

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

to

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and

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Recommendations

1. Pilot a New York City alternative-to-detention program
2. Create a dedicated mental health unit within the New York City Department of Probation
3. Include validated mental health screening in pre-sentence investigations
4. Pilot mental health screening in criminal court for individuals sentenced to community-based sanctions
5. Expand new mental health courts and alternatives-to-incarceration
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I. Executive summary

In the wake of several recent, highly publicized violent incidents involving individuals with mental illnesses, 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, substance use, 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 illnesses 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 illnesses are not violent, and that mental illness is not a major driver of violent crime—in fact, studies show that individuals with mental illnesses are far more likely to be victims of violence than the general population.² Research does suggest, however, that the risk of violence is significantly increased among individuals with mental illnesses who do not receive adequate mental health care,³ and considerably more so among those individuals with co-occurring mental health and substance use disorders.⁴ Indi-

Notes

- 1 See Appendix A for Panel's membership list.
- 2 Pandiani JA, Banks SM, et al. *Crime Victims and Criminal Offenders Among Adults With Serious Mental Illness*. Psychiatric Services. Nov. 2007; Vol. 58(11): pp. 1483-1485. Appleby L, PB Mortensen, et al. *Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study*. The Lancet. 2001; Vol. 358; pp. 2110-2112; Monahan J. *Mental Disorder and Violent Behavior: Perceptions and Evidence*. The American Psychologist. 1992; Vol. 47(4): p. 511.
- 3 Monahan J, Steadman HJ, Silver E, et al. *Rethinking Risk Assessment*. New York, Oxford University Press, 2001; Torrey EF, Stanley J, Monahan J, 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; Steadman HJ, Mulvey EP, Monahan J, 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.
- 4 Ibid Steadman et al. 1998; Swanson JW, Swartz MS, Essock SM, et al. *The social-environmental context of violent behavior in persons treated for severe mental illness*. American Journal of Public Health. 2002; Vo. 92: pp. 1523-1531.

viduals with serious mental illnesses who engage in effective mental health treatment, though, have considerably lower rates of violence than those who do not receive treatment.⁵

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 treatment 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 incidents in NYC and its system of care, the Panel believes that this report's conclusions have broader statewide application.

■ 1. Poor coordination, fragmented oversight and lack of accountability 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 fully accessible to both agencies of encounters of high-need adults within the public mental health system, enabling 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)⁶ in the juvenile justice system should be assigned a

Notes

⁵ Ibid Monahan et al. 2001; Ibid Torrey et al. 2007.

⁶ 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.

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 Office of Children and Family Services Discharge Planning and Aftercare Services** – Discharge planning should begin within 30 days of admission at a NYS Office of Children and Family Services (OCFS) facility and should engage the youth, family members and community providers. To facilitate discharge planning and aftercare in the community, adolescents should be assigned community service workers-individuals who provide aftercare services and follow-up-to collaborate with the Family Care Coordinators.
- ◆ **Implement Recommendations of the NYS OMH/Office of Alcoholism and Substance Abuse Services 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 individuals with co-occurring mental health and substance use treatment needs. 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, the use of evidence-based treatments and reimbursement for evidence-based integrated treatments.⁷

■ 2. Inconsistencies in quality of care within the mental health treatment system

■ 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 reviews should aim to reduce care errors and improve safety. Pending statutory changes to authorize this type of multi-agency incident review process, OMH and the local government authority overseeing mental health services (e.g. DOHMH in NYC) should continue to collaborate with each other on the review of critical incidents in compliance with existing law.
- ◆ **Issue and Monitor the Use of 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 clinics serving adults.⁸ These standards should also provide guidance on the initial evaluation, ongoing risk assessment and changing treatment plans when an in-

Notes

⁷ See Appendix C for more information on the Task Force for Co-Occurring Disorders.

⁸ See Appendix E for more information on Standards of Care

dividual's mental health deteriorates. OMH and DOHMH should incorporate these standards into licensing and programmatic reviews.

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

■ **3. Limited capacity to share information within and between the mental health and criminal and juvenile justice systems**

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 illnesses who have become involved in the justice system. This information would be shared, with appropriate consent, to facilitate treatment-based alternatives.
- ◆ **Increase Information Available to the New York City Police Department** – 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 locations of housing with supports for individuals with mental illnesses.
- ◆ **Include Information Sharing Protocols in the Standards of Care** – The adult mental health clinic standards of care should include clear guidance for providers regarding communication with other service providers, families and caregivers.
- ◆ **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 Determined to be Not Responsible for Criminal Conduct due to "Mental Disease or Defect"** – DCJS should provide OMH and the NYS Office of Mental Retardation and Developmental Disabilities with real-time notification of arrests of individuals who have been determined to be not responsible for criminal conduct due to "mental disease or defect" and are in the community subject to court-ordered conditions.⁹

Notes

9 NYS Criminal Procedure Law § 330.20.

4. Insufficient training, supports and tools to identify and engage individuals with mental illnesses 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 flight or a risk to public safety.¹⁰
- ◆ **Create a Dedicated Mental Health Unit at the NYC Department of Probation** – NYC DOP should create a dedicated mental health unit of probation officers with reduced case-loads, 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 more in-depth clinical assessment and may benefit from treatment-based alternatives or special probation conditions.
- ◆ **Pilot 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 (ATI) programs that link offenders to court-monitored mental health treatment as an alternative to traditional case processing.¹¹
- ◆ **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.
- ◆ **Sponsor a Statewide Mental Health-Law Enforcement Summit** – NYS should sponsor a Mental Health-Law Enforcement Summit to enhance the relationships between law en-

Notes

¹⁰ 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.

¹¹ See Appendix D for more information on mental health courts in NYS.

forcement and the mental health community. Action Plans will be developed; the Division of Criminal Justice Services (DCJS) will coordinate follow up to assist in implementation.

- ◆ **Continue Ongoing 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, 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.
- ◆ **Enhance Clinical Interventions for Youth with SED in DJJ or OCFS Custody** – DJJ and OCFS should incorporate clinical interventions into their 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 placement in an OCFS facility, 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 issues.

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.

Panel recommendations grouped by system

Adult mental health treatment system

- Establish Care Monitoring Teams to strengthen oversight of high-need adults and high-intensity providers
- Create database to track the mental health care of high-need adults
- Conduct reviews of critical incidents involving the care of individuals with mental illnesses
- Issue standards of care for mental health clinics serving adults
- 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 and substance abuse disorders

Adolescent system of care

- Create Family Care Coordinators for justice-involved youth to assist families in navigating the mental health system
- Improve OCFS discharge planning and aftercare services
- Enable information to follow adolescents through transition points in the juvenile justice system
- Enhance clinical interventions for youth with SED in DJJ or OCFS custody

Adult criminal justice system

- Pilot a program for sharing information, with individual consent, between the criminal justice and mental health treatment systems
- Increase information available to NYPD dispatch to allow for specialized responses for incidents involving individuals who may have a mental illness
- Monitor individuals determined to be not responsible for criminal conduct due to "mental disease or defect"
- Pilot a NYC alternative-to-detention program to allow eligible individuals to be supervised in the community while receiving treatment & services
- Create a dedicated mental health unit at the NYC DOP to assist eligible probationers in receiving appropriate mental health treatment services
- Include brief mental health screenings in pre-sentence investigations
- Pilot mental health screenings in the Bronx Criminal Court for individuals sentenced to community-based sanctions
- Expand new mental health courts and alternatives-to-incarceration programs providing court-monitored mental health treatment
- Train 911 call takers and dispatchers to better elicit information about whether an incident involves a person with mental illness
- Sponsor a Statewide Mental Health-Law Enforcement Summit to enhance relationships between police and mental health professionals
- Continue ongoing review of best practices to inform NYPD's training curriculum for dealing with incidents involving "emotionally disturbed persons"

II. Introduction

In the wake of several recent, highly publicized violent incidents involving individuals with mental illnesses, 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.¹²

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 illnesses and the criminal justice system.

The Panel focused on opportunities to improve services for the subset of individuals with serious mental illnesses 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,¹³ that mental illness is not a major driver of violent crime,¹⁴ and that people with mental health needs are far more likely to be victims than perpetrators of violence.¹⁵ 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 illnesses engaged in regular treatment are no more likely to commit acts of violence than the general population, and are

Notes

¹² See Appendix A for Panel membership list.

¹³ Ibid Monahan 1992.

¹⁴ Ibid Swanson, et al. 2002; Ibid Steadman 1998.

¹⁵ Ibid Pandiani et al. 2007.

considerably less likely to commit violent acts than those who could benefit from, but are not engaged in, appropriate mental health treatment.¹⁶

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 public.

Notes

¹⁶ 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 sometime in their lifetime¹⁷ and more than 20% will be affected annually;¹⁸ in addition, 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.¹⁹

Individuals with mental illnesses 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 illnesses 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 illnesses, 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 health and substance use disorders cannot fully recover and lead productive lives in the community without safe and reliable housing, and employment or

Notes

17 Kessler RC, Berglund PA, Demler O, et al. *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.

18 Wang PS, Lane M, Olfson M, et al. *Twelve-Month Use of Mental Health Services in the United States Results From the National Comorbidity Survey Replication*. Archives of General Psychiatry. 2005; Vol. 62: pp. 629-640.

19 Ibid Kessler et al. 2005.

other meaningful social roles. Yet finding suitable housing is particularly difficult because of New York's high housing costs coupled with large numbers of low-income people with disabilities and numerous obstacles to competitive employment.

NYS' law enforcement, courts and corrections agencies also struggle to meet the needs of the tens of thousands of adults with mental illnesses 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 illnesses.

A. The NYS mental health system

The NYS Office of Mental Health (OMH) funds, licenses and operates a statewide system of care for people with mental illnesses, 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 illnesses 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 NYS 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 2,500+ 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. New York States' Assisted Outpatient Treatment (AOT) and inpatient commitment laws

In 1999, NYS enacted legislation that authorizes courts to order AOT for certain individuals with mental illnesses who are unlikely to survive safely in the community without supervision.²⁰ 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 has 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.²¹ 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 2009.

With respect to non-emergency involuntary inpatient commitment, NYS has one of the broadest involuntary commitment laws in the United States.²² 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 on a non-emergency basis, NYS' standard for non-emergency, involuntary hospitalizations does not require a finding of "imminent" or "immediate" danger.

Notes

20 NYS Mental Hygiene Law (MHL) §9.60

21 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.

22 NYS Mental Hygiene Law (MHL) §9.27

C. The NYS criminal and juvenile justice systems

Each year, thousands of people with serious mental illnesses touch the State and City criminal justice systems. While the inmate census in NYS correctional facilities has declined steadily over the past three years to approximately 63,000 inmates currently, 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 illness²³ 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 911 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%).²⁴ 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 courts²⁵ and alternative-to-incarceration (ATI) programs that link offenders to court-monitored mental health treatment, often in lieu of jail or prison. In addition, NYS has nearly doubled its corrections-based mental health staff over the past decade. 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.

Law enforcement 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

23 Broner N, Lamon SS, Mayrl DW, and Karopkin MG. *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.

24 Cocozza J and Skowyrka K. *Youth with Mental Health Disorders: Issues and Emerging Responses*. Office of Juvenile Justice and Delinquency Prevention Journal. 2000; Vol. 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.

25 See Appendix D for more information about mental health courts in NYS

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 SED who came into contact with the criminal and juvenile justice systems.²⁶ 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 data indicating that people with mental illnesses 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.²⁷ The research also suggests, however, that violence among people with serious mental illness increases if they abuse alcohol or drugs, and that this risk is compounded if they fail to get treatment or receive inadequate care.²⁸ Thus, the Panel concluded that the best way to improve outcomes and safety for high-need adults with serious mental illnesses and adolescents with SED is to take concrete steps to provide people with mental health needs 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 systems, fall into four broad categories: 1) poor coordination, fragmented oversight and lack of accountability in the mental health treatment system; 2) inconsistencies in quality of care within the mental health treatment 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 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 – a proven community-based intensive treatment for those with complex needs and difficulty engaging in traditional treatment.

Notes

26 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.

27 Ibid Monahan et al. 2001

28 Ibid Monahan et al. 2001; Ibid Swanson et al. 2002

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 and juvenile justice professionals make more informed and better decisions. The Panel's review also included police training and the need for law enforcement 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.

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 and juvenile justice professionals are dedicated to ensuring both public safety and the well-being of individuals with mental illnesses.

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 individual is in regular communication. Such a provider must take 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 disorders and mental illnesses lack access to and information about treatment, 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), 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 children'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-need adults

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 Intensive Case Management. 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 that follows), the CMTs would play an important role in facilitating coordinated care and improving services. In addition, OMH and DOHMH should explore peer-based services and efforts that encompass goals specifically identified by individuals with mental illnesses – such as assistance with housing and benefits, as well as recovery-oriented treatment plans – in an effort to improve the ability to engage and retain individuals in services.

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

CMTs should have a database of information to better monitor the care provided to high-need individuals in the public mental health system. This database will help identify and address interruptions in care or the need for escalating care and will be populated initially with existing data – including Medicaid claims, with federal approval. 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 that follow for an information sharing pilot).

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. To facilitate discharge planning and aftercare in the community, adolescents should be assigned community service workers – individuals who provide aftercare services and follow-up – to collaborate with the 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 NYS 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 individuals with co-occurring mental health and addiction treatment needs. 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 for 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.²⁹

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 during the time when some individuals receive court-ordered services the individual and the provider are both engaged in the treatment process. However, when the order is allowed to expire, there are failures to provide follow-up care, often 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

Notes

29 See Appendix C for more information on the Task Force for Co-Occurring Disorders and its recommendations

that can be taken to mitigate future incidents. Yet New York has no protocol for conducting regular, system-level quality assurance reviews of critical incidents involving individuals with mental illnesses with multiple city and state agencies and community providers.

Recommendations

Conduct critical incident reviews

NYS should enact legislation to establish a protocol that 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, multi-agency 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. Pending statutory changes, OMH and the local government authority overseeing mental health services (e.g. DOHMH in NYC) should continue to collaborate with each other on the review of critical incidents in compliance with existing law.

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 illnesses 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 illnesses is conducting initial and ongoing risk assessments.³⁰ Risk assessment is a sequential process that begins with obtaining information from the individual and collateral sources regarding any history of violent thoughts or behavior and includes identification of factors that increase risk, such as the presence of a co-occurring substance use disorder. 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

Notes

³⁰ See Appendix E for Guidelines for Mental Health Clinic Standards of Care and Sequential Screening of Risk for Violence.

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 Assisted Outpatient Treatment

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, DOHMH, and the NYC Criminal Justice Coordinator (CJC) should work collaboratively with the Office of Court Administration to explore specialized judicial assignments for AOT cases and to continue 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 youth transition into and out of that system. The Panel also noted that clinicians in 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 between 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.

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 mechanisms to routinely screen for mental illnesses 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 for the purpose of ensuring continuity of care and referrals to ATI programs. Such legislation would recognize that the criminal justice system can serve as a successful 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. Improving information sharing between the mental health and criminal justice systems could result in more successful collaborative efforts to prevent individuals with serious mental illnesses from cycling repeatedly through the criminal justice system.

Several valid concerns were raised about this option, however – including that information sharing could potentially stigmatize individuals with mental illnesses and lead to punitive criminal justice system responses, raise privacy concerns, and significantly alter current practice. The Panel recommends 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 linked to long term services through the criminal justice system. The results of these programs should be closely monitored and officials from the mental health and criminal justice systems should continue to discuss this issue, including the possible need for a legislative solution in the future.

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 illnesses 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 track arrests through an exchange of data and 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 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 illnesses.

Include information sharing protocols in the standards of care

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

Enable information to follow adolescents through transitions 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. Policy and procedures should be established by which all mental health caregivers for children will provide information, with appropriate consent, to DJJ clinicians about the ongoing treatment and clinical needs of youth in their care immediately upon learning that a juvenile has entered DJJ care. City and State agencies will advance training for child mental health providers on these policies and procedures.

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.³¹ 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 (ATD) or ATI 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 statewide are often 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.

Recommendations

Pilot a NYC alternative-to-detention program

NYC should pilot a new 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 help judges 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 small scale will allow NYC to determine whether participation in a court-monitored community supervision program can reduce recidivism among offenders with mental illnesses.

Notes

31 NYS Criminal Procedure Law 330.20

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

NYC DOP should create a dedicated mental health unit of probation officers with reduced case-loads 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 individuals with mental illnesses who are on probation. 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 more in-depth 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 illnesses and promoting linkages to treatment.

Pilot mental health screening in criminal court for individuals sentenced to community-based sanctions

NYC should introduce 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 ATI programs that link offenders to court-monitored mental health treatment as an alternative to traditional case processing.³²

Notes

³² 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. Each participating jurisdiction should provide a preliminary action plan at the close of the summit that addresses the criminal justice and mental health issues identified by the jurisdiction and proposes pragmatic solutions. DCJS will coordinate follow up with the jurisdictions to assist in the implementations of these action plans.

Continue ongoing 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 justice system 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, 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 I. Gibbs, NYC Deputy Mayor for Health & Human Services

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

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

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

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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 OMH 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 illnesses in NYS. Pending statutory changes to authorize this type of multi-agency incident review process, OMH and the local government authority overseeing mental health services should continue to collaborate with each other on the review of critical incidents in compliance with existing law. 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 individuals with serious mental illnesses 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 could 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. All incident review panels should include representatives from OMH and the local government authority overseeing mental health services where the incident took place (e.g. DOHMH in NYC); other entities, such as mental health providers, schools, hospitals, law enforcement and others could be selected to participate in the review of any given incident, as well.

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

In September 2007, OMH Commissioner Hogan, and OASAS Commissioner Karen Carpenter-Palumbo accepted the report of a statewide Task Force charged with providing meaningful, measurable, and actionable recommendations that could be implemented in a timely manner to improve the care of people with co-occurring mental health and substance abuse disorders.

In any given year an estimated 160,000 adults in NYS have a co-occurring serious mental illness and substance abuse disorder. Access to care and quality of treatment are often poor. Nationally, 50 percent of individuals with co-occurring serious mental illnesses and substance use disorders receive no care; 45 percent receive poor care; and only about five percent receive evidence-based care.³³ NYS is taking strong steps to ensure that providers screen and assess for co-occurring disorders in all relevant settings and provide access to integrated care.

The Task Force identified opportunities to eliminate limitations and barriers in accessing care. In addition, the Task Force recommended ways in which to create recovery-oriented care that is hopeful and consumer-driven; recognizes the essential role of family, relationships, community and employment in fostering the quality of life; and, is culturally and linguistically competent. These agreed-upon values are to assure that clients 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; and, participate in recovery-oriented care.

Following the acceptance of the report by the Commissioners, an implementation group has continued to work on an action plan that will be launched this year that will include the following steps:

- ◆ **Advance clinical practices that integrate treatment for co-occurring disorders** through issuance of guidelines for screenings in all clinics, comprehensive assessments for those who screen positive, and the use of evidence-based treatments
- ◆ **Educate providers about regulations affecting the provision of integrated treatment**
- ◆ **Allow reimbursement for evidence-based integrated treatment**
- ◆ **Promote local innovation in the treatment of 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

Notes

33 Drake, RE, HX McHugo, M Fox et al. *Ten-Year Recovery Outcomes for Clients with Severe Mental Illness*. Schizophrenia Bulletin. 2000; Vol. 32: pp. 464-473

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.³³ These courts are based on the concepts of therapeutic jurisprudence and are often modeled on drug courts.³⁴ 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.³⁵

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, participants are able to plead to a lesser charge. The Bronx Mental Health Court, which serves large

Notes

33 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.

34 Watson A, Hanrahan P, Luchins D, and Lurigio A. *Mental Health Courts and the Complex Issue of Mentally Ill Offenders*. Psychiatric Services. 2001; Vol. 52: pp. 477-481.

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

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 alternative initiatives 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 ATI. 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 illnesses in the criminal justice system. MHCC provides judges with the resources necessary to consider effective ATI 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 to and quality of care for persons served by licensed clinics that provide mental health services. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently 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 information from other available sources, 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
- ◆ Current or past use, abuse or dependence on alcohol or other substances

-
- ◆ A thorough understanding of the client's social circumstances, support network, and ongoing 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 in order to assist the person in achieving 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 violence risk screening for all clients as part of the intake process,
- ◆ Targeted violence risk assessment when screening indicates increased risk,
- ◆ Violence 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 illnesses-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 corroboration. 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 that 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 including:
 - ◆ Interpersonal conflict, unstable relationships, poor social support
 - ◆ 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., ACT 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 violence 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 violence 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; actuarial tools will often not identify the risk of individuals who have yet to engage in serious violence. 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.

