 45 percent receive poor care; and only about 5 percent receive evidence-based care.[M2]

Treatment-Based Prevalence Rates of Individuals with Co-occurring Disorders in NYS

	For Recipients Seen in the Mental Health System During One Week in 2003			For Admissions to the Substance Abuse System During the Year 2003**		
	Total Number	Number with SA Diagnosis or Disability	Rate	Total Number	Number with Mental Illness	Rate
Inpatient	14,076	3,814	.27	40,842	16,487	.40
Residential	24,165	8,140	.34	20,669	4,680	.22
Emergency	3,916	1,021	.26	N/A	N/A	N/A
Outpatient	115,142	17,631	.15	131,281	37,316	.28
Community Support	48,722	12,333	.25	N/A	N/A	N/A
Methadone Maint.	N/A	N/A	N/A	16,573	4,470	.27
Total*	171,363	30,714	.18	209,365	62,953	.30

* Because of overlap among programs, the total is less than the sum of program classes.

** OASAS Client Data System, April 2006

Commitments:

- To identify and eliminate limitations and barriers in accessing care.
- To recovery-oriented care that is hopeful and consumer-driven, and recognizes the essential role of family, relationships, community and employment in fostering the quality of life.
- To culturally and linguistically competent care.

Values: “Clients and Families Can....”

- Access care anywhere in OMH and OASAS-licensed programs.
- Receive one evaluation.
- Learn if they have a co-occurring disorder.
- Learn about treatment options.
- Collaborate in establishing a single treatment plan.
- Receive evidence or consensus-based treatment.
- Participate in recovery-oriented care.

The Task Force issued a set of clinical, regulatory and fiscal recommendations in September 2007—all of which were accepted by the Commissioners. An implementation group of both agencies, advised by a broad stakeholder group, was charged with accomplishing the following goals in the current calendar year:

- ◆ Advance clinical practices that integrate treatment for co-occurring disorders. OMH and OASAS will issue advisory guidelines—and offer training to implement these guidelines—that call for screening for both mental health and substance use disorders in all clinics that treat mental health and/or substance use disorders; standards for comprehensive assessment of individuals who screen positive for co-occurring disorders; and the use of evidence based-practices for treating co-occurring disorders.
- ◆ Educate providers about regulations affecting the provision of integrated treatment. OMH and OASAS will provide education and outreach to mental health and substance use treatment providers to help them understand the regulatory opportunities for providing integrated co-occurring disorder care.
- ◆ Allow reimbursement for evidence based integrated treatment. NYS DOH, OMH, and OASAS are pursuing reforms to Medicaid reimbursement for mental health and substance use services that will encourage the use of evidence-based treatment by qualified professionals for co-occurring disorders.
- ◆ Promote local innovation in the treatment of co-occurring disorders. OASAS and OMH will work with local governments and provider organizations who propose budget neutral local innovations that promote integrated treatment for co-occurring disorders.

The full Co-occurring Disorders Task Force Report is available at: http://www.omh.state.ny.us/omhweb/News/COD_TASK_FORCE_REPORT_FOR_RELEASE.html

APPENDIX D: Mental Health Courts in New York State

Mental health courts are specialized dockets that link defendants with mental illnesses to court-supervised, community-based treatment in lieu of traditional case processing.³⁷ These courts are based on the concepts of therapeutic jurisprudence and are often modeled on drug courts.³⁸ Therapeutic jurisprudence has its roots in the analysis of developments in mental health law. One of the leading architects of this concept, David Wexler, describes it as “the study of the role of the law as a therapeutic agent.” In practice, the application of therapeutic jurisprudence means incorporating both legal and therapeutic goals in response to violations of the law. Treatment is not prioritized over the requirements of the legal system, but rather integrated into its very processes. Thus, mental health courts are a prime example of therapeutic jurisprudence in action.³⁹

While the development of Mental Health Courts has been on a significant upswing since the first one was developed in 1997 (there are currently over 150 mental health courts nationally), there has been little research regarding their outcomes. In the 2006 Brooklyn Mental Health Court evaluation, participants demonstrated considerable improvements in areas of functioning; suggesting that additional research with a comparison group would find that involvement in this court positively impacts these outcomes.

Program Highlight: Bronx Mental Health Court

The Bronx Mental Health Court began formal operations in January 2001 and serves approximately 225 participants on any given day. Individuals with violent or non-violent felony charges and “serious and persistent” mental illnesses are eligible for participation, while misdemeanor defendants are considered on a case-by-case basis. More than 50 percent of participants have a major affective disorder (i.e., Bipolar Disorder, Major Depressive Disorder) and more than 33 percent present with psychotic symptoms upon admission to the program. The Bronx Mental Health Court is a post-plea court where participants plead guilty and have their sentences suspended for the duration of their treatment plan. Upon completion of the program, partici-

Notes

37 Council of State Governments, *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court*. New York, NY: Council of State Governments, 2008.

38 Watson, A., Hanrahan, P., Luchins, D., and Lurigio, A. (2001). *Mental Health Courts and the Complex Issue of Mentally Ill Offenders*. *Psychiatric Services*, 52, 477-481.

39 Council of State Governments. *A Guide to Mental Health Court Design and Implementation*. New York, NY: Council of State Governments, 2005.

pants are able to plead to a lesser charge. The Bronx Mental Health Court, which serves large Hispanic/Latino and African-American communities, emphasizes cultural competence. In 2006, The Bureau of Justice Assistance (BJA) designated the Bronx Felony Mental Health Court as one of five mental health courts in the USA that are learning sites to provide a peer support network for local and state officials interested in planning or improving a mental health court.

NYS Mental Health Courts

The New York State Unified Court System's Office of Court Administration (OCA) and the Center for Court Innovation (CCI) oversee and support mental health courts and other court-based diversion efforts across the state. OCA partners with other state agencies, as well as local criminal justice and human services organizations, in the development of new mental health courts as well as the continued operation of existing courts as an alternative to incarceration. Since 2006, OMH has provided funding for statewide training for mental health courts, as well as ongoing funding in support of the Brooklyn Mental Health Court. Since 2001, DPCA has funded the Treatment Alternatives for a Safer Community (TASC) team for the Bronx Felony Mental Health Court; last year, an additional contract was awarded to expand the program to the Queens Mental Health Court.

The Mental Health Court Connections (MHCC) program is designed to support counties that do not currently have a mental health court, but are interested in providing their communities with a meaningful response to the problems posed by defendants with mental illness in the criminal justice system. MHCC provides judges with the resources necessary to consider effective alternative-to-incarceration dispositions for those defendants whose mental illness contributed to their current criminal justice involvement and whose participation in MHCC will not create an increased risk to public safety. Three counties in NYS currently have a MHCC program: Albany County, Dutchess County and Rensselaer County.

OCA has identified eight additional jurisdictions that plan to develop either a mental health court or Mental Health Court Connection in 2008. These jurisdictions participated in the jointly sponsored OCA/OMH annual training session on May 5th and 6th in Syracuse, NY to begin the implementation process.

Operational Mental Health Courts in NYS

- | | |
|---|-------------------------------------|
| 1. Brooklyn Mental Health Court | 10. Niagara Mental Health Court |
| 2. Bronx Felony Mental Health Court | 11. Plattsburgh Mental Health Court |
| 3. Bronx Misdemeanor Mental Health Court | 12. Lackawanna Mental Health Court |
| 4. Queens Mental Health Court | 13. Utica Mental Health Court |
| 5. Queens Misdemeanor Mental Health Court | 14. Jamestown Mental Health Court |
| 6. Westchester Mental Health Court | 15. Montgomery Mental Health Court |
| 7. Suffolk Mental Health Court | 16. Lockport Mental Health Court |
| 8. Buffalo Mental Health Court | 17. Nassau Mental Health Court |
| 9. Rochester Mental Health Court | |

Jurisdictions Planning New Mental Health Court or MHCC

- | | |
|---|--|
| 1. Schenectady County Mental Health Court | 5. Middletown City Mental Health Court |
| 2. Auburn City Mental Health Court | 6. Putnam County Mental Health Court |
| 3. Olean City Mental Health Court | 7. White Plains City Mental Health Court |
| 4. Dunkirk City Mental Health Court | 8. Sullivan County Mental Health Court |

APPENDIX E: Guidelines for Mental Health Clinic Standards of Care and Sequential Screening of Risk for Violence

Mental Health Clinic Standards of Care: Interpretive Guidelines

Clinical standards of care are essential for access and quality of care for persons served by licensed clinics which provide mental health services. Such standards of care must be incorporated into the policies of these licensed clinics and consistently be applied throughout the State

We provide the following description of clinical standards for adult outpatient licensed clinics at this time as a result of recent reviews of care that revealed that too often these standards, which we believe to be fundamental to good care and a longstanding expectation of clinic services, may not be explicitly understood, regularly considered or consistently met. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements.

I. CLIENT CARE

A. Evaluation

By the time the client arrives for initial evaluation, a single clinician should be designated as responsible for ensuring that a comprehensive evaluation is completed in a timely manner. With the client's permission, the clinician should pursue other available sources of information, particularly family members, significant others and current and past providers of services. The evaluation should include:

- ◆ A thorough exploration of current concerns, goals and symptoms
- ◆ A review of mental health history including past successes and difficulties, prior interaction with mental health care professionals and past treatments, including medications, adherence and preferences

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- ◆ Current or past use, abuse or dependence on alcohol or other substances
 - ◆ A thorough understanding of the client's social circumstances, support network, and on-going life-stressors, including family issues, housing stability and past traumas
 - ◆ An initial risk assessment, including risk to self and others
 - ◆ Medical history and treatments

■ **B. Care Plan**

Every client is required to have a comprehensive care plan, developed in a timely manner, and signed by all clinicians participating in the person's care and by the supervising psychiatrist. The care plan should be:

- ◆ Recovery oriented, including a focus on work and/or education
- ◆ Responsive to the client and family cultural and linguistic needs
- ◆ Person centered in that the goals are developed with the recipient of service and fashioned to meet the aims and preferences of the client
- ◆ Updated according to the client's needs and regulatory requirements

■ **C. Ongoing Care**

1. Attending to the Consumer and Family

Consistent with the mission of a clinic is the need to be available and accountable to its clients and their families. This includes flexibility in time and place of appointments, after-hours responsiveness and shared decision making. A clinic may directly provide care, make referrals and collaborate with other providers, including the client's primary care physician.

2. A Primary Clinician

A primary clinician should be identified for each clinic client in a timely manner.

3. Patient Safety and Security

The primary clinician should ensure that appropriate and ongoing safety assessments are completed. These would include assessments of risk to self and others as well as making

contact with other providers, community agencies and supports, family members and significant others, and past treatment providers when appropriate.

4. Engagement and Retention in Care

A primary goal for clinic services is client engagement and retention in care is to assist the person to achieve his or her goals. The frequency and nature of client contacts with members of the treatment team should be commensurate with the severity of problems and the prescribed treatment plan. Diagnosis and treatment of a co-occurring substance use disorder, when present, is a best practice and will enable clients to remain in care (See Appendix on Co-Occurring Disorders). The identified primary clinician should be responsible for ensuring that the appropriate level of engagement is occurring at all times.

5. Attention to Co-Occurring Disorders

Clients in mental health clinics commonly show the presence of a co-occurring medical and/or substance use disorder (including alcohol, drugs and tobacco). The treatment of a co-occurring disorder, whether at the mental health clinic, in a chemical dependency program or in primary medical care, is essential to consumer wellbeing and recovery and should be a primary clinical administrative goal for the clinic.

6. Communication with Families

Families or significant others should be contacted as soon as possible, with proper consent, when an individual is beginning treatment, and should subsequently be involved as partners in the development and implementation of the plan of care; families or significant others should also have all information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis.

7. Disengagement from Treatment

When clients refuse or discontinue participation in all or part of the agreed-upon care plan, all members of the treatment team as well as collaborating providers and agencies should be made aware, especially the treating psychiatrist and/or clinical supervisor, and should conduct a review of the client's history, previous assessments of risk to self or others and render an opinion as to any aggravating or mitigating factors related to risk, with the clinician taking appropriate actions for the timely re- engagement of the client, including assertive outreach commensurate with the degree of assessed risk.

II. CLINICAL ADMINISTRATION

■ A. Caseloads

The clinic supervisor or director should be responsible for ensuring that complex, time-intensive cases are evenly distributed and considered for more experienced clinicians, and that the number of assigned clients permits the appropriate delivery of services.

■ B. Supervision

Clinic leadership should provide regular guidance and oversight for staff (especially new staff), with attention to ongoing care as well as emerging client problems or crises.

■ C. Integration and Information Sharing

When clients receive services from more than one clinic or agency, efforts will be made to ensure that all involved treatment providers have a shared understanding of the client's goals and progress, and that the respective intervention plans are integrated, complementary and reflected in the client's records. Current State law allows clinicians from OMH-licensed or operated facilities or providers under contract with OMH or DOHMH to speak specifically about the care of a client they are treating as a best practice and when clinical circumstances warrant, and without consent of the client. Furthermore, current state law also permits these mental health providers to share relevant clinical information, without consent, when a client is referred for services to another mental health provider of a facility that is licensed, operated or contracted by OMH or DOHMH.

■ D. Communication

Complex care requires that case managers and clinicians from multiple disciplines provide concurrent services, within one agency or among multiple agencies. It is imperative that these individuals have ready access to one another and share appropriate information at regular intervals, when there is evidence of emerging instability and during periods of crisis.

Guidelines for Sequential Screening of Risk for Violence

Safety, both of individual clients and of the public, is a fundamental aspect of psychiatric treatment. Accordingly, the assessment and management of the risk for violence is an essential component of clinical care. For most clients, it can quickly be established that the risk of violence is low and, in the absence of a possible change in their level of risk, additional assessment is not needed. However, when indications of elevated risk are present, more detailed assessment is required. The process of risk assessment involves the identification of risk factors present, followed by an assessment of the significance of each factor and consideration of how these factors together indicate a certain level of risk.

The following stepwise evaluation is recommended:

- ◆ Universal risk screening for all clients as part of the intake process,
- ◆ Targeted risk assessment when screening indicates increased risk,
- ◆ Risk-focused treatment when indicated, and
- ◆ Reassessment when the client's clinical, legal or contextual status changes.

Although the emphasis of this appendix is on the assessment of the potential for violence by individuals under psychiatric care, it is important to note that-notwithstanding public perceptions of the dangerousness of persons with mental illness-they are actually more likely to be the victims of violent crime than the perpetrators. The relationship between violence and mental illness is complex and strongly correlated with additional variables besides the presence of mental illness alone, such as a history of prior violence or the influence of co-occurring substance use.

I. RISK ASSESSMENT FRAMEWORK

■ A. Universal risk screening

The routine evaluation of all new clients requires the assessment of risk. All clients should be asked directly whether they have ever fought with or hurt another person and whether they have recently thought about hurting another person. In addition, there are critical events (e.g. past hospitalizations and arrests) that raise the possibility of past violence. As with any clinical assessment, some information may be provided directly by the client. Whenever possible, collateral sources should be included in the assessment process for additional information or cor-

roboration. Collateral sources include family members, friends, or other significant close contacts and sources of support, as well as prior treatment records.

Recommended areas for screening include determining if there is any history of:

- ◆ Physical or sexual aggression towards other people
- ◆ Deliberate self-injury
- ◆ Emergency room visits or hospitalization related to threatening or violent behavior
- ◆ Arrest or orders of protection related to the client's threatening or violent behavior
- ◆ Current or recent thoughts or behaviors that others have interpreted as threatening

Additional screening areas, in cases where a higher index of suspicion is warranted regarding a predisposition to aggression, include a history of:

- ◆ Problems with controlling anger
- ◆ Expulsion from school related to violent behavior
- ◆ Workplace or domestic violence

■ **B. Targeted risk assessment of clients with histories of violence or recent ideation**

Should screening yield a history of violent behavior or recent ideation, a more in-depth analysis of the risk of future violence is derived by obtaining the details of violent behavior or ideation and by identifying factors increase the level of a client's acuity or protective factors that mitigate risk.

Ultimately, clinical judgment is necessary in assessing how various symptoms and factors are related to violent behavior. A thorough review of the following areas can be used to guide clinical judgment:

Details regarding the history of violence or violent ideation, including severity, context, and use of weapons

Presence of factors associated with incidents of aggression

- ◆ Interpersonal conflict, unstable relationships, poor social support

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- ◆ Employment or financial problems
 - ◆ Substance use, whether due to active intoxication, withdrawal, or craving
 - ◆ Psychiatric conditions or active symptoms, including those related to personality disorder
 - ◆ Treatment noncompliance or lack of insight
 - ◆ Criminal behavior
 - ◆ Ongoing access to weapons

If there is a history of violent ideation, but not violence per se, is/are there:

- ◆ A plan and available means for acting on the ideation
- ◆ Steps taken in furtherance of the plan
- ◆ Factors that inhibited acting on the ideation

Presence of protective factors, including

- ◆ Outside monitoring (court, AOT)
- ◆ Mental health outreach teams (e.g., Assertive Community Treatment teams)
- ◆ Treatment efficacy and compliance
- ◆ Stable social support, work, and/or housing

Application of assessment findings to risk-focused treatment

It is not necessarily the total number of risk factors present that indicates a heightened risk. A single, severe factor may in and of itself indicate substantial risk concerns. Similarly, protective factors may significantly mitigate risk. After factors have been identified as related to past violence, consideration must be given to how relevant these factors remain in the present or foreseeable future. Risk assessment assists in the characterization of acuity and identification of areas of need; when risk has been identified, actions to address that risk must be reflected in the initial treatment plan.

Ongoing treatment plans should:

- ◆ Reflect interventions taken to manage identified risk factors
- ◆ Include efforts to actively engage the client and involve available supports
- ◆ Take into account prior treatment successes and failures
- ◆ Monitor the improvement or worsening of significant risk factors to guide any necessary change in management

When a client already in treatment misses an appointment or drops out of treatment, a review of the risk assessment may help guide the clinician's response. A client with active symptoms, a history of violence, and numerous risk factors for violence requires a greater degree of outreach and engagement. It must be emphasized that no guideline can include every possibility; therefore treatment decisions remain in the domain of clinical judgment, as applied on an individual basis to each particular combination of circumstances and needs. Potential multidisciplinary interventions include:

- ◆ Identification and monitoring of warning signs indicative of imminent or increasing risk
- ◆ Evaluation of medication regimen and consideration of additional treatment modalities
- ◆ Involvement of family, social services, case management, or other supports
- ◆ Consideration of social stressors
- ◆ Increased monitoring, including increased frequency of clinical contact or consideration of AOT
- ◆ Increased level of care, including hospitalization

■ **D. Reassessment**

There are specific junctures in treatment when reassessment of risk, following the framework described above, should take place. If a client becomes more symptomatic, or if treatment appears to be failing, reassessment should occur. When considering a client for hospital discharge, an assessment of risk factors for violence and whether risk factors for aggression have been addressed adequately is necessary. Similarly, prior to other changes in client status such as changes in level of hospital restriction or confinement, termination of clinic care, or discontinuation of an AOT order, reassessment of violence risk is indicated.

With any framework for assessment, there remains the possibility that clinicians may encounter cases where the level of risk remains unclear, or where the management of identified risk factors is complex and difficult. In such cases, adequate supervision and/or consultation for assistance with either further assessment or management recommendations is indicated.

II. ACTUARIAL TOOLS

The methods by which violence risk is assessed have been classified as either clinical or actuarial. Despite improved accuracy over unstructured clinical risk assessment, actuarial tools have important limitations. Past violence is the most significant factor in predicting future violence; the risk of individuals who have yet to engage in serious violence will often not be identified by actuarial tools. Also, actuarial tools are typically developed on a specific target population; the general clinic population is sufficiently diverse that there is no one particular actuarial tool that has been validated for use with a general clinic population.

The importance of proper training in the use and limitations of any given actuarial tool prior to implementation must be emphasized. These tools should not be approached as simple rating scales. Without an adequate understanding of their application, actuarial tools have the potential to misguide the estimation of risk.

Rather than adding any one particular actuarial tool as a required component in the standard of care for risk assessment in the general client population at this time, we recommend the sequential screening of risk for violence outlined here. However, depending on the specific circumstances, actuarial tools, administered by clinicians versed in their administration and interpretation can enhance the accuracy of the risk assessment.

