



Virginia Department of  
Behavioral Health &  
Developmental Services

# Recommendations from the Justice Involved Transformation Team

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# History of the Transformation Team Process

- In October 2014 DBHDS Commissioner initiated a transformation process that included a comprehensive review of the state behavioral health and developmental services system.
- This effort focused on access, quality, stewardship of resources, and accountability.
- Process was grounded in the principles of recovery, resiliency, self-determination, and wellness for everyone we serve.
- Ultimate goal is to become a model system and to achieve DBHDS' vision of "A life of possibility for all Virginians".

# The Transformation Process

- Four Transformation Teams – BH, ID, Children & Justice Involved
- Each of the transformation teams analyzed services systems and developed strategic proposals for services, delivery and infrastructure.
- Recommendations from Transformation Teams shared with larger stakeholder group for review and consultation
- Recommendations then shared via a public comment period which included town-hall style meetings.
- The Commissioner will finalize recommendations and present them to legislative committees, task forces (as appropriate) and the State Board of Behavioral Health & Developmental Services.

# Justice Involved Transformation Team Membership

- Michael Schaefer, Ph.D., DBHDS, *Transformation Team Co-chair*  
David Rockwell, HAMHDS, *Transformation Team Co-chair*  
The Hon. Gabe Morgan, Sheriff, City of Newport News  
Evan Nelson, Forensic Psychology Associates, P.C.  
David Keenan, Ed. D, LCP Forensic Evaluator, private practice  
Varun Choudhary, M.D., Magellan Behavioral Health of VA  
Kelly Walker, Blue Ridge CIT/Waynesboro Police Dept.  
Gerald Wistein, Region Ten CSB  
Kathy Tolton-Sendall, Family Member  
Moriah Tolton, Self-Advocate  
Jack Ledden, Dept. of Juvenile Justice  
Hon. Charles E. Poston, Judge (Retired), Norfolk Circuit Court  
Leslie Weisman, Arlington CSB Supervisor  
Angela Torres, Region IV Jail Team Program  
Louis Fox, Henrico Court Evaluation Unit

# Resources Used

- President's New Freedom Commission on Mental Health
- Governor's Taskforce on Improving Mental Health Services & Crisis Response
- Mental Illness in Jails Report (State Compensation Board)
- Office of the State Inspector General – A Review of Mental Health Services in Local & Regional Jails
- DBHDS Creating Opportunities Plan – Forensic Workgroup
- Recommendations from the 1984 Joint Taskforce on the Mentally Ill in Virginia's Jails
- Articles/publications on various national and state promising practices
- Presentation on juvenile court services diversion programs

# What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- General consensus was that to promote quality, access, and continuity of care it would be best if CSBs were the designated provider of services for this population
  - As many individuals are uninsured they often by default will rely on CSB for services post release
  - As recommendations for treatment services are geared towards those with SMI and/or severe impairments CSBs are logical providers of care
  - CSBs exist in all regions of the Commonwealth and serve as part of the safety net thus are well positioned to provide these services
  - CSBs operate the existing jail diversion programs thus are better situated to refer individuals for diversion
  - Having the CSB as the provider of BH services would in part address issues related to inconsistent formularies
  - Having the CSB as the provider of BH services would create natural discharge planning procedures thus decreasing risk of future decompensation/ re-arrest

# What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- There are some significant challenges to having the CSBs as the provider of BH services in jail
  - Sheriff/Jail Administrator has right to chose vendor & often contract for combined medical/ psychiatric services
  - Some CSBs are not staffed sufficiently to manage demand for BH care, let alone medical care
  - Some CSBs have 6-8 jails within their region and it would be extremely difficult to provide staffing in all the various jails/detention centers
  - Lack of staff with technical expertise in working in correctional setting
  - Regional jails provide services to individuals from large catchment area (crossing over many CSB jurisdictions) thus it would be confusing as to which CSB was responsible

# What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- Ultimately Transformation Team agreed that it was best not to dictate provider of jail/detention based services, but instead set minimum standards for services
  - Caveat #1 – Every jail should have at least one staff member who's primary job is to aid in coordinating release planning. General Assembly should fund the creation of these positions.
  - Caveat #2 – Regardless of who is providing BH services in the jail, each CSB should have at least one staff member who's primary responsibility is coordinating release planning for individuals releasing from jail and needing follow up services from the CSB. General Assembly should fund the creation of these positions.



# Services Which Should Be Available to All Individuals Incarcerated/Detained

- Screening (using a validated screening instrument) upon admission for the existence of behavioral health issues by staff qualified/trained to perform screenings
- Screening(both upon admission & during the period of detention/incarceration) for suicide risk conducted by trained/qualified staff
- Mechanisms/policies/practices/resources to refer those who score (+) on behavioral health screen or suicide screen to a trained mental health professional for a more in-depth assessment and when indicated the development of a treatment plan to address the needs.
- Presence of jail/correctional/detention staff who are trained in crises de-escalation and active listening/problem solving skills
- Access to medical care, to include behavioral health care, to address any acute issues which may arise during the period of incarceration/detention.

# Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Admission Behavioral Health Assessment (by qualified/trained staff) conducted within a maximum of 72 hours post screening with indication of potential behavioral health issues
  - Assessment should identify current behavioral health treatment needs
  - Assessment of feasibility for diversion
  - Assessment of needs to decrease risk of re-offense
  - For those identified as being SMI, prompt notification of the CSB as likely these individuals will require significant post-release services
  - For those identified as being at risk to self or others or at risk of harm to self due to inability to care for self, CSB should be immediately contacted to evaluate for need for inpatient care pursuant to §19.2-169.6
- Mechanism for the prompt notification of community treatment providers that client has been arrested and mechanism for the prompt sharing of treatment records from community providers with the jail/detention center treatment provider

# Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Psychiatric Assessment by psychiatrist or psychiatric nurse practitioner or psychiatric physician assistant within 5 days of the Admission Behavioral Health Assessment
  - For those who were prescribed medications in the community – a mechanism to continue those medications until the individual can be seen by the jail mental health provider
  - For those who were prescribed medications in the community – access to those psychotropic medications which have been found to be effective in addressing individual’s behavioral health issues (should the jail mental health provider deem them clinically indicated)
  - For those not prescribed medications in the community – a formulary sufficiently broad to allow the jail/detention center psychiatrist, nurse practitioner, or physician assistant sufficient treatment options for the individual.

# Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Sufficient availability (either live or via telepsychiatry) of psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant to meet both the acute and chronic behavioral health needs of the individuals within the facility.
  - For those experiencing acute issues – access should be no less frequent than once per month
  - For those experiencing chronic issues (who's mental status is at baseline) – access should be no less frequent than once every three months
- Ongoing case management services throughout the period of incarceration/detention
  - CSB should maintain an open case for this population
  - For those not previously opened to the CSB, a case should be opened
  - Frequency/duration of case management will be dependent on individual's needs
  - Caseloads will be determined by acuity of clients served, however, every CSB should have at least one designated staff member who's primary responsibility is case management for those involved in the criminal justice system

# Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Evidenced based treatment (either individual or group)
- Access to jail environment which supports psychiatric/behavioral stability
  - Non-lockdown environment for those who don't require isolation
  - Access to structured activities
  - Ability to interact with staff and peers
  - Environment, which to the degree possible, does not re-traumatize individual
- Prompt access to inpatient psychiatric care (either at a DBHDS facility or a designated facility) when the need arises
- Access to trained forensic peers and/or WRAP facilitators
- Presence of jail/correctional/detention staff that are trained in crises de-escalation, active listening/problem solving skills, and trauma informed care.

# Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Discharge planning services
  - Include application for resumption of benefits
  - Include assistance in locating affordable, safe housing
  - Aftercare appointment for mental health services with strong preference for same day access
  - “Warm” handoff from jail to community treatment provider
    - Care navigator who ensures individual links with community provider
    - Follow up for those who don’t make appointment
    - Treatment summary from jail mental health provider should be given to community provider prior to scheduled follow-up appointment
  - Sufficient supply of discharge medications/scripts to bridge until next appointment
  - Address transportation issues to minimize risk of follow-up no show
  - Funds to purchase services to minimize risk of relapse/ re-offense



# Justice Involved Transformation Team Top Five Recommendations for Criminal Justice Diversion Initiatives

# Recommendations for Diversion

## **#1 Localities should be supported in developing mental health dockets**

- Dockets should include MH, SA, and Veterans
- Need to identify ongoing funding to support dockets
- Need funding to purchase services, for housing, and for transportation

## **#2 There should be a statute in the Code to allow judges to order pre-trial mental health evaluations to aid judges in making bail/bond determinations**

- Will require a Code change
- Will require funding for evaluations
- Need to determine who is qualified to perform these evaluations

## **#3 Judges need to receive education on the Risk Need Responsivity model of risk management. Judges need to better understand the screening process, what the research shows about the positive effect of diverting low-risk offenders, and to be trained in how to use the risk screening as a guide in determining level of supervision**



# Recommendations for Diversion

## **#4 There needs to be an oversight system of evaluators who conduct pre-trial evaluations to ensure the evaluations meet the standard of practice**

- Only those evaluators who meet a minimal standard of practice should be allowed to conduct pre-trial evaluations
- For those evaluators who produce poor evaluations, there needs to be a system of remediation

## **#5 All law enforcement agencies should have Crisis Intervention Team (CIT) programs.**

- There should be CIT and CIT Assessment Sites within reach of every Virginia jurisdiction.
- Police would like a drop-off center where they could bring individuals and then not have to return later, regardless of outcome.
- DBHDS and DCJS should work to educate all chief law enforcement officers about the importance of and benefit of CIT
- Crisis Stabilization Programs should be integrated into the emergency response network and should be expanded to include possible admission of individuals destined for incarceration
- Law enforcement agencies should include guidance on making determination to arrest vs. divert in their written policies and procedures

# Accomplishments in Implementing Recommendations

- HB 582 created oversight system of pre-trial evaluations
- HB645/ SB342 improve communication between courts and mental health evaluators/providers
- HB543/SB566 designed to remove barriers to access to inpatient psychiatric care for inmates
- 2016 Appropriation tasks DBHDS with studying and making recommendations about Behavioral Health Dockets
- 2016 Appropriation funds pilot behavioral health projects in jails
  - Criteria for eligibility reflects many of the recommendations from the transformation team
  - DBHDS has been partnering with DCJS on solicitation

# Accomplishments in Implementing Recommendations

- 2016 Appropriation included increased funding for Outpatient Competency Restoration services
- 2016 Appropriation included increased funding to aid in discharge planning for NGRI patients in state hospitals
- 2016 Appropriation included funding for permanent supportive housing – some of which will be targeted to justice involved individuals
- Center for Behavioral Health & Justice convened statewide Summit in March 2016
- DBHDS has directed CSBs/Regions to include forensic clients in their admission protocols
- DBHDS is developing guidance document for jail staff on how to access emergency psychiatric services for inmates in need (anticipate distribution August 2016)

# Accomplishments in Implementing Recommendations

- DBHDS & VACOC facilitated an MOU with every CSB on discharge planning for individuals with behavioral health issues.
- DBHDS will be sponsoring a Risk Need Responsivity Training/Conference in Fall 2016
- DBHDS and DCJS continue to serve as lead agencies to support the development and expansion of CIT across the Commonwealth
  - Currently there are 36 CIT Teams (several are multijurisdictional) – often follow CSB catchment area boundaries
  - Currently there are 32 GF funded CIT assessment Sites
  - DBHDS will announce award to four new assessment sites later this week