NYC Mental Health Care Monitoring Initiative

Accountability for engagement of high-need consumers

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

to

Governor David A. Paterson

and

Mayor Michael R. Bloomberg

Panel Co-Chairs

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What the Research Tells Us

- **Mental illness alone is <u>not</u> a major driver of violent crime; individuals w. mental illnesses more likely to be *victims* of violence**
- **Risk of violence increased among those w. <u>both</u> mental illnesses & substance use**

	% Violent	
	No Sub. Abuse	Sub. Abuse
Gen. Pop.	3.3%	11.1%
Released from psych hospital	4.7%	22.0%

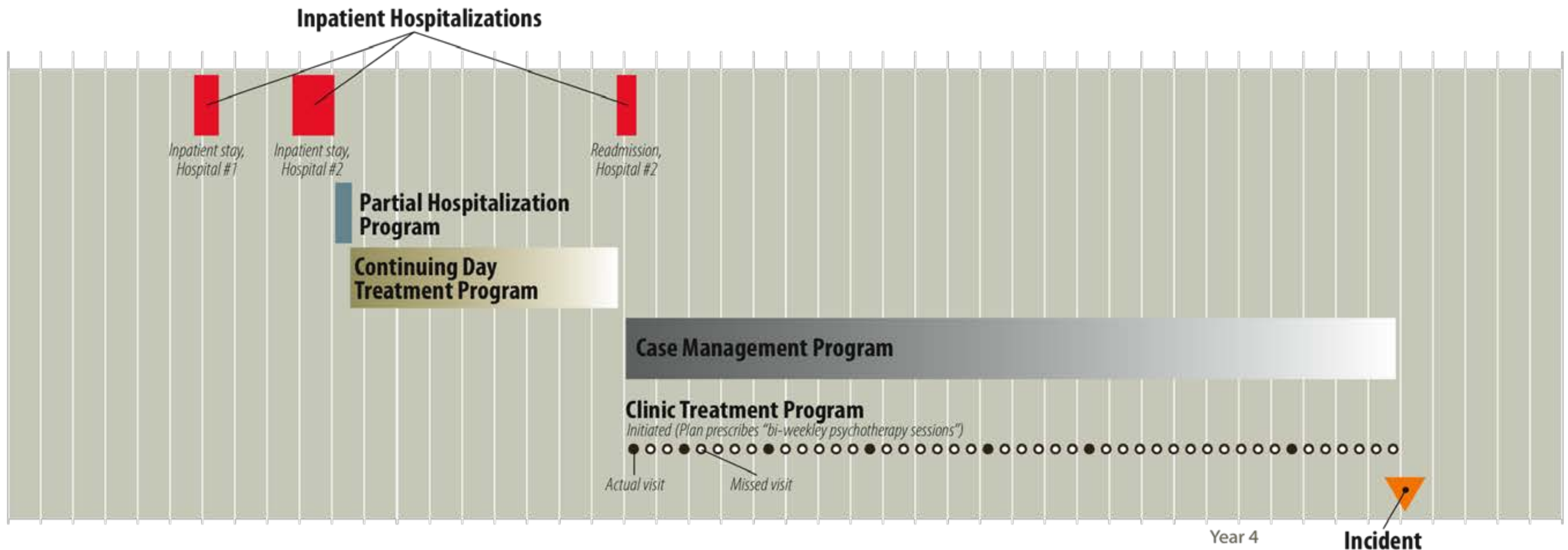
What the Research Tells Us

- **Treatment greatly reduces the risk individuals w. mental illnesses will be violent**

MI discharged from psych hospital:	% Violent
Attended weekly treatment	2.9%
No treatment	14.0%

Poor coordination, fragmented oversight and a lack of accountability; an example of treatment in the mental health system.

A Hypothetical Case:



Courtesy of Walter Boppert
OMH Public Information

Case review of individual involved in random assault

- This man had a long history of treatment non-adherence, frequent relapses, and repeated hospitalizations.
- With inpatient treatment, he would stabilize and agree to follow aftercare recommendations. Once discharged to community care, however, his engagement in treatment deteriorated and the cycle repeated itself.
- The community mental health intensive care program failed to deliver intensive care.
- The program was known to be minimally compliant with standards of care and had not improved its functions despite multiple regulatory reviews and advisor input.
- This man had a serious illness, was undergoing major family stressors and was labeled as a “client of concern,” but the program’s clinical leadership was neither sought nor provided when problems began to mount.
- The man was not offered integrated treatment for mental illness and substance abuse.
- No alternative efforts to engage him in care were carried out.
- Intervention was not “stepped up” as his condition deteriorated.
- The team had minimal contact with the patient during hospitalizations.

Panel Findings:

- Poor coordination, fragmented oversight and lack of provider accountability for high-need consumers
- Inconsistency in quality of outreach and engagement by providers
- Limited capacity to share information within and between the mental health and criminal and juvenile justice systems

Panel Recommendations:

- Issue and monitor the use of Standards of Care for mental health clinics
- Include information sharing protocols in the Standards of Care
- Create Care Monitoring Teams for high-need consumers
- Use data to track service use and flag cases for review
- Implement recommendations of OMH/OASAS Task Force on Co-Occurring Disorders regarding use of screening and EBPs
- Improve OCFS discharge planning and aftercare services

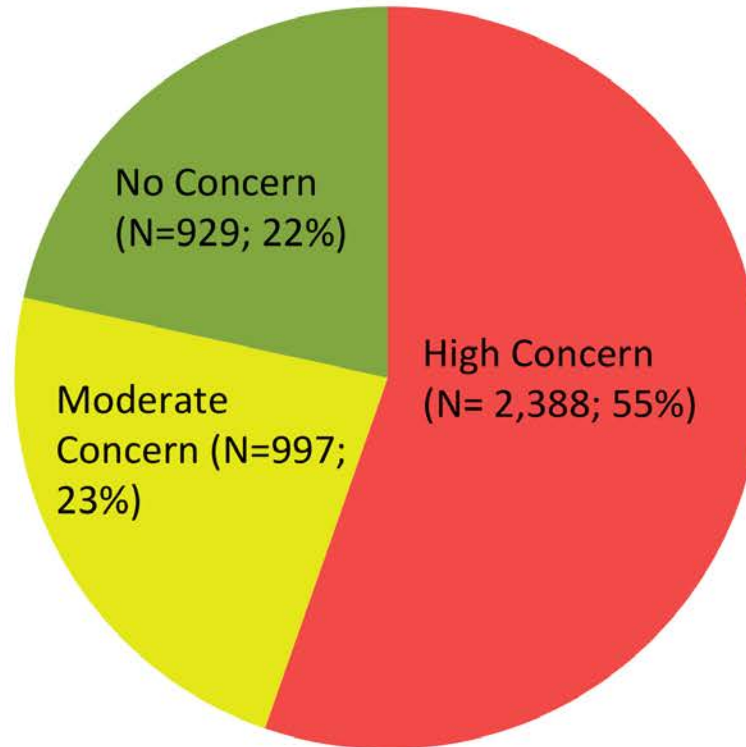
Care Monitoring Procedures

- Targets individuals who have received **AOT** or recent **ACT/case management** services; been in state **forensic** system; or had **multiple acute** (psych inpatient/ER) visits.
- Monthly reports list individuals with no recent psych medication scripts filled; no recent outpatient mental health visits; or multiple recent inpatient/ER visits.
- Care monitors review data with providers and recommend outreach/re-engagement strategies.

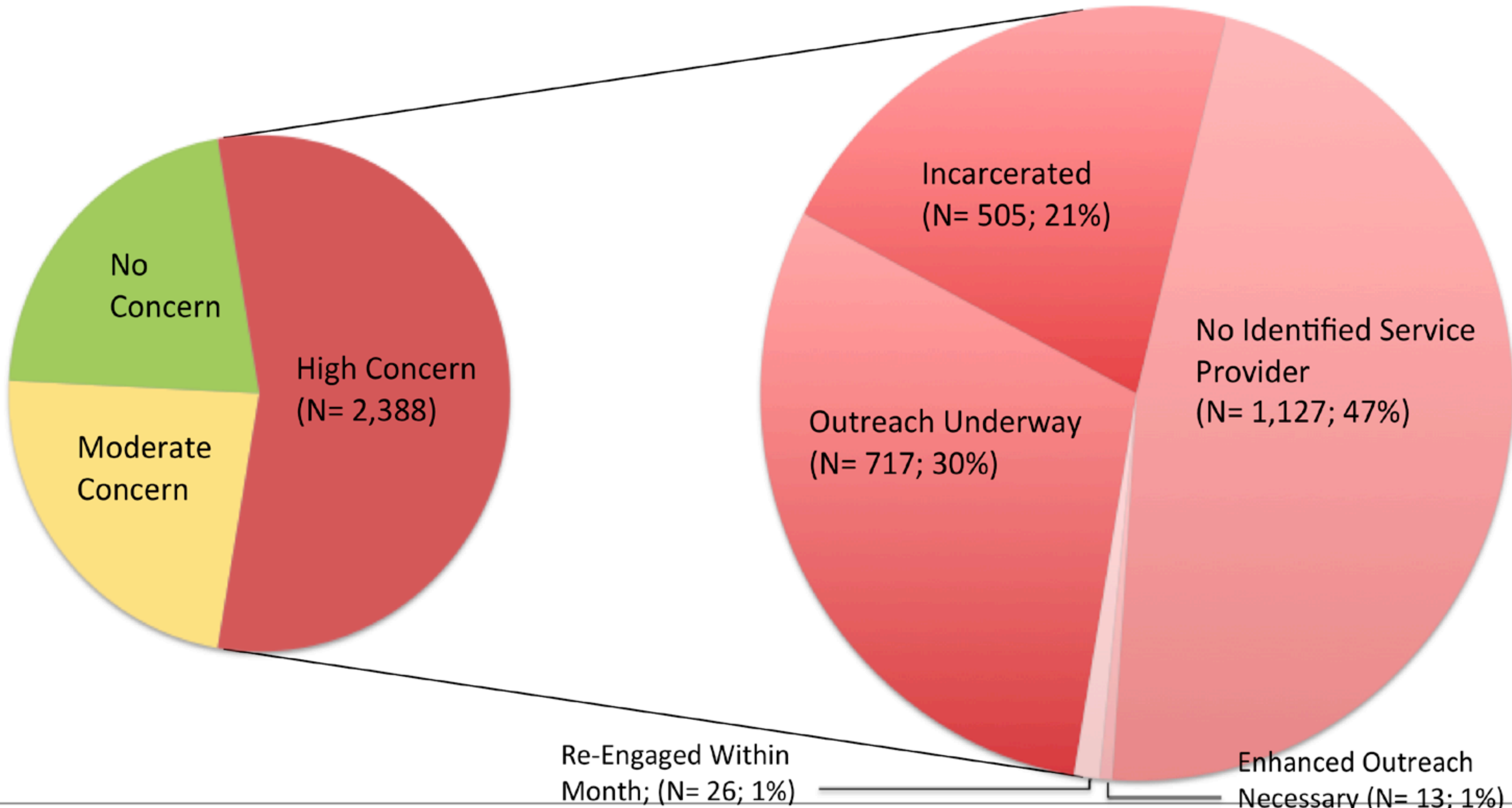
Care Monitoring Reviews, Brooklyn 2010

- 13,321 individuals in the high-need cohorts
- 10,118 (76%) met a notification at least once between Jan-Dec 2010
- Of reviews initiated, 43% could not be completed due to inadequate information:
  - No recent service use data identifying providers that could be contacted
  - Confidentiality regulations prohibited contact with providers
  - Providers did not respond to reviewers

Category assignments for 4,314 completed case reviews, Brooklyn 2010



Classification of High Clinical Concern cases

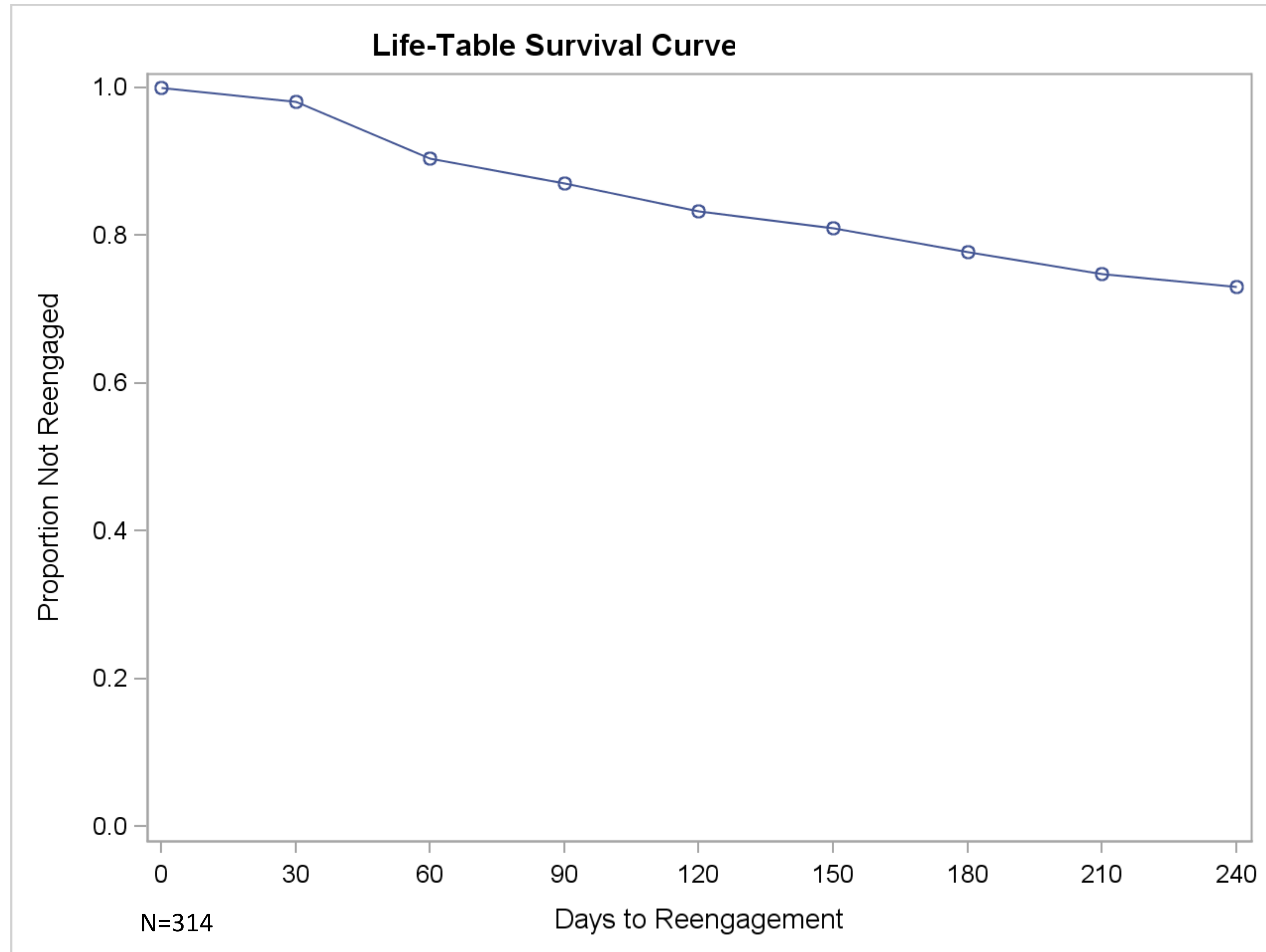


What have we learned?

- Medicaid claims data can identify individuals with SMI and high service needs who may need outreach and engagement.
- Many of these individuals are not engaged in adequate and appropriate services.
- Limits on cross-system information sharing impedes re-engagement and care coordination.
- Individuals enrolled in full-benefit managed care plans were just as likely to trigger notifications as those in fee for service.

Big question: how do you get these individuals back in care?

How many high concern individuals re-engage in care and how long does it take?



Inclusion criteria: All individuals categorized as high clinical concern from January-September 2010

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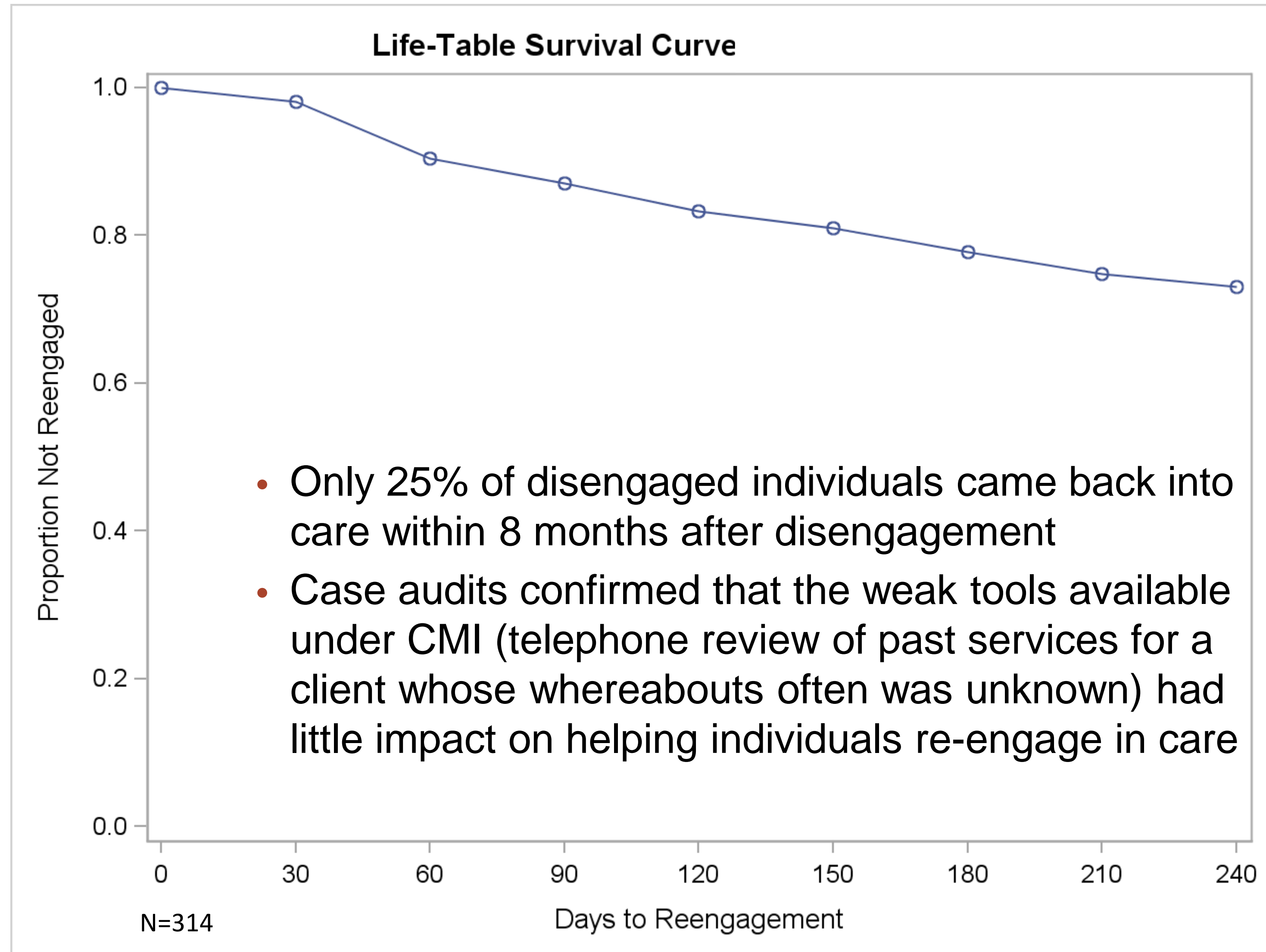

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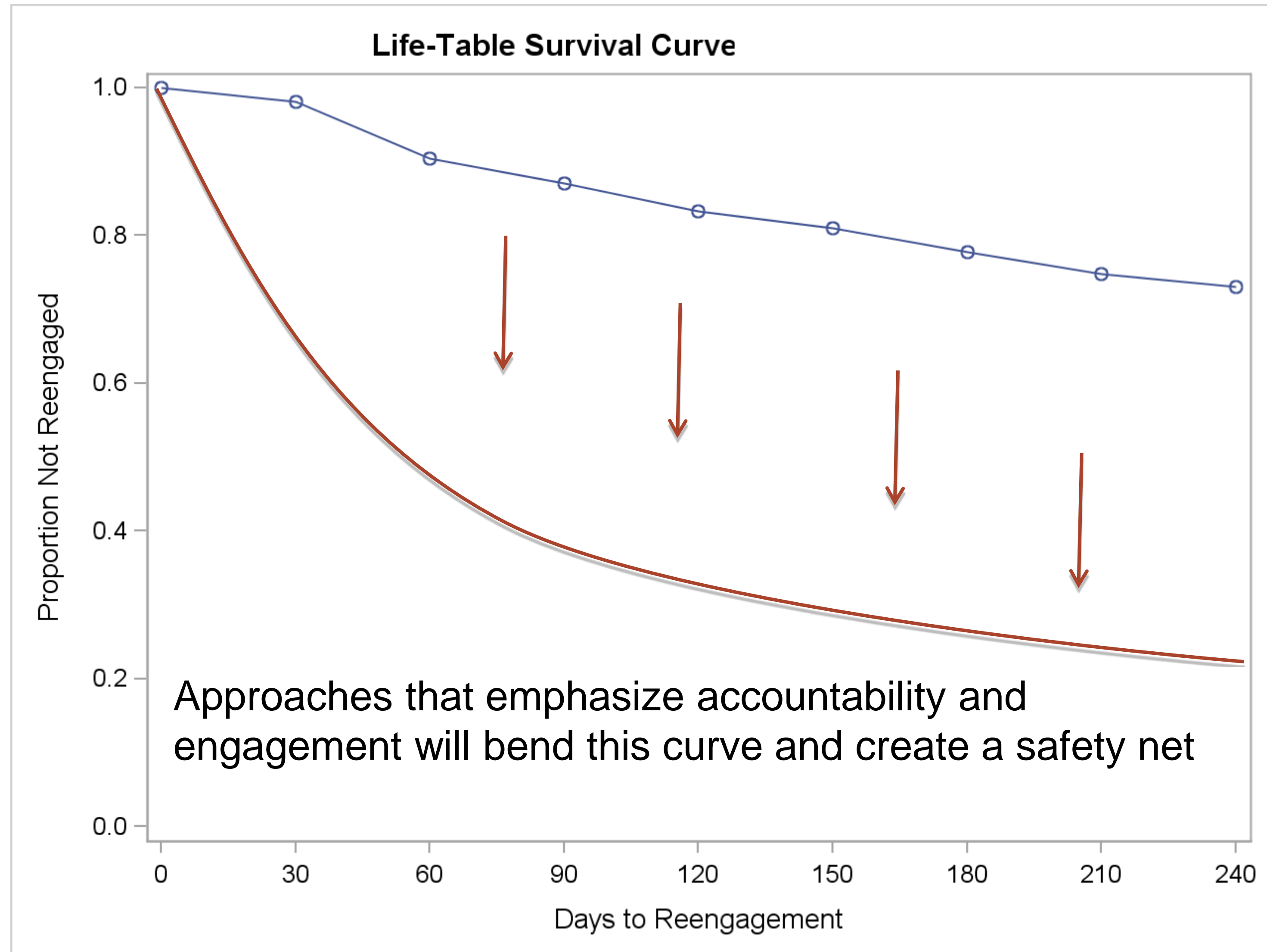

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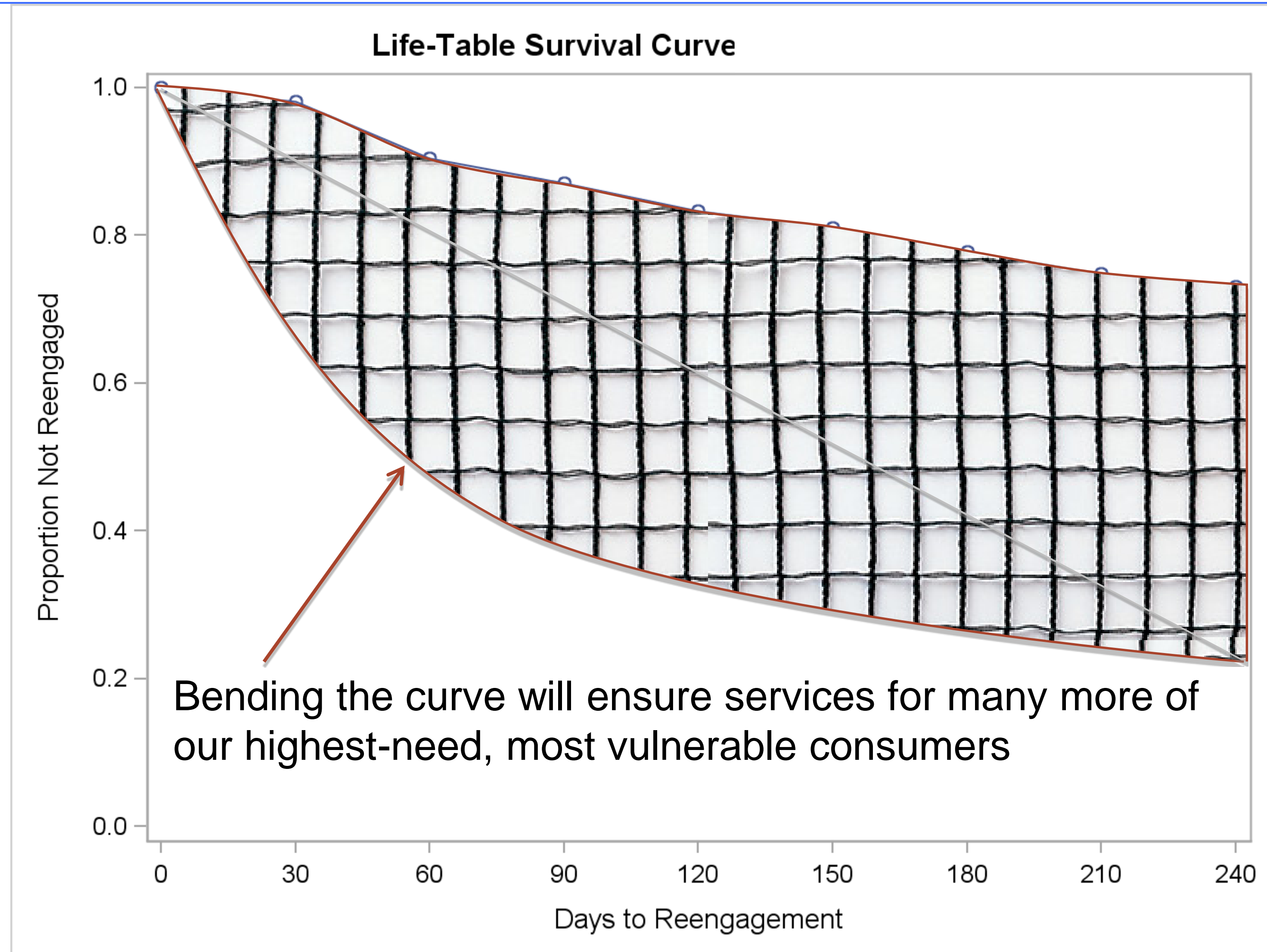

Care Monitoring: A good outcome case

Mr. M was a 31 year-old male with schizophrenia and a co-occurring substance abuse disorder who had a prior AOT order and met all 3 notifications (no outpatient mental health services, no psychiatric medication fills, and multiple acute service use). He had 13 hospitalizations in the prior year. Previous discharge plans included referrals to a shelter, walk-in clinic, and clinic appointments, which were rarely attended. Upon initial review, Mr. M was on an inpatient psychiatric unit and the team was unwilling to modify the discharge plan due to his history of poor follow-up. A joint case conference was requested and the care monitor modeled a shared decision making approach with the clinical team and Mr. M, who agreed to re-connect with an assertive community treatment (ACT) team and accept a long-acting injectable medication prior to discharge. The ACT Team engaged Mr. M during hospitalization and facilitated housing post discharge. After several months he remained engaged by the ACT team and broke the cycle of repeated hospitalizations.