House Memorial 45 Task Force Recommendations

December 2012

House Memorial 45 Task Force Findings & Recommendations

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Introduction

House Memorial 45 in 2011 asked the Behavioral Health Collaborative to convene a Task Force to consider three sets of issues related to civil commitment and treatment guardianship arising from House Bills 497, 499 and 559. HB 599 sought to amend a section of the mental health and developmental disabilities code (The Code) making changes to the provisions related to treatment guardians. HB 499 proposed changes to The Code related to criminal defendants who are civilly committed to secure facilities. HM497 amended a section of The Code to change the roles of the district attorney in civil commitment proceedings.

Each of these bills had strong proponents and significant opponents. Both groups of advocates agreed that a Memorial replace the bills and that a Task Force convene and work to find recommendations on the issues underlying the three bills.

The Task Force launched its work on August 30, 2011. The Task Force identified three priorities underlying HM 45:

- the safety of the community;
- protecting and ensuring civil liberties;
- effective treatment.

A diverse group of Task Force participants started with considerable differences of knowledge, approach and opinion, *and* considerable commonality in commitment to people who experience mental illness and to the quality behavioral health services they require. This Report and its Recommendations represent a year and a half of working to understand the knowledge in the field, the research findings and practical experiences that really make a difference in people's lives. It also represents learning from each other and learning to listen and seriously consider differing ideas. Journal publications and other materials used by the Task Force can be found on https://sites.google.com/site/hm45taskforce/

The Task Force Members and others who have participated in our discussions will continue to be available as a strong group of advocates and resources for the priorities of HM45, for an effective system of mental health and substance use treatment and prevention in New Mexico, and for individuals and families who live with the experience of mental illness. Thank you for your careful consideration of these Recommendations.

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Guiding Principles
People living with mental illness have friends and families, offer service to others, work, vote, and participate in all New Mexico's communities.
There is a perception gap between public views of mental illness and the evidence about whom in our communities commits violence.
Members of the Task Force wish to affirm that preference should be given to voluntary treatment rather than to involuntary treatment and that treatment should not be compelled in the community without a determination of incapacity.
Treatment is not simply medication or therapy; the system must support stable affordable housing and peer support services as well as a continuum of treatment services that are accessible.
***Outreach and engagement* as early as possible, as often as needed, and in forms that have been proven to work is the most important strategy for ensuring better outcomes for individuals, a respect for human rights and public safety.**
The availability of effective, comprehensive, community –based systems of care for persons living with serious mental illness are cost effective and reduce the need for involuntary commitment or other court ordered treatment.

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Recommendations

1. Outreach and Engagement Services

Problem

Some people who live with mental illness are seen to cycle in and out of jails and hospitals. People who may need mental health services *can* at times be either unable or reluctant to seek services themselves. There may be many reasonable causes including, experiences of poor mental health services, lack of access, or concerns about stigma. And some mental illnesses can include a lack of insight or symptoms that are obstacles to seeking treatment. For people living with chronic illnesses, including hypertension and diabetes as well as mental illness, voluntary treatment is preferable. For a small subset of people with serious mental illness who also lack decisional capacity, risks are many and alternatives few.

Recommendation

Amend the mental health consent to treatment statute at NMSA § 43-1-15 to allow for *Community Engagement Teams* to work to engage persons with mental health disorders who may lack decisional capacity, be unlikely to live in the community without support and do not immediately require inpatient or emergency care.

Discussion

The Task Force members held a general concern that there are people who need treatment but who are not receiving it. The challenging discussions focused on ways to facilitate treatment for individuals whose symptoms are escalating. When that individual presents a likelihood of serious harm to self or others in the near future, the civil commitment process is available.

Task Force members struggled to balance the variety of competing interests to honor public safety concerns, concerns about the importance of early intervention with many serious mental disorders, and concerns about intruding in the life of someone who is posing no immediate or current harm.

CIT detectives work closely with civilian crisis specialists and a full time psychiatrist *to achieve the goals of public safety and connection to services. The detectives and doctor meet people in their homes, in parks, in alleyways, wherever they are needed. They speak with families, talk with service providers, and develop plans to keep people safe, find treatment, and stay out of jails.*

As the Task Force reviewed the psychiatric and recovery literature and heard about data and program effectiveness, the difference of opinions about court ordered outpatient

treatment gave way to a principle to which members could agree: that **no treatment should be compelled without a determination of incapacity.** As the adult mental health code does not explicitly define capacity, the Task Force recommends adding the definition used in the Mental Health Treatment Decisions Act, §24-7B-3-C. *An individual's ability to understand and appreciate the nature and consequences of proposed mental health treatment, including significant benefits and risks and alternatives to the proposed mental health treatment, and to make and communicate an informed mental health treatment decision.*

Additionally the Task Force became aware of the research literature and of New Mexico experiences of successful outcomes gained when there is outreach to people with vulnerabilities with mental illness and when people are engaged to seek treatment or other services. The lives of individuals and the costs of crises to communities would be improved by very early intervention such as when a person first shows signs of illness through troubling behavior and symptoms. There are many disorders that damage health and are costly to society at large. In the programs that introduced the Task Force to possibilities of *engagement teams,* the Task Force was encouraged to learn that people who often cycle in and out of jail or hospital could be reached and engaged. And where a lack of capacity prevents engagement, an engagement team could intervene earlier to help prevent unnecessary contact with high levels or care or incarceration. In mental illness as well as other chronic conditions, outreach and engagement is the key to both effective treatment and personal responsibility.

There are already some New Mexico successes with aggressive outreach and also with the voluntary use of intensive community evidence-based practices like Assertive Community Treatment (ACT) teams. To help those living with mental illnesses in the community, Albuquerque Police Department also has two proactive programs: The Crisis Outreach and Support Team (COAST), and Crisis Intervention Team (CIT) detectives. Another variety of engagement that leads to positive outcomes is achieved by the specialty problem-solving courts such as Treatment Courts, Mental Health Courts or Drug Courts. While Core Service Agencies do not yet have flexible funding for additional outreach and engagement activities, they were designed to serve this very group of individuals, including outreach, engagement, education and peer support.

Albuquerque, Santa Fe, Taos and Las Cruces have ***ACT teams****, not an outreach program but an intensive community service.* *The Schizophrenia Patient Outcomes Research Team (PORT) has identified ACT as an effective and underutilized treatment modality for persons with serious mental illness.*

Evaluations of outpatient commitment or assisted outpatient treatment programs in states such as New York showed the contextual causes of some positive outcomes. These included considerable levels of new funding of community programs and engagement of people into voluntary treatment. The Task Force also reviewed research on

experiences of involuntary models and programs to divert seriously mentally ill people away from emergency rooms. Public safety outcomes in the research included keeping people safe from suicide as well as other violence. The research showed some circumstances in which court ordered participation in adequate treatment services, along with other factors such as housing, improved outcomes for individuals.

Although Task Force members did not all agree on the desirability of the use of judicially mandated treatment or its outcomes, members did see the benefits of outreach and engagement programs connecting people with services. The Task Force agreed that a comprehensive community based system of care is essential for effective delivery of behavioral health services.

Community Engagement Teams Proposal

This led the Task Force to work on a legislative proposal that could offer new opportunities to engage people *before* a crisis. Although the recommendation is an authorizing rather than a funding recommendation, Task Force members believed that some communities would choose to fund such teams, and recognize that successful engagement would reduce costs associated with hospitalization, incarceration or contact with law enforcement authorities.

In addition family members concerned about a relative who appears not to recognize the impact of their illness would have a new tool and people living with mental illness could also avoid involuntary treatment or incarceration. Recommendation #3 seeks to make clear the availability of outpatient treatment guardians and to strengthen access to that alternative.

Further, if any interested person believes that an individual living in the community may be unable to live safely in the community, is in need of mental health services and is also incapable of informed consent, that person may file an application with a Community Engagement Team (CET) if one exists in the community where the individual resides or may be found. The CET would then make reasonable efforts to assess the person's decisional capacity and to engage that individual and could make referrals for a range of other services including assistance with housing, food, health care and transportation.

Develop flexible funding streams and payment mechanisms to compensate providers for crisis outreach and other services described in these recommendations.

- HJM17 Recommendation

Where decisional incapacity is found or the CET is unable to assess the person, CET personnel would then be able to seek to engage the person in treatment. If necessary, the CET could petition the court for a treatment guardian, which could lead to the possibility of an enforcement order to compel outpatient treatment as described in the consent to treatment statute, § 43-1-15.

2. System Financing

Problem

Deficiencies in funding of the behavioral health prevention and treatment systems in communities increases costs to communities, costs in the healthcare system, costs of mental health care in jails, costs in courts, and costs to individuals and families.

Recommendation

Increase understanding of the flow of funding including the cost of using emergency care systems and expenditure for corrections, criminal justice and behavioral health. Review the use of city, county, state and federal dollars to develop flexible funding streams to create and support community based services.

Discussion

The Task Force recognizes the complexity of funding streams for behavioral health. Complexity is increased by the use of local or county funds as well as by state expenditure. The Behavioral Health Planning Council is undertaking some important work in mapping both traditional and non-traditional and recovery based resources in local communities. However, mapping the flow of funding related to costs could enable the legislature and state departments to be more responsive to identified system problems. Some other states have also sought to specifically identify the costs to other systems such as county jails, corrections and primary care of inadequate treatment and prevention resources.

There may also be a need to include in this analysis the resources and funding streams available for traumatic brain injury (TBI) services. The Task Force found that the statutory definition of mental disorder is sufficient to include people who have experienced TBI and that TBI can at times resemble a developmental disability or a mental illness. However, the Task Force further found that especially when people with TBI come in contact with the criminal justice system, there is a need for expanded services. A CET may also play a role here in facilitating connections to services and engagement.

The Task Force recommends that the Behavioral Health Collaborative be asked to commission a study of the flow of local, state and federal funding, using specialized

financing expertise as well as legal, consumer and family expertise. The study should also include a review of insurance and parity requirements in New Mexico. The goal would be to develop flexible funding streams to develop and support community based systems of care to reduce the burden on other systems.

3. Peers and PADs

Problem

Access to peer support specialists, certified peer workers, or specialized peers working on housing or criminal justice issues has an evidence base of good outcomes and is non-existent in some counties and extremely limited in most of New Mexico. While New Mexico has the benefit of psychiatric advance directives (similar to physical healthcare directives), there are a number of barriers to greater use of these directives and therefore to their effective use as a tool for ensuring early and appropriate engagement and treatment.

Recommendation

Develop programs and resources to remove barriers to increased access to peer support and widespread use of psychiatric advance directives (PADs).

Discussion

New Mexico has a system of training and certifying peer support workers who may then be able to work as Community Support Workers in Core Service Agencies and provide a Medicaid billable service. Federal grant funds also support some specialized peer workers with housing expertise. Some agencies also hire peers to work with their customers on wellness promotion and some assist with development of PADs. However there are too few funded positions in too few places in New Mexico. Some task force members believe this could be remedied in part by requiring MCOs and core service agencies to hire peer support workers and encourage other entities to do so as well.

Peer respite was deemed important as an alternative crisis response to those at risk of arrest or who are diverted to a hospital emergency department. In most communities people in crisis may show up or are taken to hospital emergency departments, not because the setting or level of medical service intensity is needed, but because there is no other option.

- *HJM 17 Task Force Recommendations*

In addition to their potential impact in engaging and reaching out to people living with mental illness, peers are also uniquely suited to assisting people in preparing PADs. New Mexico's PAD statute, the mental healthcare treatment decisions act, NMSA 1978, § 24-7B-1 to §24-7B-16 (2006), is designed to support self-determination at times when people are particularly vulnerable to loss of autonomy, to help them ensure that their preferences are known, and to minimize unwanted or involuntary treatment. There is also evidence that the very process of preparing these documents will enhance a person's sense of trust and collaboration with providers, thereby improving the engagement with treatment.

The Task Force discussed the importance of PADs both for individuals living with mental illness and also for communities and families. A wide range of individuals, advocates, state departments and others came together to support the passage of the New Mexico PADs statute. Barriers are inhibiting more widespread use of this powerful tool.

To me, mental illness meant Dr. Jekyll and Mr. Hyde, psychopathic serial killers, loony bins, morons, schizos, fruitcakes, nuts, straight jackets, and raving lunatics. They were all 1 knew about mental illness, and what terrified me was that professionals were saying I was one of them.

It would have greatly helped to have had someone come and talk to me about surviving mental illness-as well as the possibility of recovering, of healing, and of building a new life for myself.

Deegan (1993)

Some of those barriers can be easily addressed, such as requiring MCO providers and Core Service Agencies to be reminded yearly of requirements for adhering to PADs. There is also a need to embed assistance for completing PADs in supportive housing venues, in usual care settings, in hospitals and doctors' offices and not only in mental health agencies.

The Task Force heard evidence of a need for more education to hospitals and providers regarding their obligations to adhere to a psychiatric advance directive. There is also a need to educate the judiciary about requirements regarding PADs prior to appointment of a treatment guardian. Training regarding the use of PADs also needs to be available in the places where people live, for peer support workers in supported housing, for staff in health homes, for treatment guardians.

System resources and innovation can also create ways to support healthcare providers to identify someone with a PAD, retrieve the most current document, and respond appropriately. Task Force

A psychiatric advance directive empowers me to stay in control even when I am not in control.

- Jane E. Thompson, certified peer specialist quoted in HJM17 Report

members suggested investigating options for implementing a centralized information center for housing PADs and also for treatment guardian orders.

4. Access to Treatment Guardians

Problem

Access to treatment guardians in outpatient settings, including the process to obtain one, is not as commonly understood as the use of treatment guardians during a person's hospitalization. There are shortages of treatment guardians readily available in communities and shortages of resources for training and monitoring guardian activities on behalf of a person living with mental illness.   Treatment guardians have responsibilities beyond approving the use of medications or seeking orders to enforce a treatment decision, yet those activities are sometimes seen as their primary role.

Recommendation

Increase the accessibility and accountability of treatment guardians throughout the state in outpatient settings, increasing also public information about how to use the treatment guardianship process.

Discussion

A treatment guardian is a person temporarily appointed by a court to make mental health treatment decisions on behalf of an individual who the court finds by "clear and convincing" evidence is not capable of making their own treatment decisions or informed consent.

The treatment guardian can be used to make mental health treatment decisions in a community setting as well as in a hospital setting. Some members of the Task Force believed that clarification of the process to obtain treatment guardians in outpatient settings is needed in the statute and that information needs to be accessible throughout the State. A workgroup of the Task Force has attempted to draft the refinements. Although consensus was not reached on specific legislation, the work group and full task force did reach consensus on a number of principles that would need to underpin any legislative changes.

Essential elements of the draft legislation considered by the Task Force were: the application to a narrow subset of people with mental illness and decisional incapacity, the importance of supported housing and other recovery based services, the availability of skilled staff to seek engagement of an individual about whom someone is concerned, the expansion of access to treatment guardians or advice about seeking such guardians.

Areas of the draft legislation under consideration in which the Task Force could not achieve consensus included: the use of forced assessments or evaluations, judicial proceedings conducted without the presence of the person for whom treatment guardianship is sought, and the definitions of the scope of authority of Community Engagement Teams.

Additionally, current law authorizes the treatment guardian to apply to the court for an "enforcement" order that authorizes the individual to be taken to an evaluation facility if the treatment guardian believes that the individual has been noncompliant with mental health treatment decision(s) made by the treatment guardian. This order may authorize a peace officer to take the individual into custody and transport the individual to an evaluation facility. Such an order may also authorize the facility to forcibly administer medications where appropriate. The Task Force found a need for additional efforts to educate a variety of people and treatment guardians regarding the use of enforcement orders.

The Task Force also reviewed the challenges presented when treatment guardians are appointed in a different location than where the person resides or will return upon discharge from an inpatient facility. The Task Force recommends that treatment guardian participation in treatment and discharge planning could be strengthened in practice guidelines and that if a treatment guardian lives in a community other than where the hospital is located, s/he can participate by phone or other interactive technology. Reinforcement of the roles of treatment guardians could also be included in 43-1-15 (F), (H) and (I), and in 43-1-9 (B). In addition, it may be appropriate to create a simpler process to transfer a treatment guardianship appointment to another treatment guardian when the individual under a treatment guardianship order moves from one jurisdiction to another.

As New Mexico is one of the few states to authorize treatment guardians, the Task Force recommends strengthening of this program both in terms of access and also accountability. The current role of the Guardianship Program in New Mexico is to provide education and training and trained treatment guardians to the courts when others are no available.

Treatment guardianship may work best where an individual requests that his or her agent under a psychiatric advance directive be appointed as treatment guardian during a period of incapacity. Relationship is a primary driver of effective care, whether that is a relationship with a treatment guardian or relationship with a doctor, therapist or Community Engagement Team. Strengthening access points to a need to review the roles of District Attorneys in the treatment guardianship process to ensure a clear mechanism for the appointment process throughout the State.

5. Roles of District Attorneys

Problem

District Attorneys in New Mexico have statutory responsibilities in both treatment guardianship proceedings and involuntary civil commitments. There appears to be uneven adherence to the statutory roles of District Attorneys in civil commitment proceedings as well as in treatment guardianship proceedings.

Recommendation

Work with the Attorney General to devise a detailed transition plan to enable the Attorney General's Office and the Office of Guardianship to replace the roles of District Attorneys in treatment guardianship proceedings; likewise discuss implementation of legislation for the 2014 Legislative Session to authorize the Attorney General's Office to represent the State in civil commitment proceedings through the use of attorneys contracted to the Office of Guardianship.

Discussion

Throughout the United States the primary role in responding to requests for civil commitments rests with local county attorneys or district attorneys. The authority of the state to civilly commit a person due to his or her mental disorder is premised on two traditional powers of government: the police power and the *parens patriae* power.

In addition to emergency commitments, New Mexico's statutes at NMSA 1978, §43-1-11G provides that *an interested person who reasonably believes that an adult is suffering from a mental disorder and presents a likelihood of serious harm to the adult's own self or others, but does not require emergency care, may request the district attorney to investigate and determine whether reasonable grounds exist to commit the adult for a thirty-day period of evaluation and treatment.* The District Attorney must act on a petition within seventy-two hours or may file the petition.

In practice the extent to which District Attorneys fulfill this role as well as assist with treatment guardianship petitions varies from county to county. The Recommendation presented here seeks to address the uneven practices across the State that create a barrier

for people seeking to initiate treatment guardian proceedings and to increase access to treatment guardianship.

Although the Task Force did not receive a detailed data analysis of either civil commitments or treatment guardianship proceedings, it is clear that the courts in San Miguel and Bernalillo Counties conduct the largest number of civil commitment proceedings. Some counties reported that they do no civil commitments and instead transport all respondents to the Behavioral Health Institute in Las Vegas. Other counties initiate and handle petitions with fewer than 50 hearings each year. Others report 2 or 3 civil commitments each year. An Assistant District Attorney may be assigned to mental health cases or contract attorneys may be hired to represent the District Attorneys in all civil commitments. Some county's District Attorneys report that they never respond to requests for a treatment guardian petition.

Some District Attorneys advocated that for various reasons another 'state actor' should be found to petition and handle civil commitments as well as treatment guardianship cases. Others expressed a wish to maintain their authority to bring civil commitment petitions when criminal proceedings are also underway.

Task Force members were concerned about having a consistent and predictable representative of the authority of the state who is involved in civil commitments and treatment guardianships. Following considerable discussion, the Task Force and the District Attorney's Association now agree that it may be possible for Attorney General commissioned contract lawyers hired statewide by the Office of Guardianship to fulfill the state role.

The Task Force therefore recommends that the Office of Guardianship, Attorney General's office, the New Mexico District Attorneys Association and relevant state departments work together to develop a detailed implementation plan that would first transfer authority for treatment guardianship work from District Attorneys to attorneys commissioned by the Attorney General. Further transition planning and a detailed statutory review would then be recommended before authority to bring civil commitments were similarly transferred.

6. Problem-Solving Courts

Problem

Some of the concerns combined into House Memorial 45 were concerns about people involved in the criminal justice system. Pre-trial specialty courts have had proven success in

New Mexico. In some jurisdictions, access to a treatment court gives access to services that would otherwise not be accessed by the person who is charged with a crime. Additional mechanisms for supervising and treating persons whose competency to stand trial is in question would assist in preventing the revolving door of people appearing, mostly for misdemeanors and being found to lack competency.

Recommendation

Establish problem solving courts such as treatment, mental health and drug courts throughout New Mexico, particularly increasing the number and availability of mental health courts.

Discussion

There are five mental health courts, sometimes called *treatment courts*, and forty-three drug courts (adult, juvenile, family dependency, and DWI). Treatment courts/mental health courts have arisen in five jurisdictions in differing ways. For example, in one jurisdiction people were failing in drug court because their needs for treatment were primarily mental health needs that they were self-medicating with illegal drugs. In another jurisdiction the treatment court program began as a pilot and now records only an 18% recidivism rate. At least one District Attorney has initiated her own kind of voluntary pre-trial diversion and treatment program for people revolving through her office for minor misdemeanors.

Misdemeanor offenses can also disproportionately affect people with mental health disorders. Certain charges… can result in a sentence of 180 days or up to 364 days for simply sleeping in a public area.

- HJM 17 Task Force Report

The Task Force noted the importance again of relationship and especially the interest, commitment and compassion of the problem-solving court judge. Mental health or treatment courts as well as drug courts appear to succeed by including a service array with three elements: court supervision, case management and treatment provision (both individual and group). A treatment court may include the involvement of a psychiatrist and opportunities to receive assistance with medications in addition to judicial supervision. The stability of specialty court funding is a significant factor in program variations. Further, these pre-trial specialty services are often coordinated and made available to those charged with a crime in ways that are not available to people who are not involved in the criminal justice system.

7. Education & Training

Problem

There is a widespread need for guidance in the forms of training, information materials, and coaching to support implementation of the recommendations made by the HM 45 Task Force.

Recommendation

Widely disseminate guidance on early signs of mental illness, Psychiatric Advance Directives, access to treatment guardians, mental health first aid, use of enforcement orders, and other mental health education, including use of peer support and other consumer operated services.

Discussion

The practical tools and knowledge that are available cannot help people living with mental illness, their families and friends, or local communities if they are not vigorously supported and accessible throughout New Mexico. New Mexico has a powerful array of tools, including Psychiatric Advance Directives, mental health first aid trainers, provisions for treatment guardians, certified peer specialists, and dedicated healthcare professionals and judicial and law enforcement personnel.

There is a widespread lack of knowledge about mental illness and the skills needed to respond to, and deescalate, a mental health crisis. In the absence of such information, those with mental illness tend to be feared and stigmatized. This leads to an over-reliance on law enforcement intervention responses.

- *HJM 17 Task Force Report*

Other mental health education programs such as LEAP (Listen-Empathize-Agree-Partner) offer family members and friends as well as others training to help fully engage individuals with mental illness, particularly individuals described as not adhering or only partially engaged in treatment and services. This and other training can also provide coaching in de-escalation strategies and skills and communication and problem solving skills appropriate for dealing with people who lack decisional capacity.

The Task Force wishes to emphasize not a general program of awareness or training but programs that have some proven effectiveness in the daily realities of the people to whom they are addressed. For example, some law enforcement personnel will benefit from one of the new specialized forms of mental health first aid. Others will need more advanced skill

based training. Similarly one form of training may help friends, families or others learn about particular forms of mental illness. Another person who has been unsuccessfully interacting with someone daily may wish to have a different set of engagement tools. A person experiencing mental illness may have attempted to use a PAD and most value coaching on how to prepare a more detailed PAD and where to *file* it to ensure it is followed.

Guidance, whether in the form of training or the form of coaching from a peer or family specialist is critical to The Task Force urges that much can be accomplished with some resourcing to support these recommendations and without major legislative changes.

8. Crisis System Improvement

Problem

The Task Force reviewed the work of another Task Force who made recommendations relevant to House Memorial 45 (2011 Regular Session). Many of the concerns expressed in the three bills that prompted HM 45 also involved crisis services and systems. Work is underway to implement the recommendations of House Joint Memorial 17 (2011 Regular Session).

Recommendation

Implement the House Joint Memorial 17 (2011 Regular Session) Task Force Recommendations.

Discussion

The Recommendations of the HJM 17 Task Force also aim to offer recommendations regarding peer services, system improvements and training. For HM 45 as well as HJM17, the recommendations are also recommendations aimed to offer individuals the best opportunities for living a life of recovery and participation in community life.

> *One of the greatest challenges facing law enforcement agencies and detention centers in New Mexico and across the nation is how to respond to people who have mental health disorders.*
>
> - HJM17 Recommendation Report

The Task Force submitting this report on HM45 fully supports the HJM17 recommendations and urges their implementation.

Those recommendations address:

- ❑ *System improvements*
- ❑ *Regional crisis triage centers*
- ❑ *Respite services*

- *Training*
- *Call Centers*
- *Warm Lines*
- *Community crisis system planning*
- *Peer Services*
- *Criminal Laws*

9 . Perceptions of Violence, Stigma & Treatment

Problem

Most people still believe that persons with mental illnesses are dangerous. As a result, Americans are hesitant to interact with people who are identified as having mental illnesses.

Recommendation

Establish and fund mental health first aid programs for first responders, healthcare professionals, law enforcement, detention and corrections officials, and the general public.

Discussion

The Task Force is aware that many highly publicized news events either emphasize the alleged perpetrators history of mental illness or speculate about the possibility of such an illness. There is a perception gap between public views of mental illness and the evidence about whom in our communities commits violence.

Having reviewed a large body of literature on violence and mental illness, the Task Force knows that people with mental illness are far more likely to be victims than perpetrators of violent crime. People with severe mental illnesses – schizophrenia, bipolar disorder or psychosis – are 2 ½ times more likely to be attacked, raped or mugged than the general population.

There are some diagnoses or symptoms that may be more commonly found than others when a violent act is committed by someone with a mental illness. However, other risk factors are more predictive of violent behavior, including a history of violence or witnessing violence, juvenile detention, physical abuse, losing a job, substance abuse or dependence and intimate partner violence in the past.

Although the accuracy of clinical and actuarial predictions of violence among patients exceeds chance, risk management means more than detaining people who

[T]he contribution of people with mental illnesses to overall rates of violence is small and the magnitude of the relationship is greatly exaggerated in the minds of the general population.

- Institute of Medicine, 2006

might commit violent acts. Neither clinical nor actuarial schemes will be reliable in predicting instances where someone acts violently for the first time because the most powerful predictor is past behavior.

The Task Force met with members of the New Mexico Intimate Partner Violence (IPV) Death Review Team, who reported that many IPV homicide offenders have had prior system contact for IPV related offenses. The IPV Review Team observed that comprehensive IPV counseling and education programs for offenders, beyond anger management are rarely available. In its recommendations for the community at large, the Review Team observed a number of cases where offenders were known by the victim, family members and/or friends to be depressed or suicidal prior to the homicide. Public awareness of these risks and improved knowledge of safety planning and appropriate intervention where mental health problems are suspected is needed.

There is no one simple message about risks of violence and mental illness. This complexity is part of the reason groups of committed people such as those who have served on the HM45 Task Force struggle to find the 'best' recommendations to offer policy makers and funders. What we have described briefly here are two of those messages that are well supported in current research. The first message is that the vast majority of people with mental illness are not violent.

The second message is one of relative risk and it is that under some circumstances people who with serious mental illness are somewhat more likely to commit violent acts than people who are not mentally ill. For example violence risk among people with psychotic disorders may have substantially different ways of unfolding than it does among individuals experience depression and both may be influenced by the use of alcohol or drugs.

> *Today , when asked "Are people with schizophrenia more violent?: I now answer "No, Not when they are in treatment and the symptoms are well controlled."*
>
> -Xavier Amador ,Ph.D. 2008

There is a third message also supported in the research and in our common experiences in communities. It is one of *attributable risk*, the message being that violence is a larger societal problem caused largely by other things besides mental illness, including the ready availability of guns and considerable reductions in funding for prevention and early intervention programs. The use of firearms as a method for suicide and programs promoting gun safety show some success with veterans in New Mexico.

An important tool for healthcare providers, first responders, law enforcement and government officials, and the general public that offers specific skills and also reduces the stigma surrounding mental illness is Mental Health First Aid. Over two thousand people have been trained in Mental Health First Aid throughout New Mexico with support from the Behavioral Health Collaborative. Continuing efforts to

> *Asking whether mental illness causes violence is a bit like asking whether political dysfunction causes war. The correct answers are "sometimes" and "it depends."*
>
> - Jeff Swanson, Ph.D. 2011

promote mental health first aid training are restricted only by available funding in local communities.

As mentioned in the *Guidance* recommendation, there are also other important opportunities for coaching and training by peers and others, for families and friends as well as people living with mental illness and community members. Those opportunities include not only skills needed in crisis situations but also strategies that increase the early identification of mental illness and the early identification of episodes of illness.

In addition to looking at public safety concerns, the Task Force was also tasked with fostering continuing respect for the constitutional rights of people with mental illness and understanding the recovery process and the important role of individual choices in treatment effectiveness.

[M]ental health professionals are best tasked with addressing the problems in our system that make it difficult for individuals and their loved ones to obtain effective, high quality mental health care early in life.
- New England Journal of Medicine

The recommendations of this report are intended to support optimal recovery, individual choices and public safety. The Task Force recommends:

- actions that unravel the funding streams to allow more flexible ways of creating and supporting community based services;
- actions that give access to earlier treatment of psychosis and continued treatment in the community; and
- actions that give individuals, families and friends access to the tools we have in New Mexico such as peer supports, treatment guardians and PADs.

House Memorial 45

A MEMORIAL
REQUESTING THE INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE TO CONVENE A TASK FORCE TO REVIEW NEW MEXICO LAW AND PRACTICES REGARDING CIVIL COMMITMENT PROCEEDINGS AND TREATMENT GUARDIANSHIP FOR INDIVIDUALS LIVING WITH MENTAL HEALTH DISORDERS.

WHEREAS, there is statewide concern regarding the timely provision of mental health care to state residents; and
WHEREAS, a number of bills have been introduced in the first session of the fiftieth legislature concerning the appropriate entity to petition for civil commitment, consent to treatment and concerns regarding treatment guardians; and
WHEREAS, involuntary civil commitment in the state is governed by the Mental Health and Developmental Disabilities Code; and
WHEREAS, there is a diverse statewide interest in resolving these issues of mental health public policy for the benefit of all New Mexicans;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF NEW MEXICO that the interagency behavioral health purchasing collaborative be requested to convene a task force to address the issues raised in House Bills 497 and 559, as well as House Bill 499 and related legislation introduced during the first session of the fiftieth legislature; and

BE IT FURTHER RESOLVED that the task force members include, at a minimum, representatives from the New Mexico district attorney's association; the public defender department; the New Mexico association of counties; the department of public safety; the human services department; the department of health; the aging and long-term services department; the office of guardianship of the developmental disabilities planning council; the New Mexico behavioral health institute; the university of New Mexico health sciences center; other New Mexico psychiatric inpatient treatment facilities; the national alliance on mental illness; four

individuals living with mental illness; disability rights New Mexico; the New Mexico mental health association; and representatives from the behavioral health planning council of New Mexico; and

BE IT FURTHER RESOLVED that the task force be requested to report its findings and recommendations to the legislative health and human services committee and to the courts, corrections and justice committee; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the chief executive officer of the interagency behavioral health purchasing collaborative; the chief public defender; the director of the administrative office of the district attorneys; the executive director of the New Mexico association of counties; the secretary of public safety; the secretary of human services; the secretary of health; the secretary of aging and long-term services; and the manager of the office of guardianship of the developmental disabilities planning council.