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Administrative Policy Facilities/Hospital (APF) 106

Not Guilty by Reason of Insanity (NGRI) Committee & Processes

Why Now?

- Immediate need for standardization of NGRI processes across hospitals and community providers
- Ensure treatment is individualized and in accordance with Michigan Mental Health Code

Policy

All persons adjudicated NGRI and who are probate court ordered for treatment are entitled to treatment, care, and services in the least restrictive setting that is appropriate and available. Decisions regarding treatment will be made to promote safely supporting persons in the least restrictive setting with community integrated services and ongoing outpatient treatment as clinically indicated.

Policy Purpose

- Discharges and Leaves of Absence (LOA) for NGRI persons are appropriately reviewed and approved by the NGRI committee
- Treatment recommendations are based on actual individualized needs, including risk mitigation strategies
- Treatment is provided in the least restrictive setting that is appropriate and available

Leave of Absence

A temporary leave from a hospital ordered by a physician for treatment or community engagement purposes that does not exceed one year. The NGRI committee will be notified of LOAs and evaluate and approve any non-medical LOAs that include an overnight stay.

What is NOT New

- Requests for discharge or leave of absence (LOA) overnight or longer require prior NGRI committee approval
- NGRI persons may initially be placed in the community on **LOA** while still on hospitalization order – similar to former Authorized Leave Status (ALS) - patient is still considered hospitalized, but on leave
- Ninety-day reports required

What is NOT New (cont.)

- Significant events are reported to the NGRI committee
  - Deterioration of condition
  - Unauthorized leaves of absence
  - Treatment non-adherence
- Forensic Liaisons manage and coordinate services between hospitals and community settings
- The NGRI committee will seek independent forensic examination for violent offenses

What is New

- The NGRI committee may recommend discharge from a hospital to Assisted Outpatient Treatment (AOT)
- The NGRI committee will **not** recommend **continuing hospitalization** orders for NGRI persons residing in the community, but rather may recommend continuing AOT order
- NGRI committee involvement shall not exceed 5 continuous years of AOT

What is New (cont.)

- **Authorized Leave Status (ALS) and ALS contracts are being retired over the next year**
- Instead IPOS focus areas with individualized risk mitigation strategies integrated into the goals and interventions
  - Reviewed and updated regularly by teams with NGRI committee input
  - Conversion from ALS contract to IPOS with risk mitigation will occur at the time the current treatment order expires and a new AOT order is issued or when the patient requests.

Risk Mitigation Strategies

Strategies in a person's IPOS designed to reduce a person's risk of harming themselves or others. Risk mitigations strategies must be tied to the person's behavioral health treatment needs.

Assisted Outpatient Treatment (AOT) Order

A probate court order which can incorporate both outpatient and inpatient treatment.

AOT:

- may include case management services to provide care coordination
- under the supervision of a psychiatrist
- developed in accordance with person-centered planning

AOT May Include:

- Medications
- Blood testing
- Individual or group therapy
- Day or partial day programming
- Vocational, educational or self help activities
- ETOH/substance abuse treatment and testing for persons with history of substance use disorder
- Supervision of living arrangements
- Other services

If NGRI Committee Disapproves…

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- Written notification provided to person, guardian, hospital director, and team including detailed reason for decision and treatment recommendations that will lead to approval
- Team will notify patient or guardian of ability to file petition for discharge from treatment
- Person, guardian, hospital director, or team may request administrative review that decision was made in compliance with applicable mental health law. If not, reconsideration by NGRI committee and further action and approval by SHA senior deputy director

Supervisory Level Forensic Psychiatrist

A forensic psychiatrist assigned by the Center for Forensic Psychiatry director who coordinates services between the hospital treatment team, the NGRI Committee and the forensic liaison. This position advises the hospital treatment team to ensure, at a minimum, that risk mitigation strategies have been addressed based upon the person's behavioral health needs

Duties of SLFP

Meet regularly with regional hospital teams to provide input regarding

- Use of appropriate risk mitigation strategies in the IPOS of NGRI persons
- Proper administration of Clinical Certificates
- Relevant clinical and legal forensic issues
- Quality control/monitoring of above

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Clinical Certificates

What is a Clinical Certificate?
The short answer:

- Legal document containing conclusions and statements supporting the opinion whether an individual is a **PERSON REQUIRING TREATMENT**

What is a Clinical Certificate?
The long answer:

Process which incorporates:

1. Consideration of discharge planning
2. Face to face examination
3. Review of relevant records
4. Consultation with treatment team
5. Completion of appropriate form and submission to court
6. Court testimony supporting the opinions asserted

How does discharge planning impact clinical certificates?

- MMHC requires persons receive treatment in the least restrictive setting
- Ongoing assessment of individual needs – input from treatment team
- **Recommendations for hospitalization orders can not be based solely on maintaining NGRI status**

PERSON REQUIRING TREATMENT

- First criteria – Does the person have a mental illness?

  substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life

PERSON REQUIRING TREATMENT

- Second criteria – (a) and (b) as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

PERSON REQUIRING TREATMENT

- Second criteria – (c) as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

PERSON REQUIRING TREATMENT

- Second criteria – (d) whose judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

Conducting the Examination

- Make every effort for face-to-face examination
- Even if person is unwilling to participate, direct observations of mental status can be incorporated
- Clinical circumstances will determine structure/content of interview i.e. treating clinician vs. initial meeting
- Prior to interview, examiner must read or paraphrase following statement:

  I am authorized by law to examine you for the purpose of advising the court if you have a mental condition which needs treatment and whether such treatment should take place in a hospital or in some other place. I am also here to determine if you should be hospitalized or remain hospitalized before a court hearing is held. I may be required to tell the court what I observe and what you tell me.

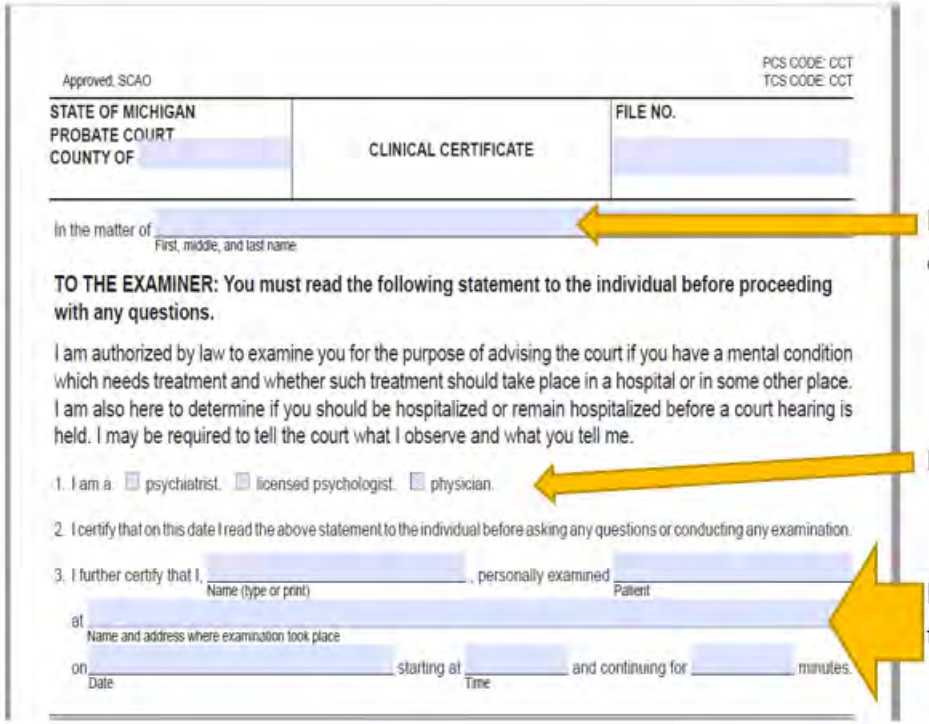
Conducting the Examination (cont)

- (a) Suicide risk assessment
- (b) Violence risk assessment
- (c) Assessment of person's ability to attend to basic physical needs
- (d) Understanding of need for treatment
  - Do you think you have a mental illness or need treatment?
  - What symptoms of mental illness do you experience?
  - How do your medications help you? What would happen if you stopped your medications?

Understanding MI and NGRI Acquitees

- How did mental illness impact thoughts and behaviors at the time of offense
- How to recognize and manage symptoms should they worsen
- What would be done differently given the same circumstances
- If the person is seeking to be discharged from the hospital, what is the plan for living in a community setting: Where would you live? Who would be a support for you? Finances? Follow-up care?

Completing a Clinical Certificate



Approved, SCAO

PCS CODE: CCT
TCS CODE: CCT

STATE OF MICHIGAN PROBATE COURT COUNTY OF	CLINICAL CERTIFICATE	FILE NO.

In the matter of _____
First, middle, and last name

TO THE EXAMINER: You must read the following statement to the individual before proceeding with any questions.

I am authorized by law to examine you for the purpose of advising the court if you have a mental condition which needs treatment and whether such treatment should take place in a hospital or in some other place. I am also here to determine if you should be hospitalized or remain hospitalized before a court hearing is held. I may be required to tell the court what I observe and what you tell me.

1. I am a ☐ psychiatrist, ☐ licensed psychologist, ☐ physician.

2. I certify that on this date I read the above statement to the individual before asking any questions or conducting any examination.

3. I further certify that I, _____ (Name (type or print)), personally examined _____ (Patient)

at _____
Name and address where examination took place

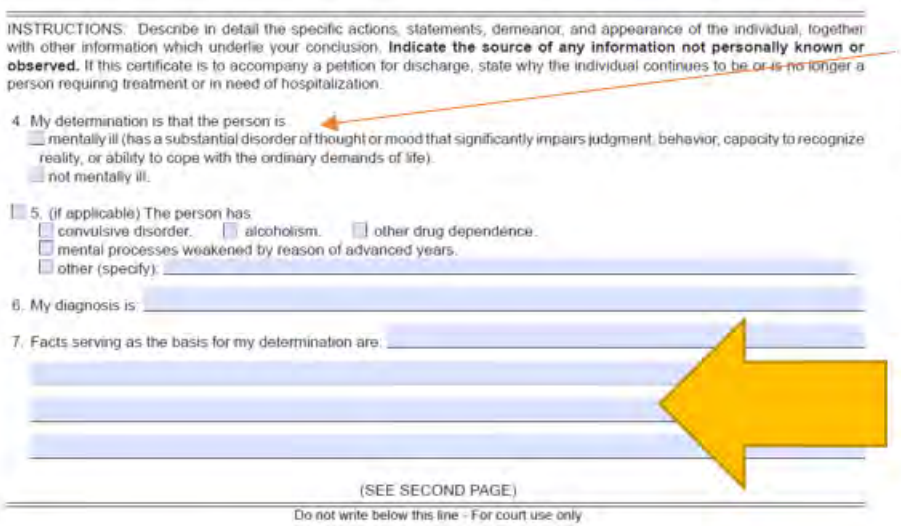
on _____ (Date) starting at _____ (Time) and continuing for _____ minutes.

Full name of person must be entered.

Examiner's Credentials

Examiner, patient, location, date, time and duration.

All of the above information must be entered. Examiner will likely be asked during voir dire/testimony about this information.



INSTRUCTIONS: Describe in detail the specific actions, statements, demeanor, and appearance of the individual, together with other information which underlie your conclusion. **Indicate the source of any information not personally known or observed.** If this certificate is to accompany a petition for discharge, state why the individual continues to be ~~or is~~ no longer a person requiring treatment or in need of hospitalization.

4. My determination is that the person is:
   - ☐ mentally ill (has a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life).
   - ☐ not mentally ill.

5. ☐ (if applicable) The person has:
   - ☐ convulsive disorder. ☐ alcoholism. ☐ other drug dependence.
   - ☐ mental processes weakened by reason of advanced years.
   - ☐ other (specify):

6. My diagnosis is:

7. Facts serving as the basis for my determination are:

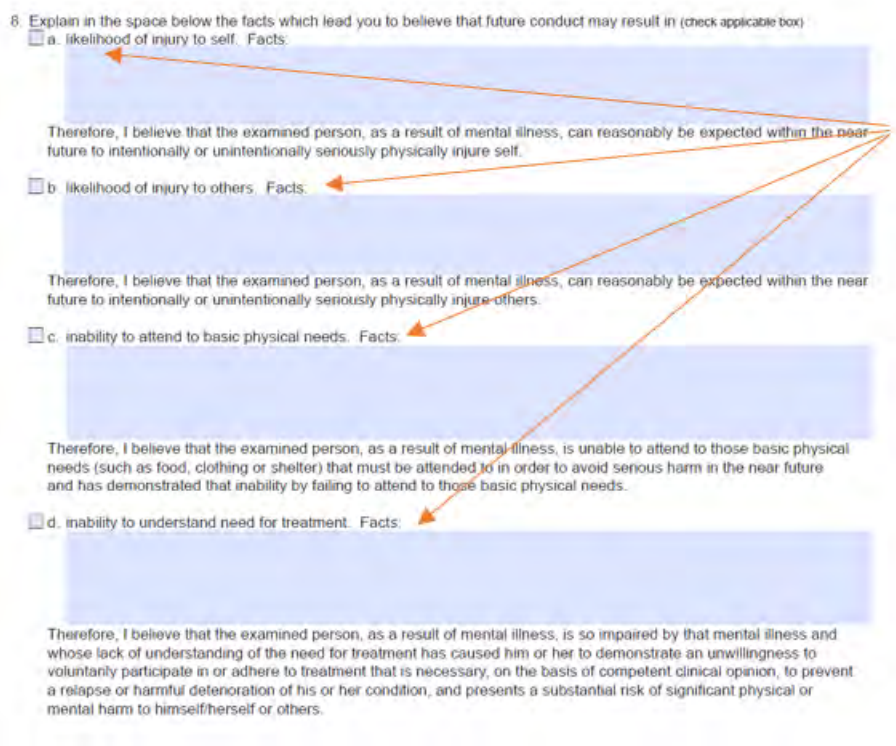
(SEE SECOND PAGE)

Do not write below this line - For court use only

In filling out the petition, you must determine whether the person is mentally ill or not. Someone not mentally ill does not meet the criteria for civil commitment.

Enter diagnosis and data supporting diagnosis and conclusion.

Facts should include pertinent observations and gathered history.



8. Explain in the space below the facts which lead you to believe that future conduct may result in (check applicable box)

☐ a. likelihood of injury to self. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self.

☐ b. likelihood of injury to others. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure others.

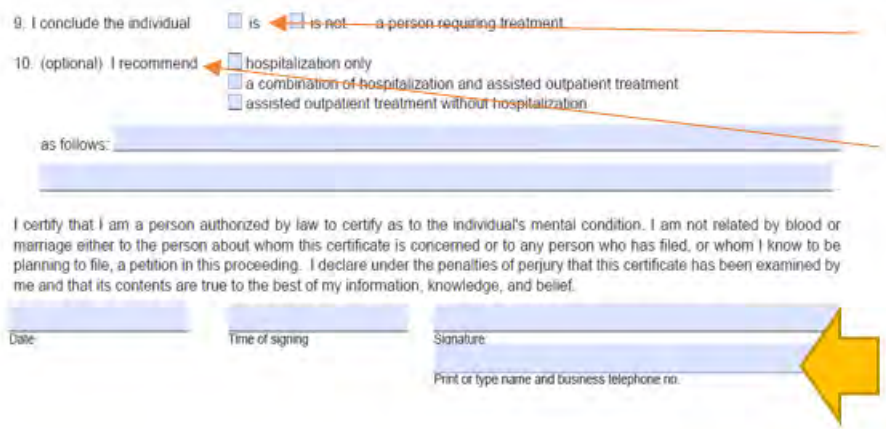
☐ c. inability to attend to basic physical needs. Facts:

Therefore, I believe that the examined person, as a result of mental illness, is unable to attend to those basic physical needs (such as food, clothing or shelter) that must be attended to in order to avoid serious harm in the near future and has demonstrated that inability by failing to attend to those basic physical needs.

☐ d. inability to understand need for treatment. Facts:

Therefore, I believe that the examined person, as a result of mental illness, is so impaired by that mental illness and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to himself/herself or others.

You should only petition for civil commitment if the individual meets either a, b, c or d. If the individual meets a, b, c, or d, you must check the correct box and enter facts supporting that conclusion.



Must conclude whether the individual requires treatment or not.

May recommend type of order.

Must sign, date/time and print examiner's name.

Petitions for involuntary mental health treatment must accurately reflect the treatment the individual will receive. Petitions for hospitalization should only be filed if the person meets the criteria for inpatient hospitalization and will receive treatment in the hospital. If the person is going to receive treatment in the community, the petition must request AOT or combined AOT/hospitalization. This is the case regardless of an individual's NGRI status.

Court Testimony

- Credentials
- Was the advisement statement at the top of the clinical certificate read prior to interviewing
- Relationship with the person, and whether they met with the person specifically for the purposes of determining the need for civil commitment
- Whether the person has a mental illness as statutorily defined
- The basis for the determination regarding mental illness (symptoms, behavior and history)
- Whether the person meets criteria as a person requiring treatment, and the basis for this determination
- What level of care the individual requires (hospital, outpatient) and why

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NGRI Committee

What will remain the same?

- Most NGRI operations will be unaffected.
- Ninety-day reports will continue to be sent to the NGRI Committee and regional hospital.
- Discharges, move requests, changes to IPOS risk mitigation strategies, and overnight leaves of absence (LOAs), and permission to leave the State will still require NGRI committee approval.
- The NGRI Committee and regional hospital will still need to be notified about:
  - ❑ Deterioration or changes in mental status of patient condition
  - ❑ Unauthorized leaves of absence (ULOA)
  - ❑ Treatment non-adherence
  - ❑ Any problematic issue which could interfere with the patient's stability, safety, and progress in treatment
- Provide consultation as needed to assist in coordinated care of individual
- Individuals can still receive NGRI Committee monitoring for a period of up to five continuous years once released into the community

Summary of Changes

- The dissolution of the ALS Contract
- Individuals will no longer be on hospitalization orders in the community
- Transition all ALS/hospitalization orders to AOT orders with appropriate risk mitigation strategies incorporated into the IPOS at the expiration of a hospitalization order or upon request if the person meets the criteria for treatment
- If they meet criteria, individuals will be transitioned to an AOT and still receive monitoring by the NGRI Committee while in the community
- NGRI Committee will no longer be reviewing ground cards or staff-escorted outings at the regional
- NGRI Committee will now consult with the CMHSP on appropriate risk mitigation strategies to be included in an IPOS once a person is discharged to the community on an AOT order

The ALS Contract

Historically

- Agreement between the patient, NGRI Committee, regional hospital, and CMH
- Identified CMH Requirements, Requirements for all NGRI patients, and Individual Requirements
- Identified court and NGRI reporting timelines
- Committed CMHs to provide care, defined placement, defined level of services
- Document to assist the individual in understanding treatment expectations
- Guided reporting of contract nonadherence, significant changes in clinical condition
- Assigned approval of overnight leaves, changes in placement, and services to the NGRI Committee

How/Why were ALS Contract Individual Requirements identified?

- Treatment teams, CMH, and NGRI Committee assessed each person's individualized risk factors
- Identified what level of care would offer the most appropriate support as the individual transitions back to the community.
- Identified what individualized services would be available and provided to patient to enhance their support and treatment in community
- Incorporated additional requirements that were **individualized** to reduce a person's risk to engage in dangerous behavior

How will we ensure continuity of care?

Transitioning ALS Contract into IPOS Development

- From the time of admission, treatment teams should be utilizing assessments to identify what factors may have led to the NGRI offense (Focus Areas and Discharge Barriers)
- Consider what factors may have led to past episodes of hospitalizations, risk of harm to self or others, or legal involvement (Focus Areas and Discharge Barriers)
- What supports/services/circumstances will increase an individual's success in the community
- Incorporating those identified services into our IPOS Focus Areas, Short/Long-Term goals, and into Interventions
- Carefully formulate IPOS interventions that correlate to the individualized risk mitigation strategies
- IPOS Focus Areas, Goals, and Interventions should be fluid and should be based on the individual's progress in treatment

Prior to release from the hospital into the community

- CMH, treatment team, and patient will consider the identified focus areas of treatment and determine if discharge criteria has been met
- Identify those services and placement options that are available in the community
- Treatment teams will submit Discharge/Release Request Memo to the Committee identifying recommended level of care and services that will be incorporated to sufficiently mitigate risk
- NGRI Committee will review and offer recommendations for placement, services, and risk mitigation strategies
- Once approved, those individualized risk mitigation interventions recommended by the NGRI committee will be incorporated into the IPOS in the community.

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How can we incorporate risk mitigation strategies into the IPOS?

Focus Area/Problem: Psychosis
Mr. Jones has a history of paranoid delusions, auditory hallucinations, and thought disorganization that continue to result in impaired interactions with others, as evidenced by isolation, accusations that others are trying to harm him, and aggression. His symptoms of paranoid delusions and hallucinations were related to his NGRI offense and have resulted in multiple past hospitalizations.

Long-term Goal:
Mr. Jones will increase reality testing and decrease paranoid delusions and auditory hallucinations as evidenced by organized and relevant thought processes and increased communication and interactions that are devoid of paranoid content.

Short-term Goal:
#1: Mr. Jones' paranoia and thought disorganization will improve to the extent that he is able to participate in individual therapy once weekly for at least 15 minutes.

#2: Mr. Jones' hallucinations, paranoia, and disorganized thinking will diminish to the extent that he is able to engage in a relevant conversation with staff or peers for 10 minutes per shift.

#3: Mr. Jones will initiate contact with staff when he is experiencing increased symptoms or warning signs to assist him in coping with his paranoia delusions or hallucinations.

Interventions:
Psychiatry: Mr. Jones will be seen for 1:1 intervention for 15 minutes once weekly. The unit psychiatrist will prescribe medication to treat his symptoms of paranoid delusions, auditory hallucinations, and thought disorganization. Psychiatrist will assess the therapeutic response to this medication and provide education regarding potential side effects.

Unit RN: RN will meet with Mr. Jones for 10 minutes per week to provide education about how his antipsychotic medication can reduce his paranoid delusions, auditory hallucinations, and thought disorganization.

Social Worker: Clinician will meet with Mr. Jones for at least 15 minutes weekly for individual supportive therapy. Sessions will be designed to provide education regarding his paranoid delusions, auditory hallucinations, and thought disorganization and to ultimately connect those symptoms to his NGRI offense.

Chief Clinician will provide weekly 50-minute Symptoms Management Group to educate Mr. Jones on his acute and persistent symptoms of schizophrenia. Chief Clinician will also provide weekly 50-minute Social Cognition Interaction Training (SCIT) group to assist Mr. Jones in accurately perceiving others' perspectives and emotions and to address his paranoid delusions and improve interactions with others.

Psychology: The unit psychologist will provide Mr. Jones once weekly 50-minute NGRI and Understanding Mental Illness groups. The focus of these groups will be to facilitate awareness of his paranoid delusions, auditory hallucinations, and thought disorganization, their influence on the NGRI offense, and relapse prevention. Mr. Jones will be encouraged to make reality-based contributions.

Rehabilitation Services Therapist: Rehabilitation Services therapist will include Mr. Jones in weekly 50- minute unit groups, which may include Arts & Crafts, Self-Expression, Wellness, Personal Interest, Leisure Skills weekly. Will engage him in reality-based group and 1:1 discussion, providing redirection to task at hand when needed. Will promote increased, attention/focus.

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Hospital IPOS Example

Focus Area/Problem: Assaultive and Threatening Behavior

Mr. Jones has physically assaulted and verbally threatened peers 6 times in the past 90 days. These episodes of physical aggression tend to be precipitated by command auditory hallucinations and paranoid delusions. These symptoms were also present during the NGRI offense (Assault with Intent to Murder).

Long-term Goal:

Mr. Jones will demonstrate adaptive coping strategies pertaining to his voices and paranoia instead of assaulting others.

Short-term Goal:

#1: Mr. Jones will be free of assaultive behavior for 60 days (or shorter duration based on how frequently patient is assaulting).

#2: Mr. Jones will identify 2 adaptive coping strategies he can utilize to address his paranoid delusions and command auditory hallucinations instead of assaulting others.

Interventions:

Psychiatry: Psychiatrist will meet with Mr. Jones for individual supportive interventions for 30 minutes per month/week to help him understand how his medication can assist in alleviating his paranoid delusions and auditory hallucinations to decrease his aggressive behavior.

Unit RN: Unit RN will offer Mr. Jones suggestions to distract him, alternative coping skills, or a prn when he is observed to be verbalizing paranoid delusions towards peers, pacing with fists clenched, or making verbal threats towards peers.

Social Worker: Chief Clinician will meet with Mr. Jones for individual supportive for 30 minutes weekly to assist him in identifying increases/changes in his paranoid delusions and auditory hallucinations and encourage him to alert staff when symptoms are increasing or becoming unmanageable.

Chief Clinician will provide Mr. Smith 50-minute weekly Anger Management Group and Stress Management groups with the focus of identifying and utilizing coping skills to address his paranoid delusions and auditory hallucinations.

Psychology: A psychological assessment will be completed with Mr. Jones within 30 days for purposes of identifying patterns of aggression, including antecedents such as mood or affect changes, sensory stimulation, and inconsistent self-report of his internal experiences.

Discharge Barriers: Mr. Jones has been assaultive over the last 30 days towards staff and peers. His symptoms are not in adequate remission at this time as evidenced by paranoid beliefs that other are talking about him and command auditory hallucinations to hit others. These symptoms were also present during the NGRI offense. Mr. Jones continues to lack insight into his symptoms, how they are associated with the NGRI offense, and struggles to identify strategies that can assist in managing his illness.

Services Needed Upon Discharge: Upon meeting discharge criteria, Mr. Jones will be transferred to a regional hospital/community/etc. Recommended services include:

Pharmacotherapy/Medication management/reviews, Individual Therapy, CMH involvement, Case Management services, Anger Management Group, DBT to address emotional dysregulation, NA/AA/Substance Abuse Treatment, Vocational Programming

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Hospital IPOS Example

Focus Area/Problem: Psychosis

Mr. Jones has a history of paranoid delusions, auditory hallucinations, and thought disorganization that continue to result in impaired interactions with others, as evidenced by isolation, accusations that others are trying to harm him, and aggression. His symptoms of paranoid delusions and hallucinations were related to his NGRI offense and have resulted in multiple past hospitalizations.

Long-term Goal:

Mr. Jones will increase reality testing and decrease paranoid delusions and auditory hallucinations as evidenced by organized and relevant thought processes and increased communication and interactions that are devoid of paranoid content.

Short-term Goal:

#1: Mr. Jones' paranoia and thought disorganization will improve to the extent that he is able to participate in individual therapy once weekly for at least 60 minutes.

#2: Mr. Jones will be available to meet with the ACT team during designated times three times per week.

#3: Mr. Jones will initiate contact with staff when he is experiencing increased symptoms or warning signs to assist him in coping with his paranoia delusions or hallucinations.

Interventions:

Psychiatry: Mr. Jones will be seen for monthly medication reviews. The psychiatrist will prescribe medication to treat his symptoms of paranoid delusions, auditory hallucinations, and thought disorganization. Psychiatrist will assess the therapeutic response to this medication and provide education regarding potential side effects.

Unit RN: RN and ACT team will meet with Mr. Jones three times per week to provide medication, assess for changes in symptomatology, and provide education about how his antipsychotic medication can reduce his paranoid delusions, auditory hallucinations, and thought disorganization.

Social Worker/Therapist: Therapist will meet with Mr. Jones for weekly 60-minute individual supportive therapy. Sessions will be designed to provide education regarding his symptoms of illness, discuss what may have led to past hospitalization and legal involvement, and to devise coping strategies to deal with persistent symptoms and enhance interpersonal interactions.

Social Worker will provide weekly 60-minute Symptoms Management Group to educate Mr. Jones on his acute and persistent symptoms of schizophrenia and to aid in recognition of warning signs and the development of relapse prevention strategies.

Psychology: The psychologist will provide Mr. Jones once weekly 60-minute Co-Occurring Group. The focus of these groups will be to assist him in identifying the connection of his acute mental illness symptoms and substance use and in identifying the negative effects of his use.

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Community IPOS Example

Assessments

What information is essential in guiding our IPOS Development and Risk Mitigation Strategies?

Legal History/History of Violence

- This includes all known prior arrests/convictions as well as violent acts which occurred without law enforcement involvement (from patient account, collateral sources – family, legal records, MDOC OTIS, social histories from prior hospitalizations, etc)
  - And…if known, were psychotic and/or mood symptoms, substance use present/prominent around the time of the arrests/violence
- Was individual off medications at time of violence/legal involvement?
- Any psychiatric hospitalizations around the time of violence/legal involvement (briefly mention, but may include more information in hospitalization section)?
- Include any history of prior NGRI adjudications
- Parole or Probation Status outcomes

NGRI Offense

- Develop a thorough understanding of the offense and factors that contributed
- If patient was returned to the hospital while on leave from the hospital, consider what factors were involved (treatment non-adherence, substance use, medication changes, type of placement/level of services)
- Does the individual have Crime Victim Notification?

Current Risk of Violence and Elopement

- Include imminent risk of violence
- Include any past history of elopement at hospitals, community settings, correctional settings
- Significant incident reports (hospital or group home setting), significant behavioral incidents

Biopsychosocial History

- Understand how social and environmental stressors may have resulted in decompensation Educational Attainment, cognitive functioning
- Occupational History
- Identify protective factors, supports that may be contributing to positive treatment outcomes
- Financial Supports
- Medical Concerns

Substance Use and Treatment

- Detail types of substances used, frequency, amount, timeline of use for each substance including most recent use
- Legal involvement, concerning behavior, social impact associated with use associated with use
- Types of treatment received, including self-help groups
- Level of participation in substance use groups and other treatment modalities

History of Mental Health Treatment

- Hospitalizations-Include if hospitalizations were voluntary or involuntary
- Key symptoms present during hospitalizations
- Include prior hospitalizations for IST or NGRI
- Outpatient Treatment History
- Treatment adherence, relationship with treatment providers
- Diagnosis
- Past Medications (efficacy, side effects)
- Suicidal/self-injurious behavior
- Supervision/Placement history (including treatment outcomes in less-restrictive settings)

Current Treatment

- Current Clinical Presentation/Updated MSE
- Level of insight into mental illness/substance use/need for treatment
- Level of understanding that behavior during NGRI offense was associated with symptoms
- Ability to report and discuss triggers and warning signs of mental illness
- Plan for continued recovery and mental wellness
- Plan for sustained abstinence from drugs and alcohol (if relevant)
- Include current diagnosis(es) and medications
- Include recent significant medication changes (anything in the past 6 months) and responses

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NGRI REQUESTS, PROGRESS REPORTS, COURTWORK, FORMS

NGRI Timelines and Reporting Guidelines

- For NGRI patients in the hospital, court work is completed by hospital staff and monitored by the hospital's court liaison.
- For NGRI patients in the community, the CMH/contractual agency is responsible for completing the paperwork, filing with the court, and sending paperwork to the regional hospital and NGRI Committee.
- The SHA Forensic Liaison or designee will monitor completion of paperwork and coordinate with the CMH/Contractual agency regarding timelines.
- The Forensic Liaison or designee will maintain communication and send notification to the assigned SOM hospital staff/CMHSPs regarding court work deadlines to maintain the court order if the CMHSP and hospital believes it is appropriate.
- Each hospital will maintain documentation of an NGRI patient's court order.

CMH Contractual Agency Paperwork

30 and 90 Day Progress Reports

30 Day Review-Direct Community Placement Program Patients Only

- Three (3) 30 Day Reports are to be completed every 30 days from date of release from CFP
- Submit to NGRI Committee with copy to Regional Hospital/Center

90-Day/180/270 Day Review

- Begins 90 Days from Date of Order
- Submit to NGRI Committee with copy to Regional Hospital/Center

Court Work

- Submit all court work to Probate Court, Regional Hospital and NGRI Committee
- Send court orders to Regional Hospital and NGRI Committee
- If team is not planning to pursue court-ordered treatment, treatment will submit a request to the NGRI Committee for review **prior** to expiration of order, in accordance with MCL 330.2050(5)

Requests to the NGRI Committee

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Requests to Move, Discharge, LOAS, Changes to IPOS Risk Mitigation Strategies

- The NGRI Committee meets on Wednesday afternoons
- Requests should be received by Tuesday at noon to be reviewed that week
- When submitting, please consider that more information may be required to make an informed decision before final approval. Please submit request in advance to allow for this additional time.
- Providing detailed information will speed up the processing of your request and allow the Committee to make an informed decision.

Helpful Hints

- Requests should contain a thorough Mental Status Exam (e.g. Mental Status addresses all aspects, if patient has history of psychosis, should address current status of those symptoms, changes in baseline presentation, descriptors of symptoms)
- Behavioral descriptions are complete (e.g. if patient was assaultive, offers descriptor about what precipitated the assault, patient's reaction, etc.)
- Description of proposed leaves are complete (addresses where the leave will occur, who will be there, who will supervise, emergency plan, how they will get there)
- Description of proposed placement is complete (e.g., addresses degree of structure/level of supervision)
- Request indicates if the treatment team supports the request.
- Requests are submitted in timely manner

SHA Forensic Contact Information

Center for Forensic Psychiatry
Forensic Liaison: Kelli Schaefer
Schaeferk@michigan.gov
Phone: (734)295-4328

Deborah Brock
BrockD2@michigan.gov
Phone: (734)295-4295
NGRI Committee Fax: (734)429-0487

Kalamazoo Psychiatric Hospital
Madeline Magnan
MagnanM@michigan.gov
Phone: (269)337-3008
Fax: (269)337-3007

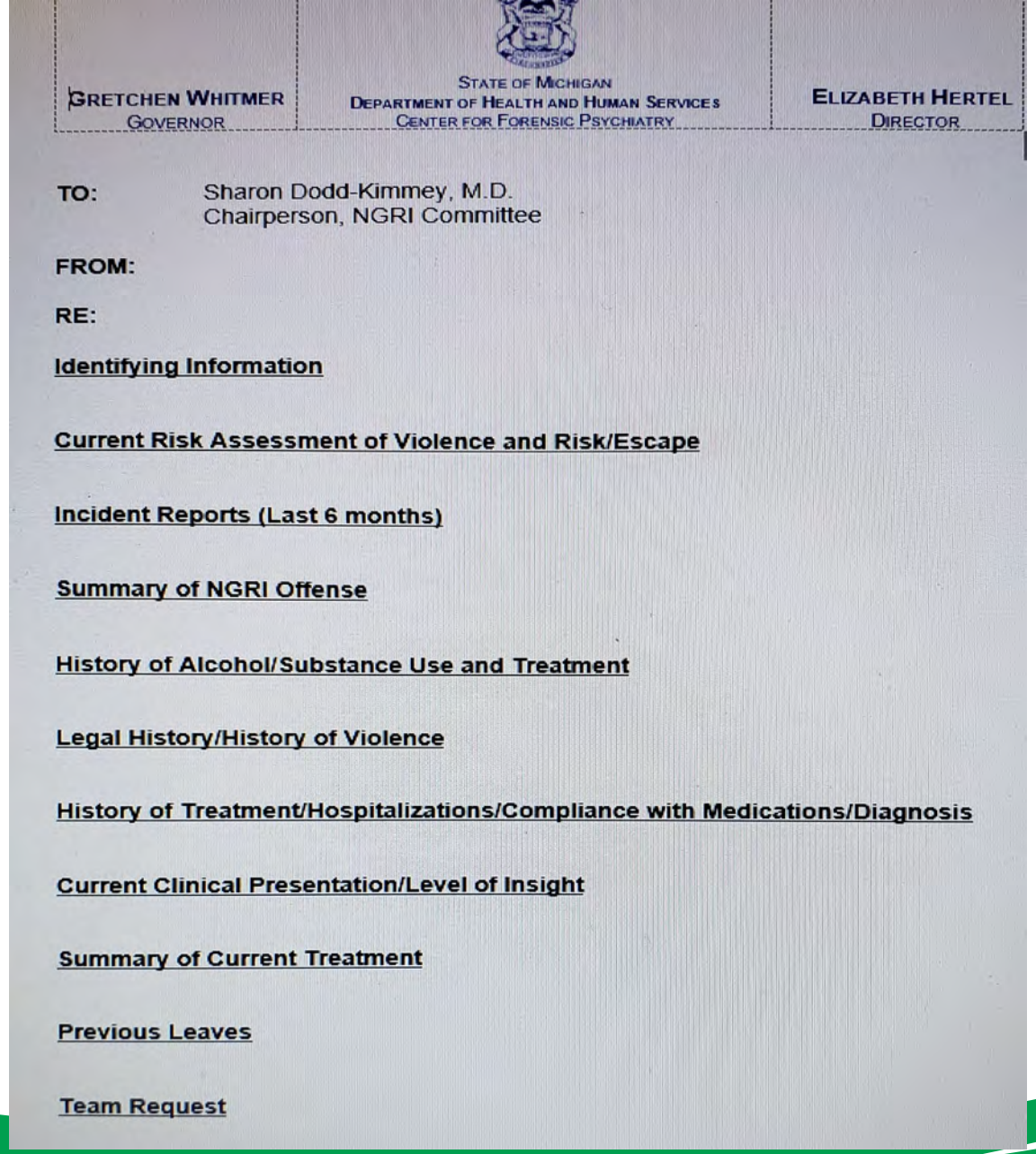
Caro Center
Forensic Liaison: Jodi Mitchell
MitchellJ16@michigan.gov
Phone: (989)672-9292
Fax: (989)672-9214

Walter P. Reuther Psychiatric Hospital
Forensic Liaison: Evette Carroll, LMSW
Carrolle2@michigan.gov
Phone: (734)367-8600
Fax: (734)367-8618
Court paperwork Fax (734)722-8056

Amanda Winn, LMSW
WinnA4@michigan.gov
Phone: (734)367-8466

NGRI Transfer/Discharge Memo

For use by CFP, Caro Center, KPH, WRPH



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR FORENSIC PSYCHIATRY

ELIZABETH HERTEL
DIRECTOR

TO: Sharon Dodd-Kimmey, M.D.
Chairperson, NGRI Committee

FROM:

RE:

Identifying Information

Current Risk Assessment of Violence and Risk/Escape

Incident Reports (Last 6 months)

Summary of NGRI Offense

History of Alcohol/Substance Use and Treatment

Legal History/History of Violence

History of Treatment/Hospitalizations/Compliance with Medications/Diagnosis

Current Clinical Presentation/Level of Insight

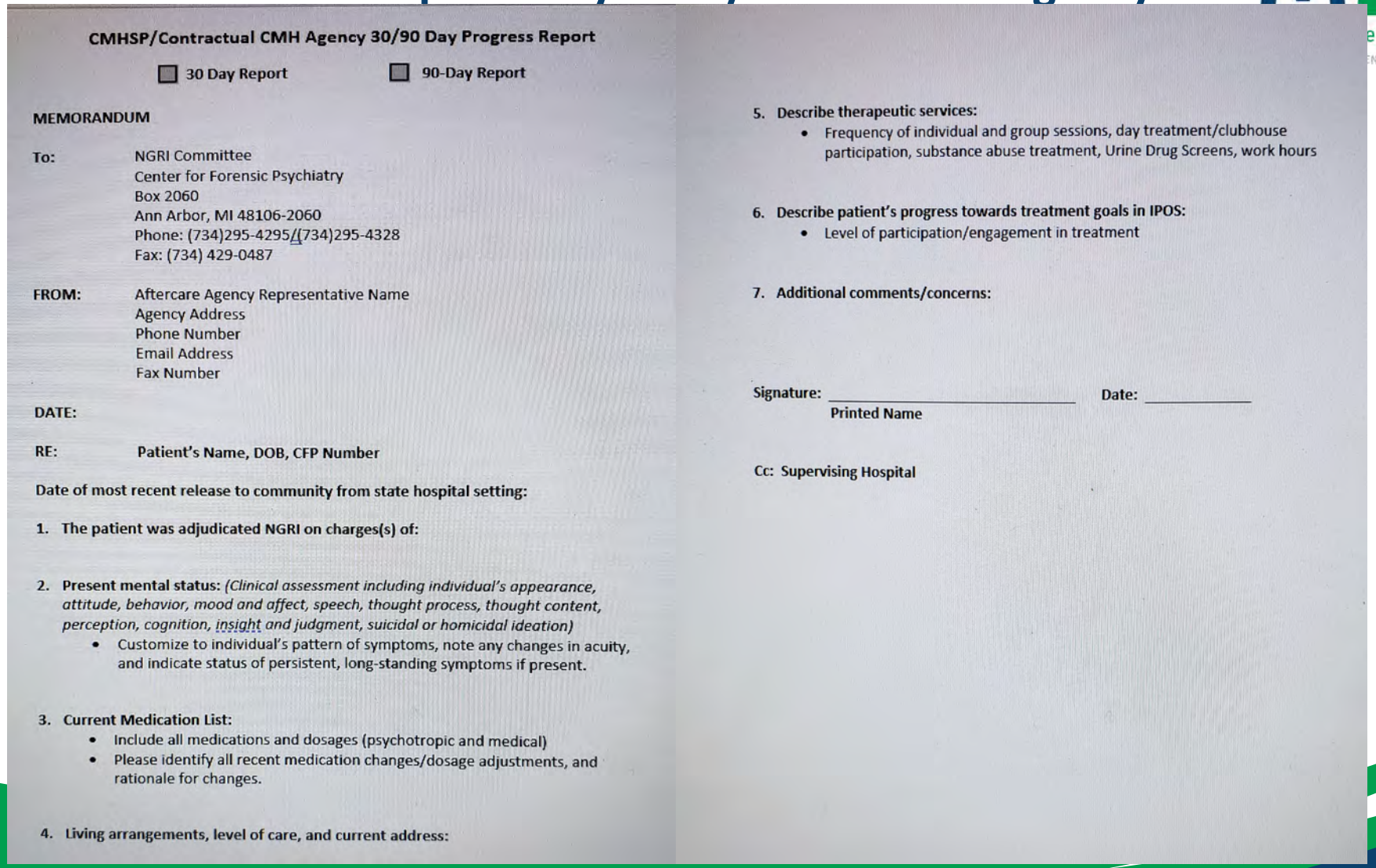
Summary of Current Treatment

Previous Leaves

Team Request

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

NGRI 30/90 Day Progress Reports
Completed by CMH/Contractual Agency



CMHSP/Contractual CMH Agency 30/90 Day Progress Report

☐ 30 Day Report ☐ 90-Day Report

MEMORANDUM

To: NGRI Committee
Center for Forensic Psychiatry
Box 2060
Ann Arbor, MI 48106-2060
Phone: (734)295-4295/(734)295-4328
Fax: (734) 429-0487

FROM: Aftercare Agency Representative Name
Agency Address
Phone Number
Email Address
Fax Number

DATE:

RE: **Patient's Name, DOB, CFP Number**

Date of most recent release to community from state hospital setting:

1. **The patient was adjudicated NGRI on charges(s) of:**

2. **Present mental status:** *(Clinical assessment including individual's appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment, suicidal or homicidal ideation)*
   - Customize to individual's pattern of symptoms, note any changes in acuity, and indicate status of persistent, long-standing symptoms if present.

3. **Current Medication List:**
   - Include all medications and dosages (psychotropic and medical)
   - Please identify all recent medication changes/dosage adjustments, and rationale for changes.

4. **Living arrangements, level of care, and current address:**

5. **Describe therapeutic services:**
   - Frequency of individual and group sessions, day treatment/clubhouse participation, substance abuse treatment, Urine Drug Screens, work hours

6. **Describe patient's progress towards treatment goals in IPOS:**
   - Level of participation/engagement in treatment

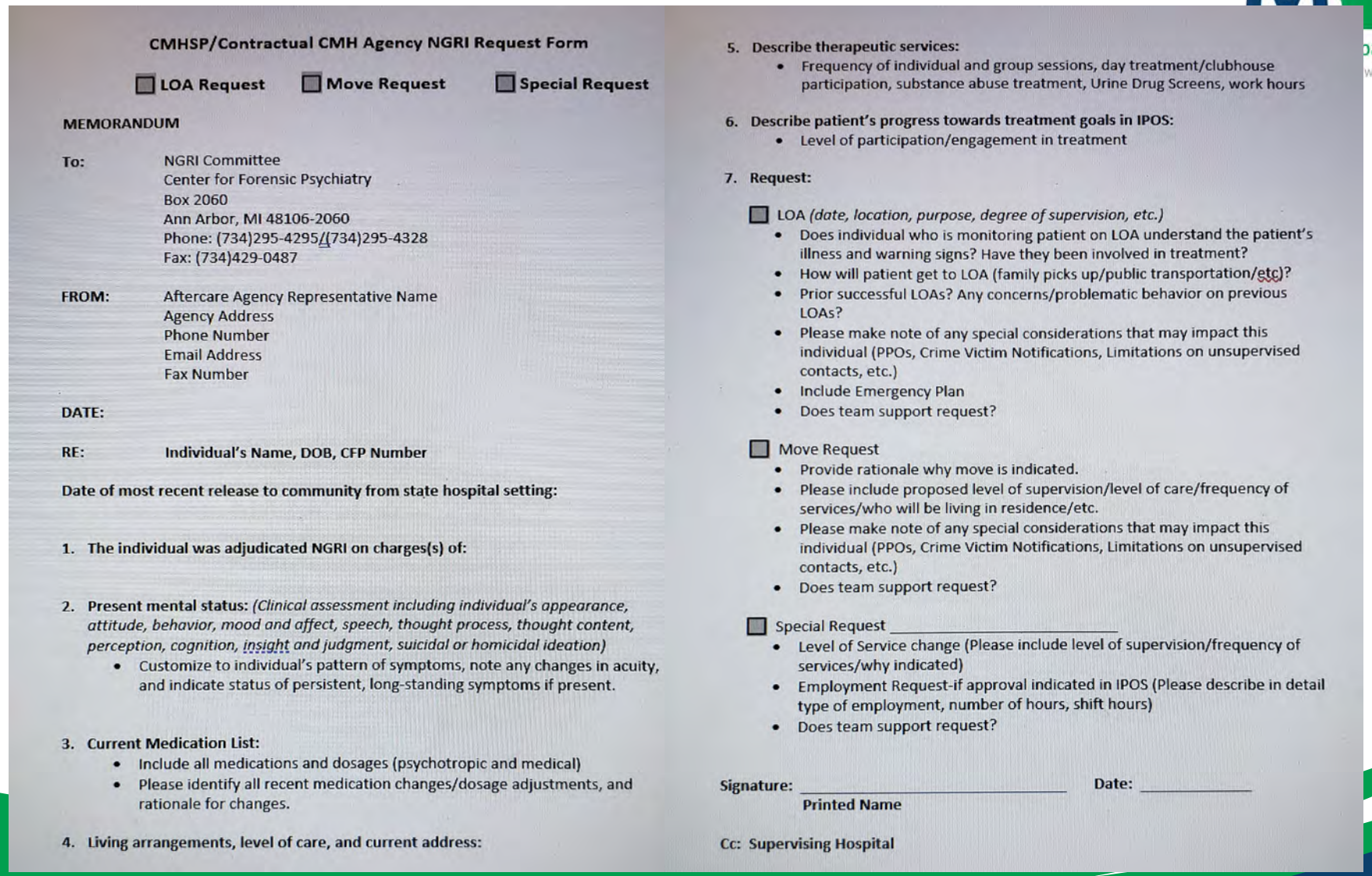
7. **Additional comments/concerns:**

Signature: _____ **Date:** _____
Printed Name

Cc: Supervising Hospital

MDHHS
Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

NGRI Request Memo
Completed by CMH/Contractual Agency



CMHSP/Contractual CMH Agency NGRI Request Form

☐ **LOA Request** ☐ **Move Request** ☐ **Special Request**

MEMORANDUM

To: NGRI Committee
Center for Forensic Psychiatry
Box 2060
Ann Arbor, MI 48106-2060
Phone: (734)295-4295/(734)295-4328
Fax: (734)429-0487

FROM: Aftercare Agency Representative Name
Agency Address
Phone Number
Email Address
Fax Number

DATE:

RE: **Individual's Name, DOB, CFP Number**

Date of most recent release to community from state hospital setting:

1. **The individual was adjudicated NGRI on charges(s) of:**

2. **Present mental status:** *(Clinical assessment including individual's appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment, suicidal or homicidal ideation)*
   - Customize to individual's pattern of symptoms, note any changes in acuity, and indicate status of persistent, long-standing symptoms if present.

3. **Current Medication List:**
   - Include all medications and dosages (psychotropic and medical)
   - Please identify all recent medication changes/dosage adjustments, and rationale for changes.

4. **Living arrangements, level of care, and current address:**

5. **Describe therapeutic services:**
   - Frequency of individual and group sessions, day treatment/clubhouse participation, substance abuse treatment, Urine Drug Screens, work hours

6. **Describe patient's progress towards treatment goals in IPOS:**
   - Level of participation/engagement in treatment

7. **Request:**

☐ LOA *(date, location, purpose, degree of supervision, etc.)*
- Does individual who is monitoring patient on LOA understand the patient's illness and warning signs? Have they been involved in treatment?
- How will patient get to LOA (family picks up/public transportation/etc)?
- Prior successful LOAs? Any concerns/problematic behavior on previous LOAs?
- Please make note of any special considerations that may impact this individual (PPOs, Crime Victim Notifications, Limitations on unsupervised contacts, etc.)
- Include Emergency Plan
- Does team support request?

☐ Move Request
- Provide rationale why move is indicated.
- Please include proposed level of supervision/level of care/frequency of services/who will be living in residence/etc.
- Please make note of any special considerations that may impact this individual (PPOs, Crime Victim Notifications, Limitations on unsupervised contacts, etc.)
- Does team support request?

☐ Special Request _____
- Level of Service change (Please include level of supervision/frequency of services/why indicated)
- Employment Request-if approval indicated in IPOS (Please describe in detail type of employment, number of hours, shift hours)
- Does team support request?

Signature: _____ **Date:** _____
Printed Name

Cc: Supervising Hospital

MDHHS
Department of Health & Human Services
WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

Thank you

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

Supervisory Level Forensic Psychiatrist

Supervisory Level Forensic Psychiatrist (SLFP)

Coordinates services between

- Regional hospital treatment team/forensic liaison
- NGRI Committee

Supervisor Level Forensic Psychiatrist

Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

Advises on risk mitigation strategies

- Helps treatment team identify risks and associated mitigation strategies relevant to the individual
- Ensures they have been adequately addressed for each individual
- Based on the person's behavioral health needs
- Remove when no longer needed

Supervisor Level Forensic Psychiatrist

Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

- Reviews clinical certificates
  - Advises on adherence to Michigan Mental Health Code
- Provides guidance on AOT conversion
- May also review IST patients at treatment team request

Supervisor Level Forensic Psychiatrist

- Meets with forensic liaison weekly
- Covering 5-6 patients per week
- Prioritizing patients with upcoming IPOS reviews and expiring court orders (cert assignments)
- Must cover all NGRI patients

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

Thank you

Petitions for Involuntary Mental Health Treatment

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

- Petitions for involuntary mental health treatment must accurately reflect the treatment the individual will receive.

- Petitions for hospitalization should only be filed if the person meets the criteria for in-patient hospitalization and will receive treatment in the hospital. If the person is going to receive treatment in the community, the petition must request AOT or combined AOT/hospitalization. This is the case regardless of an individual's NGRI status.

Assisted Outpatient Treatment (AOT)

Training Pertaining to working with Persons found Not Guilty by Reason of Insanity

Spring 2021

Debra Pinals, M.D.,
Medical Director for Behavioral Health and Forensic Programs

Michigan Department of Health and Human Services

What is Civil Commitment?

A civil (non-criminal) legal mechanism, through which the government mandates certain aspects of an individual's life because the individual has a mental illness.

Justification for the mandate is related to preventing harm and providing care

Critical Aspects

Definition of narrow target population

Procedures/Due Process

Provisions of the court order

- Inpatient
- Outpatient

Legal Context and Background

- Lake v. Cameron (1966)
- Lessard v. Schmidt (1972)
- Jackson v. Indiana (1972)
- O'Connor v. Donaldson (1975)
- Parham v. J.R. (1979)
- Addington v. Texas (1979)
- Vitek v. Jones (1980)
- Zinermon v. Burch (1990)
- Heller v. Doe (1993)

Different State Commitment Laws Require Mental Illness and a Link to SOMETHING

Mental Illness defined in state statutes, regulations or case law and linked to

- Risk of harm through self-injury or suicide
- Risk of harm through physical harm to others
- Risk of harm through “grave disability” or failure to meet basic needs

May or may not include:

- “Need for treatment” standard
- Substance use
- Risk for relapse and deterioration

Types of Commitment and Processes

Pick up orders

Emergency detention

Inpatient commitment (all states)

Outpatient commitment

- Involuntary Outpatient Treatment or Assisted Outpatient Treatment (AOT)

Medical and Legal Process

- Filing affidavits and early detention/evaluation
  - Multi-stage review often a requirement with more clinical input downstream
    - *E.g. police pick up, to clinical screening, to "doctor" certification*
- Commitment Hearings
  - Testimony
  - Deferrals/waivers etc
  - Judicial determinations
  - Standard of proof and burden of proof

What is “Outpatient Commitment”?

Types of Involuntary Outpatient Commitment

- **Conditional release** from hospital (40 states[1])
  - Early 20th century, started as trial release
- **Alternative to hospitalization** for people meeting inpatient commitment criteria (33 states[1])
  - Least restrictive alternative
- **Preventive outpatient commitment** (10 states[1])
  - Court-ordered treatment authorized at a lower threshold than inpatient commitment criteria with the purpose of preventing further deterioration

[1] Melton et al., 2007

Slide credit: Marvin Swartz, MD

Some of the Current Research

North Carolina and New York

Involuntary Outpatient Commitment
CRITIQUE

Availability of appropriate services with aggressive outreach might obviate the need

Should not be used as a substitute for inadequacies in service systems

Applying coercion to patient blames the victim for service deficiencies.

Systems of care should be held accountable for gaps in care.

Slide credit: Marvin Swartz, MD

Slide credit: Marvin Swartz, MD

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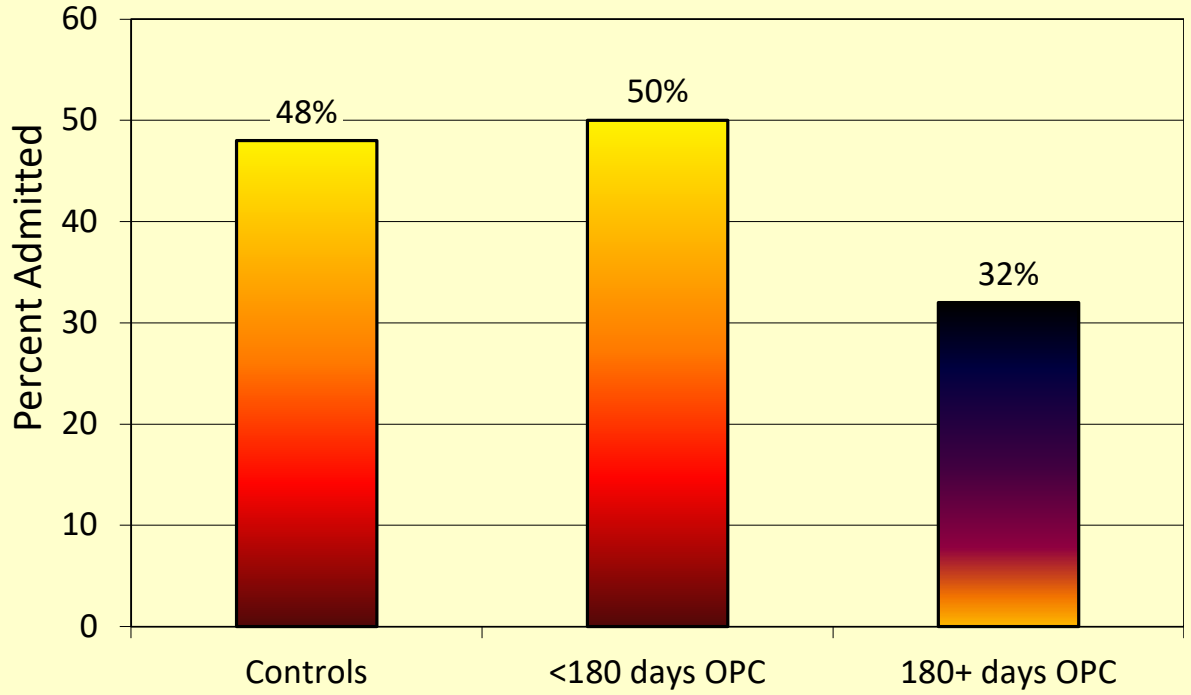
Control group [1.00]

OPC group 0.64

SUBGROUP ANALYSIS: Percent of participants rehospitalized in 12 months, **by days of outpatient commitment received**



Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum WR (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial in severely mentally ill individuals. *American Journal of Psychiatry,* 156(12), 1968-1975

Slide credit: Marvin Swartz, MD

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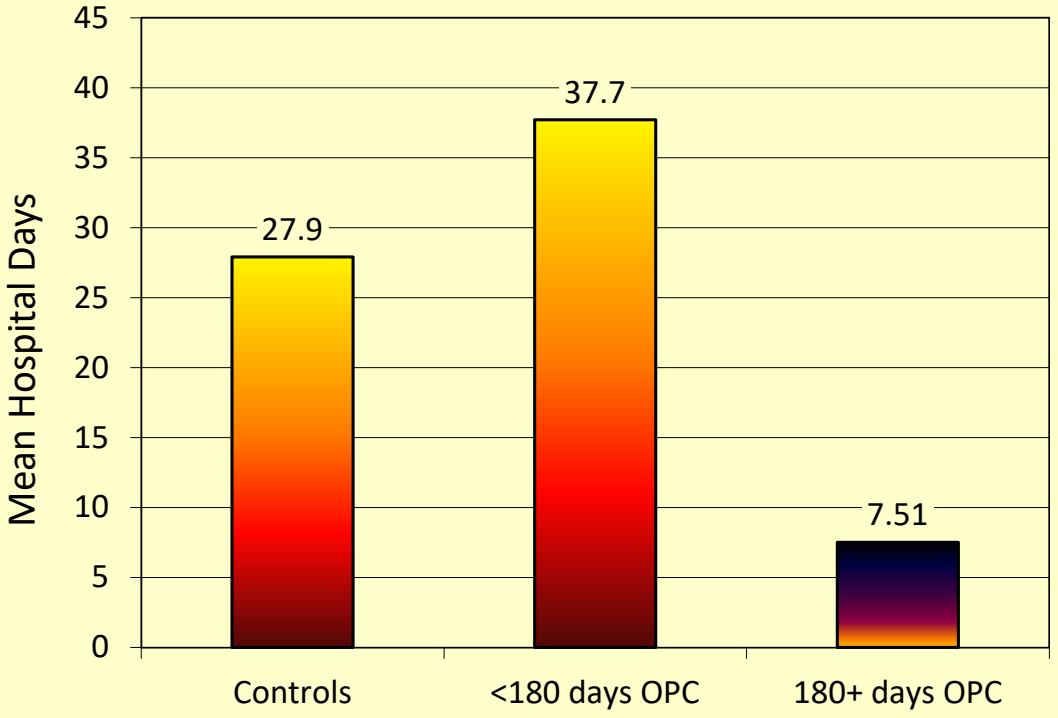
Control group [1.00]

OPC group 0.64

Mean psychiatric **hospital days** in 12 months by days of OPC



Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum WR (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial in severely mentally ill individuals. *American Journal of Psychiatry,* 156(12), 1968-1975

Reduced odds of any violent behavior in 1 year associated with extended outpatient commitment (Duke Mental Health Study)

	Odd Ratio	95% CI	P value
Baseline history of violence	1.915	(1.262 - 2.906)	<0.01
Outpatient commitment			
None	1.000	(1.000 - 1.000)	
Brief (<179 days)	0.986	(0.500 - 1.945)	
Extended (180 days or more)	0.347	(0.152 - 0.792)	<0.05

Note: logistic regression model controlled for demographic, social, and clinical characteristics including substance misuse.

Source: Swanson JW, Swartz MS, Borum RB, Hiday VA, Wagner HR, Burns BJ (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. British Journal of Psychiatry, 176, 324-331.

Slide credit: Marvin Swartz, MD

Other Key Findings of the NC Study

Reduced crime victimization of those under OPC

Improved Quality of Life measures

Hiday VA, Swanson JW, Swartz MS, Wagner HR, Borum WR (2002). The impact of outpatient commitment on victimization of persons with severe mental illness. *American Journal of Psychiatry,* Vol 159(8), 1403-1411.

Is AOT fair?

Racial disparities in AOT

Swanson, J., Swartz, M., Van Dorn, R., Monahan, J., McGuire, T., Steadman, H., and Robbins, P. (2009). **Racial disparities in involuntary outpatient commitment: Are they real?** *Health Affairs*, 28, 816-826.

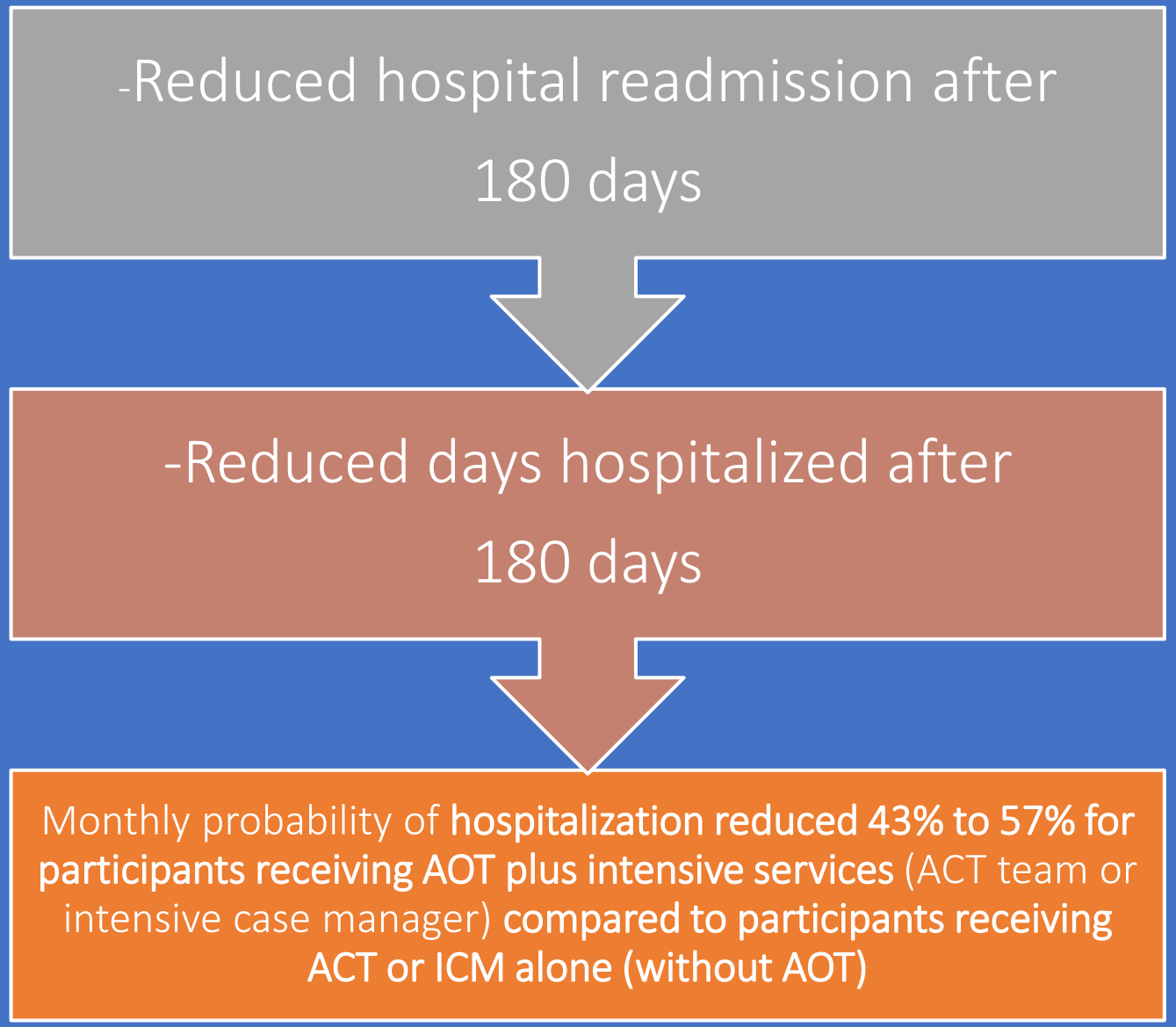
"Queue-jumping" in AOT

Swanson JW, Van Dorn RA, Swartz MS,Cislo AM, Wilder CM, Moser LL, Gilbert AR, McGuire TG (2010). **Robbing Peter to pay Paul: Did New York State's outpatient commitment program crowd out voluntary service recipients?** *Psychiatric Services* 61, 988-95.

Slide credit: Marvin Swartz, MD

Slide credit: Marvin Swartz, MD

New York AOT Evaluation Study (Swartz et al)



NY Findings on AOT

NYS's AOT Program improves a range of important outcomes for its recipients.

The *increased services available under AOT clearly improve recipient outcomes,*

The AOT *court order and its monitoring do appear to offer additional benefits in improving outcomes*.

The AOT order exerts a critical effect on service providers.

Oxford Community Treatment Center Evaluation Trial (OCTET)

Examined individuals released from hospitals on conditions vs. those on a community treatment order

- No significant differences in: Primary outcome of readmission to the hospital or secondary outcomes such as number of readmissions and days in the hospital or clinical functioning.
- Data did not compare individuals in voluntary services to those on an order so not comparable to NY studies

Summary of the Research

- When compared to voluntary services, AOT order itself seems to provide some benefit for individuals in terms of return to hospitalization and clinical outcomes.
- Findings lead national organizations to develop positions in favor of AOT
- AOT being examined nationally as a tool to assist individuals with Serious Mental Illness when used appropriately

Michigan's Application of AOT for Individuals Found NGRI

Michigan Experience

State Court Administrator and lead author of COSCA paper

Mental Health Diversion Council Activities

Legislative reform to existing outpatient commitment law took place in 2017

“Refinements” proposed for Involuntary outpatient commitment to help enhance its likelihood of being utilized

History of the 2004 Kevin's Law and the New Changes

Original Purpose: to authorize courts and community mental health agencies to develop and utilize AOT programs, generally used in lieu of hospitalization for people who fail to comply with prescribed treatments

Revised Law (2017): Modifies multiple sections of the Mental Health Code to refine qualifying commitment criteria, streamline paperwork, lengthen duration of AOT, and clarify treatment components

Definition of “Assisted Outpatient Treatment”

Modifies the definition of “assisted outpatient treatment” (AOT) to specify that AOT would mean the categories of outpatient services ordered by the court under Section 468 or Section 469a of the Mental Health Code.

AOT Definition (MCL 330.1100)

"AOT" means the categories of outpatient services ordered by the court under section 468 or 469a of the Mental Health Code. AOT orders may include:

- a case management plan and case management services to provide care coordination under the supervision of a psychiatrist and developed in accordance with person-centered planning under section 712.

AOT may also include 1 or more of the following categories of services:

- medication;
- periodic blood tests or urinalysis to determine compliance with prescribed medications;
- individual or group therapy;
- day or partial day programming activities;
- vocational, educational, or self-help training or activities;
- assertive community treatment team services;
- alcohol or substance use disorder treatment and counseling and periodic tests for the presence of alcohol or illegal drugs for an individual with a history of alcohol abuse or substance use disorder;
- supervision of living arrangements; and
- any other services within a local or unified services plan developed under this act that are prescribed to treat the individual's mental illness and to assist the individual in living and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide, the need for hospitalization, or serious violent behavior.

Mental Illness for the purposes of Commitment

"'Mental illness' means a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." (MCL 330.1400(g))

-Cannot be solely due to alcoholism, drug dependence, epilepsy or dementia

Sec. 401: “Person requiring Treatment” (a), (b), or (c)

(1) (a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

(b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

(c) An individual who has mental illness, whose judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

Development of the AOT Plan

- The development and implementation of an AOT plan shall be under the supervision of a psychiatrist. The AOT treatment plan must be completed within 30 days of the court order for AOT and filed with the relevant probate court within three (3) days of its completion.

- In accordance with APF 106, the AOT treatment plan must incorporate risk mitigation strategies and incorporated into the individual plan of service (IPOS). The plan must be reviewed and approved by the NGRI Committee.

- Prior to ordering AOT, the individual will be asked as to their preference for medications, their individualized plan of service (IPOS), and whether there is a Durable Power of Attorney (DPOA). If there are any conflicts between the AOT order and the IPOS or DPOA, a second psychiatric opinion on the AOT will be needed (MCL 330.1468.)

Types of AOT Orders

- AOT-Only
- AOT and hospitalization combined order

Importance of Coordination

- A person on a combined order can move from the hospital to the community AOT per the hospital psychiatrist and the “AOT program director”.
- Hospital must give at least 5 days notice of intent to discharge the individual to the community under AOT (MCL 330.474).

Duration of the Orders "Up to"…

Initial Orders:

- Hospitalization= up to 60 days
- AOT only = up to 180 days
- Combined hospitalization and AOT= up to 180 days (up to 60 days of hospitalization as part of the 180 days)

Subsequent orders (contiguous with the prior orders):

- Second Order= up to 90 days
- Third Order=up to 1 year
- Fourth and additional orders=up to 1 year

Concerns about Safety of "Sufficiency" of the Court Order

When the supervisor of the AOT or combined hospitalization/AOT order has significant concerns about the sufficiency of the AOT order or compliance with the AOT, they SHALL notify the court immediately (MCL 330.1475). For persons found NGRI, CMHSPs overseeing the AOT or combined hospitalization/AOT orders shall follow APF 106 involving the NGRI committee.

Concerns about Safety of "Sufficiency" of the Court Order

Upon notification of the court, if the court learns that the AOT is insufficient "to prevent harm to the individual or to others" or AOT program is "not appropriate" the court may do one of the following:

a. Consider alternatives to hospitalization and modify the AOT order for duration of AOT order; OR
b. Modify the AOT order and direct the individual to undergo hospitalization or combined hospitalization/AOT.

Noncompliance of Individual

- Non-compliance with the court-order can result in a review of the treatment plan before the judge and potentially hospitalization.
- An AOT is a “civil” remedy, therefore; there is no punishment or “sanction” for non-adherence to treatment by the individual.
- Court notified of individual’s noncompliance: Court may require 1 (one) or more of the following without a hearing:
  - Individual taken to preadmission screening unit
  - Individual hospitalized for no more than 10 days
  - Individual hospitalized for a period of more than 10 day, but no longer than AOT order of 90 days, whichever is less
  - Court may direct peace officer to transport to designated facility/PSU

  Individual may object to hospitalization

When the Agency is not Convening the Services….

Individual may petition the court for a modification of the court order

Discharge Provisions

A hospital can discharge the patient from a court order when clinically suitable and with notification of the court. (MCL 330.1476)

If the provider of AOT or combined hospitalization/AOT determines the individual is clinically suitable for discharge and no longer meets the criteria for AOT, the person can be discharged from the AOT or the combined hospitalization/AOT order with notification of the court.(MCL 330.1477)

SUMMARY POINT: Clinical team must discharge the individual if the individual no longer meets clinical criteria for involuntary treatment.

If discharged from court orders, NGRI Committee Involvement Terminates

Legal Regulation Pertaining to Individuals found NGRI

	Pre-Settlement Agreement	Going Forward
Leave status from SOM Hospital	ALS	LOA for up to 1 year
Community Status following LOA	ALS	AOT
Duration of NGRI and AOT	Up to 5 continuous community years	Up to 5 continuous community years

CMH and COMMUNITY BASED FRAMEWORK

Community systems will want to convene to best understand pathways and partners

Comprehensive role consideration will be important

- Courts
- Law enforcement
- CMH/PIHP and provider input (Clinical and Administrative)
- Emergency services
- Persons with lived experience/peers
- Family members

Conclusions

- Persons found NGRI should be treated in the least restrictive manner appropriate to their individualized needs
- Community providers work with the NGRI committee, guided by APF 106, and in compliance with contractual oblications
- Risk mitigation strategies that become part of the AOT plan must be justified based on individual circumstances
- IPOS should reflect appropriate risk mitigation to help support the individual's success and community tenure
- Strategies to maximize engagement and positive choice continue to need to be prioritized