Responding to a High-Profile Tragic Incident Involving a Person with a Serious Mental Illness

A Toolkit for State Mental Health Commissioners

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The National Association of State Mental Health Program Directors (NASMHPD) is a member organization representing state executives responsible for the $34 billion public mental health service delivery system serving 6.3 million people annually in all 50 states, four territories and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

Read more at **www.nasmhpd.org**.

The Council of State Governments (CSG) Justice Center is a national nonprofit organization serving policymakers at the local, state and federal levels from all branches of government. The CSG Justice Center provides practical, nonpartisan advice and consensus-driven strategies—informed by available evidence—to increase public safety and strengthen communities.

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NASMHPD

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

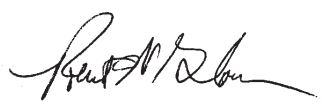
The National Association of State Mental Health Program Directors (NASMHPD) and the Council of State Governments (CSG) Justice Center are pleased to provide you with what we hope will be an invaluable tool for your stewardship of state mental health policy—*Responding to a High-Profile, Tragic Incident Involving a Person with a Serious Mental Illness: A Toolkit for State Mental Health Commissioners*. We know of no other resource that combines practical tips and experiential knowledge, supported by relevant research, to respond to the unthinkable—a terrible act of violence committed by a person with a history or current diagnosis of serious mental illness.

We all recognize that state mental health commissioners have a complex range of responsibilities, few of which involve regular contact with the media or intense scrutiny by the public. However, when a crisis occurs involving one or more individuals with mental illness, it is the state commissioner who is instantly put on the hot seat—expected to explain the unexplainable; account, fairly or unfairly, for perceived failings of the public mental health system; and calm understandable fears. There is no time to "come up to speed" to successfully manage such a high-pressure situation.

That is why this toolkit is so important. It can help you prepare for, manage and evaluate your response to a violent incident. No one wants to think about such an event happening on his or her watch, and we must always be sensitive to the stigma our constituents with mental illnesses face, despite a weak association between violence and mental illness. Yet preparing for these rare but highly visible events makes it possible to speed the healing process for victims, to avoid adverse consequences for people with mental illnesses and to continue educating the public and policymakers on the need for effective systems of treatment and support. The best way to promote recovery and mitigate potential negative consequences is to be prepared. This toolkit is designed to help you and your staff gather the information that you need to have on hand, know what challenges you are likely to face and be equipped to advance the twin goals of public health and public safety.

To that end, we strongly encourage every commissioner to name an individual on his or her staff—not a position or an office, but a specific person—to be responsible for studying this toolkit, adopting or adapting its contents, and implementing its recommendations. It won't be of use if it gathers dust on a shelf!

We are certain you will find that preparation guided by this toolkit will pay dividends in team development, time saved, resource conservation and enhanced credibility—even if a crisis never occurs on your watch. Above all, we believe the materials we have gathered and presented in this toolkit are meant to support the commitment we all share to increase public safety and to develop person-centered, recovery-oriented, evidence-based systems of care for Americans with, or at risk for, mental illnesses. They deserve nothing less.



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A Toolkit for State Mental Health Commissioners

The National Association of State Mental Health Program Directors (NASMHPD) and the Council of State Governments (CSG) Justice Center gratefully acknowledge the contributions of the diverse group of individuals who comprised the expert advisory group for this publication (see Appendix A for a full listing). These state mental health directors, communications specialists, victim advocates and other experts gave generously of their time and ideas. They provided critical advice and recommendations that developed into a successful roadmap for this document.

Special thanks are also due to Susan Milstrey Wells of Advocates for Human Potential, Inc., for her extraordinary work as the chief researcher and writer and to Damon Thompson, who was the primary communications specialist for the toolkit's development.

The work of NASHMPD and Justice Center staff who spearheaded this joint publication is also deeply appreciated: David Miller, NASMHPD Project Director; Fred Osher, M.D., CSG Justice Center Director of Health Systems and Services Policy; and Seth Prins, CSG Justice Center Policy Analyst, spent countless hours working to shape this document into a resource that could be extremely useful for state mental health commissioners and the broader mental health field.

Finally, thanks are owed to the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, for its valuable leadership during this project and to Vanguard Communications for their creative direction and design of this toolkit.

National Association of State Mental Health Program Directors and the Council of State Governments Justice Center, Alexandria, VA

Cover design and layout by Vanguard Communications.

Suggested citation:
NASMHPD/CSG Justice Center (2010). *Responding to a High-Profile Tragic Incident Involving a Person with a Serious Mental Illness: A Toolkit for State Mental Health Commissioners.*

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Introduction

When a person with a history or current diagnosis of serious mental illness is involved in a high-profile, tragic incident, state mental health commissioners face public, media, legal and legislative scrutiny. As a commissioner, you may be called on to account for perceived failures in the public mental health system and to explain the system's role in preventing or responding to such incidents.

Often, incomplete and/or inaccurate information quickly spreads not only about the incident, but also about the likelihood of violence among individuals with mental illnesses. This is often fueled by community members' mistaken assumptions that mental health treatment is ineffective and that most people with mental illnesses are violent. Though most individuals with serious mental illnesses will never be violent and can live successfully in the community with adequate treatment, housing and supports, the fear that high-profile, tragic incidents engender often leads to public debate and even new laws. Some debates have resulted in calls for extreme measures, such as re-institutionalizing large numbers of individuals in state psychiatric facilities.

- In 2008, a Northern Illinois University student with a history of psychiatric inpatient care who had allegedly stopped taking his medications shot and killed five students and wounded 18 others before taking his own life. Though he had been discharged from the Army in 2002 for withholding information about mental illness, he was still able to purchase an Illinois firearm identification card.
- In 2007, a student who had been declared mentally ill by a Virginia special justice purchased a gun and killed 32 people and wounded many others on the Virginia Tech campus before taking his own life. The incident sparked intense debate about gun violence, gun laws, gaps in the mental health system and privacy laws.
- In 1999, a young woman named Kendra Webdale was pushed in front of an oncoming New York City subway train and killed by a person with schizophrenia. The perpetrator had sought treatment, but was allegedly turned away due to a lack of available slots. The attack galvanized the public and lawmakers in support of an outpatient commitment statute known as Kendra's Law.

After a high-profile, tragic incident, you face several challenges to providing accurate and complete information while addressing understandable public concerns. In particular, you must balance your responsibility to respond appropriately to an individual tragedy, your role as a champion for the principles of recovery for individuals with serious mental illnesses and your commitment to public safety. In the aftermath of a tragic incident, coordinating efforts to improve the responses of multiple local, state and federal agencies, such as law enforcement, educational institutions and the military, adds further layers of complexity. Finally, and perhaps most important, you must field media and political inquiries in the midst of these myriad activities. This toolkit is designed to help you navigate these challenges and learn from others' experience.

About This Toolkit

The material in this toolkit was developed with input from mental health commissioners who have been involved in responding to high-profile, tragic incidents. Advocates, crime victims, consumers of mental health services and media affairs representatives also informed its development (see Appendix A). Recommendations are drawn from extant research and from promising practices in the field. The toolkit is designed to provide broad information and focuses primarily on helping you prepare for, respond to and successfully navigate an incident that captures significant public and media attention. This resource is not intended to be an exhaustive manual for responding to tragic incidents involving people with mental illnesses. Natural disasters that may have

mental health impacts, for example, are beyond the scope of this toolkit. If you would like more information about these types of events, this guide includes some excellent resources on emergency preparedness.

Using This Toolkit

In the following pages you will find practical advice, tips and specific tools to guide you ***before***, ***during*** and ***after*** a critical incident. Each of these sections is divided into the following four parts:

- **Understand your role.** These sections outline your key responsibilities at each stage of a critical incident.
- **Understand your agency.** These sections help you prepare your agency for an appropriate and timely response.
- **Understand your state.** These sections highlight knowledge you need to have about state laws, policy and operations.
- **Understand crisis communications.** These sections help you prepare for and respond to media inquiries and foster public information efforts.

The first page of each of these sections includes a list of key action steps for that section. Each section also includes links to several types of additional resources that are color coded as follows:

- **Backgrounders** (dark blue) provide briefings about strategic issues, such as effective leadership and working with the media, and about politically sensitive areas you may be asked to address, such as involuntary commitment. Some backgrounders include talking points or highlight state-specific information you may need at your disposal. *These are for your use and not for dissemination.*
- **Facts sheets** (green) include information you can use or adapt to share with the public and the media to keep them better informed.
- **Additional resources** (purple) include links to websites and materials that provide more detail on many of the issues addressed throughout the toolkit.
- **Checklists/contact sheets** (orange) include forms you can fill out with vital information to keep on hand, such as lists of contacts within your agency, your state and the media. These lists can also help guide you during high-pressure incidents and help track your response.

A literature review on mental illness and violence is included in Appendix B. If you are reading this toolkit online, you can link directly to the ancillary material. If you are reading a print version, all of the referenced material is at the back of the toolkit.

This toolkit is meant to be a living document. Though we hope it never has to be used, we suspect it will be. Ultimately, it will only be helpful if you find it practical and accessible. Toward that end, please feel free to contact the toolkit developers at the National Association of State Mental Health Program Directors or the Council of State Governments Justice Center to offer suggested revisions or needed additions. You may reach them at the offices listed below.

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Before an Incident

No one likes to think about the possibility of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. But the more prepared you are for such an incident, the better able you will be to address the concerns of victims and victims' families; respond to inquiries from the media, the public, attorneys and policymakers; and keep your other operations on track. This section highlights the types of information you need to have at your fingertips in advance of such an incident. Now is the time to

- ❑ Establish a crisis response contact within the governor's office.
- ❑ Identify your internal crisis management team.
- ❑ Identify your internal crisis communications team.
- ❑ Create crisis management and crisis communications plans.
- ❑ Create lists of emergency contacts. Include key contacts in your agency, your state, the media and external content experts.
- ❑ Familiarize yourself with your state's mental health policies and laws on such hot-button topics as involuntary commitment, firearms regulations/gun control laws and privacy laws.
- ❑ Practice responding to sensitive questions you can reasonably expect to receive.
- ❑ Create meaningful and strong relationships with media and other potential third-party endorsers to lay the groundwork needed when a crisis occurs.
- ❑ Find a mentor among your colleagues who has dealt with a high-profile, tragic incident and develop a working relationship.

Understand Your Role

When a person with a history or current diagnosis of serious mental illness is involved in a high-profile, tragic incident, the first thing you need to know is what role you will be expected to play.

- There will be different expectations about who will be the point person for the public and the media. This will vary based on the scope and scale of the incident, so you should anticipate and be prepared to address a series of contingencies.
- While your role may be similar across types of events, the individuals, organizations and structures (e.g., emergency operations center) you relate to may differ.
  - For example, if there is a death or suicide in a state-operated facility, your agency will likely take the lead.
  - Remember that in a mass casualty event, while the mental health response is subordinate to the emergency response, the criminal investigation and public safety concerns, you may be called on to support immediate and long-term responses.
- You must have good communication with the governor's office before an incident occurs so you know quickly who is in charge. *You have to know when it's appropriate for you to be the person answering questions.*
  - In many cases, the governor's office wants to take the lead in shaping the message. It's important not to step into a role that you don't have authority or resources to assume.
    - Establish a crisis response contact within the governor's office.
    - Work with him or her to develop a plan for how to act and coordinate in time of crisis.
    - Be prepared to be flexible. This plan could easily be abandoned or revised for a variety of reasons when a crisis actually emerges.
- *Your ability to help shape the message about the relationship between mental illness and violence will be critical to containing negative outcomes, including calls for more coercive interventions.*
  - You will have more leverage to do so before an incident occurs. Establish an effective working relationship with members of the media before a crisis unfolds.
  - We have included a backgrounder with talking points about mental illness and violence for you to use in communicating with the public and the media and a fact sheet that you can adapt to distribute at news conferences and public events.
- If possible, find a mentor among your colleagues who has dealt with a high-profile, tragic incident and develop a working relationship. Set up a plan for how to communicate in a crisis. He or she may be a lifeline when an incident occurs.

Understand Your Agency

You can put your agency in a better position to respond to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness by ensuring that you fully appreciate your staff's expertise, your agency resources, your authority and your priorities. Effective crisis response operates simultaneously on two fronts: operations and communications.

- Identify your internal crisis management team. The team will coordinate the agency's operational response, reporting duties (to you and other designated officials), crisis communications team efforts, and support for first responders and other emergency and law enforcement personnel, as appropriate.
  - Designate a team leader and assign responsibilities to team members.
  - Consider as key members of the team your agency attorney, emergency planner, information technology manager, human resources manager, financial manager, medical director, security manager and public information officer (who will lead the crisis communications team described below).
  - Charge this group with creating or revising a crisis management plan for your agency.
    - A crisis management plan encompasses all of the operational decisions made when a crisis occurs. It should acknowledge the need for and integrate or reference how to access your crisis communications plan.
    - For example, see the University of Memphis crisis management plan at http://bf.memphis.edu/crisis/crisis_mgmt_plan.pdf. The crisis communication plan is Annex C.
  - The crisis management plan should be updated and exercised at least annually.
- Identify your internal crisis communications team—people you will need at your side or to whom you should have immediate access when a crisis arises.
  - Identify the following:
    - Who has the resources to shape the message?
    - Who has the best access to critical information?
    - Who has the policy/political expertise?
    - Who has formed positive relationships with victim advocates, the media, the public and policymakers?
    - Who has experience communicating with your key stakeholders during a crisis?
  - Charge this group with creating or revising a crisis communications plan for your agency using key sections of this toolkit and materials from agencies in the state that have developed crisis communications plans and media lists (e.g., department of corrections, local law enforcement, etc.).
  - Having a well-defined crisis communications plan may help you head off common reactions, including discrimination and bias against individuals with serious mental illnesses, calls for more coercive interventions and unfounded yet understandable fears about future potential for violence.
  - Understand your resources:
    - Anticipate what information may be requested and determine if your agency has mechanisms for quickly retrieving it and releasing it in an appropriate form.

  - Determine which individuals would be assigned to crisis communications and plan for personnel to cover for their more routine duties.
  - Create a budget for crisis communications.

- Develop a list of emergency contacts for your agency.
  + Fill out the "My Agency Emergency Contacts List" in this toolkit or develop or revise a list of your own. A good place to find much of this information is in your agency's Continuity of Operations Plan.* Both your crisis management team and crisis communications team must have access to this list, which should be kept up to date. Each team should have its own copy, as well as cell or other emergency contact numbers for their fellow team members.
  + List primary and secondary contacts/experts for your key offices and issue areas.
    - Be certain to include experts within your agency in such key areas as trauma and disaster/emergency response, adult services, children's services, the criminal justice system, privacy laws and commitment statutes.
    - Identify in-house experts to increase the likelihood that you will be able to exercise some control over your messages.
    - Ask your chosen experts to stay current or advise you if they are unable to keep up with their area of expertise.
  + Include key legislators (those with budget/oversight authority or issue expertise) to ensure that informed mental health messages will be included in their public statements.
  + Include local and statewide law enforcement officials.
  + List cell and home phone numbers and home and office e-mail addresses.
  + Be certain these individuals have your contact information as well.

To prepare for an incident that involves mass casualties, you may also do the following:

- Review, revise and practice your state's disaster mental health plan regularly.** If a plan is developed but not kept current and practiced, it will have limited value. See the list of "Disaster Planning Resources" in this toolkit for links to relevant documents.
  + Keep your plan meaningful but also fairly basic, so that it can be maintained and updated regularly.
  + Meet with internal staff to explain crisis response procedures and perhaps conduct a tabletop exercise in which you lay out a scenario and each participant discusses how he or she would respond as a sequence of events plays out .
  + Participate in disaster planning with other state agencies and organizations with authority for emergency response. Remember that these groups may have resources to share in the event of an emergency. Include representatives of the military, such as the National Guard and Reserves, as key players in disaster drills.

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* A Continuity of Operations Plan details how the essential functions of an agency will be handled during any emergency or situation that may disrupt normal operations, leaving office facilities damaged or inaccessible.

** Since enactment in 1988 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (PL 100-707), states have been required to have a plan to focus on the mental health aspects of disasters. For guidance, see http://mentalhealth.samhsa.gov/publications/allpubs/sma03-3829/default.asp.

Understand Your State

An effective response to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness is contingent on your ability to identify and garner resources from other agencies within your state. You must also be aware of applicable limits on authority and relevant mandates. In particular, your knowledge of state and—in some cases—federal laws will be put to the test when a crisis emerges.

- You will need to be intimately familiar with your state's mental health policies and laws on such hot-button issues as involuntary commitment, firearms regulations/gun control laws and privacy laws. Backgrounders are available for each of these issues.
  - + It is critical that you have up-to-date information on your own state mandates and policies in each of these areas. Assign a member of your crisis management team to review the "What should I know about my state?" section of these backgrounders, and routinely update this information to reflect any changes.

In the event of an incident that involves mass casualties, you will also need to become familiar with your state's procedures and policies for the following:

- ***Managing disasters.*** In a mass casualty event, the mental health response is subordinate to the emergency response, the criminal investigation and public safety concerns, but it is still a critical component.
  - + In the event of a large-scale disaster, the State Emergency Management Agency (SEMA) may establish or activate an emergency operations center (EOC).
  - + You will need to be familiar with SEMA and how its representatives will coordinate with you to tap your mental health response capabilities. Your crisis management team leader should establish contacts among key SEMA staff.
  - + Likewise, your public information officer should have a close working relationship with his or her counterpart at SEMA.
  - + Your role in relation to the agencies that staff the EOC—including the state health department, state and local police, FBI and other responders—should be spelled out in your state's emergency operations plan and its disaster mental health plan.
  - + Familiarize yourself with the Department of Homeland Security's National Incident Management System (NIMS) or Incident Command System (ICS) courses to understand how public safety agencies operate in a crisis. See http://www.fema.gov/emergency/nims.
- ***Accessing resources.*** You will be responsible for helping mental health providers, including schools and universities, access state and federal funds for a disaster mental health response. Consider the following questions:
  - + Under what circumstances can your state apply for the Federal Crisis Counseling Assistance and Training Program? See http://www.mentalhealth.samhsa.gov/dtac.
  - + Through which internal state pathways do these decisions and processes flow?
  - + How do federal funds flow from the governor's office to SEMA, to your agency and to providers?
- ***Coordinating volunteers.*** Managing the outpouring of volunteers who want to provide mental health support can be a challenge following a high-profile, tragic incident.

- You will need to know and understand applicable state licensing laws.
- Systems must be in place to track mental health provider contact information, availability, relevant professional experience and areas of specialization.
- Your agency may be asked to check credentials, schedule volunteers and provide them with proper identification to gain access to sites, victims or others affected by the incident.
- Naming a volunteer coordinator as part of your crisis management team may help expedite and facilitate this process.

- ***Assisting victims.*** You will need to be familiar with federal and state regulations regarding victims' services.
  - The Federal Office for Victims of Crime (http://www.ojp.usdoj.gov/ovc) has authority to provide assistance to victims of acts of terrorism or mass violence.
  - State crime victim compensation programs reimburse crime victims or their families for out-of-pocket expenses such as medical expenses, mental health counseling, funeral and burial costs, and lost wages related to their victimization.
  - Be aware that locations where shootings or other acts of violence occurred are considered crime scenes. This may result in delayed body recovery and release of surviving victims, which may impact the mental health needs of survivors.
  - Body recovery is also difficult for staff charged with this task. The Center for the Study of Traumatic Stress (http://www.cstsonline.org) has several fact sheets on this topic.

To be nimble and proactive during a mass casualty incident, you will need to have an expanded list of emergency contacts.

- Fill out the "My State Emergency Contacts List" included in this toolkit or develop or revise a list of your own.
  - Identify the following:
    - Agency administrators and public information officers at other government authorities (e.g., state health department, state police, local law enforcement, FBI) to whom you may be asked to report or who may assert jurisdiction in a crisis situation
    - Mental health commissioners in neighboring states
    - Contacts at national organizations and federal agencies, such as the National Association of State Mental Health Program Directors (http://www.nasmhpd.org) and the Substance Abuse and Mental Health Services Administration (http://www.samhsa.gov)
    - Voluntary organizations, such as the American Red Cross (http://www.redcross.org)
    - Mental health advocates
    - Victims' services organizations
  - List cell and home phone numbers and office and personal e-mail addresses.
  - Be certain these individuals and organizations have contact information for you, your public information officer and/or other designated spokespersons in your office.
  - Plan to update this information on a regular basis.

Understand Crisis Communications

- Successful and thoughtful communications can help you prevent ineffective, fear-driven and potentially damaging responses to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Advance preparation is critical. Much of what follows can be assigned to your public information officer and his or her staff. See the backgrounder on "Crisis Communications" for more information.

- Determine who in your agency will speak with media and under what circumstances.
  - + Who should be the media's primary point of contact in your agency?
  - + Who from your agency should actually be interviewed/quoted and under what circumstances?
  - + If any of these people should be unavailable, who are suitable backups or to whom should you refer inquiries? Be certain these individuals are prepared to respond.
  - + Who should be the point of contact for keeping in-house staff up to date?
  - + Your spokesperson must be intimately familiar with the Health Insurance Portability and Accountability Act and other privacy act legislation in your state.

- Identify people outside government who have valuable expertise and respect in both government and public circles on key issues. They can often deliver messages that help reinforce and lend credibility to your statements.
  - + Add them to the "Content Experts Emergency Contacts List" included in this toolkit or develop or revise a list of your own. Include the following:
    - Professors, deans and researchers at medical schools/schools of public health
    - Representatives of professional groups (psychiatry, psychology, social work, etc.)
    - Representatives of national and state consumer organizations
    - Leading mental health professionals, including national experts
    - Experts from other fields, such as from national law enforcement associations or local agencies, who have either experienced similar crises or who are knowledgeable about criminal justice/mental health issues

- Develop a list of local, regional, state and national media that cover mental health and criminal justice issues or that have a strong background in those issues.
  - + Fill out the "Media Contacts List" included in this toolkit or develop or revise a list of your own.
  - + Include reporters for wire services (e.g., AP), television, radio, newspaper and Internet blogs.
  - + List cell and office phone numbers and office and personal e-mail addresses.

- Use your website and social media.
  - + Find out who is blogging about mental health in your community, region or state. It is worth monitoring what is being said, but don't let it absorb your attention.
  - + Consider a visible place to provide updates on your website and/or establish a presence for your agency on Facebook, YouTube and/or through Twitter. The status of emerging situations can be quickly posted and updated.

- Remember, however, that mistakes may become amplified in these fast-paced venues, so processes for reviewing communications must also be established.

- Network with reporters in advance of a crisis.
  - Confirm that they cover issues relevant to your agency.
  - Confirm their contact information (work and cell phone numbers).
  - Share contact information for yourself and your public information officer.
  - Provide background materials on yourself, your agency and key facilities.

- Help the media understand the complexity of accurately reporting on mental health issues.
  - For example, the State of Washington developed the Mental Health Reporting Project. See http://depts.washington.edu/mhreport/index.php.
    - The purpose of this website is to provide tools and information for news organizations, journalists, journalism educators and a broad coalition of news informants on ways to improve reporting on mental health issues.

- Prepare some materials in advance.
  - Develop talking points and Q-and-A/fact sheets as needed on anticipated issues. You can use or customize the fact sheets on mental illness and violence and on trauma/resilience in this toolkit.
  - Have information available on cuts to mental health programs, if applicable, and other statistics that are frequently requested, such as numbers of individuals served.
  - Have readily available materials on special programs in your state, such as forensic work release programs or mental health courts.

- Shoot B-roll (supplemental or alternate video) of facilities that may come into play (such as hospitals, special wards, probation offices, etc.). This can help avert a crush of requests in the midst of a crisis.
  - Make certain you understand the quality/format that must be shot for general use.
  - Obtain all necessary waivers and releases and resolve any copyright issues.
  - Determine how to easily distribute B-roll.

- Conduct internal media training on a regular basis.
  - You, your public information officer and other key staff should practice responding to sensitive questions you can reasonably expect to receive. The more familiar you and your spokespeople become with these messages, the easier it will be to deliver them in a reassuring manner in a time of crisis.

- Look for opportunities to discuss general mental health issues.
  - Present at meetings of professional journalists.
  - Network with professional, consumer and victims' support groups and with emergency service providers and first responders.
  - Consider submitting an op-ed piece to local, regional or national papers, writing a letter to the editor or providing comments to online news stories and respected blogs.

During an Incident

Your response to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness requires swift and decisive action on three fronts. Simultaneously, you will need to (1) activate the crisis response plans you have previously put in place; (2) frame your message and reach out to victims, victims' families, the public and the media; and (3) anticipate calls for longer-term solutions that may require legislative action or regulatory change. You will need to demonstrate and convey that you have a steady hand at the wheel. Now is the time to

- ❑ Activate your internal crisis management team. Be certain your agency attorney is available throughout the crisis.
- ❑ Activate your internal crisis communications team. Be certain your public information officer is available throughout the crisis.
- ❑ Gather information about the incident quickly and efficiently.
- ❑ Begin keeping a record of everyone you speak to and everything you do in your general and media contact logs.
- ❑ Ensure that your first message conveys empathy for the victims, support for them and their families, and recognition of all those affected.
- ❑ Prepare consistent messages, and be certain everyone on your team is saying the same thing.
- ❑ Be open about what you can and cannot share. Be certain to correct any inaccuracies that could mislead the public or the media.
- ❑ Recognize your need to be involved in discussions about potential legislative and regulatory changes. Knee-jerk reactions to such incidents cannot be the sole basis for revised policies, but they may spark conversations that point to areas that need improvement, including areas in which your agency has previously advocated change.

Understand Your Role

Rumors, speculation and fear spread quickly in the wake of a tragic incident when a person with a history or current diagnosis of serious mental illness is presumed to be involved. You will need to move quickly and efficiently to take control of the message. To do so, you will need to exercise effective crisis leadership. Specifically, you will need to be caring, to take a broad view of the crisis and to communicate effectively. See the "Effective Crisis Leadership" backgrounder and pocket card in this toolkit for details. Additional tips include the following:

- Determine who the initial spokesperson will be. Depending on the scope or scale of the incident, the governor's office may want to make the first statement. However, you will likely be called on to address issues relevant to your agency and to mental illness and violence.
  - Because of the groundwork you have laid with others in the state, law enforcement or other first responders may be open to including you in their press announcements or referring to your agency as a resource.
- Remember that *you won't have all the facts right away*. Be honest about what you know and your desire to provide updates as information is confirmed.
- Be clear about whether there is any remaining threat to public safety, if applicable, and urge calm.
- Be empathetic in your initial messages for the victims and your support for them, their families and others who are directly and indirectly affected.
- One commissioner who has been through such an incident describes your role as "equanimity under duress."
  - You have to be calm, clear and factual.
  - You have to show the governor, the media and the public that you recognize something terrible has happened and that you are eager to find out what can be done to prevent a similar tragedy in the future.
  - You have to give balanced information and state the facts with a sensitivity to not perpetuating stigma.
- Once the initial facts of the case are released (e.g., how many were injured and killed), your office should be prepared to answer questions from the media and the public, such as "How did this happen?," "Was the suspect ever in treatment?," "Did he or she have a history of violence?" and "Was he or she involved with the court system?"
- You should provide guidance to your team on crafting and managing your message. Ensure that all approvals or notifications will be made to others involved in the incident response and to state and local political leaders, as appropriate, before releasing information.

Understand Your Agency

In the wake of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness, you will need to spring into action immediately. If you have prepared your crisis management team and communications team, you will be ready to respond when an incident occurs.

- Activate your internal crisis management team.
  - Use your contact lists to reach members of the team and make sure your agency attorney is available throughout.
  - Begin monitoring media immediately in order to gauge current perceptions.
  - Establish a clear line of communication with the crisis team leaders in the governor's office and the agency leading the emergency response. Develop a secure communications process to ensure timely updates and discussions on key concerns and strategies that you do not want shared publicly.
  - Gather information quickly. Use the "Incident Response Checklist" as a starting point to determine the severity of the incident.
  - Keep a record of everyone you speak to and everything you do during the crisis. Use the contact logs in this toolkit or create your own. To help you find and fact check your messages, note the source of any information you learn.
  - Encourage staff to keep logs (or contribute to your log), as well, and to make notes as issues, concerns and ideas arise. To increase clarity and improve decision making, document deliberations during the crisis. These notes may prove useful during investigations of the incident and your response.
- Activate your internal crisis communications team.
  - Use your contact lists to reach members of the team and make sure your public information officer is available throughout.
  - Establish a clear line of communication with the governor's public information officer and the public information staff in the agency leading the emergency response.
  - See the "Understand Crisis Communications" pages in this section for more information about mounting an effective communications response.
- Assign administrative personnel to support your communications and crisis management teams.
- Begin notifying your in-house experts that they may be called on to provide you with background information, to help you craft messages for the media and the public, or to speak on behalf of your agency.

In the event of an incident that involves mass casualties, you may also

- Activate your state's disaster mental health plan. Determine the following:
  - Whether an emergency operations center (EOC) has been established
  - Which agency has the lead responsibility (e.g., local police, state police, FBI, military, etc.)
  - What your role will be in relation to the lead agency and other responders

  - + What type of assistance they need from you (e.g., crisis counselors needed on-site to assist EOC staff, first responders, victims and victims' families)

- Have your crisis management team leader and crisis communications team leader prepared to staff the EOC.
  - + They will manage the two-way flow of information, relaying vital news to you and helping you prepare messages for the media and the public.

Understand Your State

Fairly or unfairly, a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness will place considerable attention on the public mental health system. This is particularly true when the public believes that the alleged perpetrator "fell through the cracks" or that—"if only the system worked the way it was supposed to"—this tragic event could have been prevented. Calls for swift legislative and executive actions are a predictable response, even if they have minimal bearing on the incident at hand. It is easy to become defensive but counterproductive to do so.

- You will need comprehensive and current knowledge of your state's laws and policies regarding civil commitment, gun ownership, health care privacy, cross-systems information sharing and other hot-button issues.
  - + In consultation with your agency attorney, assign staff to review and update the "What should I know about my state" sections of the toolkit's backgrounders to help guide you.
- Contact any external experts you have identified who can brief you on these issues as well as speak to the media and the public.
- Brief legislators responsible for agency appropriations about the facts as you understand them and establish ongoing communications with them.
- Be in touch with the leaders of any existing state-level groups, such as criminal justice-mental health collaborations or campus safety committees. These groups may have gathered pertinent information that will help shape your statements.
- Even as the incident unfolds, you must anticipate calls for immediate legislative solutions and be prepared to respond. Though unmeasured reactions make for bad public policy, understand that *you will not be able to do nothing*. Calls for legislative and regulatory changes may be a springboard for much-needed discussions.

Understand Crisis Communications

In the event of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness, *what is communicated to the public, how it is communicated and by whom it is communicated will have a powerful impact*. Many of the action steps below will be carried out by the crisis communications team under the direction of your public information officer. See the "Working with the Media" backgrounder for successful strategies.

- Activate a response.
  - + Conduct an initial communications assessment of the situation.
    - How reliable is your information about the incident? What facts can you confirm, and what do you still need to ascertain?
    - Does the media or the public already know about the situation?
    - Are the reported facts accurate?
    - Who is the media currently speaking with, and are you an appropriate spokesperson at this point?
    - How long do you have before you need to issue a statement?
    - Will you issue a statement alone or in coordination with the governor, law enforcement or other responders?
    - Is there a perceived or actual threat to the general public or particular community (e.g., a gunman is still at large)?
    - If so, what information do law enforcement partners say can be released to help alert the public to the threat, protect them from the threat, address their fears or direct them to any assistance (first aid, counseling, etc.)?
      - What informational resources do you have prepared and ready to distribute?
      - What resources could be needed that you will have to prepare on short notice?
- Coordinate your involvement and stay informed.
  - + Be certain your public information officer contacts his or her communications counterparts in the governor's office, as well as other relevant local, state and federal partners, including an emergency operations center (EOC), if applicable. Establish the public information officer as your agency's point of contact for communications matters.
  - + Determine the lead spokesperson for your agency. This may be you, your public information officer, another agency official or an outside expert, depending on the scope or scale of the incident. This person should be in regular communication with the crisis management and crisis communications teams.
  - + Be prepared to call in extra communications staff as needed, including someone who can keep your website/blog/Twitter/Facebook page updated, someone to monitor all media, and someone who can alert agency employees about those updates. Make sure the public information officer stays in touch with these people at all times.
  - + Remember to make communications to and from your crisis management team the highest priority. Their informed involvement is vital to an effective crisis response.

- Communicate with your employees, the media, the public and stakeholders.
  - + You may need to prepare a short statement early in a crisis situation because heightened public emotions, rumors and speculation create an unstable information environment. If someone else fills the information vacuum and establishes himself or herself as a credible source of information, you may find yourself playing catch up throughout the crisis.
  - + Your agency, the governor's office, the EOC coordinator or another appropriate agency should provide a statement as soon as possible saying that you are aware of the emergency and, like others, you are deeply affected by the tragedy and are involved in the response.
    - If your agency takes the lead, the initial statement you release to the media while you gather the facts will be your first message to the public. Express empathy for victims and their families and acknowledge public concern about the incident. Indicate your intention to investigate the matter and offer updates.
    - Remember the words of Vincent Covello, founder of the Center for Risk Communication: "In high concern situations, people want to know that you care *before* they care what you know."
    - Offer reassurance and make available any prepared materials you have about crisis counseling and other support services. Provide materials about predictable responses to trauma/resilience, such as the fact sheet in this toolkit.
  - + Ensure that you share your messages with employees at the same time or before you share it with the media.
  - + Make a record of all media inquiries and your responses. Use the "Media Contacts Log" in this toolkit or create one of your own.
- Refine and add to your message (and to release strategies).
  - + Determine your main messages and then prepare consistent answers to questions you can anticipate from the public and the press. They will want to know: Why did it happen? How did it happen? Who is responsible? What is being done to keep it from happening again?
  - + Require everyone in your agency to stay on message and encourage all of your partners to do so as well. Refer all media inquiries to your designated spokespersons. Make sure they are readily available to the media at all times.
    - As the crisis unfolds, don't speculate. Provide the facts as you know them, and offer updates as soon as you have them.
    - Be honest about what you can and cannot share. Never mislead the public or the media by failing to provide information that is important to their understanding of the issues. When you have to withhold information, be clear that you are doing so and indicate why. However, don't hide behind confidentiality statutes.
    - You will have to balance the need to provide accurate information with the need to provide information quickly. The best way to address this challenge is to establish regular exchanges with the media—in person, by e-mail or by phone—at which times the information can be delivered, explained and updated. Be sensitive to deadlines.
    - Let the nature and the newsworthiness of your updates and reporter deadlines govern whether developments should be announced by e-mail, posted on websites or social media, or announced at a news conference.

- Be careful about setting up too many in-person press events. Only schedule a press conference if there is "news" you will release. Other communications can be handled with Web, e-mail and press release updates.
- Consider the logistics for press briefings. Choose a room that is large enough, easily accessible and with adequate lighting and sufficient electrical power outlets.
- You will want to do this away from an emergency operations center and other areas where you would not want media gathering and trying to interact with personnel who are not authorized spokespeople. Any on-site briefings need to be coordinated with the agencies overseeing the crime scene or area where the tragedy occurred. Determine if you will require credentials to be issued in advance of any briefings.
- Monitor media coverage about the incident and be prepared to correct misinformation or misperceptions.

+ Though it's easy to be defensive, don't try to shift blame or responsibility to others.
+ Don't use the immediate aftermath of a crisis to discuss issues in terms of their dollar value or complain about a lack of funds.
+ Remember that the media has a job to do; always treat members of the media with respect. They offer an important vehicle to get your message to the public and key stakeholders, and members of the media may provide valuable information to you as the crisis unfolds.
+ Don't shortchange local media. Tragic events will often draw national media attention, and it is easy to prioritize them over a small, local outlet. Remember that your relationship with your local media will affect how your agency is covered long after the national media have left town. Look for ways to give local media special consideration at various points during the communication process.

After an Incident

The immediate crisis involving a person with a history or current diagnosis of serious mental illness may pass quickly, but the aftermath may linger for months and even years. Ongoing media scrutiny, possible legislative hearings, and re-traumatization of victims, their families and the public on key anniversary dates may keep the incident front and center for some time. Your role now is one of continuing support and compassion, review and reconnection with stakeholders and important allies to determine if any positive change can result. You must look inward to determine how your agency performed and outward to consider how the mental health system responded. Now is the time to undertake the following:

- ❑ Begin to review your agency's actions during the crisis and consider whether and how it could do better the next time such an incident occurs.
- ❑ Review and revise your crisis management and communications plans accordingly.
- ❑ Consider writing an internal after-action report so lessons learned and recommendations for change are not lost when crisis management and communications team members change.
- ❑ Use the additional scrutiny of the public mental health system to identify service gaps and propose remedies. Be careful how you talk about lack of resources; you don't want to be perceived as making excuses.
- ❑ Begin to address calls for legislative and regulatory solutions. Remember that even a good system can be made better.
- ❑ Showcase "what works" about your agency's policies and programs.

Understand Your Role

When the immediate crisis is over, you may find that your most challenging role lies ahead. In the wake of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness, the public mental health system will be held up to the spotlight. The more serious the event is, the greater the scrutiny—perceived failures in law and policy will be magnified. Your response to public and legislative inquiries will play a part in determining whether the incident becomes a vehicle for making positive changes or a setback for community-based, recovery-oriented treatment and services.

- Resist the temptation to become defensive. You have nothing to gain from this attitude, which may be perceived as evidence of "mismanagement" or "incompetence."
- Be prepared to cooperate fully with any and all outside reviews.
- Begin to address calls for legislative responses. The public wants to feel safe, and even a good system can be made better. Your job is to balance your commitment to public health and public safety.
- Prepare for what are sometimes termed "anniversary reactions." At key points after an incident (one month, six months, one year, etc.), victims, family members and the public may re-experience anxious, angry or depressed feelings. Funerals for victims and trials or legal proceedings related to the event also may trigger trauma symptoms. Offer the support of your agency to local mental health authorities that may respond to an influx of new or returning clients during these times.

Understand Your Agency

The more serious a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness is, the more your agency and its operations may be affected. An incident that involves mass casualties may require you to continue marshalling resources and staff to the affected areas. Even an incident that does not rise to this level may affect day-to-day operations while your crisis management and communications teams finish their work and prepare to close out their operations.

Immediate Aftermath

- Be certain that the members of your crisis management team and communications team continue to document conversations with everyone they speak to and record everything they do.
  - This is vital when it comes time to review and revise your crisis response plans and may help you in preparing any written or oral testimony you are asked to give.
- Begin immediately, while the crisis is fresh in your mind, to consider how your crisis management and communications plans worked.
  - If you made notes while the crisis was unfolding, gather them in one place. Ask other team members to contribute to the file.
  - Get feedback from your media, governor's office, law enforcement agencies and other partners in the response effort.
- Keep lines of communication open between yourself, your public information officer and the governor's office, as well as with your agency's stakeholders—particularly consumer groups, key legislative leaders and your in-house and outside experts.
  - Effective two-way communication between and among these groups and your agency will be vital as you review how your agency responded and what it could do better.
- In the case of an incident that involves mass casualties, two groups will require special attention and support: first responders who have witnessed the aftermath of violence and cared for traumatized victims and your staff who may have experienced trauma as part of their work in an emergency operations center or other aspects of disaster relief.
  - Remember to plan for their needs, including adequate time off and the opportunity to address their emotional concerns. Even staff who remained off the "frontlines" may be carrying extra work and also require similar consideration.

Longer-term Actions

- Conduct a formal review of your crisis management plan, and ask the following:
  - Which parts of the plan worked and didn't work?
  - What lessons did you learn from the experience?
  - What could you do differently or better next time?

After an Incident

- Revise your plan accordingly. Remember to update it as conditions warrant.
- Ask communications or operations staff to draft a debriefing document (sometimes referred to as an after-action report) that outlines the following:
  - Your agency's efforts during the incident and the results of these efforts
  - What resource needs were identified as a result of the incident
  - What you will do to improve your agency's response in the future
  - What you have learned about how or if such an incident could have been prevented

Understand Your State

Unmeasured reactions by some individuals in the wake of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness can lead to misdirected and ineffective changes in public policy. Legislators are pressured to "do something," and your engagement in the policymaking process could have a positive effect. The extent to which you have anticipated and prepared for such reactions may determine how successful you are in allaying the fears and addressing the concerns of victims and their families, legislators, the public and the media.

- Have information about your own state laws and policies readily available.
  - + Review the backgrounders in this toolkit as a starting point for discussion.
  - + Ask your agency attorney to supplement any briefings given before and during the incident to understand how current laws and policies affect new concerns or legislative proposals.
  - + Assign staff to prepare additional backgrounders on other relevant issues, such as policies around forensic work-release programs or mental health courts.
  - + Use information vetted by your agency attorney in legislative hearings, news conferences or meetings of internal and/or external stakeholder groups convened to consider possible reforms.
  - + Be aware of any pending lawsuits from victims' families or others and how they might affect your public statements or release of documents.
- Use the additional scrutiny of the public mental health system to identify service gaps and propose remedies (e.g., the need for increased collaboration between the mental health and criminal justice systems).
  - + Be judicious in how you discuss lack of resources. State budget cuts may hurt, but complaining about shortfalls after the incident may fall on deaf ears if it's seen as a way of excusing the tragedy.
  - + Convey a positive assessment of the current system while advocating for enhancements that could mitigate subsequent tragedies.
- One frequent outcome of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness is a focus on commitment reform.
  - + You may be able to produce positive outcomes from this process if you highlight ways in which the mental health, criminal justice and broader social service systems can work together more effectively to serve individuals with multiple and complex needs.
  - + You may need to address potential downsides to a focus on commitment reform.
    - Legislators and the public may consider the problem "solved" by such policies, which may divert attention from the need for sustained, ongoing change.
    - Commitment to systems of care that do not have effective treatment models or sufficient capacity may not improve public health or public safety.
    - There is a possibility that coercion-centered reforms may further stigmatize individuals with mental illnesses and impede development of recovery-oriented services.

After an Incident

In the event of an incident that involves mass casualties,

- Remember that some individuals who have witnessed a tragic event or responded to it may be from other communities or states. This is particularly true for an incident on a college campus or military base.
  - + You will need to consider how, legally and ethically, you can share information with mental health agencies in nearby communities and states so that victims and other witnesses can access counseling and services as needed.

Understand Crisis Communications

There is still important communications work to be done once an emergency situation has subsided. In the aftermath of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness, your crisis communications team should review your communications plan and revise it as needed. The team's most important role may be to remain connected with the public and stakeholders to educate them about what happened and how you will work with them in the future.

- Review your communications plan.
  - The strengths and weaknesses of your communications plan should be evident after testing it in response to a high-profile, tragic incident.
  - Once the emergency is over, conduct an internal review with colleagues involved in both crisis management and communications. In face-to-face discussions or e-mails, consider the following:
    - Which parts of the plan worked and which parts didn't?
    - How did the public, the media and other stakeholders react to your communications?
    - What actions can you take to improve communications in future emergencies?
    - Were the information materials that you had prepared prior to the incident useful?
      - If not, how could they be improved?
      - What other materials could be prepared in advance that would be useful?
  - Talk one-on-one, in person or over the phone, with a few of your key stakeholders about their satisfaction with the communications conducted during the incident. Consider the following:
    - What information did they receive that they found particularly useful?
    - What information did they receive that was not especially useful?
    - Was the information timely and accurate?
    - Who else did they rely on as a source of information during the incident, and who was their primary source of information?
    - What information did they feel they needed but didn't get?
    - Were there any segments of the population that should have been reached during the incident but weren't?
    - How can you work together to improve communications in future emergencies?
- Revise your communications plan.
  - Take steps now to improve communications during the next high-profile, tragic incident.
  - Establish a team to plan future crisis responses and redraft the communications plan for your review. Make sure the plan's communications objectives are clear.
  - If appropriate, vet the revised plan with the governor and the State Emergency Management Agency.
  - Always remember the importance of effective two-way communication during an emergency. Explain to non-communications staff how an effective communications strategy benefits overall response, and give examples when possible.

- Review the new plan periodically to be certain it is in line with other procedures (agency, state) for an emergency response.

- Remain connected with the public and key stakeholders.
  - As the crisis winds down, you and your public information staff may face questions about how you handled it—not only from the media and the public, but from other key stakeholders, legislators, auditors and other officials.
    - Your goal is to remain connected with these individuals to educate them about what happened and how your agency will work to reduce or ameliorate future incidents.
    - Use the material you prepared about your agency's response to frame your discussions.
  - Identify key dates and occasions when you can reasonably expect public attention to refocus on the incident. These include the following:
    - Funerals of victims
    - Anniversaries (six months and one, five and 10 years)
    - Legislative hearings
    - Discussions at professional conferences
    - Trials or legal proceedings related to the incident
  - Recognize the possibility for re-emergence of trauma symptoms, particularly on key anniversaries. Work with local mental health authorities to help them publicize the fact that such reactions are normal and services are available. Remember to make clear that not everyone will respond to such events by experiencing trauma symptoms.
  - Maintain a reference file with copies of all materials released during the incident. This serves as a public record of your communications efforts and gives you a head start on preparing materials for future emergencies.
  - Remember to showcase your success stories!
    - Have readily available case studies of individuals who are recovering from serious mental illnesses and the programs that are helping them do so. You may have prepared these for annual reports or agency newsletters. Keep a file of positive stories to refer to as needed.
  - If you haven't already done so, review the State of Washington's Mental Health Reporting Project at http://depts.washington.edu/mhreport/index.php. It will help you assist the media with understanding how to report accurately about mental health issues in the future.

Using the Ancillary Materials

The previous sections of this toolkit (before, during and after an incident) suggest specific actions designed to help you prepare for, manage and evaluate your response to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. The materials that follow feature a set of resources that provide more information to further guide your response.

- **Backgrounders.** These are designed for internal use. They highlight those areas in which you may be pressed for further details—for example, about mental illness and violence or involuntary commitment statutes—and offer guidance about strategic issues such as working with the media. They include the following:
  - Mental Illness and Violence
  - Involuntary Commitment Standards
  - Firearms Regulations/Gun Control Laws
  - Understanding Privacy Laws
  - Crisis Communications
  - Effective Crisis Leadership
  - Working with the Media
- **Fact sheets.** The fact sheets are designed to be shared with the press and the general public. You may want to adapt them to the specific circumstances in your state. They include (1) What Do We Know about Mental Illness and Violence? and (2) Predictable Reactions to Trauma/Resilience.
- **Resources.** The resources pages feature links to websites and materials that provide more detail on many of the issues addressed throughout the toolkit. They include (1) Disaster Planning and Response and (2) Web Resources.
- **Checklists/Contact sheets.** The checklists are forms you can fill out to have vital information on hand and to track your response. They include the following:
  - Incident Response Checklist
  - My Agency Emergency Contacts List
  - My State Emergency Contacts List
  - Content Experts Emergency Contacts List
  - Media Contacts List
  - General Contacts Log
  - Media Contacts Log
- **Effective Crisis Leadership: Initial Communications Pocket Guide.** This detachable card contains thoughts for initial statements you can make to the media and the public.
- **Appendices.** The appendices include the names of those individuals who offered advice and recommendations for development of the toolkit and a review of the literature on mental illness and violence. They include (1) Appendix A: Expert Advisors and (2) Appendix B: Mental Illness and Violence Literature Review.

Mental Illness and Violence

One of the most predictable reactions to a high-profile, tragic incident involving a person with a history or diagnosis of serious mental illness is renewal of fears and stereotypes about the connection between mental illness and violence. Frequently, these reactions frame news stories and lead to calls for more coercive interventions, including increasing outpatient commitment and hospitalization.

The following statements about mental illness and violence are supported by research, as detailed in an accompanying fact sheet and in a literature review that can be found in the appendices of this toolkit. These statements may help you frame your responses to media and public inquiries following a tragic incident. The "What Should I Know about My State?" section at the end highlights some facts you might want to gather in advance to help you discuss these issues with confidence and credibility.

The connection between mental illness and violence is complex. Although some subgroups of people with serious mental illnesses have a higher risk of violence, including those with co-occurring substance use disorders or active psychosis, *most people with mental illnesses are not violent, and most people who are violent are not mentally ill.*[1]

- You must be honest about the connection between mental illness and violence in a way that informs but does not inflame fears. In the end, this should serve to reinforce the message that community treatment and supports are needed.
- *Remember to note that people with serious mental illnesses are more likely to be the victims rather than the perpetrators of violence.*

Correlation does not imply causation. Serious mental illness alone does not cause violence; factors other than mental illness itself relate to violent behavior. You can point out:

- Substance abuse significantly increases the risk for violence regardless of a person's mental health status.
- Also, people with serious mental illnesses frequently live in impoverished neighborhoods with few natural or social supports. These individuals report risk factors associated with violence, including physical abuse, parental criminal acts, unemployment and victimization.
- Express your commitment to the goal of providing every individual with serious mental illness access to the treatment and support services he or she needs to recover and live a safe and productive life in the community.

We cannot predict who will be violent. Despite knowledge of identified risk factors for individuals with mental illnesses as a group, we cannot accurately predict when any particular individual will be violent. Risk assessment is, at best, an inexact science.

Nothing can prevent all acts of violence among people with serious mental illnesses. However, the risk for violence can be reduced by pointing out the following:

- Some violence among people with serious mental illnesses is associated with a lack of adherence to medication regimens, so it is critical to ensure access to medications and associated strategies, such as patient education, that improve adherence.

- Some violence is related to co-occurring substance use disorders, so access to integrated mental health and substance abuse treatment (provided at the same time and in the same treatment setting) is needed.
- Some violence takes place for the same reasons that people without mental illnesses commit violence, so access to certain treatments that have demonstrated effectiveness (e.g., cognitive behavioral therapy) is good public health and public safety policy.

Calls for loosening civil commitment standards or tightening existing outpatient commitment laws are understandable but should not be determined in the context of a crisis. The public wants to feel safe. However, enhanced services, not legal coercion, generally lead to improved outcomes. Your state's existing commitment standards have been the product of thoughtful deliberations, and while review of their effectiveness is always appropriate, proposed changes may have little to do with the current event and should not be dictated by headlines or crisis conditions.

There is no reason to fear a person just because he or she has a serious mental illness. Violence committed against strangers is rare. The people most likely to be the targets of violence by a person with or without a mental illness are family members and friends who are in their own homes or in the individual's home. *Because serious mental illness affects a small percentage of the population, at best it makes a very small contribution to the overall level of violence in society, which may not be obvious given how highly publicized these incidents tend to be.*

What should I know about my state?

- Do you assess for risk of violence among people with serious mental illnesses? Routinely, as a part of ongoing program evaluation or only in specific circumstances? What are the outcomes of this screening?
- How does your state corrections department assess for mental disorders among violent offenders? Can they determine the percentage of individuals who receive public mental health services who have ever been convicted of a violent act?
- How many people in your state have co-occurring mental and substance use disorders? What types of treatment are available? What are the outcomes of treatment?
- What are your state's criteria for emergency evaluations/involuntary psychiatric evaluations?
- What are your state's outpatient commitment standards? What are your procedures for civil commitment? See the backgrounder on involuntary commitment in this toolkit for more details on what you need to know.

[1] Friedman, R.A. (2006). Violence and mental illness—How strong is the link? *New England Journal of Medicine, 355*(20), 2064–2066.

Involuntary Commitment Standards

A high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness sometimes spurs legislators, the media and the public to call for loosening civil commitment standards or tightening existing outpatient commitment laws. This backgrounder provides a brief overview of involuntary commitment and suggests some things you should know about your state's laws.

What types of involuntary commitment are permitted?

Civil commitment refers to state-sanctioned, involuntary hospitalization of individuals with mental illnesses who are believed to require treatment because of self-harming or dangerous behaviors. As forensic mental health services expert Gary B. Melton and his colleagues note in their text on psychological evaluations for the courts, "The civil commitment process permits institutionalization of an individual because of behavior deemed unacceptable to the community."[1] Every state has a civil commitment statute. Involuntary outpatient commitment (IOC) refers to court-ordered, community-based mental health treatment. As of February 2010, 42 states allow IOC.[2]

Involuntary commitment is one of the most hotly debated issues in mental health law. Proponents believe that commitment laws can increase public safety and help guarantee that the mental health needs of people with the most serious illnesses are met. Opponents feel that involuntary commitment laws can infringe on an individual's personal freedom and serve to further stigmatize mental illness. Legal challenges to civil commitment in the 1970s led to changes designed to address civil rights concerns.[3]

How are commitment laws applied?

All state civil commitment statutes require that an individual be judged dangerous to self or others as a result of a mental disorder, though the definitions of "dangerous" and "mental disorder" vary widely. In addition, almost all states permit commitment of individuals who are "gravely disabled" (i.e., unable to care for their own basic needs), either explicitly or as part of the danger-to-self rubric. In most states, commitment to a hospital is not permitted if a less restrictive alternative exists. Outpatient commitment in lieu of hospitalization, for individuals who meet commitment standards, is authorized in about two-thirds of states.[4] A second community option is conditional release, which involves continued supervision after release from a hospital. Most involuntary outpatient treatment is provided as a form of conditional release.

A third type of IOC, sometimes called "preventive commitment," has received the most attention from critics of commitment standards. In at least 10 states, such as New York, individuals who do not currently meet civil commitment standards can be involuntarily committed to community treatment if it is believed that they *would* become a danger to self or others if no intervention takes place.[5] State experiences show that IOC requires close monitoring of community treatment by the court system or other entity. A side-by-side comparison of state IOC statutes as of June 2004 is available at http://www.bazelon.org/issues/commitment/moreresources/iocchart.pdf.

What does the research say about involuntary commitment?

A review of 10 studies that compared hospitalization and community care found no evidence that hospitalization had any positive impact on average patient care. Individuals who received care in the community had more positive outcomes in almost every case.[6] Moreover, the studies found that prior

hospitalization is the best predictor of future hospitalization; individuals who received inpatient care were more likely than those treated in the community to be hospitalized again.

The most recent analysis of IOC to date compared individuals mandated to treatment under New York State's Kendra's Law to a comparison group of individuals discharged from psychiatric hospitals.[7] The researchers found that court-ordered clients showed modest improvements on clinical and public safety indicators and were more engaged in services than voluntary clients. Both groups had nearly identical perceptions about the care they received. However, the authors cautioned that because IOC in New York has been accompanied by enhanced treatment and services, such as priority for housing and vocational training, results reflect on the overall "package" of IOC and not on the legally coercive aspect alone. When the RAND Institute studied the effectiveness of IOC in eight states, it found no evidence that a court order is necessary to achieve compliance with treatment or that a court order, in and of itself, has an independent effect on outcomes.[8]

What should I know about my state?

- What are the key provisions of your state's civil commitment statute? Summarize them in a table or set of bullets that you can refer to easily. In particular, how does your state define such key terms as "mental illness" and "dangerousness"?
- When was the last time the civil commitment statute was reviewed or revised?
- Does your state have an IOC statute? What are its major provisions? Summarize them in a table or set of bullets you can refer to easily.
- Does your state permit "preventive commitment" of individuals who do not meet civil commitment criteria?
- Does your state's IOC statute require that community services be available before mandating a person to treatment? If so, is a wide range of services available?
- Is there an agency or organization that oversees IOC proceedings to be certain individuals receive appropriate and accessible treatment? If not, is there a group in the state that is prepared to assume this work?

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[1] Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin, C. (2007). *Psychological evaluation for the courts* (3rd ed.) New York: The Guilford Press.

[2] Phelan, J.C., Sinkewicz, M., Castille, D.M., Huz, S., Muenzenmaier, K., & Link, B.G. (2010). Effectiveness and outcomes of assisted outpatient treatment in New York State. *Psychiatric Services, 61*(2), 137–143.

[3] Melton, et al.

[4] ibid.

[5] ibid.

[6] Kiesler, C. (1982). Mental hospitals and alternative care: Noninstitutionalization as potential public policy for mental patients. *American Psychologist, 37*(4), 349–360.

[7] Phelan, et al.

[8] Ridgely, M.S., Borum, J., & Petrila, J. (2001). *The effectiveness of involuntary outpatient treatment: Empirical evidence and the experience of eight states*. Santa Monica, CA: RAND.

Firearms Regulations/ Gun Control Laws

Few subjects are more contentious in the United States than the right to possess firearms. There are federal and state laws that may ban the sale of guns to some individuals with mental illnesses. Your state's laws and regulations regarding the sale, possession and registration of guns may come under intense scrutiny in the wake of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. This backgrounder offers information on federal and state gun laws. It recommends that you understand the laws and regulations in your own state and how they relate to federal law.

Federal Laws

The right of Americans to own and carry firearms has been regulated by various federal, state and/or local laws dating to the early 18th century. Firearms registration has also been the subject of intensive legislative debate. With passage of the Federal Gun Control Act of 1968, specified individuals who have been determined to have a qualifying mental illness or have been institutionalized are among those restricted from owning and carrying firearms.[1] The law specifically applies to anyone who has been "adjudicated as a mental defective [sic] or has been committed to any mental institution" [18 USC § 922(d)(4)]. The applicable regulations [27 CFR § 178.11] define the term "adjudicated as a mental defective" [sic] to include the following:[2]

- Individuals who, as a result of mental illness, are a danger to themselves or others
- Individuals who lack the mental capacity to contract or manage their own affairs
- Individuals found to be insane by a court in a criminal case (i.e., not guilty by reason of insanity or other such equivalent finding)

According to the Bazelon Center for Mental Health Law, the regulations specifically exclude individuals who receive care in a mental institution on a voluntary basis. In past years, U.S. firearms legislation has followed high-profile acts of violence. The shootings of President Reagan and his press secretary, James Brady, spurred passage in 1993 of the Brady Handgun Violence Prevention Act. This act required background checks for handgun sales and the establishment of the National Instant Criminal Background Check System (NICS).[3] States submit names to the NICS voluntarily. After the Virginia Tech shootings, the FBI indicated that just 22 states were able to report any mental health information to the federal database.[4] The Brady Act was amended by the NICS Improvement Amendments Act of 2007, which provides financial assistance to aid states in sending records to NICS and financial penalties if they fail to do so.

State Laws

State laws regulating the sale of firearms vary widely, but an increasing number of them restrict access for specific categories of individuals with mental illnesses. The number of states banning gun sales to specified categories of individuals with mental illnesses jumped from 19 states in 2000 to 43 states, the District of Columbia and Puerto Rico in 2005.[5] At least 20 states and the District of Columbia have databases that contain information on people with mental illnesses submitted by courts or mental health treatment facilities. These databases differ by the type of information retained and how it is collected.

State laws diverge in their definition of mental illness, type and duration of gun restriction, and reporting practices on the part of physicians caring for these individuals. The definition of those who are prohibited from owning guns varies significantly from individuals with a history of voluntary outpatient treatment to those who are adjudicated mentally ill or "habitual drunkards."[6] States that do not define a prohibited population are governed by federal statute. However, in some states, the definition of prohibited individuals exceeds federal restrictions. For example, Texas bars from gun ownership individuals with specific diagnoses, including schizophrenia, bipolar disorder, and antisocial personality disorder, among others.[7] See an overview of state gun laws at http://www.statemaster.com/graph/gov_gun_law_per-government-gun-laws-permits.

Just as federal law provides recourse for individuals who have been prohibited from owning guns based on a mental illness exclusion, many state laws also offer an appeals process. However, in some states, such as Rhode Island, individuals have to be certified by a medical authority as being "cured" of their mental illness. As observers have noted, the legal standard of "cure" is inconsistent with the sometimes cyclical nature of many psychiatric disorders.[8]

Policy Implications

Proponents of the exclusion for people with mental illnesses believe it will help limit access by individuals like those involved in high-profile incidents. However, some opponents believe that because so few people with mental illnesses ever commit violent acts, laws prohibiting gun ownership may not be either scientifically valid or reliable.[9] Others fear that lists maintained to comply with these laws may infringe on the privacy of individuals with mental illnesses and may deter them from seeking care. Some states have tried to minimize intrusion on individuals' privacy by having the mental health system simply confirm or deny that an individual is prohibited from owning a firearm without sharing diagnoses or other specific details.

What should I know about my state?

- Does your state prohibit gun ownership by individuals with mental illnesses? If so, how is "mental illness" or other aspects of the exclusion defined?
- Does your state maintain a database on individuals with mental illnesses? If so, who reports information? What type of information do they send? How is this information used?
- Does your state report information to the NICS? If so, what information does it send?

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[1] Norris, D. & Price., M. (2009). Firearms and mental illness. *Psychiatric Times, 26*(11). http://www.psychiatrictimes.com/display/article/10168/1482320.

[2] Bazelon Center (2007). Action alert: *States may alter policies on criminal background checks for gun purchases*. http://www.bazelon.org.

[3] Norris and Price.

[4] Federal Bureau of Investigation (2007). Press release: *Response to inquiries on the FBI's National Instant Criminal Background Check System.* http://www.fbi.gov/pressrel/pressrel07/nics041907.htm.

[5] Norris, D., Price, M., Gutheil, T., & Reid, W. (2006). Firearms laws, patients, and the role of psychiatrists. *American Journal of Psychiatry, 16*(3), 1392–1396. http://ajp.psychiatryonline.org/cgi/reprint/163/8/1392.

[6] ibid.

[7] ibid.

[8] Norris and Price.

[9] Norris, Price, Gutheil, and Reid.

Understanding Privacy Laws

Two laws that govern the privacy of an individual's medical and educational records frequently are misunderstood. They are the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), respectively. Misinterpretation of these laws becomes a major barrier to cross-system collaboration. Delays in responding to information requests caused by uncertainty or time-consuming *ad hoc* legal reviews could adversely impact a timely response to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. The information in this backgrounder presents a brief overview of privacy laws. *It is not intended to serve as legal advice.* Your agency attorney and state attorney general can help you understand and interpret applicable federal and state laws and regulations.

What is HIPAA?

Congress enacted HIPAA in 1996, among other reasons, (1) to improve the efficiency and effectiveness of the health care system through the establishment of national standards and requirements for electronic health care transactions and (2) to protect the privacy and security of individually identifiable health information.

What does the HIPAA privacy rule require?

The HIPAA Privacy Rule requires covered entities—which are health plans, health care clearinghouses and health care providers—to secure individuals' health records and other protected health information (PHI) by requiring appropriate safeguards and by setting limits and conditions on the uses and disclosures that may be made of such information without patient authorization.[1] HIPAA-covered entities do not include the courts, court personnel, accrediting agencies and police or probation officers.[2] Uniform consent forms can facilitate information sharing when consent is recommended or required.

What disclosures does HIPAA permit?

HIPAA permits disclosure without an individual's consent for purposes of medical treatment. According to the U.S. Department of Health and Human Services, the HIPAA Privacy Rule also permits a covered entity to disclose PHI, including psychotherapy notes, when the covered entity has a good faith belief that the disclosure (1) is necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or others and (2) is to a person(s) reasonably able to prevent or lessen the threat. This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat or others who the covered entity has a good faith belief can mitigate the threat. The disclosure also must be consistent with applicable law and standards of ethical conduct. See 45 CFR § 164.512(j)(1)(i).[3]

What is FERPA?

FERPA is a federal law that protects the privacy of students' "education records" by requiring written consent to release information found in an education record that can be linked to an individual student. FERPA applies to educational institutions that receive funds under any program administered by the U.S. Department of Education, including most elementary, secondary and postsecondary schools.

What information does FERPA cover?

The term "education records" is broadly defined to mean those records that are (1) directly related to a student and (2) maintained by an educational agency or institution or by a party acting for the agency or institution. At the elementary or secondary level, a student's health records are education records subject to FERPA. At postsecondary institutions, an eligible student's "treatment records"—which are medical and psychological treatment records that are made, maintained and used only in connection with treatment of the student and disclosed only to individuals providing the treatment—are excluded from the definition of "education records."[4] Personal observations and conversations with a student fall outside FERPA.

What disclosures does FERPA permit?

According to the U.S. Department of Education, an eligible student's education records and treatment records may be disclosed without consent if the disclosure meets one of the exceptions to FERPA's general consent rule. One of the permitted disclosures is to appropriate parties, which may include law enforcement or parents of a student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals. See 34 CFR §§ 99.31(a)(10) and 99.36.[5] New health and safety guidelines impose a "rational basis" test on an institution's decision to disclose information in an emergency.

How do federal privacy regulations and state laws relate to one another?

HIPAA and 42 CFR Part 2, the federal regulations that govern the confidentiality of alcohol and drug abuse patient records, set minimum standards for protecting and securing PHI. If a state law is more protective of privacy than these federal laws and regulations, the state law governs. In general, state law is almost always stricter than HIPAA in providing for the confidentiality of mental health records. In contrast, federal regulations regarding confidentiality of substance abuse and alcohol treatment are rarely exceeded by state law.[6] Appropriate counsel is needed to determine which laws apply in a specific case.

What should I know about my state?

- What do state laws say about information sharing in the event of a serious and imminent threat to public health and safety? Is such an event defined?
- Have you established clear guidelines and policies for sharing information among agencies, such as schools, colleges, law enforcement and the courts, that might be involved in responding to a high-profile, tragic incident?
- Are these policies, including the use of uniform consent forms, part of these agencies' respective emergency response plans? (See the "Dispelling the Myths" article in the footnote below for a link to a sample uniform consent form.)

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[1] *Joint Guidance on the Application of FERPA and HIPAA to Student Health Records*. (2008). http://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf.

[2] *Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems*. (2007). http://www.gainscenter.samhsa.gov/pdfs/integrating/Dispelling_Myths.pdf.

[3] See note 1, above.

[4] ibid.

[5] ibid.

[6] *Information Sharing in Criminal Justice–Mental Health Collaborations.* (In press). The Bureau of Justice Assistance and The Council of State Governments Justice Center. http://www.consensusproject.org/jc_publication.

Crisis Communications

- The first rule of crisis communications is the same as that for emergency medicine: *First do no harm.* Do not release information that will interfere with an ongoing investigation, jeopardize public safety or erode your credibility.
- Remember that journalists have a job to do, and they will do it—with or without your help.
- Establish positive working relationships with local, regional and even national media. If reporters come to view you as a reliable source of information on issues related to mental illness, they may be less likely to seek information from less credible sources.
- Identify other individuals—on staff, in the community and nationally—who can speak to the treatment, legal and political issues that will be raised. You don't have to do this alone.
- Begin developing messages before you need them. It helps to have information readily available in writing.
- Craft messages that are simple, straightforward and accurate, and deliver them with brevity, clarity and compassion.
- Coordinate your message with the governor and leaders in law enforcement or other emergency responders with jurisdiction over the incident.
- Pay as much attention to your process for addressing your audience as you do to explaining the content of the information.
- Use statistics sparingly when discussing risk. Most individuals will be less concerned about overall risk and more concerned about the risks to themselves and their families.
- Be reassuring but honest in your assessment of the connection between mental illness and violence. The backgrounder on mental illness and violence features talking points for your communication with the media and the public. The fact sheet on mental illness and violence can be adapted for distribution to the media and the public.
- Focus on empathy, efforts and results.

Effective Crisis Leadership*

Crisis leadership is not the same as daily leadership. Crisis leadership is highly scrutinized, with far-reaching consequences, yet it is often executed with insufficient time and information. An effective crisis leader must act deliberately, decisively and calmly, with honesty that reflects high moral values and the ethical standards of his or her office.

One useful model for effective crisis leadership comes from the U.S. Army, which defines the three basic components of leadership as *Be, Know and Do*. "Be" is about who you are. "Know" is about the skills and knowledge you have acquired. And "Do" is about the actions that you take on a timely basis. A shorthand guide to this framework follows.

- Be caring. Demonstration of caring is one of the most important leadership traits you can have during a crisis.
  - + If you come across as uncaring, people will be outraged.
  - + Caring during crisis response is not just a feeling. Caring is a set of messages and behaviors that let stakeholders know that you and your agency truly care.
  - + You must be present, you must be sincere and you must be open to others' fears and concerns.

- Initially, you need to know what you do and do not know. As the crisis unfolds, you must be able to take a broad view of the incident.
  - + This means you need to define the crisis beyond its obvious implications.
  - + You must be knowledgeable about your state's mental health laws, policies and regulations.
  - + You can't be swept up in hasty reactions that make for bad public policy, but neither can you ignore calls to review how this incident happened and whether future crises might be averted.

- *The single most important thing you can do in a crisis is conduct effective, two-way communication.*
  - + Simply put, you will never be any better at responding to crises than your communication.
  - + Communication involves how well you listen to obtain the facts and how well you speak openly and responsively to affected stakeholders.
  - + Messaging needs to be tailored to address the needs of each stakeholder group.**
  - + People need to feel heard and understood.

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* Material for this backgrounder is adapted from several articles on strategic crisis leadership written by Bruce T. Blythe, founder and CEO of Crisis Management International, http://www.cmiatl.com. In his articles, Blythe draws on research from the Center for Risk Communication, http://www.centerforriskcommunication.com. Used with permission.

** A pocket guide at the back of this toolkit offers some suggested messages for your initial contact with victims, their families and the media.

Working with the Media*

Working with the media is critical yet challenging after a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. The following tips will help you prepare for and respond to media inquiries. Remember, members of the media have a job to do, and they will do it—with or without your help.

When You Have a Story to Tell or Information to Get Out

- Know your facts. Check existing notes, files and any previous stories. Update facts and data if using previously prepared materials.
- Identify your target audience.
- Develop a fact sheet or list of talking points with a few key messages—no more than three. Tell one story, tell it well and tell it often. What do you want your audience to remember? Think in terms of who, what, when, where and why.
- Have a list of additional experts at the ready who can provide national context or other perspectives.
- If there is a visual, examples or an individual's story to tell, be sure to have the necessary resources that media will likely ask for in follow up.
- Make sure the process for releasing the information (an electronic release versus a news conference, for example) is respectful of print and broadcast deadlines and reflects the level of newsworthiness. Make sure the place or method of dissemination is chosen to minimize interference with emergency personnel, your staff's operations and other crisis management activities.

When the Media Calls

- BE AVAILABLE! Answering calls or returning calls promptly is essential. Supplement communications staff with people who can answer the phones and escort media.
- Ask who will be conducting the interview and what areas they will cover. Determine their deadline.
- Refine the appropriate message to address the crisis, and provide additional background to the reporter if you believe more accurate/different information could change the direction of the story for the better.
- Designate one spokesperson, particularly in times of crisis.
- Establish a timeframe for getting back with members of the media.

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* Adapted in part, with permission, from material developed by Jeanne Oliver, Public Information Officer, Jefferson Center for Mental Health, Wheat Ridge, CO. See http://www.jeffersonmentalhealth.org/redpages/redpagesmain.htm.

The Interview

- Remember your scouting days—BE PREPARED!
  - Try to send background materials prior to the interview. Have a packet of materials ready for the reporter to take with him or her.
  - Know who is conducting the interview and how much time is available.
  - If the interview is at your office, notify the receptionist that members of the media will be visiting and where you will meet with them.
  - Mentally prepare for the interview. Don't assume you can "wing it."
  - Anticipate the difficult questions that may be asked. Prepare and practice your responses.
  - Be early for the interview.
  - Establish a rapport with the reporter. Treat her or him with respect.
  - However, beware of the reporter who wants to be your "buddy." He or she has a job to do, just like you do.
- Listen carefully to the questions.
  - Never answer a question that you don't fully understand.
  - Stick to your key messages. During a crisis, what you have to say is often more important than the questions media members may ask.
  - Begin each response with your most important points.
  - Turn a negative statement into a positive point. Keep your energy level up.
  - Avoid responding with "no comment." This suggests that you are guilty as charged or that you have something to hide.
  - Be brief with your answers. Don't elaborate too much. Silence is OK.
  - Avoid answering too quickly.
  - Don't speculate.
  - Avoid jargon or professional expressions. If you can't avoid using what may be unfamiliar terms, define them in simple language.
  - If you stumble or become nervous, consider asking the reporter to start over, but never on live television or radio.
- Be candid but cautious.
  - NEVER lie or try to bluff a reporter.
  - If you don't know the answer to the question, say so, and say, "I will get back to you." Then, bridge to something you do know about.
  - Don't go "off the record." There is *no such thing* as "off the record." Assume every microphone or television camera near you is live at all times. The interview lasts as long as the reporter is there. Just because he or she turns off the camera doesn't mean the microphone isn't still on or that your words aren't being written down.
  - Plan for follow up. Let the reporter know how to contact you with follow-up questions or clarifications.

FACT SHEET

What Do We Know about Mental Illness and Violence?*

What is the connection between mental illness and violence?

The relationship between mental illness and violence is complex.

- *Most people with mental illnesses are not violent, and most people who are violent are not mentally ill.*
- Studies show that people with psychiatric diagnoses who have co-occurring substance use disorders or untreated symptoms of psychosis, which means their contact with reality is lost or highly distorted, have an increased risk of violence.
- People with serious mental illnesses are anywhere from 2.5 times to nearly 12 times more likely to be the victims than the perpetrators of violence.[1]

Does mental illness cause violence?

No. Correlation does not imply causation. There is a fairly large body of research that indicates that factors other than mental illness itself relate to violent behavior.

- Substance abuse significantly increases the risk for violence regardless of a person's mental health status.
- Being young, male and of low socioeconomic status are associated with violent behavior.[2]
- Many people with serious mental illnesses live in impoverished neighborhoods with few natural or social supports. They report factors associated with violence, including physical abuse, parental criminal acts, unemployment and victimization.
- The bottom line is this: *A person with a mental illness who is not abusing substances and is adhering to treatment is no more dangerous than his or her neighbor.*[3]

Can violence in a person with a mental illness be predicted?

No. While relevant assessment instruments do exist, their ability to predict future violent acts is hampered by the complex nature of violence and limited support for the instruments' use.

- One limitation to violence risk assessments is the fact that generally they do not indicate *why* a person is high or low risk. Also, even knowledge of a factor that increases risk cannot necessarily be used to prevent an incident before it occurs.
- Most observers believe it is not practical or useful to screen every person seeking treatment for a mental illness for violence. The absolute number of people with mental illnesses at risk of violence is low, and both false positives and false negatives would be high. However, screening individuals who have acknowledged risk factors—including a past history of violent behavior—is becoming more common.
- Ultimately, it may never be possible to predict with certainty when any individual in society—with or without a mental illness—will commit a violent act.

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* Additional support for the statements in this fact sheet may be found in Appendix B: Mental Illness and Violence Literature Review.

Can violence in people with mental illnesses be prevented?

Research is inconclusive about the extent to which specific interventions for people with mental illnesses who are at risk of violence can prevent future violence.

- The success of outpatient commitment (mandated treatment to community services) depends on the availability of enhanced services, not the use of legal coercion alone.[4]
- Some violence among people with serious mental illnesses is associated with their not taking medications, so it is critical to assure access to medications and associated strategies, such as patient education, that improve adherence.
- Some violence is related to co-occurring substance use disorders, so access to integrated mental health and substance abuse treatment (provided at the same time and in the same treatment setting) is needed.
- Some violence takes place for the same reasons that people without mental illnesses commit violence, so access to certain treatments that have demonstrated effectiveness (e.g., cognitive behavioral therapy) is good public health and public safety policy.

Should the public fear being harmed by a stranger with a mental illness?

No. Studies indicate that violence committed against strangers is rare. The people most likely to be the targets of violence by a person with or without a mental illness are family members and friends who are in their own homes or in the individual's home.

- Though tragic incidents involving people with mental illnesses who are violent are relatively rare, they tend to draw intense media and public attention, which can exacerbate the misperceptions about the relationship between mental illness and violence.
- As a result of their fears, many Americans are hesitant to interact with people who have mental illnesses.[5]
- This discrimination and stigma may lead to the victimization of people with mental illnesses.

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[1] Teplin, L.A., McClelland, G.M., Abram, K.M., & Weiner, D.A. (2005). Crime victimization in adults with severe mental illness: Comparison with the National Crime Victimization Survey. *Archives of General Psychiatry, 62*, 911–921.

[2] Swanson, J.W., Holzer, C.E., Ganju, V.K., & Jono, R.T. (1990). Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys. *Hospital and Community Psychiatry, 41*(7), 761–770.

[3] Steadman, H.J., Mulvey, E.P., Monahan, J., Robbins, P.C., Appelbaum, P.S., Grisso, T., et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, *55*, 393–401.

[4] Phelan, J.C., Sinkewicz, M., Castille, D.M., Huz, S., & Link, B.G. (2010). Effectiveness and outcomes of outpatient treatment in New York State. *Psychiatric Services*, *61*(2), 137–143.

[5] Pescosolido, B., Martin, J., Link, B., Kikuzawa, S., Burgos, G., Swindle, R., et al. (2000). *Americans' views of mental health and illness at century's end: Continuity and change.* Public report on the MacArthur Mental Health Module, 1996 General Social Survey. Bloomington, IN: Indiana Consortium of Mental Health Services Research, Indiana University, and the Joseph P. Mailman School of Public Health, Columbia University.

Predictable Reactions to Trauma/Resilience

FACT SHEET

What are common reactions to a traumatic event, such as a violent act?

Traumatic events are shocking and emotionally overwhelming. No one who experiences or witnesses such an event is untouched by it. Feelings of intense fear, horror or helplessness are normal responses to abnormal events. Some potential reactions include the following:

- Becoming emotionally numb and/or unresponsive after the event
- Forgetting or blocking out certain aspects of the event
- Reliving the trauma in dreams with intrusive thoughts or imagery
- Avoiding potential reminders of the event
- Withdrawing from others; developing work or school problems
- Becoming easily frustrated or irritated over seemingly minor issues or becoming easily frightened by sudden sounds or people
- Developing physical symptoms, such as racing heartbeat, nausea, change in appetite, bodily aches and pains, fatigue, sweating, chills or insomnia

How long do these reactions last?

Feelings of distress can develop at any time and are common within days of the traumatic event. More severe and/or persistent symptoms can occur weeks or months after the incident. Sometimes these feelings will reoccur on the anniversary of a traumatic event. *In general, individuals recover from trauma naturally over time*. However, some individuals, especially those who have prior exposure to traumatic events or who have psychiatric disorders,[1] may develop symptoms of acute stress disorder or posttraumatic stress disorder (PTSD). PTSD occurs when traumatic experiences become internalized and cause persistent problems with mood, thoughts and behavior.

What are some important ways to cope?

The International Society for Traumatic Stress Studies recommends staying connected to natural support systems, whether they are friends, coworkers, family, neighbors, other familiar groups or community. Taking care of basic needs is important after trauma. This includes trying to get enough sleep, eating well, exercising, drinking enough water and avoiding excessive use of alcohol and caffeine. Keeping to routines and activities, if possible, and finding ways to assist someone else can be helpful. These activities help support resilience.

Knowing when to ask for help is also important. Warning signs include having problems with relationships, work or other important activities, or using alcohol or drugs to cope. A family doctor, member of the clergy, local mental health association or health insurer may be able to provide a referral to a counselor or therapist with experience in treating people affected by traumatic stress. Professional support groups may be helpful for victims, their families and friends.

FACT SHEET

What is resilience?

Resilience is the most important defense people have against stress. Resilience refers to the ability of an individual, family, organization or community to cope with adversity and adapt to challenges or change.[2] It is an ongoing process of drawing on beliefs, behaviors, skills and attitudes to move beyond stress, trauma or tragedy. Resilience is the ability to do the following:

- Bounce back
- Take on difficult challenges and still find meaning in life
- Respond positively to difficult situations
- Rise above adversity
- Cope when things look bleak
- Tap into hope
- Transform unfavorable situations into wisdom, insight and compassion
- Endure

Resilience is not a trait that people either have or don't have. Anyone can learn or develop resilience, and because it can be learned, it can be strengthened. Most people are resilient, even in the face of extreme trauma and distress.

What factors impact resilience?

Certain protective factors in individuals and in their environment contribute to a resilient personality. These factors include an easy-going temperament; positive self-esteem; an outgoing personality; supportive family relationships; and strong bonds to family, school and community.[3] Resilient individuals have good coping and problem-solving skills.

What resources are available for more information?

A number of the resources used to compile this fact sheet offer useful tips and links to additional information on stress, trauma and resilience. They include the following:

- The Substance Abuse and Mental Health Services Administration (SAMHSA)
  Resilience and Stress Management Resource Collection
  http://mentalhealth.samhsa.gov/dtac/dbhis/dbhis_stress/introduction.htm
- Center for the Study of Traumatic Stress
  http://www.centerforthestudyoftraumaticstress.org
- International Society for Traumatic Stress Studies
  http://www.istss.org/home.htm
- National Center for Posttraumatic Stress Disorder, U.S. Department of Veterans Affairs
  http://www.ptsd.va.gov

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[1] Nucifora, F., Langlieb, A.M., Siegal, E., Everly, G.S., & Kaminsky, M. (2007). Building resistance, resilience, and recovery in the wake of school and workplace violence. *Disaster Medicine and Public Health Preparedness, 1*(Supp. 1), S33–S37.

[2] SAMHSA, http://mentalhealth.samhsa.gov/dtac/dbhis/dbhis_stress/resilience.htm.

[3] Davis, N.J. (2002). *Resilience: Status of the research and research-based programs*. Working paper. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Disaster Planning and Response

These selected resources include a wealth of information on preparing yourself and your agency for a high-profile, tragic incident. All but the last item are available online free of charge. Inclusion of these resources does not imply endorsement by the toolkit developers but should serve as examples of the range of materials available for additional assistance.

- *Mental Health All-Hazards Disaster Planning Guidance* (SAMHSA, 2003) provides valuable guidance to states regarding important components in the planning process, as well as potential content and organization of viable plans.
  https://store.samhsa.gov/product/SMA03-3829

- *Mental Health Response to Mass Violence and Terrorism* (SAMHSA, 2004) is a training manual for mental health providers, program planners and administrators who need to know how to provide appropriate mental health support following inc idents involving criminal mass victimization.
  https://store.samhsa.gov/product/SMA04-3959

- *The National Response Framework* (U.S. Department of Homeland Security, 2008) details how communities, states, the federal government and nongovernmental partners work together to mount an effective, coordinated response to a domestic incident.
  http://www.fema.gov/emergency/nrf

- *Communicating in a Crisis: Risk Communication Guidelines for Public Officials* (SAMHSA, 2002) is a pocket-sized primer for public officials on the basic tenets of effective communications, generally, and on working with news media, specifically.
  http://www.riskcommunication.samhsa.gov/index.htm

- *The Red Pages* (Jefferson County Mental Health, 2004 and 2006) is an online crisis management guide for mental health/substance abuse agencies providing disaster response. Though much of this is specific to Colorado, a good deal of the material is general enough to help other organizations and states.
  http://www.jeffersonmentalhealth.org/redpages/redpagesmain.htm

- *The Center for the Study of Traumatic Stress*, part of the nation's Uniformed Services University of Health Sciences, generates and disseminates material to inform disaster preparedness, response and recovery. Materials are in the public domain and can be tailored to an organization's needs.
  http://www.cstsonline.org

- *Blindsided: A Manager's Guide to Catastrophic Incidents in the Workplace* (Penguin Group, 2002, 2009), available from Crisis Management International, is a manual to help managers prepare and respond to workplace tragedies.
  http://www.cmiatl.com

Web Resources

The following Web-based resources cited throughout the toolkit contain additional information at the time of this writing on many of the topics covered. Inclusion of these resources does not imply endorsement by the toolkit developers.

Sample Documents

University of Memphis crisis management plan (the crisis communication plan is Annex C)
http://bf.memphis.edu/crisis/crisis_mgmt_plan.pdf

A sample uniform consent form for information sharing
http://www.gainscenter.samhsa.gov/pdfs/integrating/Dispelling_Myths.pdf

State Laws

A side-by-side comparison of state involuntary outpatient commitment statutes (as of June 2004)
http://www.bazelon.org/issues/commitment/moreresources/iocchart.pdf

An overview of state gun laws
http://www.statemaster.com/graph/gov_gun_law_per-government-gun-laws-permits

Federal Resources

The Federal Crisis Counseling Assistance and Training Program
http://www.mentalhealth.samhsa.gov/dtac

The Federal Office for Victims of Crime
http://www.ojp.usdoj.gov/ovc

The Substance Abuse and Mental Health Services Administration (SAMHSA)
Resilience and Stress Management Resource Collection
http://mentalhealth.samhsa.gov/dtac/dbhis/dbhis_stress/introduction.htm

National Center for Posttraumatic Stress Disorder, U.S. Department of Veterans Affairs
http://www.ptsd.va.gov

National Incident Management System (NIMS)/Incident Command System (ICS)
http://www.fema.gov/emergency/nims

Media

The State of Washington Mental Health Reporting Project
http://depts.washington.edu/mhreport/index.php

Incident Response Checklist*

Gather Information Quickly

- ❑ **What happened?** _____
- ❑ **Internal event? Where?** _____
- ❑ **External to organization?** _____
- ❑ When? Where? Who? _____

  _____
- ❑ Is it over or **still in progress?** _____
- ❑ Who is the **target victim group?** _____
- ❑ What is the estimated number of people who are seriously injured and/or with high exposure to trauma? _____
- ❑ Are vulnerable populations involved (e.g., children, disabled)? _____
- ❑ **How bad is it?** _____
- ❑ Is there current or future **danger? (Take action to protect.)**

  _____
- ❑ Property damage? _____
- ❑ Business disruption? _____

Find Out What Is Being Done

- ❑ What **responders are already on scene?** _____
- ❑ Are you in communication with them? _____
- ❑ Are **evacuations needed?** _____
- ❑ Are there injury or death notifications that need to be made?

  _____
- ❑ Is there a need to **secure site?** _____
- ❑ Has an Incident Command been established? Who is in charge? _____

Verify

- ❑ Is information accurate? _____
- ❑ Is additional information needed? _____

*Adapted from *The Red Pages*, www.jeffersonmentalhealth.org/redpages/redpagesmain.htm. Used with permission.

My Agency Emergency Contacts List

Use, expand and/or adapt the following form to include those individuals within or closely connected with your agency who you want to have on hand in the event of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain to update this list regularly and file it with your other emergency preparedness materials.

Deputy Commissioner

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Attorney

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Public Information Officer

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Disaster Coordinator

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Issue Expert (add as many as needed)

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Issue Expert

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Issue Expert

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Issue Expert

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Legislator (add as many as needed)

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Legislator

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Add other contacts as appropriate

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

My State Emergency Contacts List

Use, expand and/or adapt the following form to include those individuals within or closely connected with your state who you want to have readily at hand in the event of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Include agency heads and public information officers (PIOs) for key agencies. Be certain to update this list regularly and file it with your other emergency preparedness materials.

Governor's Office

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Governor's Office

PIO: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

State Health Department

Director: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

State Health Department

PIO: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Substance Abuse Agency

Director: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Substance Abuse Agency

PIO: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

State Emergency Management Agency

Director: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

State Emergency Management Agency

PIO: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

State Police

Director: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

State Police

PIO: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Local Police/County Law Enforcement

Chief Executive: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Local Police/County Law Enforcement

PIO: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

District Attorney's Office/Victims' Assistance

District Attorney: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Military Base

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

National Guard

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Reserves

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

American Red Cross Chapter

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

National Mental Health Association Chapter

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

National Alliance on Mental Illness Chapter

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

NASMHPD

Key contact: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

SAMHSA

Key contact: _____ Cell: _____

Work Address: _____ Phone: _____

Home Address: _____ Phone: _____

Add other contacts as appropriate

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Content Experts Emergency Contacts List

Use, expand and/or adapt the following form to include external content experts who you want to have on hand in the event of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain to update this list regularly and file it with your other emergency preparedness materials. Make sure that experts have given prior approval for their contact information, biographies or other background information to be shared with media before releasing it.

Content Expert (add as many as appropriate)

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Content Expert

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Content Expert

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Content Expert

Name: _____ Cell: _____

Work E-mail: _____ Phone: _____

Home E-mail: _____ Phone: _____

Areas of Expertise: _____

Content Expert

Name: ______________________________ Cell: ____________________

Work E-mail: ______________________________ Phone: ____________________

Home E-mail: ______________________________ Phone: ____________________

Areas of Expertise: ____

Content Expert

Name: ______________________________ Cell: ____________________

Work E-mail: ______________________________ Phone: ____________________

Home E-mail: ______________________________ Phone: ____________________

Areas of Expertise: ____

Content Expert

Name: ______________________________ Cell: ____________________

Work E-mail: ______________________________ Phone: ____________________

Home E-mail: ______________________________ Phone: ____________________

Areas of Expertise: ____

Content Expert

Name: ______________________________ Cell: ____________________

Work E-mail: ______________________________ Phone: ____________________

Home E-mail: ______________________________ Phone: ____________________

Areas of Expertise: ____

Content Expert

Name: ______________________________ Cell: ____________________

Work E-mail: ______________________________ Phone: ____________________

Home E-mail: ______________________________ Phone: ____________________

Areas of Expertise: ____

Media Contacts List

Use, expand and/or adapt the following form to include local, regional and national media that may report on a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain to update this list regularly and file it with your other emergency preparedness materials. Use this form to make calls to reporters to establish a working relationship in advance of an event. Make note of key deadlines.*

Associated Press or Other Wire Service

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Radio Station

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Newspaper

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

*If your agency or key partner has access to commercial media database software, you may be able to compile these lists for "health," "crime" or other categories of journalists by media type, state or other elements.

Newspaper

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Television Station

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Television Station

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Blogger

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Blogger

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Add other contacts as appropriate

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

Media outlet:_____

Reporter's name:_____ Cell: _____

Work E-mail:_____ Phone: _____

Personal E-mail:_____

News deadlines: _____

Notes: _____

General Contacts Log

Use, expand and/or adapt the following form to keep track of all communications related to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain all staff in your agency who are authorized to answer phones during an emergency have a copy of this form. File this list with paperwork related to the incident to be used in internal and external reviews and legislative hearings.

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Agency/affiliation: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Agency/affiliation: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Agency/affiliation: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Agency/affiliation: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Agency/affiliation: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Agency/affiliation: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Media Contacts Log

Use, expand and/or adapt the following form to keep track of all press inquiries related to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain all staff in your agency who are authorized to take media calls have a copy of this form. Make careful note of when reporters need a response. File the form with your agency public information officer or designee.*

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Media outlet: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Media outlet: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

*Any agency with access to commercial media software may want to have staff log all notes in a searchable field that can be saved to a shared database.

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Media outlet: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Media outlet: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Media outlet: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Contact

Staff who took call: _____ Date and time: _____

Name of caller: _____ Phone: _____

Media outlet: _____

Reason for call: _____

Response: _____

Follow-up needed: ❑ Yes ❑ No When: _____ By whom: _____

Preferred number/e-mail address for follow-up: _____

Status: _____

Notes:

Effective Crisis Leadership: Initial Communications

Effective Crisis Leadership: Initial Communications

Use or customize these messages when you first meet with victims, their families and the media.

- **Be caring.** For example, "I want to begin by expressing my deep sadness for the loss of life that occurred at [location]. The thoughts of all who have been witness to this tragedy are with the victims, their families and all who have been affected. You have the full support and assistance of [agency name] during this difficult time."
- **Know what you do and do not know.** For example, "I know you have many questions. I will answer as many as I can. When I don't have the information you need, I will do my best to get it for you. I can assure you that we will conduct a thorough investigation. Here is what we do know at this time [review any confirmed facts]."
- **Perform effective two-way communication.** For example, "While we don't have all the facts at this time, we are in the process of gathering the information, and we will keep you informed of our progress." Explain where your listeners can get more information, for example, if you have set up a Web page, and tell them when and how you will stay in touch.

Appendix A: Expert Advisors

Council of State Governments Justice Center
National Association of State Mental Health Program Directors

Toolkit: Responding to High-Profile, Tragic Incidents Involving People with Mental Illnesses
Expert Advisors Meeting

September 29, 2009

Participant List

Bob Carolla, J.D., *Director of Media Relations, National Alliance on Mental Illness (VA)*

Elizabeth Dodd, *Project Associate, Council of State Governments Justice Center (NY)*

Carol Dorris, J.D., *Public Policy Senior Staff Attorney, National Center for Victims of Crime (DC)*

Joel Dvoskin, Ph.D., *Assistant Clinical Professor of Psychiatry, University of Arizona College of Medicine (AZ)*

Brian Flynn, Ph.D., *Center for the Study of Traumatic Stress, Adjunct Professor of Psychiatry, Department of Psychiatry, Uniformed Services University of Health Sciences (MD)*

Robert Glover, Ph.D., *Executive Director, National Association of State Mental Health Program Directors (VA)*

State Rep. Michael Lawlor, J.D., *Connecticut House of Representatives*

Michael Maples, *Assistant Commissioner, Mental Health and Substance Abuse Division, Texas Department of State Health Services (TX)*

David Miller, *Project Director, National Association of State Mental Health Program Directors (VA)*

Fred Osher, M.D., *Director of Health Systems and Services Policy, Council of State Governments Justice Center (MD)*

Judy Pal, *Past President, National Information Officers Association, (WI)**

Joe Parks, M.D., *Director, Division of Comprehensive Psychiatric Services, Department of Mental Health (MO)*

Ashley Pearson, *Director of Emergency Management Services Mental Health Services, Department of Mental Health (MA)*

Martha Plotkin, J.D., *Director of Communications, Council of State Governments Justice Center (MD)*

James Reinhard, M.D., *Commissioner, Department of Behavioral Health and Developmental Services (VA)*

Lorrie Rickman Jones, Ph.D., *Director, Division of Mental Health, Department of Human Services (IL)*

Hank Steadman, Ph.D., *President, Policy Research Associates, Inc. (NY)*

Damon Thompson, *Communications Consultant, DTCC (DC)*

Kristan Trugman, *Special Assistant to the Sergeant at Arms, Capitol Division (DC)*

Susan Milstrey Wells, *Senior Writer, Advocates for Human Potential, Inc. (NY)*

*Unable to attend the meeting, but reviewed a draft of this publication.

Appendix B:
Mental Illness and Violence Literature Review

The Literature on Mental Illness and Violence

Research and practice over the last 20 years reveal that "most people who are violent are not mentally ill, and most people who are mentally ill are not violent."[1] That being said, "Denying that mental disorder and violence may be in any way associated is disingenuous and ultimately counterproductive."[2]

The following statements are supported by the literature cited herein. The backgrounders and fact sheets that accompany this toolkit summarize this information.

- Mental illness may be a consistent, though modest, risk factor for violence, though there is no clear evidence of the causality between them.
- Demographic variables such as age, gender and socioeconomic status are more reliable predictors of violence than mental illness.
- Substance abuse among people with mental illnesses significantly increases the risk of violence.
- A person with a severe mental illness who has no history of substance abuse or violence has the same likelihood of being violent as any member of the general public.
- People with mental illnesses are more likely to be the victims than the perpetrators of violence, and prior victimization is a risk factor for future violence.
- Because serious mental illness affects a small percentage of the population, it makes—at best—a very small contribution to the overall level of violence in society.

Epidemiological Surveys

Many studies of violence and mental illness are hampered by selection bias. In particular, individuals who are "arrested, incarcerated, or hospitalized are by definition more likely to be violent or very ill and thus are not representative of psychiatric patients in the general population."[3] Three studies of community samples avoid this bias. They are (1) the National Institute of Mental Health's Epidemiological Catchment Area (ECA) project; (2) the Congressionally mandated National Comorbidity Survey (NCS); and (3) the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) conducted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The authors of each of these studies note that the way in which they measured violence (in most cases by self-report) may limit the ability to generalize from their findings.

The Epidemiological Catchment Area Project

The ECA project involved structured diagnostic interviews conducted between 1980 and 1983 with 3,000 to 5,000 household residents in each of the five sites. One group of researchers reported on data from three of the five large surveys that made up the ECA project.[4] Data from Baltimore, Raleigh-Durham and Los Angeles were pooled to form one large database of 10,059 respondents. Key findings include the following:

- Being young, male and of low socioeconomic status all were found to be associated with violent behavior.

- Each of the disorders was associated with increased risk of violence, ranging from a four-fold increase in risk of violent behavior for some disorders (e.g., schizophrenia) compared with no disorder, to a 10-fold increase for substance abuse disorders.
- The risk was highest among those with alcohol abuse or dependence disorders (24.57 percent) and other drug abuse or dependence disorders (34.74 percent).
- The interaction of substance abuse with major mental illness was significant; the combination of substance abuse with other major psychopathology is more volatile than either alone.

The National Comorbidity Survey

The NCS is based on a stratified, multistage area probability sample of persons aged 15 to 54 years in the non-institutionalized civilian population. Data were collected in the 48 contiguous states between September 14, 1990, and February 6, 1992. Investigators studied a subset of the NCS sample (5,865 out of 8,098 respondents). Violent behavior was defined as one of two items from the NCS survey that indicate whether the person had been in serious trouble with the law or had been in a physical fight that resulted in the need for medical attention for the person or someone else.[5] Key findings include the following:

- The prevalence of violent behavior in people who did not meet diagnostic criteria for any psychiatric disorder in the past year was 2 percent, a rate similar to that reported in the ECA study.
- Psychiatric diagnosis was associated with increased violent behavior, from a three to four times greater likelihood of violence for people with anxiety or depressive disorders to a 9.5 times greater likelihood for people with bipolar disorders or alcohol and other substance abuse disorders.
- Demographic variables such as ethnicity and gender are better predictors of violent behavior than psychiatric diagnosis.
- The presence of a co-occurring substance abuse disorder can double the frequency of violent behaviors compared with people with only a non-substance abuse disorder.
- Mental illness is only a weak predictor of violent behavior.

The National Epidemiologic Survey on Alcohol and Related Conditions

The NESARC was a two-wave, face-to-face survey of a representative sample of the non-institutionalized U.S. population ages 18 and older. A total of 34,653 subjects completed NESARC waves 1 (2001–2003) and 2 (2004–2005) interviews. Data on mental disorder and violence were collected as part of NESARC. Wave 1 data on severe mental illness and risk factors were analyzed to predict wave 2 data on violent behavior. Key findings include the following:[6]

- Severe mental illness is not a robust predictor of future violence.
- People with co-occurring severe mental illness and substance abuse/dependence have a higher incidence of violence than people with substance abuse/dependence alone.

- People with severe mental illness report histories and environmental stressors associated with elevated violence risk. These include physical abuse, parental criminal acts, unemployment and victimization.
- Severe mental illness alone is not an independent contributor to explaining different types of violence.

The study's authors conclude: "The data shows it is simplistic as well as inaccurate to say the cause of violence among mentally ill individuals is the mental illness itself; instead, the current study finds that mental illness is clearly relevant to violence risk but that its causal roles are complex, indirect, and embedded in a web of other (and arguably more) important individual and situational cofactors to consider."

The MacArthur Violence Risk Assessment Study

This oft-cited study enrolled 1,136 male and female patients ages 18 to 40 from acute inpatient facilities in Pittsburgh; Kansas City, Mo.; and Worcester, Mass.[7] The comparison group consisted of 159 people from the Pittsburgh neighborhoods in which patients resided after hospital discharge. Data collection began in mid-1992 and ended in late 1995.

Data were collected for three primary groups: individuals with a major mental disorder with no history of substance abuse or dependence; individuals with a major mental disorder and co-occurring substance abuse or dependence; and individuals with a diagnosis of "other" mental disorder (e.g., personality disorder) and co-occurring substance abuse or dependence. Key findings include the following:

- The one-year prevalence of violence was 17.9 percent for individuals with a major mental disorder and no substance use disorder; 31.1 percent for individuals with a major mental disorder and a substance use disorder; and 43 percent for individuals with other mental disorders (e.g., personality disorders) and a substance use disorder.
- The prevalence of violence among individuals with mental illnesses who have no symptoms of substance abuse is statistically indistinguishable from the prevalence of violence among others in their neighborhoods without symptoms of substance abuse.
- Substance abuse significantly raised the prevalence of violence in both patient and community samples.
- The people most likely to be the targets of violence are family members and friends who are in their own homes or in the individual's home.

To control for exposure to environmental opportunities for violence between the patient and the comparison groups, researchers sampled from the census tracts in which the patients resided after discharge. The researchers noted that many of these neighborhoods were disproportionately impoverished and had higher violent crime rates than the city as a whole. "The comparison group was not intended to be an epidemiologically representative sample of the general population of Pittsburgh," they wrote.

Specific Correlates of Violence among People with Mental Illnesses

A number of smaller studies identified specific correlates of violence among people with serious mental illnesses, including active psychoses and medication non-adherence.

- One study looked at rates of violence and other illegal activities for both patients with psychiatric disorders and non-patients in the Washington Heights neighborhood of Manhattan. The researchers concluded that among the patient group, only individuals with currently active psychotic symptoms had elevated rates of violence.[8]

- Another study examined potential predictors of serious violence in a randomized sample of 331 involuntarily committed inpatients awaiting release through court-ordered involuntary outpatient treatment. They found that individuals with substance abuse problems who were also medication non-adherent were almost 2.3 times more likely to commit violent acts. In this study, people who had only one of these problems (substance abuse or non-adherence) had no increased risk of violence.[9]

- One group of researchers studied 802 adults with psychotic or mood disorders receiving public mental health services in four states. The researchers found that three variables—past violent victimization, violence in the environment and substance abuse—showed a cumulative association with risk of violence. Each of the three factors alone raised the risk, but the combination of all three factors increased the risk to almost 35 percent.[10]

- In a review of 1,410 individuals with schizophrenia who were enrolled in the National Institute of Mental Health's Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE), investigators found that "positive" psychotic symptoms, such as feelings of persecution, increased the risk of minor and serious violence. "Negative" psychotic symptoms, such as social withdrawal, lowered the risk of serious violence.[11]

Victimization and Its Role in Future Violence

Several studies and at least one literature review that examined this issue have concluded that individuals with mental disorders are more likely to be the victims than the perpetrators of violence.

- Two studies report on a sample of 331 involuntarily committed inpatients. The first study reported that the rate of criminal victimization of this group was 2.5 times higher than that of the general population—8.2 percent versus 3.1 percent.[12] In the subsequent study, the researchers noted that the more likely a respondent was to have been victimized by a violent or nonviolent crime and to have been injured, the more likely he or she was to have engaged in a fight or to have threatened someone with a weapon.[13]

- Researchers in 2005 reported the results of a multisite, randomly selected, stratified sample of 936 people aged 18 and older receiving outpatient, day or residential mental health treatment in Chicago. The investigators found that more than 25 percent of the sample had been victims of a violent crime (attempted or completed) in the previous 12 months. This is 11.8 times higher than National Crime Victimization Survey rates for the general population. *People with psychiatric disabilities were more than twice as likely to be a victim as a perpetrator of crime.*[14]

- Results of a literature review of perpetration of violence and violent victimization found that 3 percent of the general population has been victimized, compared to 25 percent of people with severe mental illnesses. Despite this disparity, investigators found 13 times as many articles on perpetration of violence by people with mental illnesses than on violent victimization.[15] A focus on perpetration of violence by people with mental illnesses may contribute to negative stereotypes, the researchers concluded.

The Role of Substance Abuse in Violence

Several studies that specifically examined the role of substance abuse in violence found that the use of alcohol and other drugs raises the risk of violence for individuals diagnosed with serious mental illnesses.

- One group studied 64 people referred to an urban Assertive Community Treatment team over a one-year period to examine the relationship between violence and substance abuse among people with serious mental illnesses living in the community.[16] Investigators found that substance abuse was a major factor associated with violence among people diagnosed with serious mental illnesses. They also found that onset of alcohol or drug abuse before age 15 was the strongest risk factor for violence, however, they cautioned that the small sample size limits the ability to generalize from their findings.

- A 2003 report is one of the few studies to differentiate subgroups of subjects by type of substance used.[17] Researchers studied a sample of 233 adults diagnosed with both psychotic disorders and substance abuse problems who were being treated by 13 community mental health teams in London. Results reveal that users of stimulants—including cocaine or amphetamines—were significantly more likely than users of alcohol only, alcohol and cannabis, and cannabis only to ever have committed a violent act. This finding did not vary by age, gender, marital status or ethnicity.

- Other investigators examined the relationship between substance use and violence at the daily level in a sample of 132 individuals with mental illnesses who had recent histories of substance use and violence.[18] The researchers found that participants were 1.7 times more likely to engage in serious violence (defined as causing injury or involving use of a weapon) on days that only alcohol was consumed and 3.4 to 7.1 times more likely to engage in serious violence on days when alcohol and other substances were used.

- Another study examined the relationship between substance use, mental health problems and violence in a sample of offenders released from prison and referred to substance abuse treatment programs.[19] Data from 34 sites that enrolled 1,349 participants in a federally funded cooperative, the Criminal Justice Drug Abuse Treatment Studies, were analyzed. Researchers found that the quantity of alcohol consumed and the frequency of drug use were associated with a greater probability of self-reported violence, but mental health problems were not indicative of increases in violent behavior. The exception was antisocial personality disorder, which was associated with violence.

Violence and Risk Assessment

Several researchers have examined either specific risk assessment instruments or the concept of risk assessment in general. They note that violence assessment instruments do exist, but their predictive value is limited by the complex, multifactorial nature of violence and by limited support for their use.

- One group of researchers compared the Classification of Violence Risk (COVR) instrument developed from the MacArthur Violence Risk Assessment Study to the Violence Risk Appraisal Guide (VRAG), a well-established actuarial instrument. Their study sample was a group of 52 forensic psychiatric inpatients in the United Kingdom. Investigators found that, similar to the VRAG, the COVR was a good predictor of both verbal and physical aggression. The VRAG was a better predictor of violence to property.[20] This study examined institutional violence, rather than community violence. Its authors also noted that "the COVR does not provide much information about why a person is high or low risk and what can be done about it."

- Another group of investigators conducted a historical cohort study in Sweden of a selected sample of 4,828 offenders given community sentences. Participants were assessed by a psychiatrist during 1988–2001 and followed up for an average of five years. After adjusting for sociodemographic and criminal history variables, the researchers found that only substance use disorders and personality disorders were significantly associated with an increased risk of violent reoffending.[21] However, the study's authors noted that diagnostic information on these disorders provided minimal additional predictive value beyond that provided by age, sex and criminal history. They concluded, "A factor that increases risk does not necessarily mean that knowledge of that factor can be readily used to predict an event before it occurs."

- At least one researcher has noted that at the base rates of violence usually encountered in psychiatric populations, "current assessment methods would require hospital admission of large numbers of patients who are potential offenders in order to prevent the actual offending of a few."[22]

- One commentator has pointed to the need for a public health (population-based) approach to violence risk assessment. He noted, "We have large numbers of people with severe mental illness living in jails, homeless shelters and substandard apartments in impoverished neighborhoods where every block has two liquor stores and a pawn shop. Then we talk about preventing violence by tweaking antipsychotic treatment regimens."[23] Treatment should target actual risk factors for violence, at least indirectly, in order to prevent violence, he concluded.

Interventions for People with Mental Illnesses at Risk of Violence

The literature on specific interventions for people with mental or substance use disorders who may be at increased risk of violence is limited and inconsistent in its findings.

- One group of researchers proposed that intensive case management coupled with comprehensive support services are the keys to reducing violence by people with mental disorders in the community.[24] In contrast, another set of investigators found no evidence that intensive case management reduced the prevalence of violent behavior over a two-year period for patients with psychosis who were randomly assigned to intensive case management or standard care. The authors hypothesized that intensive case management models may need considerable modification to address the different needs of patients who are prone to engage in violent or illegal behavior.[25]

- Still other researchers found that extended outpatient commitment (more than six months) combined with regular outpatient services resulted in a significant reduction in community violence in people with severe mental illnesses at risk of violence. However, the authors found no significant impact for outpatient commitment that lasted less than six months or for outpatient commitment in the absence of regular services.[26]

- Researchers studied the role of medication in reducing violence among participants in the NIMH CATIE study. Among patients taking their prescribed medication for six months, the researchers found no advantage for second-generation antipsychotics in violence risk reduction when compared with a representative first-generation antipsychotic. They also found that adherence to antipsychotic medication did not significantly reduce violent behavior in patients with a childhood history of antisocial behavior. The study's authors concluded, "for patients with many developmental, social and environmental risk factors, even optimal

pharmacotherapy might not reduce violent behavior; pharmacotherapy alone cannot be expected to mitigate essentially non-clinical causes of violence."[27]

Media and Public Perceptions of Mental Illness and Violence

In many cases, fear of violence is engendered or exaggerated by repetitive or negative portrayals in the media. Some observers have noted that these fears may lead to victimization of people with mental disorders and more potential for violence.

- In a representative survey of 70 major U.S. newspapers in 2002, researchers reported that 39 percent of all stories published about people with mental illnesses focused on dangerousness—the single largest area of the media's coverage of mental health. In contrast to stories that discussed mental health treatment or public policy, those that touched on violence were far more likely to be front page news. Only 4 percent of all treatment-related stories focused on recovery.[28]
- Results of a nationwide survey show that 75 percent of the public views people with mental illnesses as violent, and twice as many Americans in 1996 viewed people with mental illnesses as violent as did so 40 years ago.[29]
- As a result of their fears, many Americans are hesitant to interact with people who have mental illnesses. One study revealed that 38 percent are unwilling to be friends with someone having mental health difficulties. Sixty-four percent do not want someone who has schizophrenia as a close co-worker, and more than 68 percent are unwilling to have someone with depression marry into their family.[30]
- Education about the relationship between mental illness and violence may not be as beneficial as some would hope. In 2004, researchers randomly assigned 161 participants to one of three conditions: 1) an anti-stigma educational program; 2) a program highlighting the association between violence and psychiatric disorders; and 3) a control group. Compared to the anti-stigma education and control groups, people in the education-about-violence group were more likely to have negative attitudes and increased fear about people with psychiatric disabilities and to be less willing to help them or their families. They showed no increased willingness to support public funding of mental health services. The authors concluded that "community groups should not use information about the link between mental illness and violence in an attempt to improve resources for mental health programs."[31]

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