CITIZENS CRIME COMMISSION OF NEW YORK CITY

DEEP TOOLKIT AND PROGRAM MODEL

CITIZENS CRIME COMMISSION OF NEW YORK CITY

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CHAPTER 1: THEORETICAL FOUNDATIONS AND PROPOSED MODEL

Pathways to violent extremism and mechanisms of change

The literature on the progression to extremist violence consistently posits that there is no one path to extremism. Studies looking for identifiable stages in the process or characteristics of people who engage in extremist violence have also failed to come up with a profile. Every person has a unique pathway to violent extremism that will be related to their particular life circumstances. This suggests a standardized approach to reducing or managing the risk for extremist violence is unlikely to succeed. In order to effectively mitigate the process, one must have a highly individualized approach that is tailored to the person being helped and their particular reasons for engaging in violent extremism.

One well regarded theoretical approach to describing the processes of engaging and disengaging in violent extremism is that of Pro Integration Model (Barelle, 2015). This approach was constructed based on a systematic content analysis of interviews of people who had voluntarily engaged in behavior change processes. It recognizes that in order for an individual to make progress in non-violent ways, they must genuinely engage in mainstream society, and this can only happen if there is an identity shift from feeling like an outsider to feeling like they belong.

Importantly, the Pro Integration Model is not deemed to follow a linear progression but aims to describe areas in which change may happen for any given individual in any order and with a variety of starting and ending points. The five domains identified in the model are:

1. Social relations: Social relationships to members of groups promoting violent extremism are really important for the maintenance of group cohesion. Similarly, establishing relationships with people outside said groups is a vital part of the process of disengaging. This allows the individual to establish connections and potentially distance themselves from the violent group. A state of disillusionment with leaders was identified as a sign of early disengagement in the group studied by Barelle.
2. Coping: Barelle also identified numerous mental health concerns in the group she studied. Coping within extremist violent groups can be dysfunctional and further damage someone's mental health. Coping may also be a highly social activity that is tied to relationships established within the group. Expanding the

person's social circle and helping them learn other ways of coping sets the foundation for disengagement.

3. Identity: Most of the people in Barelle's sample reported high rates of identification with the extremist group. Those who disengaged, reported feeling less of a fit, or feeling like the group did not represent them anymore.
4. Ideology: In this domain, it seems like they key is for the person to be able to accept differences with others who hold views different than theirs, regardless of whether the intensity of their own beliefs changed.
5. Action orientation: Engagement with extremist violence is characterized by a willingness to take action. Disengagement may happen at different levels, the deepest of which would be, not only to stop using violent methods, but to engage with society in a prosocial manner.

Some aspects of these domains better lend themselves to intervention than others. Not all lend themselves to a mental health-based intervention and may be better approached with socially-based interventions. DEEP aims to clearly identify areas of need for each participant and then provide or procure services that address those needs, with the purpose of managing or reducing the participant's risk of engaging in violent extremism. For example, "social relations" may respond well to social skills training and engagement in prosocial activities, while "coping" and "identity" might lend themselves more to psychotherapeutic work. With the exception of ideology, which is not a target in DEEP, all other domains are addressed through a variety of interventions depending on the participant's unique circumstances.

Risk factors and relationship with mental illness

Studies examining the relationship between mental illness and violent extremism or terrorism have generally failed to find a strong relationship between the two[1]. That is not to say a mentally ill person is not at risk of committing extremist violence but, rather, that they are no more likely to commit a terrorist act than a non-mentally ill person. This mirrors findings of extensive scientific body of research examining the relationship between mental illness and general violence risk. Generally speaking, the variables that increase a non-mentally ill person's risk for violence (e.g. history of violence, substance use, unstable relationships, employment problems, early maladjustment, lack of personal support) will also increase said risk for a mentally ill person[2]. However, said

[1] Borum, R. (2014). Psychological vulnerabilities and propensities for involvement in violent extremism. *Behavioral Sciences & the Law*, 32(*3*), 286–305. https://doi-org.ez.lib.jjay.cuny.edu/10.1002/bsl.2110

[2] Monahan J. Steadman HJ. Silver E, et al. Risk assessment: the MacArthur Study of Mental Disorder and Violence. Oxford: Oxford University Press; 2001.

body of research has identified certain specific variables related to mental illness that can increase someone's risk for general violence, including active command auditory hallucinations of violent content, non-adherence to medication (only if the person has a history of becoming violent when non-adherent), history of poor response to treatment, among others[3].

It should also be noted that some association has been found between problems that are psychological in nature and the risk for extremist violence. Some of these include anxiety, feelings of inadequacy, lack of a sense of belongingness, mood instability, among others[4]. While these are not necessarily symptoms of severe mental illness, they could be amenable to psychological and social interventions.

RNR framework

RNR stands for Risk, Needs and Responsivity. RNR is used as a model to understand recidivism in the fields of criminology and forensic psychology and is currently the gold standard for assessing and managing risk[5]. It is widely used by law enforcement and forensic mental health providers to assess risk and determine appropriate levels of supervision/intervention. It has been proposed as useful a tool to understand the risk of ideologically driven criminal activity[6]. According to the RNR model, the risk of engaging in criminal activity can be understood as the result of a series of fixed historical variables and intensity of service should be guided by level of risk. In order to best manage or reduce that risk and understand what to target, one must take into account the individual's criminogenic needs, which are dynamic or changeable, as well as factors that can affect the individual's ability to respond to the intervention. The 8 major areas of criminogenic needs according to RNR are antisocial personality, antisocial cognition, antisocial companions, family or marital stressors, substance use, lack of employment, lack of education and lack of pro-social leisure or recreation. These areas are assessed with a variety of standardized measures. DEEP will be using the Level of Service Inventory-Revised- Screening Version, or LSI-R-SV to identify criminogenic needs to be addressed in the service plan, as well as the level of intensity of intervention needed.

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[3] Wilson, C. M., Desmarais, S. L., Nicholls, T. L., Hart, S. D., & Brink, J. (2013). Predictive validity of dynamic factors: Assessing violence risk in forensic psychiatric inpatients. *Law and Human Behavior*, 37*(6)*, 377–388. https://doi-org.ez.lib.jjay.cuny.edu/10.1037/lhb0000025

[4] Kashdan, T. B., & McKnight, P. E. (2010). The darker side of social anxiety: When aggressive impulsivity prevails over shy inhibition. *Current Directions in Psychological Science, 19*(1), 47-50.

[5] Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The Risk-Need-Responsivity (RNR) Model: Does Adding the Good Lives Model Contribute to Effective Crime Prevention? Criminal Justice and Behavior, 38(7), 735–755. https://doi.org/10.1177/0093854811406356

[6] Khoeler, D. (2017). Understanding deradicalization: Methods, tools and programs for countering violent extremism. New York: Routledge; 2017.

Under this model, mental illness would be a responsivity factor, and would be considered something that needs to be addressed ONLY if it affects how well the person is able to respond to the intervention. Other responsivity factors include age, gender, ethnicity, motivation, etc. RNR places much greater emphasis on social variables such as education level, use of leisure time, employment, housing stability and substance use, as they are considered to be the way to effectively manage risk. In addition, it should be noted, that these criminogenic and responsivity factors relate closely to those outlined by Barelle in the Pro Integration Model. For example, things like employment, education, and companions connect directly to Barelle's domain of *identity*; use of leisure time, family or marital stressors and companions relate to the domain of *social relations*; and mental health (including antisocial personality and cognitions) and substance use relate to the domain of *coping.* The domain of *action orientation* relates more closely to motivation (a responsivity factor under RNR).

Mechanisms of change

Based on the review of the literature, including some of the most rigorous effectiveness studies, interventions that have had the highest chance of success in this space are those that integrate all the components outlined above in a manner that is tailored to each participant's particular configuration of risk, needs and responsivity factors. It appears, then, that, because engagement in, or mobilizing towards, violent extremism is a highly complex process that takes place on multiple domains, disengagement from violent extremism can only be achieved by targeting those same domains. This may explain why approaches that target only the ideological part, or only the mental health part, have had questionable effectiveness.

Current Model

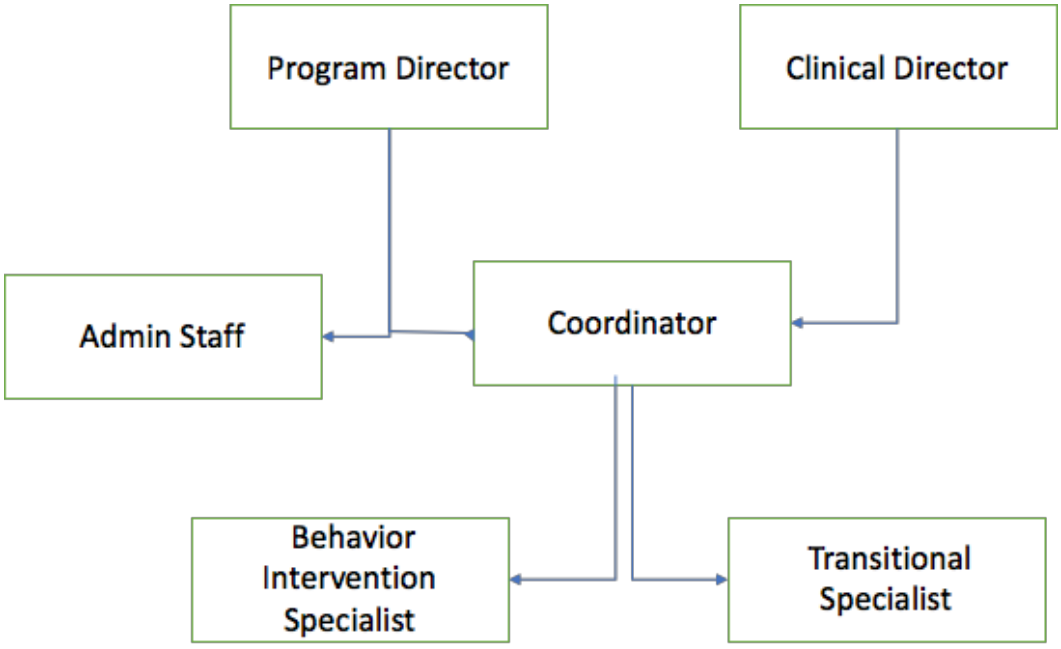
In light of the information presented here, we believe that the ideal program model would consist of a team of intervention specialists, who would be supervised by a doctoral level, licensed clinician. These specialists would be masters level clinicians who would be trained in the assessment and intervention of extremism. They would also receive special training in the assessment of risk, with the aim that they be able to identify a situation in which a fully-fledged risk assessment would be needed. These intervention specialists would first assess the participant in order to identify individualized areas of intervention based on the RNR model as well as their risk factors for violence. These areas include, but are not limited to, social skills, various aspects of mental health, leisure, work and education, critical thinking, substance use, housing, and medical needs. They would soon after, with the help of the participant, come up with a service plan that will include the participant's goals in a measurable manner in

each of the areas identified as a need. Some of these goals (e.g. vocational goals, social skills training, housing services, medication management by a psychiatrist) may require external referrals. The intervention specialist will carefully identify which goals can be attained in-house and which need to recruit the help of community resources. They will meet with the participants at least on a weekly basis to coach them through the process, monitor progress and assess risk on an ongoing basis. This will be done while encouraging the development of critical thinking and social skills. Intervention specialists will also maintain communication with other providers and coordinate services (with permission from the participant). Once goals have been completed, a transitional specialist will provide continued support to the participant as they move on in their process. Details on these roles and the process are provided later on in this document. Addressing these needs in an individualized manner is thought to help reduce and manage risk effectively.

It is important to note that, while this would not be strictly considered psychotherapy, it is an intervention in the sense that a DEEP staff member would help guide the participant through the process, as well as pull from already existing resources that would otherwise not be reaching that individual in a coordinated manner. Moreover, pulling carefully vetted community resources would help foster a sense of belongingness and connectedness in the participant, the lack of which has also long been associated with risk for violent extremism. Lastly, DEEP staff members would maintain regular contact with participants and family (if needed) and retain significant flexibility in terms of how to intervene (which would not be available to psychotherapists).

CHAPTER 2: TEAM STRUCTURE AND WORKFLOW

2.1.- TEAM STRUCTURE



The DEEP team will consist of a clinical and program director, a coordinator and administrator, and several behavior intervention and transitional specialists. The last two will be directly delivering services. Each post is described below.

Coordinator:

The coordinator will be a master's level clinician, preferably with a license, who will manage incoming referrals and make preliminary eligibility decisions, with support from the clinical director. The coordinator will take the initial referral call and complete basic information to be gathered on the referral form, before making the preliminary decision. The coordinator will also make case assignments and manage day to day operations of the program, as well as provide crisis intervention as needed. The coordinator will also provide administrative support as needed.

Behavior Intervention Specialist Role (BIS):

The main point of contact between the participant and DEEP will be the BIS. BISs are master's level mental health workers who have received formal training in the DEEP intervention. Their role is to provide support and monitoring in the process of disengagement and demobilization for DEEP participants. BISs will conduct a thorough eligibility assessment to evaluate the participant's needs and design a service plan that is in line with those needs, with support from the Clinical Director. Support from the BIS may take the form of check-in sessions, encouragement and assistance in enrolling in certain activities, and help connecting the participant to appropriate services if those are outside of services provided by DEEP. The next section in this manual outlines the areas in which a BIS might intervene with a participant. For each of these areas, attempts have been made to identify the point at which intervention from a supervisor or an outside referral is needed.

The BIS should maintain regular contact with the participant, at a frequency to be decided after the eligibility assessment phase is complete. In addition, the BIS should maintain regular contact with providers involved in the participant's care or involved in the provision of services included in the service plan. The BIS should help coordinate some of the participant's care to ensure it is provided smoothly and efficiently. The BIS will also help the participant advocate for themselves in terms of obtaining their desired services.

Special note for ATI cases:

Not all participants who come to DEEP will do so voluntarily. Some might be mandated by the court or by parole or probation. Should this be the case, BIS's should be sensitive to the situation, explain the limits of confidentiality clearly (especially the fact that the BIS may be required to report on the participant's progress) and take special care to ensure the participant has understood, has been able to ask questions, and is willing to engage prior to beginning the provision of services. In the provision of services, the BIS may need to frequently remind the participant of their role and may choose to maintain different boundaries, if needed. This is something best navigated in supervision and determined on a case by case basis.

Transition Specialist Role:

Once a participant has been deemed to have successfully met all their goals, they will be introduced by their BIS to a Transition Specialist (TS) prior to completion of their work with the BIS. The TS will focus on maintenance of behavior change and promoting stability. The TS will also remain alert for any warning signs and promptly bring a case to the attention of supervisors if the participant shows indications of

decompensation or needing additional support. The frequency of meetings with the TS should be no more than 2 times a month, save clear exceptions. Should a participant need weekly meetings, their case should be discussed in team meetings to determine if they need to be assigned back to a BIS.

Administrative Assistant:

Under the program director's supervision, the administrative assistant will provide support to the team with filing, maintenance of paperwork and other administrative tasks.

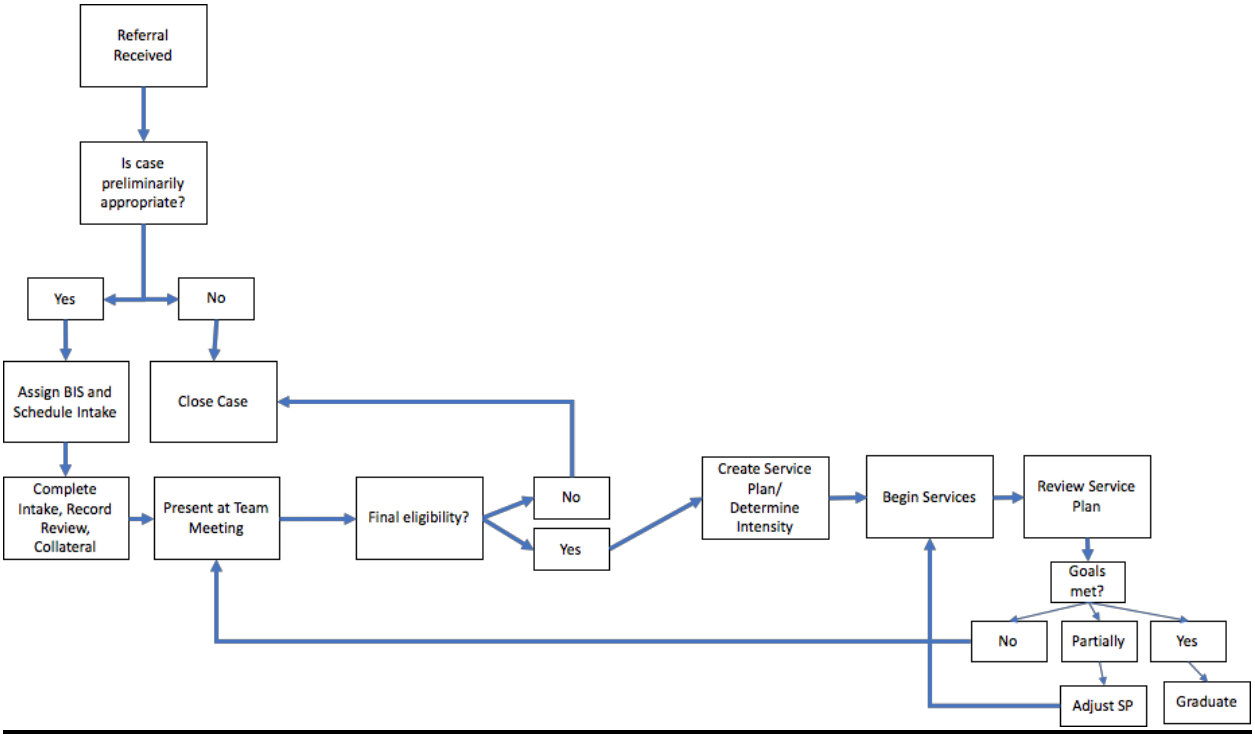
Clinical Director:

The clinical director will provide clinical oversight and support for the team. The clinical director should ensure services provided meet industry standards. The clinical director will provide specialized psychological assessment services when needed, and will provide crisis intervention when appropriate. The clinical director will also be responsible for providing and/or coordinating training for all DEEP staff and to ensure services are provided in a culturally sensitive manner.

Program Director

The program director will handle administrative leadership. This may include interfacing with funders, generating reports and performance evaluations as needed, as well as managing staff in all non-clinical matters. The program director will also be responsible for ensuring adherence to all documentation protocols and creating or modifying procedures in collaboration with the clinical director.

2.2.- WORKFLOW



2.3.- INTERVENTION COURSE

REFERRAL

Once a case is referred to DEEP, the coordinator will make a preliminary determination on *initial eligibility*. This process will include handling the referral call and collecting the information needed to fill out the referral form. The coordinator will consult the clinical and program directors as needed to make this decision. If the participant is deemed too unstable or high risk to participate in DEEP at the time, the referral source will be advised of this fact and a recommendation will be made regarding whether another referral should be attempted at a later time. If the participant is deemed initially eligible, they will be assigned a BIS and scheduled for an eligibility assessment as soon as possible. Final determination of eligibility will be made once the eligibility assessment process has been completed and the case has been discussed with the clinical supervisor and/or clinical director.

ELIGIBILITY ASSESSMENT

An eligibility assessment will be scheduled once *initial eligibility* has been established. Eligibility assessments will consist of a series of screening measures designed to assess for the need of more in-depth evaluation and the presence of immediate risk for suicide or violence. Eligibility assessments may take several meetings to complete and should be done within a month of the case being opened.

BIS's should begin by explaining the purpose and nature of the eligibility assessment to the participant, including an explanation that this is a way in which we get to know them better and get a sense of what their needs are and how we can be of help. The informed consent process, including the limits of confidentiality, should be clearly explained prior to beginning the eligibility assessment and time should be allowed to answer all of the participant's questions. Participants should also be aware that they can, at any point, refuse to answer questions or terminate the process, if they choose to. For ATI participants, the potential consequences of doing so should be clearly laid out. At a minimum the consent to participate and consent for emergency contact and collateral should have been completed BEFORE the assessment begins.

A full version of the eligibility assessment can be reviewed in appendix III. One possible outcome of the eligibility assessment process is that the BIS makes a determination that *further assessmen*t is needed before the intervention can begin. In those cases, the participant will be referred to the clinical director or to an outside psychologist for an extended assessment and the provision of services may be delayed until the results of said assessment are available.

SERVICE PLAN

Once the eligibility assessment is complete and the person is deemed eligible, the BIS and participant can begin to make a service plan to be used as a guide for the next three months. Service plans will have *goals* and *objectives* for each domain that has been identified as a need. *Goals* are general aims in one domain that may not be attainable in a service period, or even for the duration of DEEP. *Goals* are meant to aid the participant and the BIS in guiding their work in one particular domain. For example, a goal in the Social Skills domain might be “Improve sense of connection with others in participant’s community”. *Objectives*, on the other hand, should be attainable within DEEP’s intervention period and should be phrased in a way that is measurable. For example, “Identify one social activity to engage in 1 time a week”, or “attend 80% of mental health appointments”. *Objectives* can be as small or as ambitious as the participant and the BIS deem is realistic, but there should always be a reasonably good chance that the participant will be able to attain it by the next service plan review.

At the end of each service period (i.e. 3 months), the BIS and the participant should formally meet to go over the objectives that were agreed upon when the service plan was created and determine how much of the objective has been attained. By the end of this meeting, some objectives may be carried over to the next service period, others might be deemed completed and new ones might be added.

Needs/Goals should be established on each of the domains associated with the intervention targets outlined elsewhere in the toolkit (i.e. social skills, anxiety, trauma, leisure/work and recreation, critical thinking, family issues and other). *Objectives* should be based on needs identified during the eligibility assessment process, as well as areas that can serve a risk management purpose. Service plans should also lay out what frequency of meetings are necessary. Details on what to take into account to determine this are outlined below.

LEVEL OF INTENSITY

The intensity/frequency of meetings with DEEP BIS and other providers will be based on the needs and level of risk identified during the eligibility assessment process. Care should be taken not to place a participant who is at low risk in a high intensity intervention (or vice versa) as it may be counterproductive.

This decision should be made taking all the available information into account. For example, a participant may have one area of high need that places them in high intensity group until those needs are addressed. Another participant may have moderate levels of need in many intervention areas, requiring more cumulative attention and placing them in the high intensity group. In addition, logistical limitations related to the participant’s individual circumstances should be taken into account so as not to

overwhelm the participant to the point that DEEP interferes with other important areas of their life. At a minimum, participants should be having once weekly meetings with their DEEP BIS. Below are some examples of patterns of intensity/frequency:

1. Low intensity intervention (1x week meeting with BIS)
2. Moderate intensity (2-3x a week-with BIS or BIS + other professional)
3. High intensity (5x a week- BIS, psychologist and psychiatrist, mentor, + others)

The level of intensity is, therefore, dynamic. It can, and should, fluctuate as the intervention progresses. For this reason, service plans should be reviewed *every three months* so goals and level of intensity can be adjusted accordingly. As the time for revision approaches, the BIS should plan to discuss the case with their supervisor prior to their meeting with the participants. This meeting should help the BIS determine level of engagement and response to the intervention and guide the conversation with the participant. Then, a formal meeting should happen between the BIS and the participant to collaboratively revise the service plan.

CRISIS INTERVENTION

Crisis intervention is necessary in cases in which the situation does not allow for the standard eligibility assessment to be completed and immediate or near-immediate action must be taken. One possible scenario is when a participant is experiencing acute suicidal ideation at the time of referral. There is also the possibility of a crisis happening mid-intervention. In either case, the participant should be linked with an appropriate level of care to be determined after the BIS has discussed the case with the Clinical Director. *The main aim of a crisis intervention is to maintain safety.* Facilitating stability is also important but should come only once the safety of the participants and others has been established.

Often times, once a participant is matched with appropriate care, some time would need to pass before the acute crisis is managed and the eligibility assessment and treatment planning process can begin, or the intervention can resume. At a minimum, the BIS should obtain consents, demographics and risk information from the participant in order to facilitate the crisis referrals and provide direct services.

Any crisis intervention should be managed with significant support from the clinical director, who will help assess the situation and guide the intervention. DEEP is only equipped to provide short term crisis intervention. Should there be a determination that the participant will need medium to long term services to manage the crisis (e.g. hospitalization or residential substance use treatment) a recommendation might be

made not to engage in DEEP until the crisis is resolved and for the participant to be re-referred or engage on their own once they have been stabilized.

CHANGE ASSESSMENT

Every 6 months, all measures contained in the eligibility assessment should be repeated and entered into the participant's record in order to measure and document any behavioral changes that have occurred since the participant was last assessed. In addition, the behavior change form (appendix VI) should be completed and entered.

INTERVENTION COMPLETION OR TERMINATION

Completion/Graduation:

A participant is deemed to have graduated from DEEP when all their service goals have been met to at least 80%, or when they are connected to services that will help them attain those goals that are in progress. Some needs are chronic in nature and will be present for most, if not all, of the participant's life (e.g. a serious mental illness). If those needs have been stabilized and the participant is connected with appropriate long-term services to maintain that stability, that need is considered to be met for DEEP's purposes. These determinations will be made by the BIS, coordinator, clinical director and participant every time the service plan is revised.

Once a participant has been deemed to be ready to graduate from DEEP, their BIS will create a transition plan for the participant that will clearly lay out what DEEP recommends the participant do in order to maintain the intervention gains during the transitional period. The BIS will explain the next phase to the participant and introduce them to the person who will be providing transition services 2-4 weeks before work with the BIS ends. Like the service plan, the participant will have a chance to review and contribute to their transition plan and this plan will be discussed in a meeting with the BIS, transition specialist and participant.

The participant will then be issued a graduation certificate to be presented by their BIS and coordinator or clinical director. At that point they will formally enter the *follow up phase* and will be connected with a DEEP-trained transition specialist who will provide ongoing support and monitoring for up to 6 months. This person will be trained in all of DEEP's principles, will be familiar with the participant's case and process and will be there to assist the participant in their transition out of the program, and to help identify any need for reengagement into a higher level of care. Follow up contact should follow a tapering pattern starting from the level of intensity the participant was receiving at the time of completion and should not exceed 2 times a month, save exceptional circumstances.

Special note for ATI cases:

In cases in which the participant is mandated to DEEP, completion will occur at the time the mandate ends. However, the level of intensity within DEEP should still be determined by clinical need, barring any court or law enforcement opposition.

Termination:

A participant's case may be terminated for several reasons. Below are the reasons anticipated to be the most frequent and recommendations on how to deal with them.

1. Lost to follow up
   A participant may cease to have contact with DEEP at any time. If that is the case, efforts should be made to reach out to the participant via phone upon the first missed appointment and at a frequency that matches the frequency of DEEP encounters outlined in the service plan. If the participant (or guardian, if participant is a minor) does not respond and a voicemail can be left, the BIS should give the participant a certain amount of time to respond before the next step is taken. The next step (following week) would be to contact the participant's providers to see if they have made it to those appointments. The BIS should ask the providers to let the participant know the BIS has been reaching out. If unsuccessful, the next step would be to reach out to the participant's emergency contact. The BIS should alert a supervisor anytime there is loss of contact, as there may be cases in which law enforcement needs to be notified. A case is to be closed after 30 calendar days of no contact.
2. Lack of progress/motivation
   If a participant is not making any progress towards their goals for 2 consecutive service plan reviews (i.e. 6 months), termination should be considered. Termination due to lack of progress should be considered carefully and after all possible adjustments have been made to help the participant move towards their goals. This is a decision to be made by a supervisor or clinical director.
3. Unmanageable risk
   In some cases, changes in circumstances may increase the participant's risk to a level that DEEP is unable to manage safely in the community. This determination should be made by the clinical director only. In said cases, the case is to be closed and the appropriate law enforcement agencies should be notified and briefed immediately.
4. Criminal Justice system opposition

In cases in which the participant is being considered for an ATI, and has been deemed eligible and evaluated by DEEP, there is the possibility that the CJ agency may withdraw their ATI offer. In those cases the participant's case will be closed, unless they are willing to enter the program voluntarily.

CHAPTER 3: TOOLS AND INTERVENTION TARGETS (i.e. TOOLKIT)

Disengagement: "The process whereby an individual experiences a change in role or function that is usually associated with a reduction in violence participation. It may not necessarily involve leaving the movement, but is most frequently associated with significant temporary or permanent role change." (Horgan & Braddock, 2010, p. 152)[7]

This chapter offers guidance on how to approach difficult topics with the participant and what to focus on in your work with the participant. The intervention targets to be discussed here touch on each of the domains to be covered in the service plan. They help enhance critical thinking skills, broaden perceived options for the participant, and manage the factors that have been associated with increased risk for violence as outlined in the RNR framework and Barelle's Pro Integration Model. This intervention is meant to be led and mainly delivered by a behavior intervention specialist, so the content is addressed to them.

[7] Horgan, J, and Braddock, K. (2010). Rehabilitating the Terrorists?: Challenges in Assessing the Effectiveness of De-radicalization Programs. *Terrorism and Political Violence* (March): 267-291.

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DO's AND DON'TS

DO'S	DON'TS
Maintain a non-judgmental stance in all your interactions with the participant	Argue with the participant about religion or ideology
Check in with your participant with every encounter -how are you feeling? -is there anything you would like to accomplish today?	Ignore warning signs If you need help addressing them, get a supervisor
Be alert for signs of increased risk	Take an authoritarian stance or lecture the participant
Reach out to a supervisor when in need for additional support	Use information the participant gives you as intelligence
Center your interventions around the *participant's goals* as much as possible	Rush the intervention. It's important to be responsive to the participant's pace.
Be clear with your participant about the limits of confidentiality at the beginning of your work with them	
Allow the participant to correct you if they think you are wrong	

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HOW TO DEAL WITH IDEOLOGY

Due to the nature of extremist violence, ideology is likely to be a central element of your participant's life. It is also likely to be used as a justification for participating or contributing to violent acts. Ideological beliefs are often (but not always) deeply held, rooted in culture, and shared by people who your participant deems important in some form.

Because your participants may have been told at some point in the referral process that their ideology is part of the reason they were sent to work with DEEP, they might arrive to their meeting with you already feeling defensive and likely to resist any attempt to convince them their beliefs are wrong. **You should avoid directly and explicitly trying to change your participant's beliefs in your work with them.** In addition, depending on what your own cultural and ethnic background is, your participant may make assumptions about you and your own beliefs that are likely to affect your interactions with them. It is important to keep all these things in mind, particularly in the initial stages of the intervention, when you and your participant are getting to know each other and developing trust.

Having said all of this, DEEP does not shy away from having conversations around ideology, especially when your participant is verbalizing it as a justification for violence. In those cases it is important to first aim to understand your participant's belief system in a non-judgmental manner. This means doing your best not to think of their beliefs as right or wrong, but rather gather information with the purpose of gaining a deeper view into your participant's opinions. It is also important to maintain a non-directive stance in your statements to the participant, and use techniques such as socratic questioning and reflections, to help them think through their reasoning and consider other perspectives. Be very careful not to get into any arguments with your participant. If the conversation takes that turn, it might be best to table the discussion and pick it back up at a later time.

HOW TO IDENTIFY ESCALATION

The first thing to take into account is that incidents of extremist violence are rarely impulsive, unplanned acts. This may allow room for preventative interventions, should there be any identifiable signs of escalation or should the person discuss their intentions with people close to them. Gill, Horgan and Deckert (2014)[8] looked at a sample of lone actors and found that 83% of offenders had broadcasted their grievances, 79% had publicly expressed commitment to an ideology, 64% told a friend or loved one of their violent intent, 58% told someone else about specific plans and 59% made public declarations about their intention of committing an extremist violent act.

Secondly, it is important to remember that there is no reliable profile for people who engage in extremist violence. This means that people may resort to extremist violence for a variety of reasons and in many different manners. This means providers must remain alert, as there is no exhaustive list of warning signs, and **any concerning statements or behavior should be discussed with the team and a supervisor as soon as possible**. With that said, below are some things that may indicate a participant is escalating, based on Dr. J. Reid Meloy's research on the topic[9]:

1. Any change in participant behavior noted by the clinician or reported by people close to the participant should be taken seriously and assessed. For example, participant becoming increasingly isolated/withdrawn, missing appointments with the clinician or other providers, not taking medication (if they are prescribed), having unusual angry outbursts with family members or providers, worsening of MH symptoms, etc.
2. New fixation on a person or cause, or an intensification of previous ones
3. Efforts to obtain firearms or explosives or intensifying interest in firearms or explosives
4. The participant begins referring to specific targets or plans for violence (leakage)

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[8] Gil, P., Horgan, J. & Deckert, P. (2014*) Bombing alone: tracing the motivations and antecedent behaviors of lone-actor terrorists. Journal of Forensic Science. 59*(2):425-35. doi: 10.1111/1556-4029.12312.

[9] Meloy, J.R. (2016). Identifying warning behaviors in the individual terrorist. *FBI Law Enforcement Bulletin.* April 2016.

5. The participant references intent to use specific methods or steps to implement them (i.e. building a pipe bomb, securing materials)
6. Anything else that might cause concern. When in doubt, consult!

ii. What to do in case of an emergency

1. In case of an emergency, the number one priority must always be safety.
2. Alert a supervisor as soon as you are safely able to do so. If possible, do so in front of the participant. Explain you are concerned and you would like your supervisor to hear the situation in order to make the best decision to ensure everyone's safety.
3. In cases in which a participant is making statements related to self-harm or suicide, be empathetic. Do not tell the participant that everything will be all right or make promises you cannot keep. Explain that suicidal thoughts are often a symptom and a sign that help is needed. Then, call a supervisor who will help you make a decision as to how to handle the situation and whether EMS needs to be called.
4. In cases in which a participant is making concerning statements regarding violent thoughts or thoughts of harming others, ask the participant if they have a plan. Try to get as much information as possible about the participant's potential target or method, if there are any. Then, call a supervisor.

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INTERVENTION TARGETS

Social skills

- Why is this important?

In some cases, social isolation and anxiety may be a prominent part of the participant's presentation. Often times, these can be driven by a sense of inadequacy, a belief that one will fail at attempting to establish relationships and therefore will be rejected. This tendency may make people particularly vulnerable to any person or organization that offers them unconditional acceptance and that may encourage extremist violence. The good news is that social "awkwardness" is generally seen as a deficit in social skills and, like any other skill, these can be taught, trained and improved on.

- How can you assist your participant?

There are several ways in which you can help the participant develop or improve on their social skills. One such way is to provide real-time feedback on their interactions with you in a non-judgmental way. This should be done only when you have established a strong alliance with the participant and you can reasonable predict they would be able to accept this feedback. Another way would be to encourage your participant to participate in activities in which there is a low likelihood of social rejection (e.g. Attending meet-ups of people with similar interests to the participant's) and where they can practice their social skills and build their confidence.

- When should you get outside help?

Some participants may need more formalized social skills training. This is commonly, but not only, seen in cases of people who have certain severe mental illnesses. If you think your participant needs this type of services, there are two options: one is to have this addressed in individual therapy, another is to have it addressed in a group setting. In the former, strong preference should be given to a therapist who specializes in cognitive behavioral therapy (CBT). In the latter, you might want to look for social skills training groups in the participant's community, or in connection with their mental health provider, if they have one. These groups often have a didactic approach to social skills and include homework and *in vivo* practice.

- Transitional work on social skills

Once a participant has completed their work with the BIS, you (transition specialist) will continue to provide support and monitoring to ensure the intervention

gains are maintained. In the case of a participant who has been working on social skills, the transition specialist should routinely ask about the participant's continuing engagement with any activities started during DEEP (e.g. hobbies, clubs, etc.). The transition specialist should also help the participant troubleshoot if they are having issues maintaining their connection to these activities, or help them seek out new ones, if that is what the participant wants. If a participant suddenly drops out of all social activities or becomes withdrawn, expresses feelings of alienation or otherwise feels disconnected from people this should be brought to the attention of a supervisor so a decision can be made on how to approach the situation.

Anxiety

- Why is this important?

Anxiety has also been found to have been present in some cases of violent extremism. It is important to keep in mind that anxiety is a very common mental health issue that may even be part of normal functioning. It may not be an issue that is specifically relevant to your participant and you should take time to explore that with them.

- How can you assist the participant?

One thing to do if you have a participant who is struggling with anxiety is to normalize it and explain how common it is. It might also be helpful to explore with your participant what is the focus of their anxiety. For example, some people may experience anxiety related to public speaking, or social situations. Others may experience anxiety related to very specific stimuli or situations (i.e. phobias). Others still may experience what is called generalized anxiety disorder (GAD), which is a pervasive pattern of excessive worry that happens in many contexts and impairs the person's ability to function. Developing awareness of their symptoms and triggers can be a big help for the participant to start managing their anxiety. In addition, helping the participant build a list of healthy coping skills can also be a big help. Some examples of coping skills include deep breathing, self-distraction and exercise. Everyone will have preferences when it comes to coping, so encouraging your participant to develop their own list is most likely to be effective.

- When should you get outside help?

If the participant is actively avoiding certain places or activities they need to or want to engage in because of their anxiety, it is possible they need treatment for it. You

might want to consider speaking to your supervisor to determine if a formal evaluation is necessary.

Lots of empirical research has found several types of psychotherapy to be effective in managing and reducing symptoms of anxiety. CBT is considered the first line of treatment for this type of disorder but other therapies, like psychodynamic therapy, can be effective as well.

In some cases, psychotropic medication could be a helpful addition to psychotherapy. This determination should only ever be made by a medical professional. Typically, a participant's therapist would be the one to suggest an evaluation for medication, but if you think your participant could benefit from such an evaluation, it might be helpful to discuss it with them and, with their permission, contact the therapist to discuss facilitating a referral. Beware that some, but not all, anxiety medications (i.e. benzodiazepines) have a high potential for addiction and are considered controlled substances. If your participant is under a court mandate or under correctional supervision, it is important to make sure that taking such medications will not result in negative legal consequences for them.

- Transitional work on anxiety

Transitional work around anxiety should follow whatever the recommendation of the transition plan is. If the participant is under the care of a psychologist or psychiatrist, they should be consulted and you (transition specialist) should support the participant in following those recommendations. Anxiety can be a chronic life-long issue for some people and ongoing professional support may be necessary in those cases. If the participant has mild or no anxiety symptoms, asking about those symptoms on a regular basis may be all that is needed.

Trauma

- Why is this important?

"Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being"[10].

[10] https://www.integration.samhsa.gov/clinical-practice/trauma

While the vast majority of people experience some kind of traumatic event in their lifetime, only a small percentage develop post-traumatic stress disorder (PTSD). At DEEP, participants are screened for PTSD symptoms using the Post Traumatic Stress Checklist- Civilian version (PCL-C). When using the PCL-C, keep in mind that avoidance of reminders is one of the symptoms of PTSD and it is not uncommon for people experiencing PTSD symptoms to deny they are experiencing them.

Besides PTSD, trauma can affect people in a variety of ways. Difficulty establishing trust is one of the ways in which long-term impact of trauma can manifest itself. Another possible effect is that people may experience great challenges in learning how to self-regulate their moods and emotions, sometimes behaving in impulsive ways or resorting to unhealthy alternatives (e.g. substance use, violence).

- How can you assist your participant?

It is important *not to encourage* the participant to recount details of a traumatic experience in their work with you. Often times, remembering these incidents can lead to very intense re-experiencing symptoms that may not subside for an extended period of time. It might also lead to the participant wanting to leave your meeting with them, which may reinforce their avoidance response, worsening their symptoms in the long term. If a participant begins to spontaneously share this type of memory with you, you may try to gently re-direct or inquire if they have discussed this with their therapist. This should be done taking care to acknowledge the importance of their experience. Some ways in which to redirect might look like this: “I know this event had a big impact in your life and I’m honored that you would trust me enough to share it with me, but I think this might be something you’d be better off discussing in therapy, that way you can be sure to have the support you need”. Another way might be “It sounds like what you’re about to tell me is really important. I’m concerned we don’t have the privacy right now to go into it. Maybe talking to your therapist about it would be better”.

As far as what you *can* do as DEEP staff to help your participant deal with trauma-related symptoms, like with anxiety, it can be really useful to help them make a list of coping strategies that they can refer to the next time they experience symptoms. This works best when the participant can give you their own list of coping skills. Chances are they already have some way to deal with their symptoms. Only after they have given you some options should you suggest some alternatives, keeping in mind they might not work for that particular participant. Some options include: listening to music, calling a friend (specify who and include their number), going for a walk, taking a hot/cold shower, meditate, among others.

- When should you get outside help?

If you think your participant has a significant trauma history and may be experiencing symptoms of PTSD, or if they flag the PTSD screening measure on the intake, you should talk to a supervisor and possibly schedule an evaluation.

If the evaluation results suggest your participant should get treatment to target their trauma symptoms, psychotherapy is usually the best treatment. At times, medication can be helpful as well. While there is a variety of treatment options out there, there are three types of highly specialized therapies that have strong empirical support in their effectiveness for dealing with PTSD symptoms. You will see details on these approaches below so you can be informed when searching for a specialist for your participant or providing information to them. If you think your participant needs trauma-specific treatment, you should try to look for people who have training in one of these approaches.

One effective treatment for PTSD is prolonged exposure (PE), in which participants will be asked to recount their traumatic experiences repeatedly in treatment and at home, until the anxiety response is reduced or eliminated. This treatment is very effective at reducing symptoms, but very difficult to tolerate, and may not be appropriate for everyone. Another treatment is cognitive processing therapy. This treatment targets the thoughts and behaviors around traumatic events and memories to help the participant modify them to more adaptive ones. Yet another trauma-specific treatment that has been empirically supported is Eye Movement Desensitization and Reprocessing (EMDR) in which exposure is combined with eye movement training to reduce symptoms.

In some cases, you might see that a clinician or clinic states they provide “trauma informed care”. This means they have received general training on the effects of trauma and how to deal with it. It does not necessarily mean they have specialized training. Depending on the severity of the trauma and the prominence of trauma symptoms in your participant, you might want to recommend a more or less specialized treatment.

- Transitional work on trauma

Similar to anxiety, trauma can bring chronic life-long symptoms. The recommendations of the transition plan and/or the participant’s treatment provider will guide transitional work in this area. Any worsening of symptoms should be reported to a supervisor so recommendations can be adjusted, if necessary. The same guidelines provided for the BIS apply to the transition specialist in terms of how to handle spontaneous trauma-related narratives from the participants.

Use of free time, work and education

- Why is this important?

One of the factors commonly associated with risk for recidivism within the RNR model is the lack of prosocial activities engaged in during one's leisure time. With that in mind, it is vital that you carefully assess what your participant does during their free time, what they do for fun and what they might like to do but are not currently doing. *Prosocial activities* are any activities that are not conducive to illegal or violent behavior, so there are many options within that category. The more time a participant uses in prosocial activities the less likely they are to engage in activities that increase their risk for extremist violence. At times, participants may attend or engage in activities that reinforce an extremist ideology. As long as this activity does not promote violence, DEEP would abstain from directly discouraging the participant from attending. However, you can still have a discussion with the participant to explore their reasons for attending and encourage them to engage in critical thinking and perspective taking around it.

- How can you assist your participant?

Should you and the participant identify this as an area to work on, you might help them schedule prosocial activities that align with their interests. These may include finding low-cost classes on topics they are interested in, looking at meet-ups with people who have common hobbies, volunteering or participating in group exercise classes or sports. Keep in mind that not all prosocial activities must be done with other people. If your participant enjoys, for example, reading or cross-stitching, helping them get a library card or downloading cross-stitching patterns, or creating a reading list might help in this domain.

Other important options to consider are trainings. If there is a skill, job-related or otherwise, your participant wants to develop helping them navigate the process of finding a training, filling out applications, etc. would also help address this goal. Same goes for academic objectives. If your participant would like to get their GED or work towards a college degree, those are great ways to address this area.

It is important to help the participant consider factors that may facilitate success. For example, signing up for full time college classes while working full time might not be advisable for most people. Looking at their schedule and mapping out the best use of their time might help guide their decision. Be mindful to keep the participant accountable and responsible for arranging these activities. Your role is that of a facilitator in this process.

- When should you get outside help?

It is likely that you will be able to help the participant get set up for most of their goals in this area. If they have some disabilities that may require special accommodations, you might need to refer them to agencies that are tailored to serve people with those needs. As usual, it is always helpful to consult with your supervisor, when in doubt.

- Transitional work on use of free time, work and education

Transitional work on this area is likely to consist of maintaining whatever has been established during work with the BIS. Your work will consist of helping the client troubleshoot any issues related to maintaining employment, pursuing educational work or engaging in prosocial leisure activities. One of the most likely issues to arise in this phase relate to time management. Helping the participant create a realistic schedule they can maintain is one of the most useful transitional tools to share with them.

Critical thinking

- Why is this important?

Some of the techniques that have been used in helping people disengage from extremist violence are those that help enhance critical thinking. Critical thinking is defined as "... that mode of thinking — about any subject, content, or problem — in which the thinker improves the quality of his or her thinking by skillfully analyzing, assessing, and reconstructing it."[11] In other words, it is the ability to question assumptions and objectively evaluate information before deciding what to believe. People who have poor critical thinking skills are quick to accept one view without considering other perspectives, which makes them more vulnerable to ideological violence.

- How can you assist your participant?

It can be challenging to encourage participants to engage in critical thinking without directly contradicting their beliefs. The key here is to maintain a curious and respectful stance, rather than an authoritative or argumentative one. For example, if someone expresses a belief that all members of X group are evil, you might say something like "hmm… I wonder, what do you think someone from X group would say to that" or "how would you imagine it would feel like if someone said that about you?". In other words, you are encouraging your participant to take the other person's perspective. This does not mean they need to agree with this other perspective, but

[11] https://www.criticalthinking.org/pages/our-concept-and-definition-of-critical-thinking/411

merely that they can put themselves in that position intellectually. This will foster open-mindedness and cognitive flexibility.

Another way to encourage critical thinking it to invite your participant to engage in metacognition. Metacognition is thinking about one's own thinking. For example, when a participant shares one of their views, express interest and ask them, "how did you come to think this way?" or "did you always see it like that?". That way they will be reflecting about the origin and development of their opinions.

The type of questions presented in these examples are part of what is known as the *Socratic method*. It is a hallmark of CBT, an approach to therapy that enjoys a great deal of empirical support. The Socratic method is, above all, collaborative. It encourages the formation of hypotheses and then the search for evidence in support or against that hypothesis. Curiosity and exploration are fostered and encouraged. Open questions are preferred, as they allow for more thinking and elaboration on the part of the participant.

This method may be particularly useful when discussing attitudes towards the use of violence. While your participant will likely be discussing these topics in other contexts (i.e. therapy), it will probably come up in your direct work with them. In that sense, some researchers (Clubb, 2015) have proposed that there are three levels that influence the use of violence. These are:

1. The perceived strategy benefit or attraction to violence
2. The perceived control over the use of violence
3. The perceived norms surrounding the use of violence

Be alert for statements that touch on these levels, as it is important to help your participant develop critical thinking around those issues in order to help manage or reduce their risk for violence. To that end, for example, a participant may express a justification of the use violence to make a particular point, and may believe that the *only way* to make that point is through the use of violence. A possible way to encourage critical thinking about such a belief might be to ask questions like:

1. *"What do you think would happen right after the incident? What changes would you want to see? What changes do you think are likely?"*
2. *"Have there been any other social changes that happened in a different way? Is there any other way to get the change that you want to see?"* (provide examples of non-violent activism, if necessary)
3. *"What could happen if X incident goes wrong? Are there any possible unintended consequences? How would you feel if someone innocent got hurt?"*

It is important to remember that changes in attitudes are rarely sudden. It takes time to take in information, question your point of view and possibly change it. Do not

get discouraged if you feel like nothing changed after you engaged in Socratic dialog with a participant. Maintaining your encouragement to explore other ways of thinking in a curious, non-judgemental way is vital to helping your participant think through some of these issues.

- When should you get outside help?

If you feel like these conversations always turn into an argument, you may benefit from discussing it with a supervisor to help identify the reasons and help you develop other strategies.

If you think that lack of change in this area may be psychotic in nature (i.e. the result of a delusion), you might want to request an evaluation or discuss the case with a supervisor to help you determine whether this is an issue best handled psychiatrically.

IMPORTANT: If a participant is expressing intention of carrying out a violent act you must notify a supervisor immediately.

- Transitional work on critical thinking

As in every other area, the key here is maintaining gains. You should keep an eye out for any signs that the participant is not engaging in critical thinking and follow the same principles outlined for the BIS In your work with them. If you notice any serious gaps in critical thinking, make sure they are discussed with a supervisor to determine if further intervention must be made.

Family/partner issues

- Why is it important?

Family conflict can be very dysregulating and affect multiple areas of your participant's functioning. Often times, families are a significant source of support for individuals and carry great influence on someone's behavioral and emotional stability. Assessing the quality of your participant's home environment and the potential effect it can have on your participant should take place early in your work with the participant, or as soon as your participant feels comfortable enough to share. Your participant's perception of their home environment can also change as they progress through the program, so ongoing discussions should be had about family relationships.

- How can you assist your participant?

Family dynamics are highly complex. You should limit your intervention to providing support to your participant and validating their frustrations and feelings. You might consider integrating family members in your work with your participant on a limited basis and only if your participant is in favor of it. Make sure you discuss the boundaries of your work with the family with your participant before you invite them over. This includes what information you will and will not share with the family and what the objective of your conversation would be.

- When should you get outside help?

Like everything else, the degree of intervention to improve family relationships will vary depending on the situation and the willingness of both participant and family to engage in further intervention. In some cases, family or couple's therapy may be recommended. In other cases, inviting family members (with approval from participant) to join in on aspects of the intervention can suffice. You can work with your supervisor and your team to help determine what to recommend. It might also be helpful to discuss with your participant's individual therapist whether they think family therapy could be helpful.

- Transitional work on family/partner issues

As with any other domain, the transition plan will be the guiding document here. Any changes in family dynamics, increase in family conflict, changes in housing arrangements, changes in health conditions of family members, or anything else of note should be discussed with the participant so they can be supported in facing those challenges. On occasion, changes in someone's home life can lead to general instability. As a transition specialist, you should be alert to such changes and inform the team if you think more than transitional support is needed.

7. Other targets of intervention

On occasion you or your participant may identify some issues that fall outside of the areas outlined below. If you or your participant think this may help with disengagement or demobilization, you should allow space for that in your service plan. Some things that may fall under this category include:

- Serious mental illness (SMI): If your participant has a diagnosed or suspected SMI and they are not currently being seen by a psychiatrist and psychologist, there should be an automatic referral generated. DEEP interventions will have limited effect if psychiatric symptoms are not well managed, so priority should be given to addressing these needs. If they

do have a psychiatrist and psychologist, releases of information should be obtained, and you should introduce yourself and DEEP to these professionals so coordination can occur.

- Substance use: If the participant has an active substance use disorder, a determination should be made as to what level of care they need. If the substance use is severe enough, they might require detoxification or rehabilitation services. Consult with your supervisor so appropriate recommendations can be made in this area.
- Housing instability: The type of help you'll be able to provide to your participant will depend on many factors. People with certain kinds of medical or mental health conditions may qualify for supportive housing, while others may benefit from guidance on how to look for and secure an apartment or a room. Keep in mind applying for supportive housing is a complicated matter and will take a significant amount of time, so make sure your service plan goals are realistic.
- Medical issues (participant's or family members'): If your participant or a family member has a serious or chronic physical illness, you should ensure they have access to appropriate healthcare. This may mean helping them schedule appointments or helping them obtain health insurance. The most important thing is to connect them with professionals qualified to treat the illness.

Keep in mind that the range of things you as a BIS can target in your work with your participant is wide. Should there be anything not included on this list that you think should be addressed, you should discuss with your supervisor to decide what is the best course of action. In addition, transition workers should aim to help participants maintain stability and should be vigilant for anything in that person's life that may jeopardize the gains made by participating in DEEP. <u>If ever in doubt on whether more than transitional intervention is needed, consult a supervisor and/or discuss in a team meeting.</u>

APPENDICES

Appendix I: Referral form

Interim Referral Form

Referral Information

Referral date:

Referral agency: ○ FBI ○ EDNY ○ SDNY ○ Probation ○ Other (text box)

Referral contact:

Name:

Position:

Number:

Email:

Basic Information of Potential Participant

Name (if consent granted):

Age:

Address (if consent granted):

Phone number (if consent granted):

Language:

Ethnicity:

Gender: ○ Female ○ Male ○

Reason for Referral

Primary reason for referral: ○ Domestic terrorism ○ International terrorism

Does this person have a diagnosed mental health condition? Yes No

If no, do you think there is a psychiatric issue going on? Yes No

Records available? Yes No

Is this person currently suicidal or homicidal? Yes No

Does this person have a history of making violent threats? Yes No

If so, how recent?

Details

Does this person have a history of violent behavior? Yes No

If so, how recent?

Details:

Does this person have access to weapons?

Details:

Arrested: ○ Yes ○ No

Date:

Rap sheet available? Yes No

Charged: ○ Yes ○ No

Date:

Charges pursued:

Convicted: ○ Yes ○ No

Sentenced:

Currently incarcerated: ○ Yes ○ No

DEEP HANDOFF INFORMATION

Has DEEP been discussed with this person?

Were they open to talking to DEEP?

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Please give full details of your request and why:

REFERRAL DISPOSITION

<table>
<tr><th>Date case was conferenced with supervisor</th><th>Disposition</th><th>Assigned BIS</th><th>Date referral source was informed of disposition</th></tr>
<tr><td rowspan="2"></td><td>Preliminarily accepted (proceed with assessment)</td><td rowspan="2"></td><td rowspan="2">Notes:</td></tr>
<tr><td>Ineligible

Specify reason:</td></tr>
</table>

Appendix II: Consents

INFORMED CONSENT TO PARTICIPATE IN DEEP

_____ DEEP is a program designed to help individuals in the process of disengaging from activities that may make them more likely to behave in a violent manner. Because everyone is different, the initial part of the process will consist of a series of questions designed for us to get to know you better. Some of these questions may be uncomfortable or difficult to answer. You are free to decline to answer any questions at any time; however, keep in mind this information will be used to help us create the best plan for you. With your permission, DEEP may also request records from other providers, speak to people close to you and/or law enforcement to help gather information. This process usually takes up to a month. After that process is done, you and your assigned worker will create a list of goals to work on and steps to take to achieve them ("Service Plan").

_____ In your work with your DEEP worker you will be meeting with them several times a month. In addition, your DEEP worker may connect you to people in your community who would be able to help you achieve the things you want to achieve. With your permission, your DEEP worker will maintain contact with those providers to help you coordinate those services. You and your worker will review this plan regularly and will adjust it, if necessary. Once you have reached the goals you and your worker have set out, you will graduate to the next phase. At that point you will be assigned to someone who will help you transition out of the program and maintain the gains that you have made.

_____ Your participation in DEEP is **voluntary**. That means you may withdraw at any point. If you are having thoughts about quitting the program, we encourage you to discuss it with your assigned worker so we have the opportunity to address your concerns. Should DEEP be unable to get in contact with you for more than 30 days, your case will be automatically closed and the referral agency may be notified.

_____ DEEP may be required to inform the referring agency of your attendance and level of engagement with the program, as well as whether you are making progress in the process at the end of every service plan review. When reviewing your service plan with you, your DEEP worker will go over what information, if any, will be shared.

_____ Other than the cases explained before, DEEP will not share your information with anyone without your permission, with some exceptions as outlined below:

1) If DEEP staff estimates that you are an imminent danger to yourself.

2) If DEEP staff estimates that you are a danger to others. Should this be the case, DEEP may notify mental health and/or law enforcement professionals so everyone's safety can be ensured and so you get appropriate help.
3) If you or anyone discloses information to DEEP about a child who is being abused or neglected.
4) If you are mandated to DEEP and you are not adhering to your service plan.
5) If DEEP is subpoenaed by a court of law.

_____ While DEEP may, at times, be in communication with law enforcement, DEEP is part of a non-profit organization not affiliated with law enforcement and participation in this program does not grant any protection from legal consequences.

_____ If there are any issues with the services provided at DEEP, participants should first contact the person's supervisor who will work to address their concerns. If that is not satisfactory, the participant may contact the following person in writing:

Steve Velasquez
velasquez@caasny.com

By signing this form I acknowledge that I have read its contents, have been given an opportunity to ask questions, and those have been answered to my satisfaction. By signing this form I agree to the above-outlined parameters and agree to participate in DEEP.

Client or Client Representative Signature _____

Print Name _____ Date_____

Witness _____

CITIZENS CRIME COMMISSION OF NEW YORK CITY

INFORMED CONSENT TO PARTICIPATE IN DEEP-ATI

_____ DEEP is a program designed to help individuals in the process of disengaging from activities that may make them more likely to behave in a violent manner. Because everyone is different, the initial part of the process will consist of a series of questions designed for us to get to know you better. Some of these questions may be uncomfortable or difficult to answer. You are free to decline to answer any questions at any time; however, keep in mind this information will be used to help us create the best plan for you. With your permission, DEEP may also request records from other providers, speak to people close to you and/or law enforcement to help gather information. This process usually takes up to a month. After that process is done, you and your assigned worker will create a list of goals to work on and steps to take to achieve them ("Service Plan").

_____ In your work with your DEEP worker you will be meeting with them several times a month. In addition, your DEEP worker may connect you to people in your community who would be able to help you achieve the things you want to achieve. With your permission, your DEEP worker will maintain contact with those providers to help you coordinate those services. You and your worker will review this plan regularly and will adjust it, if necessary. Once you have reached the goals you and your worker have set out, you will graduate to the next phase. At that point you will be assigned to someone who will help you transition out of the program and maintain the gains that you have made.

_____ Your participation in DEEP is **voluntary**. That means you may withdraw at any point. If you are having thoughts about quitting the program, we encourage you to discuss it with your assigned worker so we have the opportunity to address your concerns. Should DEEP be unable to get in contact with you for more than 30 days, your case will be automatically closed and the referral agency may be notified.

_____ DEEP may be required to inform the referring agency of your attendance and level of engagement with the program, as well as whether you are making progress in the process at the end of every service plan review. When reviewing your service plan with you, your DEEP worker will go over what information, if any, will be shared.

_____ If you are participating in DEEP because you have been **mandated by _____,** DEEP is obligated to report to the referring agency on your attendance and level of engagement with the program, as well as whether you are making progress in the process. Whenever possible, DEEP will share this information with you as well. Should you not adhere to your service plan, there may be negative legal consequences. We encourage you to discuss this at length with your legal representative.

_____ Other than the cases explained before, DEEP will not share your information with anyone without your permission, with some exceptions as outlined below:

1) If DEEP staff estimates that you are an imminent danger to yourself.
2) If DEEP staff estimates that you are a danger to others. Should this be the case, DEEP may notify mental health and/or law enforcement professionals so everyone's safety can be ensured and so you get appropriate help.
3) If you or anyone discloses information to DEEP about a child who is being abused or neglected.
4) If you are mandated to DEEP and you are not adhering to your service plan.
5) If DEEP is subpoenaed by a court of law.

_____ While DEEP may, at times, be in communication with law enforcement, DEEP is part of a non-profit organization not affiliated with law enforcement and participation in this program does not grant any protection from legal consequences, unless this has been explicitly agreed to in court.

By signing this form I acknowledge that I have read its contents, have been given an opportunity to ask questions, and those have been answered to my satisfaction. By signing this form I agree to the above-outlined parameters and agree to participate in DEEP.

Client or Client Representative Signature _____

Print Name _____ Date_____

Witness _____

CITIZENS CRIME COMMISSION OF NEW YORK CITY

EMERGENCY CONTACT CONSENT

I hereby authorize DEEP to contact the following person in case of an emergency:

Name _____

Relationship to Client _____

Phone number _____

Email _____

Address _____

_____

_____

Client or Client Representative Signature _____

Print Name _____ Date_____

Witness _____

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COLLATERAL INTERVIEW CONSENT FORM

I hereby authorize DEEP to contact the following person for the purpose of gathering information to help in the provision of services:

Name _____

Relationship to Client _____

Phone number _____

Email _____

Address _____

_____

_____

Client or Client Representative Signature _____

Print Name _____ Date_____

Witness _____

CITIZENS CRIME COMMISSION OF NEW YORK CITY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to:

☐ DISCLOSE the following information: _____

☐ EXCHANGE the following information: _____

To / With:

Name _____

Phone number_____

Relationship to client _____

For the following purpose(s):

_____

_____

This authorization expires on the date selected or in one year, whichever date is sooner. I understand I can revoke permission to disclose my information at any time, by submitting my revocation in writing to the authorized party designated on this form.

By signing this authorization form:

I understand that my records contain information regarding my mental health. I give specific permission for this information to be released. I understand that my records are protected under State and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

Client or Client Representative Signature: _____

Print Name: _____ Date: _____

CITIZENS CRIME COMMISSION OF NEW YORK CITY

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____
  _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

CITIZENS CRIME COMMISSION OF NEW YORK CITY

Appendix III: Eligibility assessment

PART 1.- DEEP ELIGIBILITY ASSESSMENT FORM

Demographic information

<table>
<tr><td>Name</td><td></td><td>DOB</td><td></td></tr>
<tr><td rowspan="3">Address</td><td></td><td>POB</td><td></td></tr>
<tr><td></td><td>SSN</td><td></td></tr>
<tr><td></td><td>Tel.</td><td></td></tr>
<tr><td>Insurance</td><td></td><td>Ins. No.</td><td></td></tr>
<tr><td>Gender</td><td>Male Female MTF FTM nonbinary</td><td>Email</td><td></td></tr>
<tr><td>Ethnicity</td><td></td><td>Race</td><td></td></tr>
<tr><td>Relationship status</td><td></td><td rowspan="3">Employment</td><td rowspan="3">Ever Employed? Y/N

Current Status:
PT FT Unempl.
Other

Specify_____</td></tr>
<tr><td>Education</td><td>Highest Education Completed (No HS, Some HS, HS Degree, GED, Some College, Associates, Bachelors, Graduate, Other)</td></tr>
<tr><td>Education</td><td>Currently enrolled? Y/N Type:
Attending regularly? Y/N</td></tr>
<tr><td>Housing Status</td><td>Homeless (street)
Homeless (shelter)
Homeless (couch surfing)
Rented room
Rented apartment
Owns home
Lives with family</td><td>Children (include ages)</td><td></td></tr>
</table>

Emergency Contact

Name		Relationship	
Address		Tel.	
		Email	
		Consent?	Y N

Collateral Contact

☐ Same as emergency contact

Name		Relationship	
Address		Tel.	
		Email	
		Consent?	Y N

MOTIVATION FOR DEEP (PARTICIPANT)

Rated items on a scale of 1-5, with 1 being the lowest and 5 the highest

1. How do you think DEEP can help you?

2. Are you willing to attend all your DEEP meetings? Y N Maybe _____

3. Would you be open about any issues you're having with how things are going in the program? Y N Maybe _____

4. How likely do you think it is that you will be able to accomplish the goals you set out in this program? 1 2 3 4 5

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MOTIVATION FOR DEEP (BIS)

Rated items on a scale of 1-5, with 1 being the lowest and 5 the highest

1. How would you rate this participant's motivation to engage with DEEP? 1 2 3 4 5
2. How likely is it that this person could benefit from DEEP? 1 2 3 4 5
3. In your estimation how likely is it that they will adhere to the meeting schedule set in the service plan? 1 2 3 4 5
4. List any barriers to engagement

5. List any initial concerns (re: safety, mental health or anything else)

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CLINICAL HISTORY

Now I will ask you some questions about what type of mental health treatments and diagnoses you have received.

	When? For how long?	Reason?
Have you ever been to a psychiatric emergency room?	Y N	
Stayed in an inpatient psychiatric unit?	Y N	
Gone to a hospital outpatient clinic?	Y N	
Attended a support group?	Y N	
Gone to detox/rehab?	Y N	
Long term residential treatment?	Y N	
Outpatient substance use treatment?	Y N	
Received a mental health diagnosis? *If yes, please list*	Y N	
If yes, did you agree with it? Why?	Y N	

Been prescribed psychotropic medication? *If yes, list them*	Y N	
If yes, did you take it? Why or why not?	Y N	
Currently taking any psychotropic medication?	Y N	If yes, note medication names and doses
Currently attending any outpatient MH treatment?	Y N	If yes, pct. attendance?
Any other medications?		
Any medical diagnoses? (circle any that apply) Diabetes Hypertension Epilepsy HIV Heart disease Kidney issues Other_____		

CITIZENS CRIME COMMISSION OF NEW YORK CITY

COLUMBIA SUICIDE SEVERITY RATING SCALE

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them*."		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: *Was this within the past three months?*		

Low Risk

Moderate Risk
High Risk

NEED TO ADD:
VIOLENCE RISK ASSESSMENT (VERA)

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COLLATERAL INTERVIEW

Name _____ Consent on file? Y N
Contact Information_____
Relationship to client _____
Date_____
Interview medium: Phone Face to Face Other _____

How long have you known the client?

Have you noticed any recent changes in behavior or mood?

Has client recently become withdrawn?

Have you noticed a recent drop in their ability to fulfill their responsibilities? (e.g. job loss, class failure in school, etc.)

Have you ever known client to be verbally aggressive?

Physically aggressive?

Do you know client to ever use drugs/alcohol? Has this ever become problematic?

Have you heard client make any statements that are concerning?

What do you think client needs the most help with?

Do you have any concerns about client we did not ask about?

CITIZENS CRIME COMMISSION OF NEW YORK CITY

PART 2.- SERVICE PLANNING SECTION

This section should only be completed if the participant has been deemed eligible for DEEP and expresses motivation to engage. The purpose of this section is to gather information to design an individualized service plan in collaboration with the participant.

LEVEL OF SERVICE INVENTORY SCREEN

To be used to complete quick-score LSI-R-SV form.

Question	Ans.	Notes
1. Have you been convicted of any crime as an adult? a. If yes, How many times? _____	Y N	
2. Were you ever arrested before age 16?		
3. Are you currently employed?	See pg 1	
4. Have any of your friends been in trouble with the law?	Y N	
5. Have you had problems in school work because of your use of drugs or alcohol? For example, not gone to school of work because you were hung over or lost a job because you were intoxicated?	DAST SMAST	
6. Psychological assessment indicators (circle any that you think need further assessment) Intellectual functioning Academic/vocational potential Academic vocational interests Excessive fears, negative attitudes towards self, depression, tension Hostility, anger, potential for assaultive behavior, over assertion/aggression Impulse control, self management skills	Y N	

Interpersonal confidence, interpersonal skills, under-assertive Contact with reality, severe withdrawal, over-activity, possible delusion/hallucination Disregard for the feelings of others, possibility of reduced or inability to feel guilt/shame, superficially charming but disregards rules Criminal acts that do not make sense or appear irrational other_____		

7. How is your relationship with your parents?

8. How do you feel about the reason you were referred to DEEP?

CITIZENS CRIME COMMISSION OF NEW YORK CITY

DRUG AND ALCOHOL USE

Please indicate which of these substances you have EVER tried, age at first use and date of last use as well as how frequently and how much of the substance is used.

If client says yes to alcohol or drug use in the last year, complete the SMAST (alcohol) and DAST (drugs) respectively.

	Age at first use	Last use	Frequency/Amt.
Alcohol			
Marijuana			
Cocaine			
Crack			
Heroin			
Methamphetamine			
Opioids (Oxycontin, Percocet, Vicodin, etc.)			
K-2			
Methadone			
PCP (a.k.a. Angel Dust)			
Hypnotic/Sedatives			
Benzodiazepines (e.g. Xanax, Valium, Ativan, etc.)			
Hallucinogens (e.g. LSD, acid)			
Ecstasy, Molly			
Other _____			

CITIZENS CRIME COMMISSION OF NEW YORK CITY

SHORT MICHIGAN ALCOHOL SCREENING TEST (SMAST)

NAME: _____ Date:_____

The following questions concern information about your involvement with alcohol during the past 12 months. Carefully read each statement and decide if your answer is “YES” or “NO”. Then, check the appropriate box beside the question. Please answer every question. If you have difficulty with statement, then choose the response that is mostly right. These questions refer to the past 12 months only.

	Y	N
1. Do you feel that you are a normal drinker? (by normal we mean do you drink less than or as much as most other people.)		
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?		
3. Do you ever feel guilty about your drinking?		
4. Do friends or relatives think you are a normal drinker?		
5. Are you able to stop drinking when you want to?		
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
7. Has your drinking ever created problems between you and your wife, husband, a parent or other near relative?		
8. Have you ever gotten into trouble at work because of your drinking?		
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
10. Have you ever gone to anyone for help about your drinking?		
11. Have you ever been in a hospital because of drinking?		
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?		
13. Have you ever been arrested, even for a few hours, because of other drunken behaviors?		
TOTAL		

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DRUG ABUSE SCREENING TOOL (DAST-10)

NAME: _____ Date:_____

In the past 12 months…

	Y	N
1. Have you used drugs other than those required for medical reasons?		
2. Do you abuse more than one drug at a time?		
3. Are you unable to stop abusing drugs when you want to?		
4. Have you ever had blackouts or flashbacks as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Does your spouse (or parents) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?		
TOTAL		

CITIZENS CRIME COMMISSION OF NEW YORK CITY

MODIFIED MINI SCREEN

Section A – Please circle "yes" or "no" for each question			
Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	Y	N	
In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	Y	N	
Have you felt sad, low, or depressed most of the time for the last two years?	Y	N	
In the past month, did you think that you would be better off dead or wish you were dead?	Y	N	Answer in **CSSRS**
Have you ever had a period of time when you were feeling up, hyper, or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	Y	N	
Have you ever been so irritable, grouchy, or annoyed for several days, that you had arguments, had verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	Y	N	
Section A Total Score			
Section B – Please circle "yes" or "no" for each question			
Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable, or uneasy, even when most people would not feel that way? Did these intense feelings get to be their worst within ten minutes? (If the answer to both questions is "yes," circle "yes"; otherwise circle "no.")	Y	N	
Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples: being in a crowd, standing in a line, being alone away from home or alone at home, crossing a bridge, traveling in a bus, train, or car?	Y	N	

Have you worried excessively or been anxious about several things over the past six months? (If you answer “no” to this question, answer “no” to NEXT question proceed)	Y	N	
Are these worries present most days?	Y	N	
In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples: speaking in public, eating in public or with others, writing while someone watches, being in social situations.	Y	N	
In the past month, have you been bothered by thoughts, impulses, or images that you couldn’t get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples: being afraid that you would act on some impulse that would be really shocking, worrying a lot about being dirty, contaminated, or having germs, worrying a lot about contaminating others, or that you would harm someone even though you didn’t want to, having fears or superstitions that you would be responsible for things going wrong, being obsessed with sexual thoughts, images, or impulses, hoarding or collecting lots of things, having religious obsessions	Y	N	
In the past month, did you do something repeatedly without being able to resist doing it? Examples: washing or cleaning excessively, counting or checking things over and over, repeating, collecting, or arranging things, other superstitious rituals	Y	N	
Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples: serious accidents, sexual or physical assault, terrorist attack, being held hostage, kidnapping, fire, discovering a body, sudden death of someone close to you, war, natural disaster	Y	N	**If yes,** **Complete PCL-5**
Have you re-experienced the awful event in a distressing way in the past month? Examples: dreams, intense recollections, flashbacks, physical reactions.	Y	N	
Section B Total Score			
Section C – Please circle “yes” or “no” for each question			

Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	Y	N	
Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	Y	N	
Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?	Y	N	
Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	Y	N	
Have your relatives or friends ever considered any of your beliefs strange or unusual?	Y	N	
Have you ever heard things other people couldn't hear, such as voices?	Y	N	
Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	Y	N	
Section C Total Score			

CITIZENS CRIME COMMISSION OF NEW YORK CITY

PTSD Checklist (PCL)- 5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the **past month.**

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
Repeated, disturbing, and unwanted memories of the stressful event?	0	1	2	3	4
Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
Trouble remembering important parts of the stressful experience?	0	1	2	3	4
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4

Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
Loss of interest in activities that you used to enjoy?	0	1	2	3	4
Feeling distant or cut off from other people?	0	1	2	3	4
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
Being “superalert” or watchful or on guard?	0	1	2	3	4
Being jumpy or easily startled?	0	1	2	3	4
Having difficulty concentrating?	0	1	2	3	4
Trouble falling or staying asleep	0	1	2	3	4
TOTAL SCORE					

CITIZENS CRIME COMMISSION OF NEW YORK CITY

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their worker. Some items refer directly to your worker with an underlined space -- as you read the sentences, mentally insert the name of your worker in place of _____ in the text. Think about your experience in DEEP, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

Seldom Sometimes Fairly Often Very Often Always

2. What I am doing in DEEP gives me new ways of looking at my problem.

Always Very Often Fairly Often Sometimes Seldom

3. I believe_____ likes me.

Seldom Sometimes Fairly Often Very Often Always

4. ___and I collaborate on setting goals for my work in DEEP.

Seldom Sometimes Fairly Often Very Often Always

5. ___and I respect each other.

Always Very Often Fairly Often Sometimes Seldom

6. ___and I are working towards mutually agreed upon goals.

Always Very Often Fairly Often Sometimes Seldom

7. I feel that___appreciates me.

Seldom Sometimes Fairly Often Very Often Always

8. _____ and I agree on what is important for me to work on.

Always Very Often Fairly Often Sometimes Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

Seldom Sometimes Fairly Often Very Often Always

10. I feel that the things I do in DEEP will help me to accomplish the changes that I want.

Always Very Often Fairly Often Sometimes Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

Always Very Often Fairly Often Sometimes Seldom

12. I believe the way we are working with my problem is correct.

Seldom Sometimes Fairly Often Very Often Always

Note: Items copyright © Adam Horvath.

Goal Items: 4, 6, 8, 11
Task Items: 1, 2, 10, 12;
Bond Items: 3, 5, 7, 9

Appendix IV: Service plan (forms folder)

SERVICE PLAN

Date of service plan completion _____

Date of service plan review with client_____

Service period (3 months) _____

Recommended frequency of meetings with BIS for this service period _____

Next review due on _____

	Goals: **General aim in this domain**	**Objectives:** **Measurable, attainable in 3 months or less.** **Include deadline** **Multiple goals possible within one domain**	**% attained by end of service period**	**Rate the intensity of this need (BIS)** 1= not requiring attention 2= requires some attention 3= requires moderate attention 4= requires significant attention 5= requires major attention	**Rate the intensity of this need (Client)** 1= not requiring attention 2= requires some attention 3= requires moderate attention 4= requires significant attention 5= requires major attention
Social skills					
Anxiety					
Trauma					
Leisure,					

work and education					
Critical thinking					
Family/partner issues					
Other Mental health Substance use Housing Medical Other					

I have reviewed this plan and have had the chance to add or remove items and discuss the contents of this plan with my DEEP worker. I agree to meet with my DEEP worker ____ times a week for the next three months. This service plan will be reviewed again on _____.

Participant Signature _____ Date _____

DEEP staff signature _____ Date _____

Appendix V: Encounter form

ENCOUNTER FORM

Participant/person contacted		
DEEP staff/title		
Date		Phone _____ F2F Email_____
Time		
Location		
Type of encounter	Scheduled Unscheduled Crisis Outside provider	
Encounter summary:		
Intervention target addressed (circle all that apply): Social Skills Anxiety Trauma Leisure, work and education		

Critical thinking Family/partner issues Other Mental health Substance use Housing Medical Other		
Risk assessment indicated?	Y N	Why?
Next Steps		
Follow up appointment scheduled for:		

External Referrals

Type	Date	Outcome	Current Status	Referral Contact Information
MH Social skills Trauma specialist Vocational specialist Academic counselor		Accepted Ineligible Px not interested Waitlisted	Attending Not Attending Regularly Completed	

Appendix VI: Behavior change form

BEHAVIOR CHANGE FORM

Participant name
Date of intake
Instructions: For each of the following variables note its status of each for the corresponding time frame following the way it is recorded in the eligibility assessment. If this form is being completed at another time, indicate that in the date field. If there has been no change since the last record, write “no change” in the appropriate field.

Check if this variable was part of the SP	VARIABLE	Intake Date_____	6 months Date_____	1 year Date_____	Graduation Date_____	End of transition Date_____
	Relationship status					
	Housing status					
	Education level (indicate if P has engaged in any activity to further education, even if no degree has been obtained)					

	Employment					
	Children					
	Current outpatient MH treatment					
	Current outpatient MH treatment attendance %					
	Current MH diagnosis (list all MH diagnoses)					
	Current psychotropic medication (iist all prescribed medications)					
	Current adherence to psychotropic medication (%)					
	Medical diagnoses (list all medical diagnoses)					
	DEEP Attendance (% of scheduled appts. attended)					
	CSSRS risk level	High Mod Low	High Mod Low	High Mod Low	High Mod Low	High Mod Low
	LSI-R-SV risk level	High Mod Low	High Mod Low	High Mod Low	High Mod Low	High Mod Low
	VERA-2R risk level	High	High	High	High	High

		Mod Low	Mod Low	Mod Low	Mod Low	Mod Low
	SMAST score					
	DAST score					
	Drug of choice #1 use frequency					
	Drug of choice #2 use frequency					
	Drug of choice #3 use frequency					
	MMS Section A score					
	MMS Section B score					
	MMS Section C score					
	PCL-5 score					
	WAI-SV score					

Appendix VII: Transition summary and plan (forms folder)

TRANSITION/CLOSURE SUMMARY AND PLAN

This form is to be completed once work with BIS has concluded and before work with TS begins or whenever services end, whichever comes first. This form can be filled out twice: once at the point of transition and once at the point of case closure.

Start of Service _____

End of service _____

Reason for transition/closure (circle one):

TRANSITION

- Graduation to transitional phase

CLOSURE

- Successful completion
- Lost to f/u
- Lack of progress/motivation
- Unmanageable Risk
- Criminal justice system opposition
- Other

Describe reason for transition or closure:

Course of services (describe level of service, response to intervention, level of engagement and any other relevant information):

Recommendations for f/u in each domain:

DOMAIN	IDENTIFIED AS NEED IN SP?	AFTERCARE RECOMMENDATION (Objective)	Recommendation followed during transition? (%)
Social skills	Y N		
Anxiety	Y N		
Trauma	Y N		

Leisure, work and education	Y N		
Critical thinking	Y N		
Family/partner issues	Y N		

Other Mental health Substance use Housing Medical Other	Y N		

I have reviewed this plan and understand the recommendations made to me by the DEEP team.

Participant Signature _____ Date _____
DEEP staff signature _____ Date _____
Transition staff signature _____ Date _____