Report of the Criminal Justice Diversion Expert Panel

Recommendations for Criminal Justice Diversion in Rural Virginia Communities

To the Criminal Justice Diversion Workgroup of the General Assembly's Joint Subcommittee to Study Mental Health Services in the 21st Century

November 2017

Criminal Justice Diversion Expert Panel Members

Leslie Weisman
Expert Panel Chair
Client Services Entry Bureau Chief
Arlington Community Services Board

Heather Zelle
Expert Panel Vice Chair
Assistant Professor, UVa Department of Public Health Sciences
Clinical Psychologist, UVa Inst. of Law, Psychiatry, & Public Policy

Steve Austin
Director of the Office of Criminal Justice Services
Prince William County

Jana Braswell
Coordinator, Center for Behavioral Health & Justice
Department of Behavioral Health and Developmental Services

Pete Earley
Author and Advocate

Lori Galbraith
Chief Deputy Commonwealth's Attorney
City of Chesapeake

Patrick Halpern
CIT Coordinator
New River Valley Community Services

Anne Metz
Research Specialist
UVa Inst. of Law, Psychiatry, & Public Policy

Gabriel (Gabe) Morgan, Sr.
Sheriff
City of Newport News

Allison Redlich
Professor
Department of Criminology, Law, and Society
George Mason University

Caitlin Reynolds-Vivanco
Senior Trial Attorney
Martinsville Public Defender's Office

Robert Trestman
Professor and Chair of Psychiatry
Carilion Clinic and VTC School of Medicine

Tanisha Trice
Certified Peer Recovery Specialist
Emergency Services
Arlington Community Services Board

Amy Woolard
Senior Policy Attorney
Voices for Virginia's Children

Recommendations for Criminal Justice Diversion in Rural Virginia Communities

Table of Contents

Executive Summary

In 2016, the Joint Subcommittee to Study Mental Health Services in the 21st Century established four workgroups to focus on specific domains of mental health services in Virginia. Four parallel "expert panels" were simultaneously established to support each workgroup. The Criminal Justice Diversion Expert Panel was thus established to aid the Criminal Justice Diversion Workgroup. Following the 2017 General Assembly session, the Criminal Justice Diversion Workgroup expressed an interest in identifying ways to improve diversion activities at early stages of criminal justice-mental health intersection, with a particular focus on Intercept 1 (law enforcement) and Intercept 2 (initial detention and court hearings) diversion in rural communities.

The Expert Panel identified several rural jurisdictions that lacked diversion programs, as well as two largely rural jurisdictions that have established successful diversion programs. Panel members reviewed existing material on criminal justice diversion efforts in Virginia and spoke with experts familiar with the history (or lack of history) of efforts in the struggling rural jurisdictions. The Panel also reviewed relevant literature and applied its members' own expertise to identify relevant considerations for implementing diversion programs in rural jurisdictions. The Panel thus identified target communities and key considerations for implementing criminal justice diversion in such communities.

Key considerations identified by the Panel include the establishment of stakeholder groups and the need for comprehensive and ongoing funding. Stakeholder groups are vital to the success of diversion programs for several reasons, including a) fostering appreciation for the unique perspectives and challenges of criminal justice, mental health, and the intersection of the two, b) sharing ownership of problems and the need for intervention, c) combining resources to produce sustainable programs, and d) maintaining a clear mission and engagement of partners.

The Expert Panel strongly supports providing funding for Intercepts 1 and 2 diversion programs *only to those rural localities that have thus far struggled to implement such programs*. To that end, the Panel makes the following recommendations:

- Intercept 1
    - Funding for CIT training, including funding to cover overtime in small law enforcement agencies to backfill on-duty positions while officers are in training; and
    - Funding for CIT Assessment Centers.
- Intercept 2
    - Funding for initial detention and/or initial court hearing diversion programs; and
    - Suggested components for the design of such programs.

The Panel derived cost estimates from existing programs in largely rural localities, and calculated funding for three-year periods. However, the Panel also recommends that funding for the programs be ongoing, as previous grant-based funding in some of the targeted jurisdictions was clearly insufficient for establishing sustainable diversion programs. Notably, diversion programs that achieve sustainability may ultimately subsume at least some of the costs of the programs into stakeholder partners' existing budgets.

Panel Process

The Expert Panel is comprised of a variety of members representing diverse areas of expertise, including a majority of members who are mental health care providers or criminal justice partners, as well as a few scholars. Importantly, members represent a variety of community types from across the Commonwealth.

Already well-versed in the relevant literature, the Expert Panel devised a strategy to review Virginia-specific material, identify rural communities that had lagged behind other communities in successfully implementing diversion programs, and prepare targeted recommendations for the Criminal Justice Diversion Workgroup's consideration.

The Expert Panel reviewed material about the state of Cross Systems Mapping that was co-administered by the Department of Criminal Justice Services (DCJS) and the Department of Behavioral Health and Developmental Services (DBHDS)[i] and spoke with relevant DBHDS personnel (i.e., the Statewide Diversion Program Coordinator, the Statewide CIT and CIT Assessment Site Coordinator) to identify rural localities that were apparently lacking in diversion programs. Discussion with the DBHDS staff also helped to identify impediments that had undermined efforts in those localities. The Expert Panel cross-validated the information with its own members who were familiar with the latest developments in localities.

The Expert Panel further discussed potential barriers to program implementation, as well as potential shortcomings of some implementation strategies or program designs given the rural and/or low-resourced nature of the targeted communities. The Panel agreed that flexibility will be needed in any efforts to encourage diversion programs because locality strengths and shortcomings must be taken into consideration. For this reason, the Panel determined that it would make recommendations for both Intercept 1 and Intercept 2 programs, as some communities may be readier to implement one more than the other. Further, the Panel determined that its recommendations for Intercept 2 programs would need to allow for flexibility in program design because of variations in localities (whereas Intercept 1 CIT training and CIT Assessment Centers have been shown to be practicable and should be relatively well-defined in any recommendations).

The Expert Panel also identified two successful rural localities during those conversations. It obtained details about the design and funding of the successful programs through the help of one member who is involved in a successful rural program, and by dispatching another member to meet with leaders from the other successful program. In addition, a third panel member arranged conversations with law enforcement from several rural localities in southwest Virginia. This tack was undertaken because the Panel did not want to proceed on the basis of presumptions about rural law enforcement offices' perceptions of diversion programs.

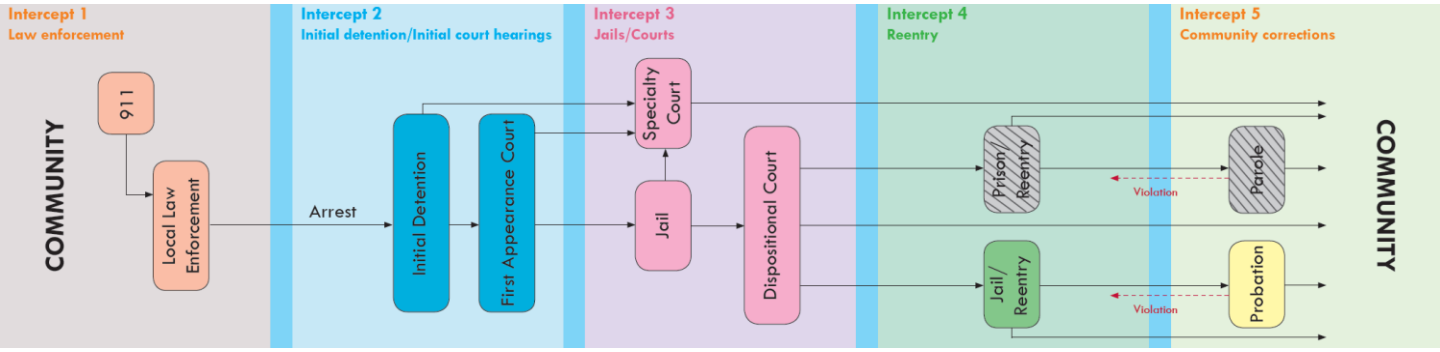
Given the availability of Virginia-specific information, as well as established best practices in the field, the Panel was able to reach the recommendations made in this report. Nevertheless, the Panel also gleaned a need for additional attention to rural jurisdictions that have struggled because such communities have unique impediments to establishing diversion programs and best practices have largely been established based on better-resourced localities. The Panel therefore

plans to, over the coming year, undertake needs/readiness assessments in rural, low-resourced communities to further identify points for intervention. To be clear, the Panel's recommendations in this report are not premature because there are many points at which diversion programs may be established and lack of readiness in one area does not necessitate lack of readiness in another. The urgency of the need for diversion requires providing funding for programs that can be feasibly undertaken now while simultaneously examining other points of intervention that appear to be especially difficult for localities.

Brief Review of Relevant Background Information Regarding Criminal Justice Diversion of Individuals with Mental Illness

Sequential Intercept Model

The Sequential Intercept Model is a framework used to assist communities in reviewing when, where, and how the mental health system and criminal justice system intersect. It was developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D., in conjunction with the National GAINS Center for People with Co-occurring Disorders in the Justice System.[ii] The Model begins with the premise that people with mental health disorders should not "penetrate" the criminal justice system by virtue of their mental illness. To that end, the Sequential Intercept Model envisions strategic thinking and innovative programming for diversion of people with mental health disorders from the criminal justice system at "intercept" points. The model describes five intercepts: 1) law enforcement and emergency services; 2) initial detention and initial hearings; 3) jails, courts, forensic evaluations and forensic commitments; 4) reentry from jails, state prisons, and forensic hospitalizations; and 5) community corrections and community support. The ultimate goal is to identify gaps and opportunities across each intercept to improve the rates of early identification, diversion, and linkage to appropriate treatments and supports at the earliest possible juncture in order to avoid or reduce involvement in the criminal justice system when it is appropriate to do so for individuals with behavioral health disorders *The Panel's recommendations concentrate on Intercept One, law enforcement and emergency services, and Intercept Two, initial detention and initial hearings.*



CMHS National GAINS Center. "Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model." Delmar, NY: Author.

Stakeholder Groups

In communities across Virginia, developing and successfully maintaining a highly functioning stakeholder team has been critical in problem solving for both criminal justice and mental health issues. *In order to make meaningful and sustainable impacts, it is crucial that stakeholders invest the time to become aware of problems, understand roles and responsibilities of each stakeholder, and the impact that agencies, organizations, and citizens can have when addressing the needs of individuals identified with mental illness.*

Since 2008, the majority of communities in Virginia have participated in "Cross System Mapping," an initiative co-administered by the Department of Criminal Justice Services (DCJS) and the Department of Behavioral Health and Developmental Services (DBHDS). Based on the Sequential Intercept Model (SIM), Cross System Mapping provides an opportunity to identify the community's resources and gaps, and to develop an action plan to guide stakeholders. This initiative in Virginia provided an opportunity for communities, with assistance from facilitators, to invite criminal justice and behavioral health stakeholders, as well as consumers and advocates, to spend time together mapping their local system. For many communities, this was the launching point for successful collaboration resulting in partnerships that address the intersection of criminal justice and mental health at all points of the Sequential Intercept Model. These stakeholder groups have developed initiatives including crisis intervention teams, mobile crisis teams, crisis assessment centers, post-arrest diversion, specialized jail treatment services, mental health dockets, and re-entry services.

In order to be high functioning and successful, stakeholder teams should develop and maintain a clear mission and engage in continuous collaborative strategic planning across the Intercepts. Doing so can also help overcome differences in perspective that often occur between mental health professionals and criminal justice professionals, which might otherwise reify the status quo and undermine attempts at finding successful solutions. Stakeholder teams should meet regularly and include critical stakeholders from criminal justice, behavioral health, and the community. These members often include judges, magistrates, Commonwealth's Attorneys, public defenders/defense bar associations, jails, probation, pretrial, family members, consumers, and advocates. In addition, they should include organizations such as the National Alliance on Mental Illness (NAMI), Community Services Board staff, and other community treatment providers.[iii,iv]

In April 2017, the Criminal Justice Diversion Expert Panel surveyed Virginia communities about the existence of criminal justice-behavioral health stakeholder groups in their community. Surveys were distributed via CSBs, and 31 of 40 localities responded. Of those, 87% reported that their communities have a criminal justice and mental health stakeholder team. Of those stakeholder teams, over 70% reported that their teams provided monitoring or oversight to the local criminal justice and behavior health initiatives. Additionally, 100% of the respondents believed their teams had benefitted their local criminal justice and mental health systems by focusing their work on problem solving, collaboration, and improving responses to individuals with mental illness who become involved in the criminal justice system. Localities with successful criminal justice and behavioral health collaboration indicated that proactive teams were the catalyst for important initiatives and change.

Notably, in localities that have struggled to implement diversion, only 33% of those responding reported having a criminal justice and mental health stakeholder team and that prevalence would likely be lower if all struggling jurisdictions had responded. What is more, the membership of the groups was not as comprehensive, with one respondent reporting that there is still some limited buy-in from certain representatives and another reporting that more law enforcement initiative was needed. In terms of what the groups were focused on, both noted that funding/sustainability is a current focus.

Jail Diversion Expansion for Rural Virginia Communities: Intercept 1 Recommendations

Review of Relevant Research and Background

Crisis Intervention Team Programs

Crisis Intervention Team (CIT) programs are recognized as a best practice model for law enforcement intervention for individuals experiencing a behavioral health crisis.[v] CIT is a community collaborative approach to safely and effectively address the needs of individuals in behavioral health crisis, provide linkage to services, and divert them from incarceration, if appropriate. The Commonwealth of Virginia has experienced remarkable success with the development and expansion of CIT programs. Over the past 15 years, Virginia has become recognized as a national leader in the development and support of CIT programs within the Commonwealth.[vi] What is more, Virginia is home to what is considered the first rural, multijurisdictional CIT program in the nation, New River Valley CIT.[vii] As of October 2017, 36 of 40 Virginia Community Services Boards, in collaboration with law enforcement and other community partners, have successfully developed CIT programs. Despite this widespread success and acclaim, several rural communities in western, southwestern and central Virginia have not been as successful with the adoption of CIT in their communities.

A CIT Assessment Site is a non-criminal justice setting where persons in behavioral health crisis can be taken by law enforcement officers in lieu of arrest or incarceration. The Assessment Site is designed to enable police officers or sheriff's deputies to take a person experiencing a behavioral health crisis to the site for mental health assessment and connection to services, so that officers may quickly return to their public safety duties. Individuals transported to a CIT Assessment Site are often in the officer's care under an Emergency Custody Order (ECO) for their own safety, and must remain in custody until assessed and treated. This process of assessment while in custody has historically kept law enforcement officers away from other law enforcement duties for lengthy periods of time. The Assessment Sites allow for the best and fastest outcome for the mental health consumer and quick return of officers to their public safety law enforcement duties. The Commonwealth's General Assembly supports the operation of 37 CIT Assessment Sites across 33 Community Services Boards.

Response to behavioral health crises in rural Virginia communities is often challenging because of the lack of services and the great distance that must be travelled for evaluation and

hospitalization. For law enforcement in rural, far-southwest Virginia, for instance, involvement in mental health crises can be extraordinarily time consuming. Without a CIT program and associated CIT Assessment Site, law enforcement officers must maintain custody of individuals who are subject to an emergency custody order, which removes the officers from their patrol responsibilities for up to 8 hours. If hospitalization is deemed necessary and placement for the individual can be found at a local psychiatric facility,[1] total involvement in the process can be from 8 to 15 hours. However, if placement is secured at a facility in northern Virginia or east of Richmond, involvement can be as great as 24 hours. The creation of a state-supported alternative transportation program will alleviate some of this burden on the back-end, and the development of CIT programs with a CIT Assessment Site will reduce the amount of time involved on the front-end.

Barriers to CIT Implementation in Rural Communities

The barriers to CIT implementation in rural Virginia are numerous, but, as evidenced by the successful rural programs in the Commonwealth, the barriers are not insurmountable. It is not uncommon for law enforcement to feel as though they are asked to do too much[viii] and that the adoption of CIT within their respective departments would consume more of their time and take them away from their primary community policing duties. *This perception is indicative of a lack of understanding of what CIT is and how it can benefit law enforcement officials.* One of the outcomes of a fully integrated and operational CIT program is to reduce the amount of time law enforcement is involved in the emergency custody process. This goal is achieved through the implementation of a CIT Assessment Site (previously referred to as a "drop-off center" or "receiving facility") that enables law enforcement to exchange custody of an individual in emergency custody with security at an assessment site. The New River Valley CIT (NRVCIT) program, a largely rural program that covers approximately 1,500 square miles in southwest Virginia, *reduced law enforcement involvement in the emergency custody process by 80% through the development of their CIT Assessment Sites*. The average custody length for law enforcement officials who are able to transfer custody at an assessment site is 60 minutes.[ix]

Furthermore, the development of a CIT program does not necessarily add more responsibility to law enforcement officials or agencies. *Responding to behavioral health crises is a statutory obligation of law enforcement in the Commonwealth of Virginia, and the nature of those responsibilities does not change with a CIT program*. However, additional training on behavioral health issues, communication skills, and community resources through CIT training can dramatically enhance law enforcements' response to complex and often challenging situations. Additionally, communities often forge stronger community partnerships and more open relationships among law enforcement and behavioral health agencies through the development of CIT.[x]

Perhaps the greatest barrier to development of a CIT program in rural communities is the lack of human and financial resources. Research and anecdotal evidence from Virginia law enforcement executives confirm that *scarce resources present two primary challenges for CIT training in rural communities: 1) the cost of operating and filling a training, and 2) staffing law enforcement patrol shifts while officers attend training*.[xi] It can cost as much as $1,200 to

[1] E.g., local hospitals in Bristol, Lebanon, Galax, Radford, Martinsville or Roanoke.

conduct a 40-hour CIT training and many communities are unable to bear this cost on their own. Furthermore, for rural communities that do not have many law enforcement agencies, it is difficult to staff a training with instructors as well as send officers to receive training. For instance, one rural community in western Virginia has three law enforcement agencies: a small county sheriff's office, a small city police department, and a small town police department. Each of those agencies have committed to provide personnel to be CIT instructors but it is hard to balance the needs of providing instructors and providing students for the class without incurring overtime expenses to backfill positions during the week.

A 2015 report published by the International Association of Chiefs of Police (IACP) summarizes the overtime issue for rural departments succinctly:

> The biggest issue smaller agencies encounter with training is manpower and the ability to backfill an officer's position. When an officer is attending a training, another colleague must cover their shift in order to have appropriate staffing in the office or on patrol. This may involve a shortage of staff or incurring overtime costs. Participants commented that they could usually afford training and even limited travel expenses from their training budgets, *but the cost to backfill a position is typically what prevents officers from attending a specialized training on areas of interest or to advance their professional development* (p. 6, emphasis added).[xii]

Many small-town police departments in these rural communities have a patrol division of four or five officers, and the county sheriff's offices in some rural areas have a patrol division of as few as nine deputies. Thus, the issue of overtime is particularly salient in these communities.

A final barrier that has impacted rural Virginia communities' implementation of CIT is the *nature of grant funding and the lack of local resources to ensure programmatic sustainability*. Four of the six communities that do not have operational CIT programs have previously received grant funds from the Virginia Department of Behavioral Health and Developmental Services (DBHDS) or the Virginia Department of Criminal Justice Services (DCJS). The nature and duration of those grant funds were varied: one was a one-year planning grant, a couple were multi-year planning and implementation grants, and another was a one-year training grant. In all cases, however, each communities' program development efforts were stalled when their respective grant terms ended.[2] *Stable funding for a CIT Coordinator, CIT training, and a CIT Assessment Site is critical for program sustainability in these rural communities*.

Panel Recommendations

The Panel offers the following recommendations along with cost estimates for the Workgroup to consider.

1. **The Panel recommends that the General Assembly provide funding to DBHDS to support the development, implementation, and sustainment of CIT in up to six rural Virginia communities. The communities would be selected by DBHDS in consultation with relevant agencies and community experts.**

[2] One of the six communities has a multi-year planning and implementation grant whose term ends in February. They have indicated that program sustainability is in jeopardy due to financial hardship and an inability to secure local funds to maintain the program.

Without stable funding, these remaining communities in the Commonwealth are unlikely to successfully implement a CIT program. DBHDS funds should be eligible *only to rural Virginia communities that do not have operational CIT programs or lack a CIT Assessment Center*. DBHDS awards should encourage programs to develop in accordance with the Essential Elements for the Commonwealth of Virginia's Crisis Intervention Team Programs, a program development guide created by DBHDS, DCJS and the Virginia CIT Coalition.[xiii] Each community should receive funds to support the following essential program components:

- **A CIT Coordinator in each community and funding to support this position.** Each CIT program requires a designated individual to serve as CIT Coordinator in order to manage the program's various elements. The CIT Coordinator is responsible for stakeholder engagement, community education, training scheduling and coordination, inter-departmental communication, and data collection and management. The Panel recommends each community employ a full-time CIT Coordinator. A full-time Coordinator may not be necessary in communities with a small number of law enforcement agencies. Generally speaking, however, a full-time Coordinator is needed to manage day-to-day logistics and inter-departmental communication. Refer to Appendix A for a sample job description.

- **A CIT Task Force or Oversight Committee**. A stakeholder group of critical community partners is essential in order to guide initial planning and implementation of a CIT program and to provide ongoing oversight of the program's operation and sustainability, including critical incident review, funding, policies and procedures, and community outreach and education. Funds should be provided to support the monthly meetings of this stakeholder group.

- **Funding to support three annual CIT trainings**. The 40-hour Core CIT training is a resource intensive enterprise that requires subject matter experts and law enforcement instructors. The Essential Elements for the Commonwealth of Virginia's Crisis Intervention Team Programs recommends a maximum class size of 24 students.

- **Funding provided to support law enforcement personnel overtime to small departments to enable them to send personnel to the 40-hour CIT training.** The IACP[xiv] report recommends the provision of funding to offset the overtime cost that must be incurred by small departments in order to send officers to training. The Panel supports this recommendation and believes that *it is a critical component* to ensure that small law enforcement agencies (total sworn personnel of less than 25) are able to fully participate in the CIT program and training.

2. **The Panel recommends that the General Assembly provide funding to DBHDS to support the development and operation of a CIT Assessment Site in up to six rural Virginia communities. The communities would be selected by DBHDS in consultation with relevant agencies and community experts.**

Without stable funding the remaining communities in the Commonwealth will not be able to develop a CIT Assessment Site. DBHDS funds should be eligible only to rural Virginia communities that do not have operational CIT programs or lack a CIT Assessment Center. DBHDS awards should encourage new programs to develop in accordance with the Essential Elements for the Commonwealth of Virginia's Crisis Intervention Team Programs and DBHDS guidance. Each community should receive funds to support the following essential program components:

- **Funding to support 5.0 FTEs of on-site security personnel to support the site by accepting transfer of custody of individuals and to provide for the safety of all personnel involved in the evaluation process.** Twenty-four hour, year-round availability of the assessment site for law enforcement to use as an access point for services is ideal because jail diversion, when practicable, is the ideal. However, based on volume of service and other criteria, communities may be able to meet their specific needs with fewer hours of service per day. In existing programs around the Commonwealth, various types of security personnel are utilized, including on-duty sworn law enforcement, off-duty sworn law enforcement, and private security personnel.

- **Funding to support 1.0 FTE of an Emergency Services Clinician to provide on-site and immediate evaluation and triage of persons in behavioral health crisis.** The implementation of a CIT assessment site can dramatically change a Community Service Board's Emergency Services staffing levels and community response. In most instances, it is useful to hire at least one additional Emergency Services Clinician.

- **Funding to support 0.5 FTE of a Peer Recovery Specialist to provide peer support to individuals awaiting evaluation or transportation to a psychiatric hospital for temporary detention.** Peer support is an often overlooked but important element to the recovery process for individuals who are going through the civil commitment process. Peers are individuals who have significantly recovered from their behavioral health illnesses who are able to help others direct their own recoveries and lead meaningful lives in their communities. At an assessment site, they are able to support individuals going through the evaluation process with empathy, education, and other support.

Cost Estimates

The following are cost estimates for DBHDS to implement a CIT program (i.e., CIT training and/or a CIT Assessment Center) in rural communities. DBHDS would allocate this funding to Community Services Boards for selected communities. Cost estimates are based on the New River Valley CIT Program, a rural, multi-jurisdictional program in southwest Virginia.

1. Cost Estimates to Support CIT Training Program

Service	Cost Methodology	Year 1	Year 2	Year 3
Crisis Intervention Team Program				
CIT Coordinator	1.0 FTE at an estimated $45,500	$45,500	$45,500	$45,500
Law Enforcement Overtime	Overtime costs for law enforcement to allow positions to be backfilled for CIT training Year One: • 36 law enforcement officials x 36 hours x $25 per hour Year Two • 36 law enforcement officials x 36 hours x $25 per hour Year Three (and all subsequent years) • 18 law enforcement officials x 36 hours x $25 per hour	$32,400	$32,400	$16,200
Initial CIT Training	Training costs for 8 law enforcement officials and 4 mental health professionals: • 5 nights lodging x $100 per night x 12 = $6,000 • 5 days per diem x $50 per day x 12 = $3,000 • Mileage reimbursement for 3 vehicles x 400 round-trip miles x $0.48 = $576	$9,574	-	-
Train the Trainer Training	Cost of bringing out of area training team to local community: • Four instructors x 2.5 days x $450 per day = $4,500 • 3 nights lodging x $100 per night x 4 = $1,200 • 3 days per diem x $50 per day x 4 = $600 • Mileage reimbursement for 2 vehicles x 400 round-trip miles x $0.48 = $384	$6,684	-	-
CIT Training & Supplies	Training manuals, supplies and refreshments, CIT lapel pins, printing and copying: • $50 per student x 24 students x 3 trainings per year (2 trainings year 1)	$2,400	$3,600	$3,600
Local Mileage	1,562 miles traveled x $0.48	$750	$750	$750
Out of Area Mileage	1,562 miles traveled x $0.48	$750	$750	$750
Lodging & Per Diem	Lodging and per diem to allow participation in quarterly Virginia CIT Coalition meetings	$750	$750	$750
Stakeholder Meetings	Supplies and refreshments for monthly stakeholder meetings: 12 meetings x $200 = $2,400	$2,400	$2,400	$2,400
Conference Travel	Travel for 4 stakeholders to Virginia CIT Conference and CIT International Conference. Virginia: • 2 nights lodging x $125 per person x 4 = $1,000 • 3 days per diem x $50 per day x 4 = $600	$8,400	$8,400	$8,400

	• $150 registration fee x 4 = $600 CIT International: • 3 nights lodging x $150 per person x 4 = $1,800 • 4 days per diem x $75 per day x 4 = $1,200 • $400 registration fee x 4 = $1,600 • $400 airfare x 4 = $1,600			
Total Per Program		**$109,608**	**$94,550**	**$78,350**
TOTAL FOR SIX PROGRAMS		**$657,648**	**$567,300**	**$470,100**

2. Cost Estimates to Support CIT Assessment Site

Service	Cost Methodology	Year 1	Year 2	Year 3
CIT Assessment Site				
Security/Law Enforcement	5.0 FTE at an estimated $45,500 to support the assessment site by accepting transfer of custody and to provide for the safety of all persons involved	$227,500	$227,500	$227,500
Emergency Services Clinician	1.0 FTE at an estimated $45,500 to provide on-site triage, assessment and hospital placement for individuals at the assessment site	$45,500	$45,500	$45,500
Peer Recovery Specialist	0.5 FTE at an estimated $21,000 to provide peer support, education and empathy to individuals going through the evaluation process at an assessment site	$21,000	$21,000	$21,000
Rent	Rent expense for facility at an estimated $950 per month	$11,700	$11,700	$11,700
Facility Expense	Facility expense, such as electricity, telecommunications, water/sewer/trash, and oil/gas, at an estimated $583 per month	$7,000	$7,000	$7,000
Office Supplies	Consumable office supplies at an estimated rate of $100 per month	$1,200	$1,200	$1,200
Furniture & Furnishings	Office furniture (two desks, two desk chairs, couch and sitting chairs) and furnishings for office space	$7,000	-	-
Total per program		**$320,900**	**$313,900**	**$313,900**
TOTAL FOR SIX PROGRAMS		**$1,925,400**	**$1,883,400**	**$1,883,400**

Jail Diversion Expansion for Rural Virginia Communities: Intercept 2 Recommendations

Review of Relevant Research and Background

Each year in the United States, more than two million people with behavioral health disorders are incarcerated in jails and prisons.[xv] Research suggests that the human toll as well as the costs to

the taxpayer for incarcerating this population are staggering.[xvi] Jails spend two-to-three times more money to incarcerate an inmate with a behavioral health disorder as compared to an inmate without these concerns.[xvii] And research suggests that the additional costs associated with jail-based interventions do not result in improved clinical outcomes or greater public safety.[xviii]

The Sequential Intercept Model (SIM) encourages the diversion of persons with behavioral health issues away from detention in jails at Intercept 2. "Intercept 2" is an umbrella term for any diversion effort occurring during the initial detention or initial court hearings. The justice system does not have a built-in mechanism to identify individuals with mental illness or substance use disorders. The creation of diversion programs at initial detention and/or court hearings, however, can divert individuals with behavioral health issues away from costly jail stays into community-based treatment and supervision. Thus, research suggests that Intercept 2 programs can produce significant costs savings to localities without compromising public safety.[xix]

Intercept 2 may involve some or all of the following: initial screenings, jail diversions, and linkage to community-based treatment services. Once a person has been arrested, screening and assessment for mental illness and substance use disorders may be conducted by personnel at jail booking and by pretrial service staff. In some communities, arrestees are initially detained in a police or court lockup rather than jail prior to their initial appearance. Pretrial services may be the first opportunity to screen for mental illness and substance use disorders. For courts with a court clinic, embedded clinicians, or diversion program case workers, screenings may flag individuals with disorders and identify potential service recipients.

A challenge at this intercept is the limited time, as individuals may be held for only a matter of hours before being released. Nevertheless, embracing the ideals of consumer empowerment, self-determination, and recovery through cross-agency system partnership, Intercept 2 programs provide for the prompt identification of such individuals in local jails to minimize the length and extent of their involvement in the criminal justice system by connecting individuals to appropriate treatment and services.

Best Practices: Screening and Assessment

Screening and assessment for mental health concerns are part of a larger process of information gathering that begins when the individual becomes justice-involved. Screening is used to identify problems related to mental health and substance use, and the need for further assessment. Screening is intended to quickly identify acute issues that require immediate attention, such as suicidal thoughts or behaviors, risk for violence, withdrawal symptoms and detoxification needs, and symptoms of serious mental disorders. Often, multiple screenings are used at the same interview to identify multiple potential concerns (Table 1). Assessment is conducted when a screen reflects a need for more detailed information (Table 2). Assessment differs from screening as it informs treatment or case planning. Several types of assessments are available that vary according to the scope and depth of coverage needed.

All individuals entering the justice system should be screened for mental health and substance use disorders. Universal screenings are warranted due to 1) the high rates of these disorders

among justice-involved individuals and 2) the serious risks of non-detection (e.g., recidivism, suicide).

Universal screening should also be conducted in both men and women for trauma history and for posttraumatic stress disorder (PTSD), as these predispose individuals to serious adverse consequences if not recognized and addressed. Mental health and substance use screening should be completed at the earliest possible point, as this information may assist in establishing conditions of release (e.g., drug testing, involvement in treatment) that increase the chances of community stabilization and participation in the judicial process.

Building on Standardized Screening in Virginia Jails

Fortunately, the standard for screening and assessment in Virginia jails was raised by the 2017 General Assembly thanks to the work of the Joint Subcommittee to Study Mental Health Services in the 21st Century. Localities that do not currently have Intercept 2 diversion programs may now build upon that early screening by identifying feasible steps to take at initial detention or initial court hearings for individuals who screened positively for mental health and/or substance use disorders.

As noted earlier, Intercept 2 programs can vary to fit a locality's needs and resources. Nevertheless, SIM guidelines identify important program characteristics that should be included in program design to achieve successful and sustainable interventions. Such considerations informed the Panel's recommendations as described in the next section. The recommendations do not outline programs with the same specificity as for Intercept 1 in order to allow for the variation seen in Intercept 2 programs and localities' need to tailor programs.

Table 1: Evidence-Based Screening Tools for use at Intercept 2 (from SAMHSA 2015)

Mental Disorders	Substance Use Disorders	Co-occurring Disorders	Motivation & Readiness	Trauma History & PTSD	Suicide Risk
	Brief				
Brief Jail Mental Health Screen (BJMHS) (or) Correctional Mental Health Screen (CMHS-F/ CMHS-M) (or) Mental Health Screening Form-III (MHSF-III)	Texas Christian University Drug Screen-V (TCUDS V)* (or) Simple Screening Instrument (SSI)* (or) Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)	Mini International Neuropsychiatric Interview-Screen (MINI-Screen) (or) Brief Jail Mental Health Screen (BJMHS)* and TCU Drug Screen V (TCUDS V)* (or) Correctional Mental Health Screen* (CMHS-F/ CMHS-M) and TCU Drug Screen V (TCUDS V)*	Texas Christian University Motivation Form (TCU-MotForm)* (or) University of Rhode Island Change Assessment Scale-M (URICA-M)*	Trauma History Screen (THS)* (or) Life Stressor-Checklist (LSC-R)* (or) Life Events Checklist for DSM-5* (and) Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)*	Interpersonal Needs Questionnaire (INQ) and Acquired Capability Suicide Scale (ACSS)* (or) Beck Scale for Suicide Ideation (BSS) (or) Adult Suicidal Ideation Questionnaire (ASIQ)
	Extended TCU Drug Screen V (TCUDS V)* and Alcohol Use Disorders Identification Test (AUDIT)* (or) Simple Screening Instrument (SSI)* and Alcohol Use Disorders Identification Test (AUDIT)*				

Table 2: Evidence-Based Assessment Tools for use at Intercept 2 (from SAMHSA 2015)

Mental Disorders	Substance Use Disorders and Treatment Matching	Co-occurring Disorders	Trauma History and PTSD	Suicide Risk
Personality Assessment Inventory (PAI)	TCU Drug Screen V (TCUDS V)*, TCU Client Evaluation of Self and Treatment (TCU CEST)*, TCU Mental Trauma and PTSD Screen (TCU TRMA)*, and TCU Physical and Mental Health Status Screen (TCU HLTH)* (and/or) TCU Criminal Justice Comprehensive Intake (TCU CJ CI)*	Alcohol Use Disorders and Associated Disabilities Interview (AUDADIS-IV)* (or) Mini International Neuropsychiatric Interview (MINI) (or) Structured Clinical Interview for DSM (SCID)	Posttraumatic Symptom Scale (PSS-I)* (or) Posttraumatic Diagnostic Scale (PDS) (or) Clinician Assisted PTSD Scale for DSM-5 (CAPS-5)*	Suicide Risk Decision Tree (SRDT)*

Panel Recommendations

After identifying the benefits and challenges of implementing programs at Intercept 2, the Panel offers the following recommendations along with cost estimates for the Workgroup to consider.

1. **The Panel recommends that the General Assembly provide funding to the Department of Behavioral Health and Developmental Services to support the creation of new Intercept 2 diversion programs in up to six rural Virginia communities. The communities would be selected by DBHDS in consultation with relevant agencies and community experts.**
   To be qualified for these funds, jurisdictions must have or be willing to establish quickly a stakeholder group that includes, but is not limited to, representatives from the law enforcement, community services board, courts, and community corrections sectors. Eligible jurisdictions for funding are those lacking an Intercept 2 diversion program, and should have identified this as an area for improvement through the cross-systems mapping process or established collaborative stakeholder team.

   Without such funding, localities without Intercept 2 programs are unlikely to fully implement a strategy of diverting individuals with behavioral health disorders. Although the funding recommended by the Panel may appear substantial, when it is compared to the costs to communities for the incarceration of individuals with behavioral health

disorders, diversion to less expensive, community-based treatment is less expensive to taxpayers. The Panel recommends that this funding be ongoing to support the continuation of these programs in communities.

2. **The Panel recommends that communities be afforded flexibility in designing Intercept 2 programs for which they seek the funding.**
   Recognizing the range of Intercept 2 programs that have proven effective and the locality-specific variations among Virginia communities that do not have Intercept 2 programs, the Panel recommends that communities be afforded flexibility in the type of programs that would be funded. Options would include:
   - Post-booking programs in which magistrates are granted authority to release individuals post-arrest but before the initial arraignment hearing; and
   - Pre-trial release programs in which individuals are diverted at the earliest possible juncture in legal proceedings, i.e., at the initial arraignment when possible or at a bond hearing, which often occurs within a few days of the initial arrest.

3. **The Panel recommends that funding include remuneration for treatment team personnel.**
   To support the successful operation of Intercept 2 programs, the provision of mental health services must be included. This recommendation is based on best practices, but also the Panel's review of existing Intercept 2 programs in Staunton City/Augusta County, New River Valley, and Arlington County. Based on existing Intercept 2 programs, the Panel recommends that all program personnel be forensically trained and capable of working across all of the Intercepts.

   Although existing programs suggest that successful programs aim to include the following clinical positions, the Panel supports a scalable approach to program personnel. The personnel needs of each program will be dictated by the volume of individuals with behavioral health concerns within a jurisdiction. Relevant clinical positions include:

   - **Clinical Team Lead:** This position would ideally be employed by a Community Services Board and would be responsible for providing daily clinical services to program participants. The forensically-trained Clinical Team Lead would serve as a boundary spanner across the Intercepts, and be responsible for administrative and reporting tasks as well as clinical functions.

   - **Case Manager:** This position would also be employed by the local Community Services Board. This position would report directly to the Clinical Team Lead, and be responsible for providing a full range of case management activities across the Intercepts for participants, including: initial intake and assessment, group and individual counseling, and clinical case management. The Case Manager would also complete all required clinical paperwork and reports.

   - **Criminal Justice Liaison:** This position would also be employed by the local Community Services Board. The criminal justice liaison would be a full-time position that would have the following responsibilities across the Intercepts:

serving as the Court/Treatment Team liaison, assisting staff in developing and providing evidence-based treatment, completing all required paperwork and reports.

4. **In addition to recommendations regarding clinical personnel, the Panel recommends that funding should be sufficient to allow each proposed program to reflect in its design the following elements of Intercept 2 programs, as informed by best practices in the field:**
    - **Eligibility** – description of who is eligible to receive diversion services.
    - **Process** – procedural steps for how individuals will be identified and diverted from the criminal justice system.
    - **Treatment** – the means by which clients will be served, the treatment, and services available to them.
    - **Administration** – supervision, oversight, program modification and compliance for all components of the program.
    - **Evaluation** – evaluation protocols and program-identified data collection needs.

    Eligibility: The Panel recommends that Intercept 2 programs target individuals with post-booking involvement in the criminal justice system. Individuals must have a mental illness or co-occurring disorder as determined by the Brief Jail Mental Health Screening (BJMHS) or the Correctional Mental Health Screen for Men or Women (CMHSM or W). Participants must have current pending legal charges. Enrollment in the program can occur as a condition of an individual's pretrial release, sentence, or condition of probation. Participants commit to a minimum of six months of services. If the individual successfully completes the treatment program, charges will be resolved as per Commonwealth Attorney's agreement.

    Process: As mentioned previously, the Panel supports the funding of a variety of Intercept 2 programs, including Magistrate Post-Booking Diversion as well as Pre-trial/Bond Release Programs. Based on the findings of this study, the Panel recommends that program process reflect collaboration between jail booking staff, the courts, pretrial services agencies, community-based treatment, the Commonwealth Attorney's Office, and the Office of the Public Defender, such as the example collaborative work described in the following paragraphs.

    Jail booking staff may inform the program team of any eligible individuals who screened positively for SMI based on the BJMHS or CMHS-M or W. If defendants are willing to participate in an eligibility interview, the individual would then meet with a program representative (e.g., lead clinician, case manager, pre-trial investigator) to determine interest and appropriateness. During this interview, a treatment team would provide information about the diversion program to the eligible defendant as well as defendant's attorney. If the defendant expressed interest, a recommendation for program diversion would be made to the court prior to the initial hearing. The Commonwealth Attorney's Office would also be informed.

If approved by the Commonwealth Attorney's Office, presiding judge or magistrate, the consenting defendant would be accepted into the diversion program at the initial hearing. At that time, the defendant would be referred for a full assessment with program staff. At that initial assessment intake, the individual would be enrolled in the program and provided with written documentation of expectations regarding treatment compliance, including information regarding how program non-compliance, positive screens, and new charges will be addressed. An Individualized Treatment Plan (ITP) would also be developed. At the same time, the defendant would also be referred to the Community Corrections office for pre-trial or diversion supervision

Based on similar existing programs in Virginia, the Panel recommends that individuals periodically return to court to ensure treatment compliance and to review status. Non-compliant individuals and individuals who wish to leave the diversion program would have their bond revoked and be returned to the court of origin for traditional adjudication.

Treatment: All funded programs must provide appropriate access and/or linkage to community-based mental health, substance use, and co-occurring disorders assessment and treatment. The Panel recommends that programs should provide access to community-based services based on the individual's need, level of participation, and level of attendance. Ideally, community-based services would include individual counseling and group counseling, psychiatric services and medication assistance, case management, substance use treatment services, and psychosocial treatment targeting recidivism.[xx] Based on best practices at Intercept 2, the Panel recommends that funded programs connect participants with evidence-based interventions that address criminogenic risk. Potential community-based programs include:

- **Thinking for Change (T4C),** an integrated cognitive behavioral change program. T4C incorporates research from cognitive restructuring theory, social skills development, and the learning and use of problem solving skills.

- **Moral Reconation Therapy (MRT),** a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. This cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth.

- **Reasoning and Rehabilitation (R&R and R&R2),** is a multi-faceted, cognitive-behavioral program for teaching the cognitive skills, social skills, and values that are required for prosocial competence. R&R provides 35, highly structured, manualized, two-hour sessions for groups who are evidencing antisocial behaviors or delinquent or criminal behavior.

Funding should be provided for the training of program personnel in evidence-based treatment modalities.

Administration: Strong leadership and oversight will be required to address implementation issues, assure continued participation among the array of stakeholders, supervise the Treatment Team, and respond to consumers.

The Expert Panel recommends that Intercept 2 programs be administered by a full-time Administrator who is knowledgeable and respected among members of the criminal justice and mental health systems and has experience working with consumers. The Administrator should also be tasked with overseeing the provision of continued funding.

Evaluation: Programs should develop procedures for ongoing program evaluation to ensure quality and reliance on evidence-based decision making. Programs should include evaluation procedures that will involve data collection at the program event level to capture the volume of activities. Data should also be collected on the individual level to track program compliance, and provide demographic information regarding treatment engagement, stability at induction and at discharge, as well as information regarding any new charges. Ideally, a data collection cycle will include assessment periods at baseline, six months and twelve months.

Cost Estimates

The following are cost estimates for the DBHDS to support the implementation and ongoing expenses of new Intercept 2 programs. These cost estimates are based on existing Intercept 2 programs in Staunton City/Augusta County and New River Valley.

Cost Estimates to Support the Recommendations

Service	Cost Methodology	Year 1	Year 2	Year 3
Intercept 2 Program				
Clinical Team Lead	1.0 FTE at an estimated $71,065	$71,065	$71,065	$71,065
Program Administrator	1.0 FTE at an estimated $53,855	$53,855	$53,855	$53,855
Case Manager	1.0 FTE at an estimated $49,846	$49,846	$49,846	$49,846
Criminal Justice Liaison	1.0 FTE at an estimated $44,855	$44,855	$44,855	$44,855
Training & Supplies	Training manuals, Training costs for four attendees (example costs based upon MRT training)	$10,000	$3,600	$3,600
Local Mileage	1,042 (year one) & 1,562 (subsequent years) miles traveled x $0.48	$500	$750	$750
Out of Area Mileage	1,042 (year one) & 1,562 (subsequent years) miles traveled x $0.48	$500	$750	$750
Stakeholder Meetings	Supplies and refreshments for monthly stakeholder meetings: 12 meetings x $200 = $2,400	$2,400	$2,400	$2,400
Professional Development	Travel and registration for ongoing professional development: • 2 nights lodging x $125 per person x 4 = $1,000	$1,200	$1,200	$1,200

	• 3 days per diem x $50 per day x 4 = $600 • $150 registration fee x 4 = $600			
Total Per Program		**$236,221**	**$229,821**	**$229,821**
TOTAL FOR SIX PROGRAMS		**$1,417,326**	**$1,378,926**	**$1,378,926**

Conclusion

The Expert Panel strongly supports the idea that criminal justice diversion at early stages can be improved in several rural localities in western, southwestern, and central Virginia. Evidence and experience, including from more rural jurisdictions in Virginia, show that diversion at the initial point of interaction with officers and at initial detention or court proceedings is feasible and sustainable when localities have the necessary financial resources and a functioning criminal justice-behavioral health stakeholder group.

Review of relevant literature and Virginia-specific information, as well as discussions with relevant officials and among Expert Panel members, led to consensus that the commitment of sufficient, rural-jurisdiction-targeted funds for CIT training, CIT Assessment Sites, and collaborative pretrial diversion programs is a reasonable and necessary action for addressing the concerns identified be the Criminal Justice Diversion Workgroup. The provision of funds via DBHDS will provide a structure for requiring that localities demonstrate important building blocks, such as a criminal justice-behavioral health stakeholder group (or current efforts to convene one), as well as plans for leveraging locality-specific resources, such that programs are tailored and more likely to succeed. Thus, the funding process should stimulate important prerequisites for program success, as well as then providing sufficient funding to support the build-up of programs that will be primed for sustainability in the long term.

In sum, the Expert Panel strongly supports providing funding for Intercepts 1 and 2 diversion programs only to those rural localities that have thus far struggled to implement such programs. To that end, the Panel makes the following recommendations:

- Intercept 1
    - Funding for CIT training, including funding to cover overtime in small law enforcement agencies to backfill on-duty positions while officers are in training; and
    - Funding for CIT Assessment Centers.
- Intercept 2
    - Funding for initial detention and/or initial court hearing diversion programs; and
    - Suggested components for the design of such programs.

Appendix A

Sample CIT Coordinator Job Description

Duties and Responsibilities

- Coordinate communications with community stakeholders;
- Manage the logistics and coordination of training presenters and activities;
- Develop and produce a training manual for participants;
- Oversee course evaluations and enhance the quality of the training;
- Enhance the system for gathering and analyzing data;
- Work with the planning committee to develop smaller, more focused trainings for other criminal justice players such as probation/parole officers, dispatchers, and EMS;
- Provide law enforcement agencies with technical assistance on CIT-related issues;
- Educate the community about the goals and purpose of the program;
- Enhance community awareness as well as following state mandates and protocols;
- Interface with the criminal justice system, county and private social services, mental health services, state and other systems;
- Maintain and complete all appropriate records related to logistics and planning, preparing written reports, entering statistical data;
- Conduct program evaluation and monitoring.

The Coordinator will develop close working relationships with various agencies including (but not limited to) the Police Department, Magistrates, Sheriff's Office, Emergency Departments, Probation and Parole, Commonwealth's Attorney and Public Defender's Office. The Coordinator must be able to communicate and understand the many complexities that arise from interaction with different systems.

QUALIFICATION REQUIREMENTS

Minimum: Bachelor's degree in Criminal Justice, Sociology, Psychology, Communications, Business Administration or related field plus one year's experience working with criminal justice system and/or mental health.

Substitution: Additional qualifying experience may substitute for educational requirement on a year for year basis. Directly-related higher level criminal justice degrees may substitute for the Bachelor's degree, education requirement and one year of experience.

Desirables:

- Experience with law enforcement, criminal justice system and logistics;
- Experience in developing and training professionals;
- Experience in and general knowledge regarding mental health and community based mental health programs.

Appendix B
References

[i] Department of Behavioral Health and Developmental Services, Office of Forensic Services (n.d.) Cross Systems Mapping Statewide Initiative (2008-2013) Final Report. Retrieved from http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20final%20xsm%20initative%20report%202013pdf.pdf

[ii] Munetz, M.R. & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services,* 57(4), 544-549.

[iii] Council of State Governments Justice Center (2008). Improving responses to people with mental illness: The essential elements of a specialized law enforcement-based program. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2012/12/le-essentialelements.pdf

[iv] Department of Criminal Justice Services & Department of Behavioral Health and Developmental Services (2014). Virginia Crisis Intervention Team Programs: Essential Elements. Retrieved from http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20vacitessentialelements.pdf

[v] Walker, L.E.A, Pann, J.M., Shapiro, D.L., Van Hasselt, V.B. (2016). *Best Practices for the Mentally Ill in the Criminal Justice System*, SpringerBriefs in Psychology, Behavioral Criminology: New York.

[vi] http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20fy2016%20cit%20assessment%20site%20annual%20report.pdf

[vii] Walsh, N. & Taylor, C. (2016). Mental health crisis intervention training teams form in SW Virginia; hailed as rural model. *National Association of Counties: County News*. Retrieved from http://www.naco.org/articles/mental-health-crisis-intervention-training-teams-form-sw-virginia-hailed-rural-model

[viii] https://www.washingtonpost.com/news/post-nation/wp/2016/07/11/grief-and-anger-continue-after-dallas-attacks-and-police-shootings-as-debate-rages-over-policing/?utm_term=.5178f6c8f912

[ix] http://www.nrvcs.org/2015/03/09/data-shows-cit-assessment-center-is-reducing-law-enforcement-involvement/

[x] Skubby, D., Bonfine, N., Novisky, M., Munetz, M., Ritter, C. (2013). Crisis Intervention Team (CIT) Programs in Rural Communities: A Focus Group Study. *Community Mental Health Journal*, 49:756-764.

[xi] ibid

[xii] http://www.theiacp.org/Portals/0/documents/pdfs/SmallerAgencyFocusGroupReport.pdf

[xiii] http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20vacitessentialelements.pdf

[xiv] http://www.theiacp.org/Portals/0/documents/pdfs/SmallerAgencyFocusGroupReport.pdf, pp. 7

[xv] CMHS National GAINS Center. (2015). Developing a comprehensive plan for Behavioral Health Collaboration from the CMHS National GAINS Center. Delmar, NY: Author

[xvi] Osher, F., Steadman, H.J., & Barr, H. (2002). A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model. Delmar, NY: NationalGAINS Center

[xvii] Osher, F., D'Amora, D.A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery. New York: Council of State Governments Justice Center.

[xviii] CMHS National GAINS Center. (2007). Practical advice on jail diversion: Ten years of learnings on jail diversion from the CMHS National GAINS Center. Delmar, NY: Author

[xix] CMHS National GAINS Center. (2007). Practical advice on jail diversion: Ten years of learnings on jail diversion from the CMHS National GAINS Center. Delmar, NY: Author

[xx] Monahan, J., & Skeem, J. L. (2014). The evolution of violence risk assessment. *CNS spectrums*, *19*(5), 419-424.