



Briefing to SJ 47 – Criminal Justice Sub November 5, 2018

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IMPLEMENTATION OF FUNDING FROM 2018 SESSION

Item 312 of Biennial Budget

- T.2. Out of this appropriation, \$900,000 the first year and \$1,800,000 the second year from the general fund is provided for grants to establish Crisis Intervention assessment centers in six unserved rural communities.
- T.3. Out of this appropriation, \$657,648 the first year and \$657,648 the second year from the general fund is provided for grants to establish CIT training programs in six rural communities.

Item 312 of Biennial Budget

- MM. Out of this appropriation, \$1,600,000 the first year and \$1,600,000 the second year from the general fund is provided for discharge planning at jails for individuals with serious mental illness. Funding shall be used to create staff positions in Community Services Boards and will be implemented at two jails with a high percentage of inmates with serious mental illness.
- NN. Out of this appropriation, \$708,663 the first year and \$708,663 the second year from the general fund is provided to establish an Intercept 2 diversion program in up to three rural communities. The funding shall be used for staffing and to provide access to treatment services.

CIT Funding

- DBHDS issued Notice of Funding to all CSBs with rural jurisdictions who lacked CIT/ CIT assessment sites
- Five CSBs applied for funding – Northwestern, Alleghany-Highlands, Crossroads, Highlands, and Planning District 1
- Multidisciplinary Panel has reviewed applications
 - Overall, applications were relatively weak and demonstrated need for greater technical assistance
 - Jurisdictions varied in their understanding of CIT/ CIT assessment sites
 - Budgets were not very realistic or aligned with what other programs need to operate
 - DBHDS is currently providing further guidance/ technical assistance

Forensic Discharge Planning

- DBHDS issued notice of availability of funds to the CSBs who are associated with the five jails with the highest proportion of SMI
- Several CSBs submitted joint proposals with one CSB serving as fiscal agent for project
- The following programs were selected:
 - Hampton Roads Regional Jail – Chesapeake CSB as fiscal agent with Norfolk, HNN, Portsmouth, and Chesapeake CSB providing services
 - Southwestern Virginia Regional Jail Authority – Highlands CSB as fiscal agent with PD1, Cumberland Mountain, Mount Rogers, and Dickenson Co CSB providing services

Rural Intercept II Diversion Programs

- DBHDS issued notice of availability of funds to all CSBs who serve rural jurisdictions (as defined by CMS)
- Four CSBs applied
- Two programs were selected for funding
 - Northwestern CSB
 - Mount Rogers CSB
- Still have enough funds for one more program so are seeking more applications.

UPDATE ON MENTAL HEALTH DOCKETS

Mental Health Dockets

- Designed to quickly identify and treat individuals involved in the criminal justice system
- In Virginia, dockets are post plea
- Function within the existing court structure with goal of identifying and addressing mental health issues which contributed to involvement in the criminal justice system
- Participation in voluntary
- Frequent hearing before judge to assess progress, reinforce progress and address non-compliance
- Commonwealth Attorney must agree to allow defendant to be placed on docket

Why are Dockets Created?

- Research has shown an over-representation of individuals with serious mental illness in the criminal justice system
- Goals of Docket are:
 - Increase public safety by addressing factors which caused involvement in criminal justice system
 - Increased treatment engagement
 - Decreased criminal recidivism
 - Decreased use of crisis system
 - Improved quality of life
 - Decreased overall costs to the community

National Research Outcomes of MH Courts

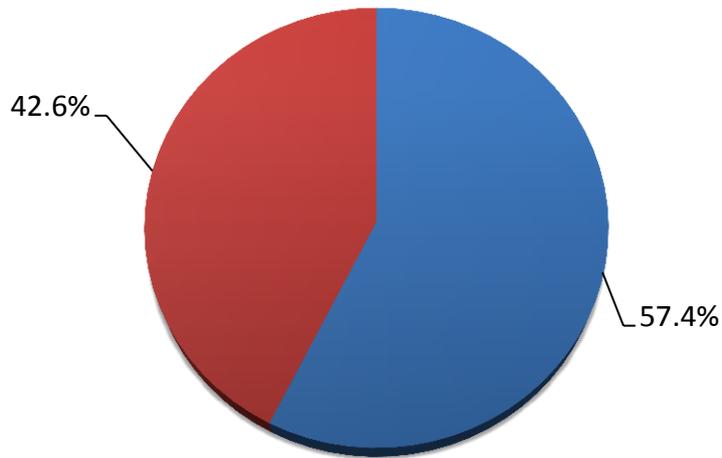
- Participants in mental health courts less likely to incur new charges post participation in MH court
- For those who did re-offend, they do so much later than non-participants
- Participants incurred few arrests post- participation than their pre-participation arrest rate
- Recidivism rate of 10- 15%
- Accessed treatment more rapidly and high participation rates
- Received more intensive services
- Few crises episodes
- Results related to cost savings are mixed

Specialty Dockets in Virginia

- Rule 1:25 of the Supreme Court of Virginia allowed for the establishment of specialty dockets (Effective Jan 16, 2017)
- DBHDS received a federal grant to support dockets in October 2015
- Began funding dockets in Roanoke/Salem and Staunton/Augusta in 2016
- Federal funding ended in September 2018
- Enrolled Participants (N=155) FY17-FY18

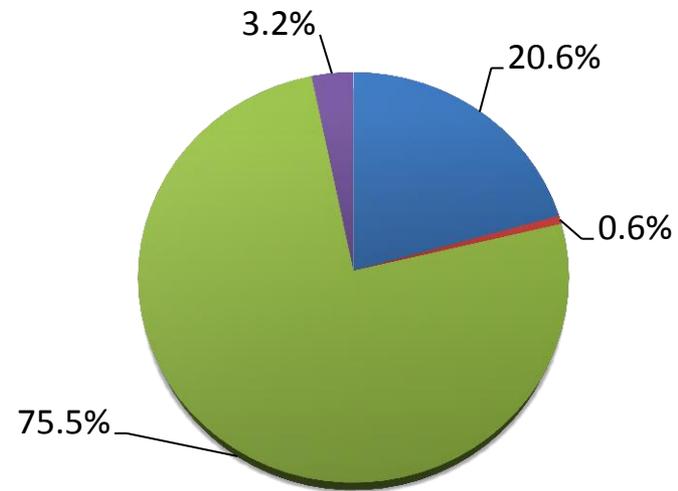
Race and Gender

Gender



■ Male ■ female

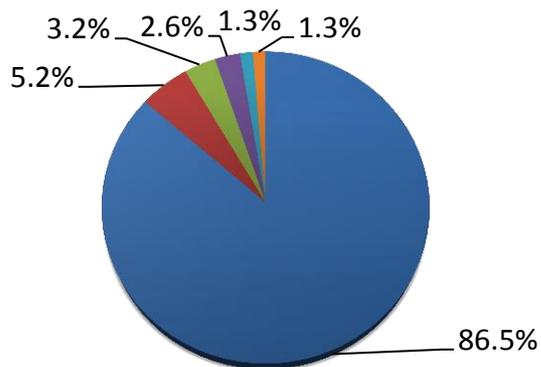
Race



■ African American ■ Asian ■ Caucasian ■ Other

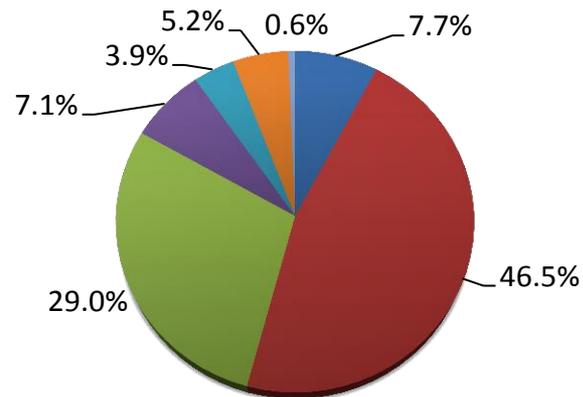
Referral Source and Charges

Referral Source



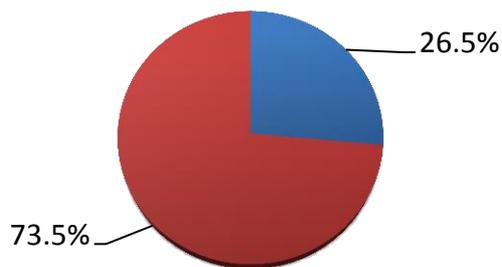
- Docket Judge
- Probation/Pretrial
- Private Attorney
- Public defender

Charge Categories



- Minor
- Violent
- Property
- Drug
- Other
- Potentially Violent
- Sex

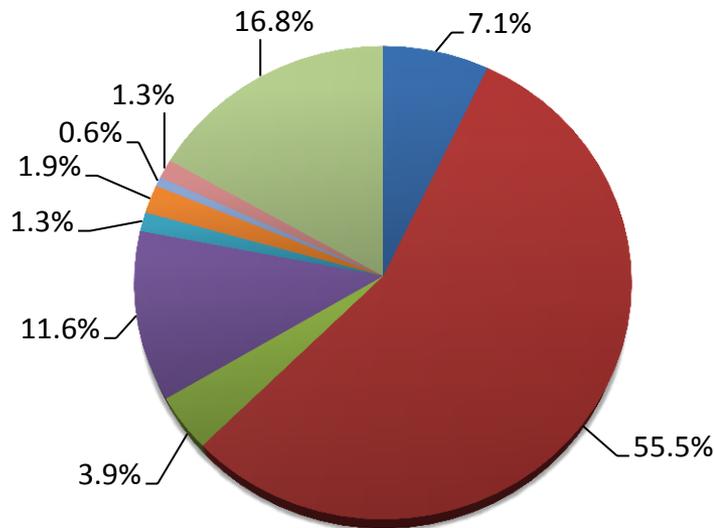
Charge Type



- Felony
- Misdemeanor

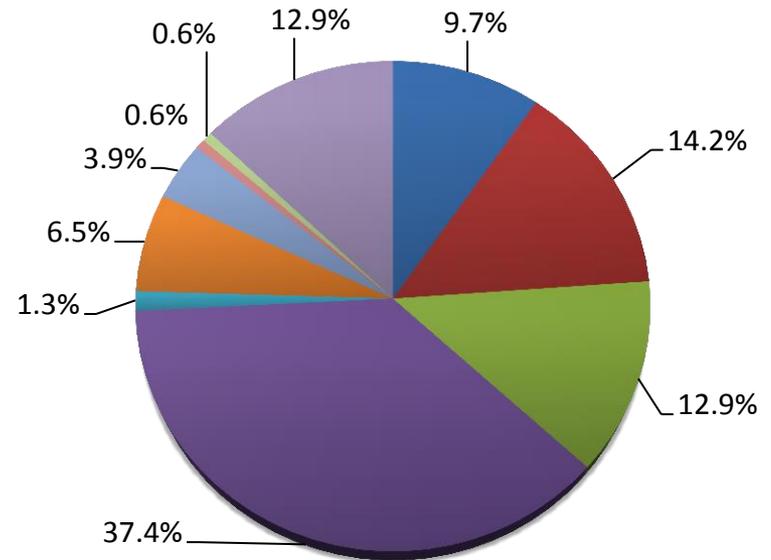
Primary and Secondary Diagnosis

Primary Diagnosis



- Anxiety Disorder
- Mood Disorder
- Other mental disorder
- Substance Use Disorder
- Adjustment Disorder
- Intellectual/Developmental Disability
- Personality Disorder
- Impulse Control Disorder
- Psychotic Disorder

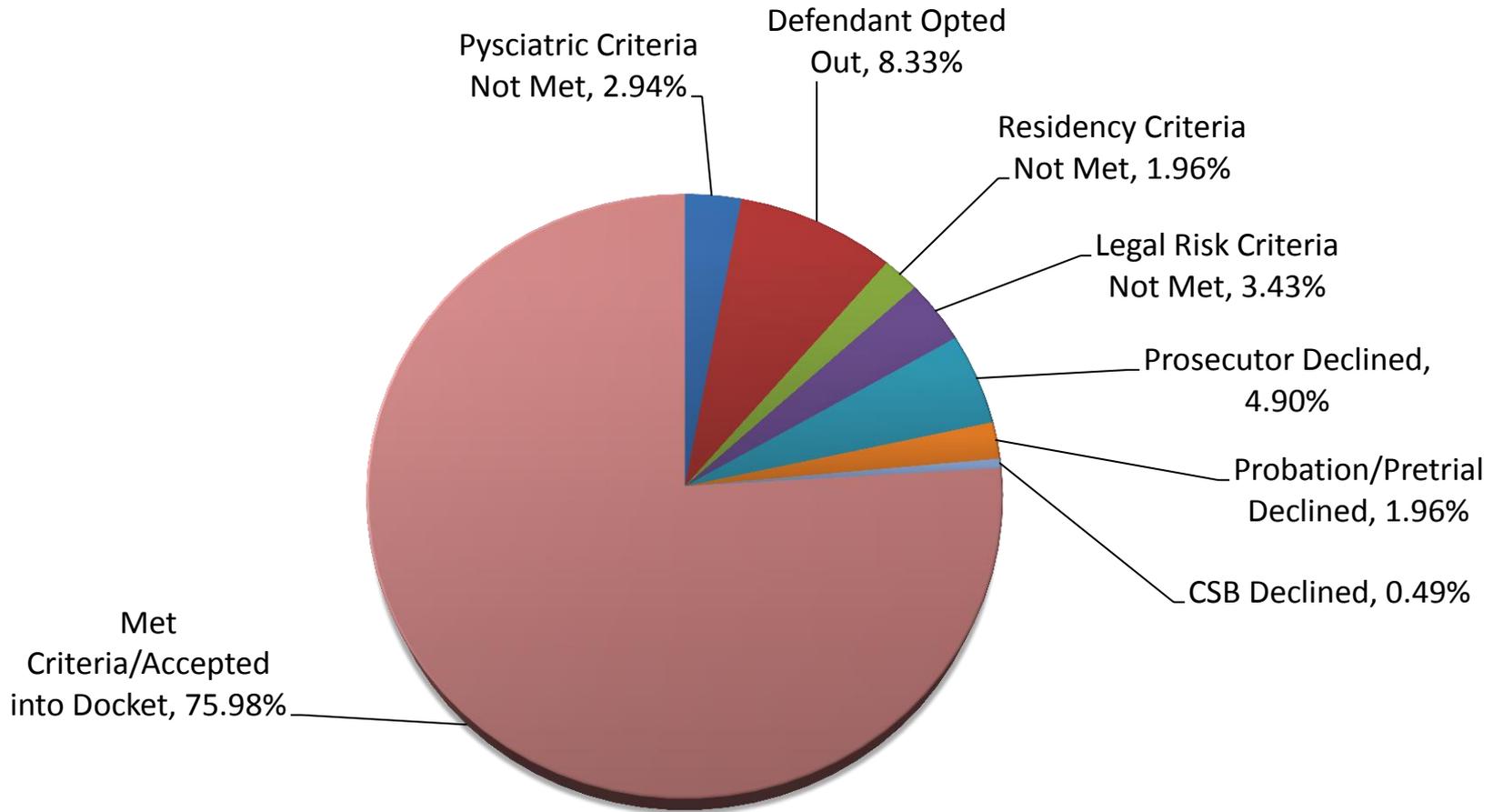
Secondary Diagnosis



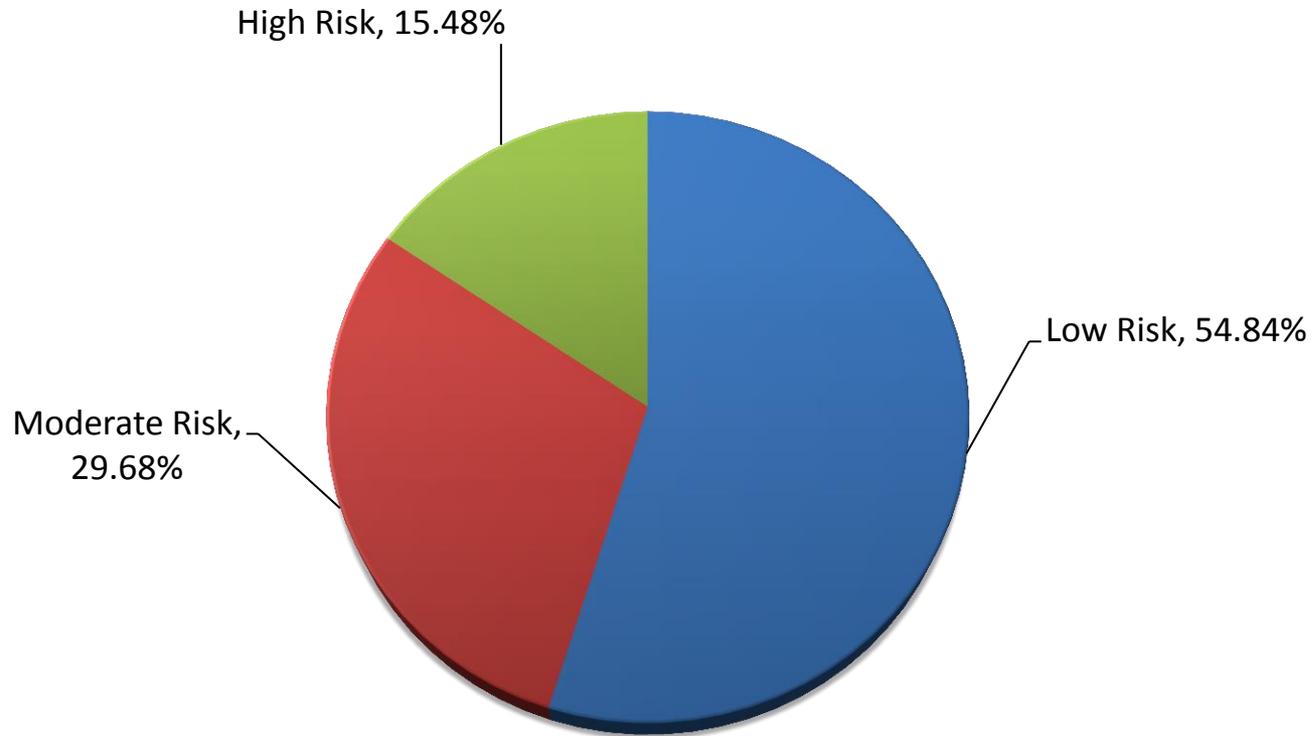
- Anxiety Disorder
- Mood Disorder
- Other Mental Disorder
- Substance Use Disorder
- Adjustment Disorder
- Intellectual/Developmental Disability
- Personality Disorder
- Impulse Control Disorder
- Pyschotic Disorder
- None

Screening for Eligibility

76% of those screened met criteria and were enrolled in the dockets



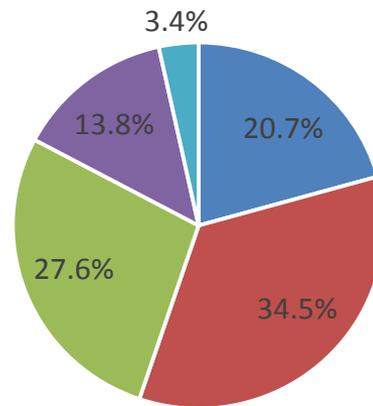
Criminogenic Risk Level



Pre-arrests

- Of the 155 docket participants, 29 had previous arrest data *prior to their MH Docket enrollment (18.7%)*

Pre docket Charges

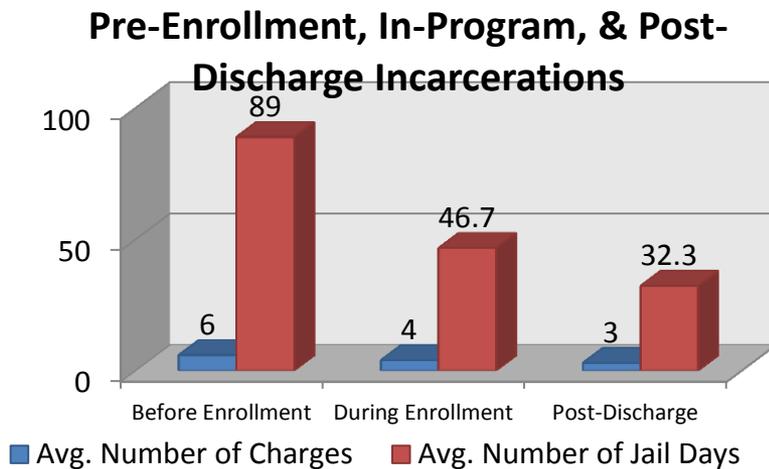


■ Minor ■ Property ■ Violent ■ Drug ■ Other

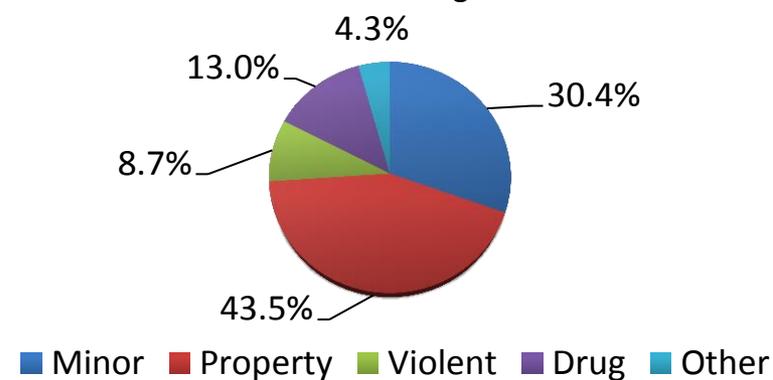
Arrests Before, During, After Enrollment

Of the 65 docket participants to complete the docket program:

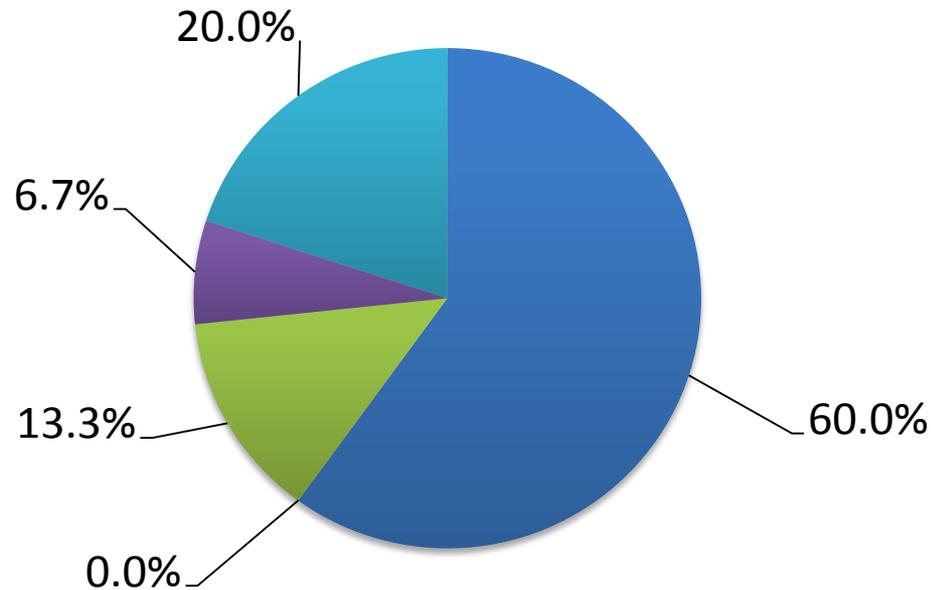
- **20%** had arrest data before enrollment
- **14%** had arrest data during enrollment
- **9%** had arrest data after program discharge.



Charge Types for In-Program and Post-Discharge Re-Offending



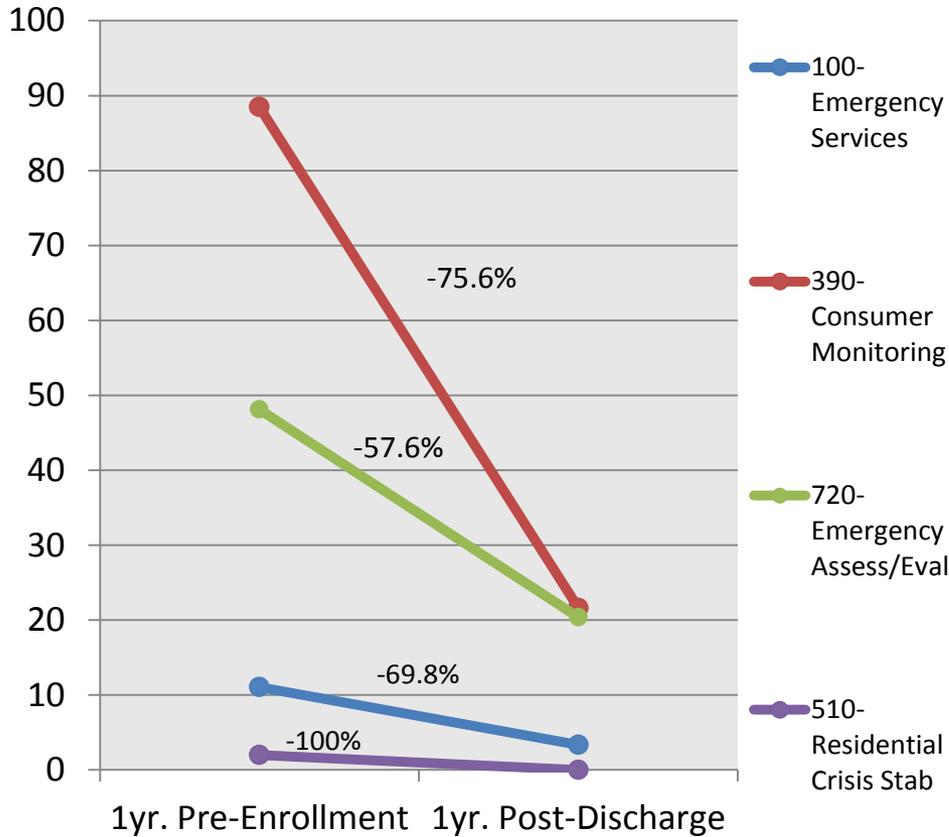
Time from Enrollment to Re-Arrest



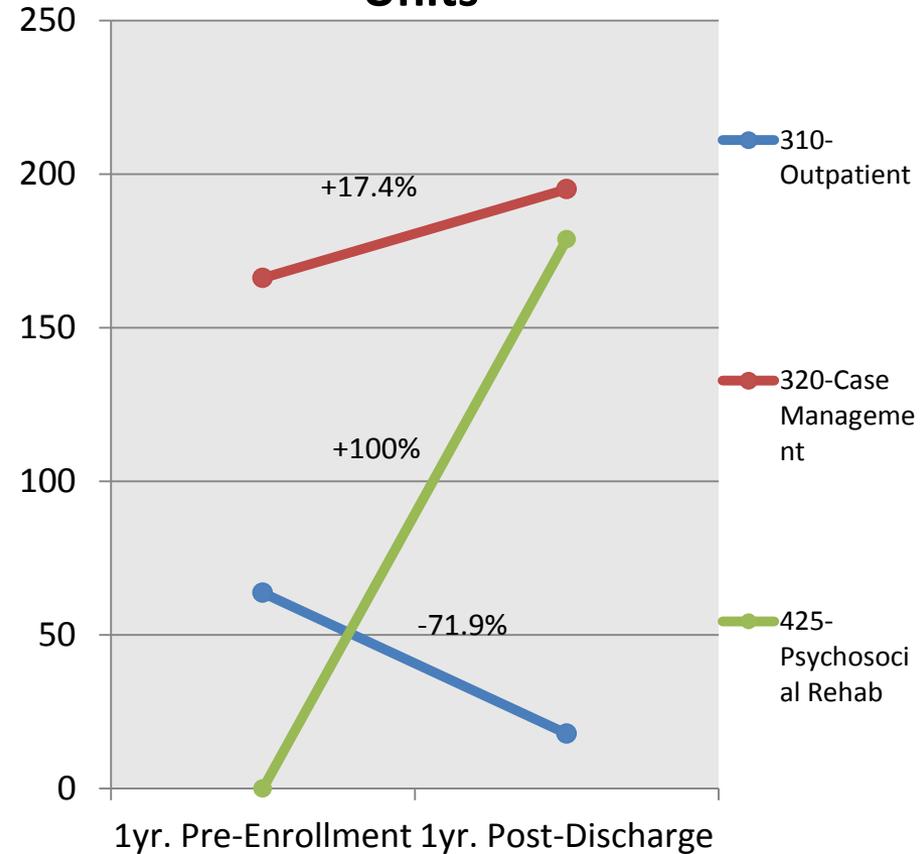
- In-docket
- 0-30 days post-docket
- 30-90 days post-docket
- 90-180 days post-docket
- 180+

Clinical Service Utilization (Discharged Participants Only, N=65)

Crisis Service Utilization Units

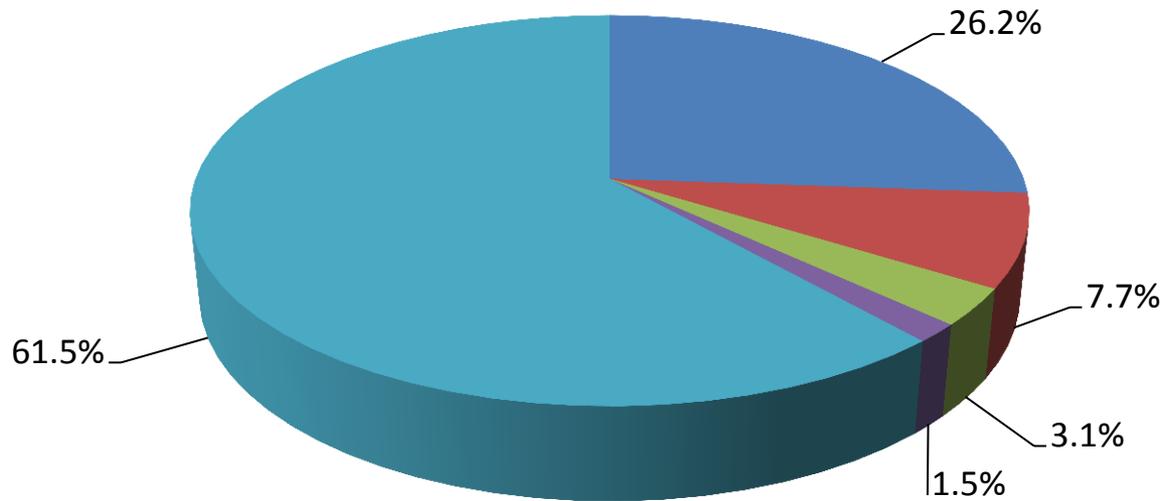


Non-Crisis Service Utilization Units



Discharge from Docket (N=65)

Discharge Reason



■ Lack of Participation ■ New Criminal Involvement ■ Death ■ Absconding ■ Successful Completion

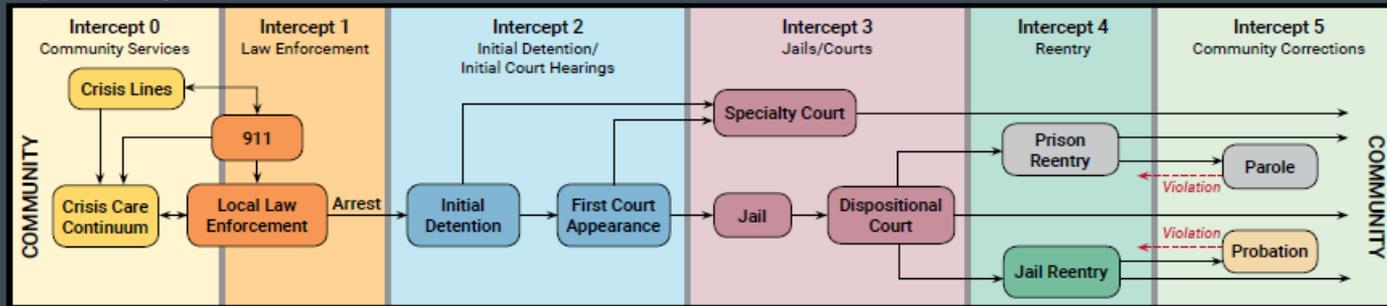
- Average Length of Time in Program = 371 days
- Range = 0 to 965
- Median = 344 days

Intercept 0

- The Sequential Intercept Model Identifies 6 intercepts across the criminal justice continuum
- Intercepts are places where you can divert/deflect individuals from the criminal justice system or ensure better linkages to services
- The deeper an individual penetrates into the criminal justice system the more difficult it is to have a positive impact
- Not everyone can/should be diverted, thus it is also important to ensure access to services for those unable to be diverted

The Sequential Intercept Model

The Sequential Intercept Model



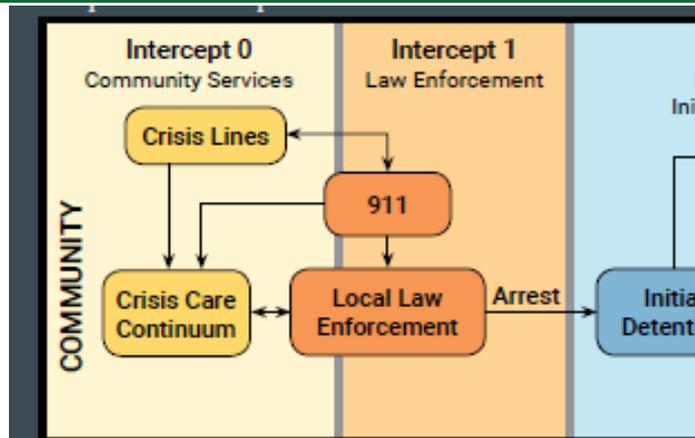
Key Issues at Each Intercept

Intercept 0	Intercept 1	Intercept 2	Intercept 3	Intercept 4	Intercept 5
<p>Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a behavioral health crisis or co-respond to a police encounter.</p> <p>Emergency Department diversion. Emergency Department (ED) diversion can consist of a triage service, embedded mobile crisis, or a peer specialist who provides support to people in crisis.</p> <p>Police-friendly crisis services. Police officers can bring people in crisis to locations other than jail or the ED, such as stabilization units, walk-in services, or respite.</p>	<p>Dispatcher training. Dispatchers can identify behavioral health crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.</p> <p>Specialized police responses. Police officers can learn how to interact with individuals experiencing a behavioral health crisis and build partnerships between law enforcement and the community.</p> <p>Intervening with super-utilizers and providing follow-up after the crisis. Police officers, crisis services, and hospitals can reduce super-utilizers of 911 and ED services through specialized responses.</p>	<p>Screening for mental and substance use disorders. Brief screens can be administered universally by non-clinical staff at jail booking, police holding cells, court lock ups, and prior to the first court appearance.</p> <p>Data matching initiatives between the jail and community-based behavioral health providers.</p> <p>Pretrial supervision and diversion services to reduce episodes of incarceration. Risk-based pre-trial services can reduce incarceration of defendants with low risk of criminal behavior or failure to appear in court.</p>	<p>Treatment courts for high-risk/high-need individuals. Treatment courts or specialized dockets can be developed, examples of which include adult drug courts, mental health courts, and veterans treatment courts.</p> <p>Jail-based programming and health care services. Jail health care providers are constitutionally required to provide behavioral health and medical services to detainees needing treatment.</p> <p>Collaboration with the Veterans Justice Outreach specialist from the Veterans Health Administration.</p>	<p>Transition planning by the jail or in-reach providers. Transition planning improves reentry outcomes by organizing services around an individual's needs in advance of release.</p> <p>Medication and prescription access upon release from jail or prison. Inmates should be provided with a minimum of 30 days medication at release and have prescriptions in hand upon release.</p> <p>Warm hand-offs from corrections to providers increases engagement in services. Case managers that pick an individual up and transport them directly to services will increase positive outcomes.</p>	<p>Specialized community supervision caseloads of people with mental disorders.</p> <p>Medication-assisted treatment for substance use disorders. Medication-assisted treatment approaches can reduce relapse episodes and overdoses among individuals returning from detention.</p> <p>Access to recovery supports, benefits, housing, and competitive employment. Housing and employment are as important to justice-involved individuals as access to behavioral health services. Removing criminal justice-specific barriers to access is critical.</p>

Best Practices Across the Intercepts

<p>Cross-systems collaboration and coordination of initiatives. Coordinating bodies improve outcomes through the development of community buy-in, identification of priorities and funding streams, and as an accountability mechanism.</p>	<p>Routine identification of people with mental and substance use disorders. Individuals with mental and substance use disorders should be identified through routine administration of validated, brief screening instruments and follow-up assessment as warranted.</p>	<p>Access to treatment for mental and substance use disorders. Justice-involved people with mental and substance use disorders should have access to individualized behavioral health services, including integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.</p>	<p>Linkage to benefits to support treatment success, including Medicaid and Social Security. People in the justice system routinely lack access to health care coverage. Practices such as jail Medicaid suspension vs. termination and benefits specialists can reduce treatment gaps. People with disabilities may qualify for limited income support from Social Security.</p>	<p>Information-sharing and performance measurement among behavioral health, criminal justice, and housing/homelessness providers. Information-sharing practices can assist communities in identifying super-utilizers, provide an understanding of the population and its specific needs, and identify gaps in the system.</p>
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Intercept 0



Key Issues at Each Intercept

Intercept 0

Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a behavioral health crisis or co-respond to a police encounter.

Emergency Department diversion. Emergency Department (ED) diversion can consist of a triage service, embedded mobile crisis, or a peer specialist who provides support to people in crisis.

Police-friendly crisis services. Police officers can bring people in crisis to locations other than jail or the ED, such as stabilization units, walk-in services, or respite.

Intercept 1

Dispatcher training. Dispatchers can identify behavioral health crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.

Specialized police responses. Police officers can learn how to interact with individuals experiencing a behavioral health crisis and build partnerships between law enforcement and the community.

Intervening with super-utilizers and providing follow-up after the crisis. Police officers, crisis services, and hospitals can reduce super-utilizers of 911 and ED services through specialized responses.

Best Practices Across the Intercepts



Cross-systems collaboration and coordination of initiatives. Coordinating bodies improve outcomes through the development of community buy-in, identification of priorities and funding streams, and as an accountability mechanism.



Routine identification of mental and substance use disorders. Individuals with mental and substance use disorders should be identified through routine administrative validated, brief screening and follow-up assessment warranted.

Intercept 0

IMPLEMENTING INTERCEPT 0



CRISIS RESPONSE

Crisis response models provide short-term help to individuals who are experiencing behavioral health crisis and can divert individuals from the criminal justice system.

Crisis response models include:

- Certified Community Behavioral Health Clinics
- Crisis Care Teams
- Crisis Response Centers
- Mobile Crisis Teams



POLICE STRATEGIES

Proactive police response with disadvantaged and vulnerable populations are a unique method of diverting individuals from the criminal justice system. Proactive police response models include:

- Crisis Intervention Teams
- Homeless Outreach Teams
- Serial Inebriate Programs
- Systemwide Mental Assessment Response Teams

Intercept “0” in Virginia

- Having a well funded, streamlined BH system where individuals can access the full continuum of evidenced based care, when they need, where they need is the ultimate Intercept “0”
- Building out STEP-VA is building out Intercept 0 by providing same day access and bolstering the scope of services is helping to build out Intercept 0
- Examples of specialized Intercept 0 programs
 - Henrico County STAR program
 - Alexandria