COMMISSION ON MENTAL HEALTH LAW REFORM

REPORT

OF THE

TASK FORCE ON CRIMINAL JUSTICE

September 2008

COMMONWEALTH OF VIRGINIA

COMMISSION ON MENTAL HEALTH LAW REFORM

PREFACE

The Commonwealth of Virginia Commission on Mental Health Law Reform ("Commission") was appointed by the Chief Justice of the Supreme Court of Virginia, The Honorable Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups, including consumers of mental health services and their families, service providers, and the Virginia State Bar. The Commission was directed by the Chief Justice to conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities. Goals of reform include reducing the need for commitment by improving access to mental health, mental retardation and substance abuse services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have greater choice regarding the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

The Commission has been assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group"). Information regarding the Commission and its Reports is available at http://www.courts.state.va.us/cmh/home.html.

The Commission also conducted three major empirical studies during 2007 under the supervision of its Working Group on Research. The first was an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April 2007. The study is available at http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf.

The second major research project was a study of commitment hearings and dispositions (the "Commission's Hearings Study"). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings). Findings from the Commission's Hearing Study have been presented to the Commission and have served an important role in shaping the Commission's understanding of current commitment practice. The study can be found at http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf.

Finally, the Commission's third project was a study of every face-to-face crisis contact evaluation conducted by Community Service Board ("CSB") emergency services staff during June 2007 (the "Commission's Crisis Contact Study"). (There were 3,808 such evaluations.) Final reports of the Hearing Study and the CSB Crisis Contact Study can be found at http://www.courts.state.va.us/cmh/2007_06_emergency_eval_report.pdf

Based on its research and the reports of its Task Forces and Working Groups, the Commission issued its *Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform* ("Preliminary Report") in December, 2007. The Preliminary Report, which is available on-line at http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf, outlines a comprehensive blueprint for reform ("Blueprint") and identifies specific recommendations for the 2008 session of Virginia's General Assembly.

This document is the Report of the Commission's Task Force on Criminal Justice ("CJ Task Force"). Although the Commission embraced many of the Recommendations of the CJ Task Force in its Preliminary Report, this Report is the work of the CJ Task Force and has not been adopted or endorsed by either the Commission or the Supreme Court. It was prepared as a resource for the Commission and for the public.

Richard J. Bonnie, Chair
Commission on Mental Health Law Reform
October, 2008

The Report of the Task Force on Criminal Justice

The Report of the Task Force on Criminal Justice was generated by one of the five Task Forces established by the Commission in 2006. It has focused on the important intersection between the mental health and the criminal justice systems for individuals with serious mental illness. The Report discusses the nature of the problems facing this population and the types of interventions that seem best suited to address these problems, and presents specific recommendations for consideration by the Commission.

Over the course of its meetings and deliberations, the CJ Task Force reviewed many major academic studies and policy documents related to the topic of diversion of people with serious mental illness from the criminal justice system. CJ Task Force members have also familiarized themselves with published information regarding existing jail or prison diversion, treatment, and reentry programs in the United States and Canada and met with innovators of programs in Virginia and other states. This Report synthesizes the work of the CJ Task Force within the context of recent state and national efforts directed at improving access to mental health services for individuals who have become involved with the criminal justice system or are at-risk for such involvement.

Members of The Task Force on Criminal Justice

The Criminal Justice Task Force is a multidisciplinary body of professionals from the mental health, criminal justice, the courts, and consumer and family advocates from across the Commonwealth, representing rural and urban areas in small towns and large counties.

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Criminal Justice Task Force Report

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GUIDING PRINCIPLES AND GOALS

Charge to the Task Force on Criminal Justice

The Commonwealth of Virginia's Commission on Mental Health Law Reform (the "Commission") created five Task Forces to address the major challenges in providing mental health treatment and support services to all persons with mental illness in Virginia. The Chair and Vice Chair of each Task Force are Commission members and, as such, actively participated in all Commission deliberations.

The Commission adopted a Guiding Principle:

> **The mental health services system, whatever the source of financing, should assure access to recovery-oriented services needed by persons with serious mental illness, should facilitate consumer choice, and should protect consumers and others from harm**.

The CJ Task Force was charged with a primary goal and five subsidiary goals

Primary Goal:

Divert individuals with mental illness from the criminal justice system to the maximum extent consistent with the goals of criminal justice and increase access to appropriate mental health services for individuals with mental illness while detained, incarcerated or under community supervision.

Subsidiary Goals:

1. Examine proposals to facilitate diversion of seriously mentally ill offenders from the criminal justice system before or after arrest.

2. Examine alternative approaches to adjudication and disposition of mentally ill criminal defendants, including mental health courts.

3. Consider modifying civil commitment criteria to permit commitment in lieu of otherwise authorized arrest or detention within the criminal justice system.

4. Ascertain prevalence of serious mental illness and treatment needs among detainees and prisoners in jails and prisons and identify circumstances under which appropriate treatment can and cannot be provided in a jail or prison setting.

5. Enhance continuity of care by strengthening the links among jail-based and prison-based services and the community-based mental health and related services needed during detention and upon release.

Primary Reform Priorities

During the course of its work, the CJ Task Force synthesized the information it gathered with these goals and identified four mental health reform priorities. The Criminal Justice Task Force recommends that the Commission focus its attentions on four central aims for improving care at the intersection of mental health and criminal justice. These include:

- Improved coordination and oversight of mental health care supervised by case monitoring teams for high-risk adults;

- Diversion of individuals with mental illness from the criminal justice system to the maximum extent at the earliest point feasible consistent with the aims of criminal justice;

- Enrichment of appropriate mental health services for individuals with mental illness while detained, incarcerated, or under community supervision; and,

- Active re-entry support for individuals being released from local jails, state prisons, and juvenile correctional centers to help minimize the destabilization that often leads to re-incarceration or acute hospitalization.

These efforts have to be implemented in an integrated manner within each region of the Commonwealth of Virginia to ensure that the added effects of each intervention can be realized and that the vulnerability of any one component does not give rise to a breakdown in the continuum of care that is essential to the success of the overall effort.

INTRODUCTION

This Report of the CJ Task Force makes the case that persons with serious mental illness are disproportionately represented in the criminal justice system not because they are more violent than the population in general but largely as the result of the inadequate access to the services needed to treat their underlying mental illness and to maintain their recovery in their communities. There are several elements that translate into more encounters with law enforcement as well as more negative outcomes in the criminal justice system for persons with serious mental illness.

First, mental health care, generally, is poorly covered by private health insurance in the United States, and for the seriously mentally ill, often under-or unemployed, mental health services are even more difficult to access. For many, publicly funded, community-based mental health services are the only services available. In Virginia such mental health services are mediated through 40 CSBS, which are statutorily mandated to provide emergency services but not a broader array of services that are necessary to maintain the well-being of individuals with serious mental illness in recovery in their communities. Although some jurisdictions do provide a fuller array of services using funding supplemented by the local jurisdictions, such coverage varies from region to region and all jurisdictions are under-resourced. In addition to limited access to mental health services, the unavailability of other critical supports for housing and employment also contribute to instability of this population. Risk factors associated with serious mental illness, such as homelessness, also increase the likelihood for encounters with law enforcement and complicate re-entry to communities. For example, persons with serious mental illness are disproportionately represented among the homeless where non-violent but publicly disruptive or confused behavior may lead to arrests. As a result, many individuals with serious mental illness, unable to successfully manage their illness, have a higher likelihood of contacts with law enforcement than the general population.

Second, although minimizing inappropriate incarceration of persons with serious mental illness is a significant challenge facing the criminal justice system, there is little in-depth training of law enforcement related to mental illness or development of the skills needed to respond to crisis situations involving the seriously mentally ill. Furthermore, the lack of crisis stabilization facilities where law enforcement can transfer such individuals instead of making arrests also drives the greater likelihood of arrest compared to persons *without* serious mental illness.

Additionally, the lack of appropriate screening and treatment while mentally ill persons are in jails leads to a higher likelihood of their being booked, having harsher sentences imposed, and being involved in more behavioral incidents leading to longer sentences or disciplinary actions than for the population without mental illness. After sentencing, the under-diagnosis and treatment for mental illness both in jails and prisons results in a greater number of behavioral incidents and resultant longer stays.

Finally, when release from jails or prison is scheduled, inadequate pre-release planning and coordination with mental health providers, often leads to the inability to comply with the terms of release or to another mental health crisis cycling back into the criminal justice system. The general lack of both community-based mental health services and community supports

promoting the likes of housing and employment put this population at high risk of renewed entanglement with criminal justice.

The public policy issue is, fundamentally, how to address the fact that the population of adults with serious mental illness in Virginia jails in 2.7 to 4 times greater than that the general population.[1] Although the criminal justice system is making a valiant effort juggling its mission of public safety with that of addressing the challenges of managing a large population of persons with serious mental illness, is this the appropriate public response? Since most of these individuals pose no public safety risk, it is the view of the CJ Task Force that a policy favoring a law enforcement response squanders valuable criminal justice resources. We believe the solution is to break this wasteful cycle by strengthening community-based mental health services and supports to prevent the initial contacts, to minimize the adverse consequences while engaged in the criminal justice system by facilitating service-oriented dispositions where appropriate, and to maximize successful recovery and stable re-entry into communities.

A. The Nature of the Problem

The over-representation of persons with mental illness in the U. S. criminal justice system is well-documented.[2] It is notable that, although the prevalence of all mental illness in the general adult population is approximately 11% and between 2-3% for serious mental illness, according to a 2006 DMHMRSAS Survey, 16% of Virginia's jail inmates had a mental illness, and 50% of these had a serious mental illness.[3] Research by the Bureau of Justice had found that each year approximately 1,100,000 individuals are booked into local jails with current symptoms of mental illness, often compounded by concomitant substance abuse disorders.[4] The 2005 Virginia Jail Survey also found a high prevalence of co-occurring substance abuse disorders among jail inmates with mental illness.[5]

Jails and prisons have not always had the responsibility for so many individuals with serious mental illness. Historically, public mental health policy was focused on supporting large state

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[1] Morris, James J., *Mental Health Treatment Needs of Individuals with Mental Illness in the Virginia Justice System*, DMHMRSAS Briefing, 2006. In a survey of jail populations in Virginia conducted on September 13, 2005, 4006 of 24,595 inmates (16%) had a mental illness, a disproportionately higher percentage than among the general population.

[2] Ditton, Paula. M. (July 1999). *Mental Health Treatment of Inmates and Probationers*, Washington DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; CMHS National GAINS Center, Steadman, H.J. (2007). *Practical Advise on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center*, Delmar, NY. Available at: http://www.prainc.com/pdfs/PracticalAdviceOnJailDiversion.pdf.

[3] Morris, James J. (2006). *Mental Health Treatment Needs of Individuals with Mental Illness in the Virginia Justice System*, DMHMRSAS Briefing. In a survey of jail populations in Virginia conducted on September 13, 2005, 4006 of 24,595 inmates (16%) had a mental illness, a disproportionately higher percentage than among the general population.

[4] James, Doris J. and Glaze, Lauren E. (2006). "Mental Health Problems of Jail and Prison Inmates," Bureau of Justice Statistics Special Report. Available at: http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf.

[5] Morris, James. Data from 2007 *Virginia Local and Regional Jails Survey: Results and Implications* (Power Point from James Morris, Virginia DMHMRSAS, presented at the Governor's Conference for Mental Health and Criminal Justice Transformation, May 21, 2008, Virginia Beach, Virginia).

mental hospitals. The National Institute of Mental Health estimates that, in 1960, about 535,400 people resided in U.S. state and county psychiatric hospitals. However, institutionalizing persons with serious mental illness in large public hospitals was not an ideal solution either. Beginning in the 1960s, changes in the philosophy and policy concerning how best to provide mental health services to the seriously mentally ill led to the closing and downsizing of state mental hospitals. Several factors contributed to this. First, the availability of more effective psychotropic medications meant many persons with mental illness could be successfully treated and live in communities. In addition, because of changing views about mental illness, public policies were crafted to shift mental health services to community-based care as a more humane alternative to institutional care.[6] Further, court challenges to institutionalized care, in support of less restrictive, community-based care were also instrumental in this process.[7] By 1990, the number of residents in state mental hospitals had declined to 92,000.[8] Between 1970 and 1998, the number of public psychiatric beds plummeted by 85 percent.[9]

Both therapeutic and legal advances supported the shift in public policy toward community-based care for persons with serious mental illness. Unfortunately, the services required to implement such care failed to materialize following the release of many thousands of seriously mentally ill individuals to the community.[10] Not only were funds to support community-based mental health services lacking, but the lack of adequate community residential options meant discharge from state mental hospitals often resulted in loss of food and shelter as well. Over time, many individuals who once would have been in state mental hospitals were increasingly incarcerated in local jails and state prisons, often for minor infractions arising out of their mental illness. Sadly, research has demonstrated that the total number of individuals with severe mental illness in *either* prisons or psychiatric hospitals has remained constant over the past thirty years,

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[6] Public financing of mental illness also shifted from largely a state obligation to increased federal support through Medicaid, SSI, SSDI, and block grants. However, inadequate funding undermined developing an adequate community-based mental health system.

[7] The U.S. Supreme Court rejected the state of Georgia's appeal to enforce institutionalization of individuals with disabilities in *Olmstead v. L.C and E.W 527 U.S. 581(1999)* citing that under Title II of the federal Americans with Disabilities Act "states are required to place persons with mental disabilities in community settings rather than in institutions when the State¹s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

[8] National Institute of Mental Health. 1990. *Mental Health, United States*. Washington, DC: U.S. Government Printing Office. The decline meant that the number of psychiatric beds plunged from 314 beds per 100,000 persons to 40 per 100,000.

[9] Substance Abuse and Mental Health Services Administration, *Medicaid Financing of State and County Psychiatric Hospitals* (Washington, D.C. 2002). See: http://mentalhealth.samhsa.gov/publications/allpubs/sma03-3830/content02.asp.

[10] Note that as part of his New Frontier, President Kennedy signed the Community Mental Health Act of 1963 (CMHA) (also known as the Community Mental Health Centers Construction Act, Public Law 88-164, or the Mental Retardation and Community Mental Health Centers Construction Act of 1963) to provide Federal funding for community mental health centers. Unfortunately, Congress failed to appropriate any money to fund this legislation.

despite an 80 percent drop in the number of public psychiatric beds available to the chronically mentally ill. (See Figure 1, below).[11]

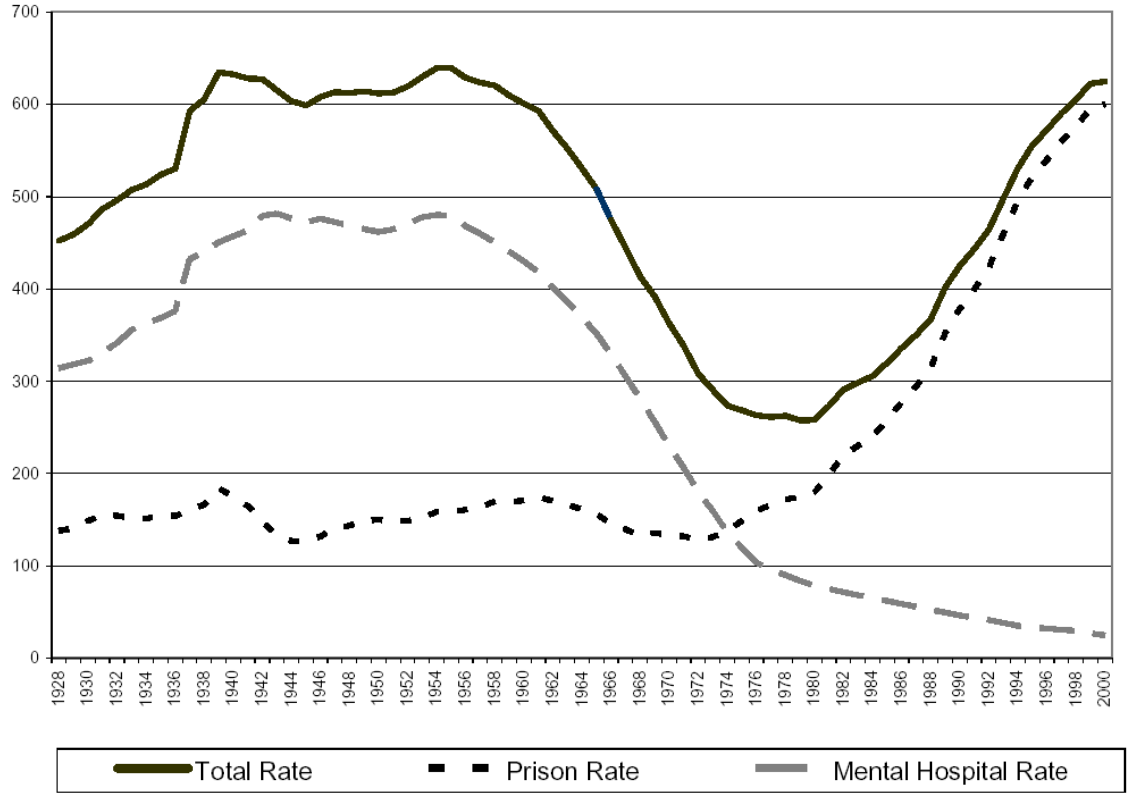

Figure 1. Institutionalization in the United States, 1928-2000 (per 100,000 adults)[12]

Although the fact that large numbers of seriously mentally ill persons frequently encounter law enforcement while in crisis and are disproportionately incarcerated in jails and prisons, public policy has been slow to respond to this challenge. As a result, both the individuals and the criminal justice system are adversely affected. In the recent GAINS Center report, *Ten Years of Learning on Jail Diversion*,[13] Steadman concludes that "nowhere is service system fragmentation and its devastating impact on individuals more evident that in the lack of coordination between the criminal justice and mental health systems." In particular, he observes:

[11] Id.

[12] Harcourt, Bernard E., (January 2006). "From the Asylum to the Prison: Rethinking the Incarceration Revolution," University of Chicago, Public Law Working Paper No. 114 Available at SSRN: (Figure 1.).

[13] CMHS National GAINS Center (2007), *Practical Advise on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center*, Delmar, NY, Author. Henry J. Steadman is the Director of the GAINS Center.

- People with mental illness and substance abuse disorders are greatly over-represented in the criminal justice system and tend to cycle in and out of the mental health, substance abuse, and criminal justice system, often receiving little or not treatment.

- Dealing with these individuals with mental illness is costly and time-consuming for law enforcement and local jails and contribute to courts becoming backlogged as they seek to address these complicated issues.

- People with mental illness, if untreated, may act in ways that the public finds frightening and threatening and, in small number of instances, can act violently if left untreated.

Recently the New York Mental Health-Criminal Justice Panel (the "New York Panel")[14] convened its own review of these same issues following a number of highly publicized violent incidents involving individuals with mental illness. In offering a far-reaching set of recommendations for reform, the New York Panel underscores that the majority of individuals with mental illness are not violent and that individuals with mental health needs are far more likely to be victims rather than perpetrators of violent crime.[15] However, they also confirm that the risk for violence increases significantly among mentally ill persons when they do not receive adequate metal health treatment and is considerably higher for those individuals who suffer not only from serious mental illness but also concomitant substance abuse disorders. The Panel directed their attention and policy reform efforts to the needs of these individuals – who often have the most acute mental health needs and the most minimal forms of social support.

Based upon our experience, the growing literature, and the rich experience of other state panels, we have crafted a set of integrated recommendations to promote better communication across the two systems and provide empirically-based mental health interventions at various points in criminal justice administration.

B. The Mental Health Criminal Justice Interface

The engagement of large numbers of persons with serious mental illness with the criminal justice system has adverse consequences for all involved. For the criminal justice system, it takes law enforcement and judicial time. Further incarcerating persons with serious mental illness contributes to the overcrowding in jails and prisons and large public expenditures for the construction of new facilities. For individuals with serious mental illness, treatment options are even more limited in jails and prisons than they were in their communities. Once in the criminal

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[14] New York State/New York City Mental Health-Criminal Justice Panel: Report and Recommendations (June 2008). Available at: http://www.omh.state.ny.us/omhweb/justice_panel_report/.

[15] Monahan, Jonathan. (1992). "Mental Disorder and Violent Behavior: Perceptions and Evidence," 47 *American Psychology* 511; Steadman, Henry, J; Mulvey, Edward P; Monahan, John; Robbins, Pamela Clark; Appelbaum, Paul S.; Grisso, Thomas; Roth, Loren H.; and Silver, Eric. (1998). "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods," *Archives of General Psychiatry* 55:393-401. Swanson, Jeffrey W., Swartz, M.S., Essock, S.M, et al. (2002). "The Social-Environmental Context Of Violent Behavior In Persons Treated For Severe Mental Illness." *American Journal of Public Health*, 92, 1523-1532.

justice system, even seriously mentally ill individuals often are not hospitalized even if their illness would ordinarily clinically warrant it.

As a result, throughout the country as well as in some localities in Virginia, initiatives to minimize the adverse consequences to both the criminal justice system and to individuals with serious mental illness have been undertaken. The term " diversion" is used by the U.S. Department of Justice and the Gains Center[16] and refers to programs that have interventions to provide linkages to community-based treatment and support services for individuals with serious mental illness (and often co-occurring substance use disorders) to minimize the likelihood that such persons will engage the legal system to begin with and divert many who have had encounters with law enforcement away from arrests, jail, and engagement with the courts and prison systems. Although not all persons with serious mental illness may be appropriate candidates for diversion, it has been estimated that nearly half of inmates in prison with a mental illness were incarcerated for committing a nonviolent crime.[17]

The CJ Task Force believes that diverting those whose actions are less criminally serious, are substantially related to a mental health crisis or to serious mental illness, and who, without treatment, are at risk of cycling repeatedly through the criminal justice system, will benefit both the individual and the criminal justice system. The CJ Task Force's Recommendations address three aspects of diversion:

1) Diverting individuals to evidence-based community treatment at the earliest possible point in their involvement in the criminal justice process;

2) Unless and until diversion to community-based treatment is appropriate, providing clinically adequate and appropriate mental health services in jail and prison; and,

3) Creating integrated criminal justice and mental health treatment teams skilled in working with forensic populations including participation of peers and mental health professionals working in coordination with the community corrections professionals.

Diverting an individual to treatment instead of incarceration will likely reduce the burden of mental illness to society, leading to cost-savings. Although there are benefits to interventions at all points of possible interactions with the criminal justice system, including during incarceration and upon re-entry to the community, diversion is most beneficial and cost-effective when delivered at the earliest possible time in the criminal justice process.

[16] The National GAINS Center in the Justice System has operated since 1995 as a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system.

[17] Ditton, Paula. M. (July 1999). *Mental Health Treatment of Inmates and Probationers*, Washington DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

C. Criminal Justice Costs

Incarcerating persons with serious mental illness is costly. Nationally, the annual cost for a prisoner in both state and federal (throughout) prisons is approximately $22,600.[18] However, this average masks significant variability. For example, according to a 2004 report, costs in Miami-Dade County, Florida were $18 per day to house inmates from the general population in jail (or $6,570 per year) compared to $125 per day (or $45,625 per year) to house inmates with serious mental illness.[19] In addition to the higher costs per day, individuals with mental illness and substance abuse disorders spend longer time in jails and prisons than do those without these disorders charged with similar crimes. At Riker's Island in New York, inmates with serious mental illness serve an average of six months longer than inmates without serious mental illness adding to the per-individual costs.[20]

In addition to costing more while incarcerated than the general inmate population, as a result of inadequate discharge planning and community-based services and supports, persons with serious mental illness are more likely to be re-arrested and re-incarcerated. The lack of adequate community-based mental health services results in the disproportionate representation of persons with serious mental illness in all elements of the criminal justice system -- law enforcement, jails and prisons, court proceedings, and community supervision after release. The costs of these encounters -- often repeated -- are significant.

The failure to provide adequate access to mental health services in the community places enormous demands on law enforcement and other areas of the criminal justice system. For example, it is estimated that approximately 7 percent of all police contacts in U.S. cities with populations over 100,000 involve persons with mental illness. [21] In addition, in a study of 331 hospitalized people with serious mental disorders, 20 percent reported being arrested or picked up by police for a crime some time during the four months prior to their hospital admission, most often for alcohol, drug, or public disorder crimes.[22]

Virginia's jails house many persons with serious mental illness.[23] Data about the prevalence of mental illness in Virginia's jails show the following:[24]

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[18] Virginia's Department of Corrections Strategic Plan, 2006, See www.vadoc.virginia.gov/resources/vpb/paroleboard-strategicplan.pdf - 2007-05-31. Estimated 2008 funding for Virginia's Department of Corrections ("DOC") operations is over $1.1 billion, or approximately $27,000 per capita.

[19] Stephan, J. (2004). "State Prison Expenditures, 2001." Bureau of Justice Statistics Special Report.

[20] Circuit Court of the Eleventh Judicial Circuit of Florida. (2004). *Final Report of the Miami-Dade County Grand Jury.* Accessed Feb 13, 2008 at: http://www.miamisao.com/publications/.

[21] Fact Sheet: Law Enforcement and People with Mental Illness, Consensus Project, (available at: www.consensusproject.org) citing Deane, Martha, Steadman, Henry J., Borum, Randy, Veysey, Bonita, Morrissey, Joseph P. (January 1999). "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services*, 50(1): 99-101.

[22] Panzarella, Robert and Alicea, Justin O. (1997). "Police tactics in incidents with mentally disturbed persons," *Policing: An International Journal of Police Strategies & Management*, 20(2):326-338.

[23] There are three populations of jail inmates in Virginia to be considered in the context of jail diversion. First, is that population recently arrested and awaiting booking and a court hearing. Secondly, are inmates who are sentenced to a jail term. In addition, the jails are obliged to house convicted felons if prisons are full, providing a back-up to prisons. In September 2007, Virginia's jails accommodated a 2,700 prison-inmate overflow.

- Total jail census on October 16, 2007: 28,281
- Rough estimate of average per diem cost for jail inmate with mental illness: $100
- 5060 total inmates with mental disorder in all Virginia jails on October 16, 2007
- People with mental disorder represented 17.9 % of total population on October 16. 2007 (compared to 2006 results showing 16%)
- 3091 inmates (61%) had a concomitant mental illness and substance abuse disorder

The number of persons with serious mental illness also showed an increase from 8% in 2005 to 9% in 2007. This survey demonstrated that Virginia's jails house more persons with mental illness than do all state hospitals. Given that the number of new jail admissions in 2007 was 389,799, and the estimated per-diem costs of housing an inmate with mental illness of $100, even a modest diversion program could have a significant financial impact. The capital and operating costs to house persons with serious mental illness who would be candidates for diversion programs is substantial and could be redirected to support mental health programs in the community.

Other data provides us with some estimates of what portion of persons with serious mental illness in jails could be candidates for diversion. Virginia jail survey data from September 2006 indicates that about 5-8% of inmates are on antipsychotics or mood stabilizers.[25] Assuming this as a rough estimate of the percentage of people whose incarceration is due substantially to their mental illness, and approximating the number of state and local inmates at 27,000, the number of people who may be eligible to be diverted from jails is between 1,350 and 2,160. Although not all of these would be candidates for diversion, if even half were such candidates there could be substantial savings in new jail construction and operating costs.[26]

Persons with serious mental illness also have contributed to an explosion in the size of prison populations. Virginia's Department of Corrections ("DOC") projects that between 2007 and 2010 there will be a 9.6% increase in the prison population in Virginia, a growth from 39,527 to 43,328 inmates, requiring an additional 3,801 beds. To mitigate this projected increase, the Commonwealth is considering several options including modifying its sentencing structure. But even with new sentencing guidelines, and under a best-case scenario, there is a projected increased need of 2,700 new prison beds by 2010.[27]

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[24] Morris, James. (2007).

[25] Morris, James J., *Mental Health Treatment Needs of Individuals with Mental Illness in the Virginia Justice System*, DMHMRSAS Briefing, 2006. Note the study cited in the previous footnote found 9% of jail inmates had a serious mental illness. And, of course, the estimate based on those receiving psychotropic medications may be an undercount because it just counts those who have had some mental health care and may be an underestimate.

[26] As noted elsewhere in this Report, there is considerable variability in who is deemed eligible for diversions across jurisdictions. Many jurisdictions narrow those eligible to persons who were picked up/arrested/convicted of non-violent misdemeanors, and eliminate from consideration anyone involved with domestic violence, crimes against children, sex offenses, etc.

[27] *Exploring the Diminishing Effects of More Incarceration: Virginia's Experiment in Sentencing Reform.* (August 2005). The JFA Institute Available at: http://www.jfa-associates.com. See, also, a recent report to the Senate Finance Committee that projected over the next six years, the number of state-responsible adult offenders with

According to a report presented to Virginia's Senate Finance Committee in 2007, over the next six years (June 2007 to 2013), Virginia's prison population will grow by the equivalent of one new prison each year requiring significant capital and operating cost increases.[28] Capital spending on new prisons in Virginia between 1990 and 2007 totaled over $978 million, adding over 21,200 beds, and raising total adjusted capacity to 33,823. Capital spending for two new facilities in the 2006 biennium was over $172 million. Construction costs for each new thousand-bed prison facility is approximated to be $70-100 million. [29] Even with this aggressive prison expansion effort, the Department of Corrections projects that it will be short by 3,400 beds by 2012. Using the lower estimated cost per bed, the projected cost of those needed beds will be $230 million.[30]

Incarceration is not the only criminal justice cost for persons with serious mental illness who could be diverted. For example, Oklahoma estimates that 13% of the state's total mental health expenditures, including criminal justice, civil mental health care services and education were attributable to criminal justice system costs, including judicial, corrections and law enforcement.[31]

Criminal justice cost-savings are significant in the pre-booking period as well. In a study of 203 people followed up in a New Hampshire program for concomitant disorders, the average law enforcement cost of a non-arrest encounter was $385, compared to $2,295 for an arrest encounter. And a Connecticut study found that people diverted from criminal justice averaged $1,322 for inpatient care compared to $3,818 for those going through the usual criminal justice process--saving two-thirds of the cost.[32]

D. Costs and Benefits of Diversion to the Community

There is evidence of cost savings to the criminal justice system at all points of diversion, whether the focus is on prevention by improving access to community services, providing crisis intervention options to arrest or diverting people after they enter the criminal justice system.

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prison sentences (those sentenced to one year or more) is projected to increase almost 18 percent – adding over 6,700 offenders by 2013. Hickman, D. *Adult Corrections*, Virginia Commonwealth, Senate Finance Committee, Retreat, November 15-16, 2007.

[28]Hickman, D. *Adult Corrections*, Virginia Commonwealth, Senate Finance Committee, Retreat, November 15-16, 2007. According to Hickman, each new 1,000-bed facility will require an initial capital construction cost of at least $100 million and, as of 2010, each new facility will add $25 million ($25,000 per bed) to the annual DOC operating budget.

[29] *Adult Corrections*. Presentation at the Senate Finance Committee Retreat, November 15-16, 2007, available at: http://sfc.state.va.us/pdf/retreat/2007%20Retreat%20-%20Blacksburg/2007%20Adult%20Corrections%20Report.pdf.

[30] Id.

[31] Task Force Recommendations, Oklahoma Governor's and Attorney General's Blue Ribbon Task Force on Mental Health, Substance Abuse, and Domestic Violence, February 17, 2005. Available at: http://www.odmhsas.org/web%20page%20publications/BR.pdf.

[32] *Jail Diversion*. (June 21, 2001). Connecticut Department of Mental Health and Addiction Services, Issue Brief. Available at: http://www.ct.gov/dmhas/LIB/dmhas/infobriefs/6.21.01.pdf.

For example, increased access to mental health treatment in the community decreases arrest rates of persons with serious mental illness and, supplemented by alternative adjudication practices, reduces the number of them in jails and hospitals. For example: In Oklahoma, just one year after implementation of an Assertive Community Treatment ("ACT") program, the number of inpatient hospital days decreased by 63 percent and the total number of jail days decreased by 70 percent for ACT team clients.[33] In Georgia, ACT saved $1.114 (is this correct?) million dollars for the criminal justice, psychiatric hospital and shelter systems in just one year. A 2004 economic review of a jail diversion program in Bexar County, Texas showed the diversion of 1700 individuals resulted in an estimated $3.8 million to $5 million in avoided costs for the Bexar County Criminal Justice System.[34]

Cost savings are not automatic, however, and may not be achieved unless effective diversion options are made available. For example, in mental health crises, where entanglement with law enforcement often leads to the choice of costly arrests or costly hospitalization, diversion options should include both crisis stabilization centers and crisis residential programs. The latter have been shown to cost about half that of acute-care hospitalization, but provide similar results. In New York, supportive housing for homeless people with serious mental illnesses resulted in a marked reduction in shelter use, hospitalizations (regardless of type), and involvement with the criminal justice system. These reductions in criminal justice and acute care hospitalizations costs offset 94 percent of the costs of supportive housing, including operating, service, and debt service costs.[35]

In addition, although policy-makers would have to prescribe eligibility for diversion criteria, there is precedent in Virginia for diverting non-violent felons to alleviate prison bed shortages. In 1994, Virginia's General Assembly set a goal of diverting up to 25% of Virginia's low-risk non-violent felony offenders to community corrections. To date, judges have exceeded that goal and have diverted 28% of offenders identified by the DOC as eligible. A program to divert populations of persons with serious mental illness could further alleviate the prison bed shortages. According to the DOC, the average daily population of inmates for whom the state is responsible in October 2007 was 32,620, a nearly 6% increase from the inmate population

[33] Assertive Community Treatment is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia. Professionals including those in social work, rehabilitation, counseling, nursing and psychiatry provide ACT services. Among the services are: case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual's ability to live successfully in the community. An evidence based practice, ACT has been extensively researched and evaluated and has proven clinical and cost effectiveness. (From the ACT website: http://www.actassociation.org/.

[34] Evans, Leon, President/CEO of The Center for Health Care Services. Testimony before the Subcommittee on Crime, Terrorism, and Homeland Security of the Committee on the Judiciary, U.S. House of Representatives, March 27, 2007.

[35] NAMI Fact Sheet: CIT Toolkit, Criminalization Facts, available at: http://www.neoucom.edu/CJCCOE/NAMI_CIT_toolkit.pdf citing Culhane, D., Metraux, S., & Hadley, T. (2001)."The Impact Of Supportive Housing For Homeless People With Severe Mental Illness On The Utilization Of The Public Health, Corrections, And Emergency Shelter Systems: The New York-New York Initiative." Fannie Mae Foundation.

recorded a year earlier. If even half of the estimated 8% with serious mental illness could be diverted that would translate to more than 1300 fewer inmates in the state's prisons.

E. Services Needed in Jails and Prisons

The CJ Task Force recognizes that not everyone is a suitable candidate for diversion and that many persons with mental illness will remain in the prison population and will need to receive appropriate and adequate treatment there.[36] Treatment while incarcerated is necessary in order to prevent the exacerbation of mental health conditions, reduce symptomatic behaviors that can result in injury to persons with mental illness or others and increase the cost of caring for and housing individuals with mental illness in jail, stabilize individuals in order to increase options for release at the earliest possible time, and increase the potential for successful and long-term re-entry.

In their study of the shift from hospitals to jails and prisons, Lamb and Weinberger estimate that the number of incarcerated persons with mental illness per capita nationally, in jail or prison in the year 2000, was five times the number confined in hospitals.[37] The CJ Task Force acknowledges that some people with serious mental illness may be incarcerated for reasons unrelated to their illness. Consequently, access to mental health treatment for individuals with serious mental illness who are detained, incarcerated in jails or prisons, or under community supervision is one of the CJ Task force's reform priorities.

F. Access to Acute Residential Treatment

A subset of the population of persons with serious mental illness engaged with the criminal justice system will need more intensive mental health treatment while incarcerated. Even among this population, the CJ Task Force urges an exploration of alternatives to state hospitalization. Such alternatives for *convicted* persons with serious mental illness have been shown to be successful both therapeutically and economically. For example, California provides private, locked, long-term 24-hour facilities similar to state hospitals and are able to treat and manage most of the patients formerly served only by state hospitals. California contracts with local jurisdictions to provide care at daily costs much less than the daily costs of care in state hospitals.[38] Virginia law already provides that local jurisdictions may establish municipal

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[36] "Persons with mental illness" is a broad category of all persons with mental illness. Persons with severe mental illness or persons with severe mental illness is a subset of persons with mental illness characterized as having a severe and persistent mental disorder that impairs functioning as defined along three dimensions: 1) having a major mental illness (schizophrenia, major mood disorder, paranoia, organic or other psychotic disorders, personality disorders or others leading to chronic disability), a level of disability resulting in functional limitations in major life activities (such as exhibiting behavior that causes intervention by mental health or the judicial system), and whose illness requires services for an extended duration. (Paraphrase of DSM-IVR).

[37] Lamb, H. Richard and Weinberger, Linda E. (2005). "The Shift of Psychiatric Inpatient Care From Hospitals to Jails and Prisons," Journal of the American Academy of Psychiatry and the Law 33:4:529-534.

[38] Id. Note that much of the research the CJ Task Force examined was on male prisoners or all prisoners. The prevalence of mental illness among women, who account for about 3 million arrests per year, is double that of women in general and higher than that of male detaineees. From Abram, Karen M.; Teplin, Linda A.; and

hospitals to satisfy such an unmet need.[39] This solution would have the advantages of better mental health care than is generally provided in prisons and jails and, also, of the persons' being in community with a greater possibility of interacting with family and other close associates.

However, to minimize incarcerating persons with serious mental illness, hospitals that offer a level of structure and security may be desirable for persons with serious mental illness who may not be able to manage for themselves with community support and services. Although a recent study by Virginia's Joint Legislative Audit and Review Commission concluded that the number of psychiatric beds in Virginia was adequate, if not ideally distributed,[40] Virginia perhaps should investigate an increase in civil beds if required to minimize incarceration as a prerequisite for transfer to a forensic hospital bed. Hospitalization contributes much less to subsequent difficulty of integration into society than incarceration accompanied by a criminal record.

G. Conclusion: Primary Reform Priorities

The momentum to transform Virginia's mental health system provides an opportunity to aggressively pursue prevention strategies to facilitate persons with serious mental illness accessing community-based mental health services and diverting from the criminal justice system those persons whose encounters with law enforcement stem largely from their mental illness. As previously suggested, not all persons with serious mental illness will be candidates for diversion -- but the evidence suggests that a large majority may be. Directing most persons with serious mental illness into treatment will alleviate the untenable burdens on the criminal justice system and promote better care and outcomes for persons with serious mental illness.

In sum, the CJ Task Force recommends that the Commission focus its attention on four central goals:

- Improved coordination and oversight of mental health care supervised by case monitoring teams for high-risk adults;
- Diversion of individuals with mental illness from the criminal justice system to the maximum extent at the earliest point feasible consistent with the aims of criminal justice;
- Enrichment of appropriate mental health services for individuals with mental illness while detained, incarcerated, or under community supervision; and
- Active re-entry support for individuals being released from local jails, state prisons, and juvenile correctional centers to help minimize the destabilization that often leads to re-incarceration or acute hospitalization.

McClelland, Gary, M. (2003). "Comorbidity of Severe Psychiatric Disorders and Substance Use Disorders Among Women in Jail," American Journal of Psychiatry, 160:1007-1010.

[39] VA Code § 15.2-5200 *et seq.*

[40] *Availability and Cost of Licensed Psychiatric Services in Virginia*, Joint Legislative Audit and Review Commission, Commission Draft (October 9, 2007).

CHAPTER I. COORDINATION, PREVENTION AND INITIAL CONTACTS WITH LAW ENFORCEMENT

To the extent possible, even before diversion strategies are employed, policy makers should work to *prevent* encounters between persons with serious mental illness and law enforcement, which will require strengthening mental health services throughout the Commonwealth. Using law enforcement, the courts, and jails and prisons as a policy response to persons with serious mental illness endangers both individuals with mental illness as well as law enforcement[41] and is an inefficient use of public resources.[42]

As a result, diverting as many individuals with mental illness from the criminal justice system as possible, consistent with the aims of criminal justice, as well as increasing access to mental health services for individuals with mental illness while detained, incarcerated or under community supervision makes good public policy sense.

This Chapter addresses some overarching issues for minimizing the entanglement of persons with serious mental illness with the criminal justice system. It then addresses issues related to prevention and the initial, pre-booking interaction with law enforcement linking them to the stated goals of the CJ Task Force.

A. The Need For Coordination

Key to both prevention of criminal justice entanglements of persons with serious mental illness as well as successful diversion programs is an improved coordination of mental health services and supports with law enforcement and the criminal justice system. In their report on jail diversion, Steadman and Naples observe that numerous clinical and systemic dynamics collide to create barriers to individuals with concomitant mental health and substance abuse disorders to find the care and support they need.[43] He suggests that these barriers include:

- Lack of funding for mental health services;
- Lengthy wait for treatment and services;

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[41] Shortly after the Memphis Crisis Intervention Team was implemented, injuries to individuals with mental illnesses caused by police decreased by nearly 40 percent. Vickers, B. "Memphis, Tennessee Police Department's Crisis Intervention Team," *Bulletin from the Field, Practitioner Perspectives,* U.S. Department of Justice, Bureau of Justice Assistance. Available at: www.ncjrs.org/pdffiles1/bja/182501.pdf.

[42] For example, during the year 2000, law enforcement officers in Florida transported more than 40,000 people with mental illness for involuntary 72-hour psychiatric examinations. This exceeds the number of arrests in Florida during 2000 for either aggravated assault (39,120) or burglary (26,087). Deane, Martha, Henry J. Steadman, Randy Borum, Veysey, Bonita, Morrisssey, Joseph P. (1999). "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services*, 50(1): 99-101.

[43] Steadman, Harvey J. and Naples, Michelle. (2005). "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders," Behavioral Sciences and the Law 23(2): 163-170.

- Lack of adequate housing;
- Fragmentation between mental health, substance base (?), housing social service, and health care providers;
- Lack of culturally competent service delivery and trauma informed care;
- Lack of evidence-based practices being delivered at a community level; and,
- Stigmatization, discrimination and negative past experiences within the mental health and criminal justice systems.

When we look specifically at the mental health service delivery realties that face Virginia, we find that all of the problems addressed by Steadman and Naples are found within our own situation. Using the national estimate of the number of adults with serious mental illness as 5.4% of the population, for Virginia translates to 308,037 adults with serious mental illness. [44] In FY 2006, slightly more than a third of this number, or 118,732 unduplicated individuals received mental health services from CSBs.[45]

Overall, the number of persons with serious mental illness who are seeking treatment is growing, with an estimated 36 percent increase over the past decade. This expansion in the request for treatment however is not being met with a parallel provision of more treatment resources in the community. A recent presentation to the Commission by the Joint Legislative Audit and Review Commission Briefing,[46] indicated that 47 Virginia localities have no adult psychiatrists, half of all psychiatrists are located in seven communities, and wait times to get an initial, non-emergency appointment mental health appointment with CSBs may be months.

According to the DMHMRSAS Comprehensive Plan for Mental Health Services 2008-2014 ("Comprehensive Plan"), a survey conducted between January and April 2007, also identified service characteristics during the four months between January and April 2007:[47]

- There were 4029 adults with serious mental illness on CSB waiting lists assessed as needing one or more mental health services;
- 3,418 of these were receiving some CSB services; and,

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[44] U.S. Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration in the Federal Register, Volume 64, No. 121, Thursday, June 24, 1999.

[45] Virginia has 39 Community Services Boards and one Behavioral Health Authority (referred to together as CSBs) with the statutory mandate to provide emergency mental health services to their communities. Community Services Boards receive both State and community funding, with community-based funding ranging from 5% to 70%. Some of the more generously funded CSBs provide services beyond emergency services.

[46] JLARC (October 9, 2007), *Availability and Cost of Psychiatric Services in Virginia*, http://jlarc.state.va.us/Meetings/October07/psychbrf.pdf.

[47] Id. See, also, DMHMRSAS 2008 Draft Comprehensive Plan.

- 611 were receiving no services at all.

Of those on CSB waiting lists:

  - 287 (10%) were in jail, prison or had criminal justice involvement;
  - 2,020 had insufficient social supports;
  - 1153 had a concurrent major health problem;
  - 1,073 lacked transportation; and,
  - 1,934 had unsatisfactory housing situation or were homeless.

Virginia's limited community-based mental health services is a likely significant factor in the growth of inmates with serious mental illness in jails and prisons. Although the trend of a growing population of persons with mental illness in jails and prisons throughout the country, Virginia has the dubious distinction of housing more persons with serious mental illness in jails than the national average. In FY 2006, Virginia reported to the federal Center for Mental Health Services ("CMHS") that its rate of people with serious mental illness "living" in jails or prisons was more than twice the national rate.[48]

In their Report, New York Mental Health-Criminal Justice Panel reiterated their concerns concerning the lack of adequate mental health coverage to individuals with mental health needs within their state system but added to this assessment the observation that even when services are available "mental health providers often act in parallel rather than in concert." [49] Among their key recommendations was for the establishment of care monitoring teams ("CMTs") and a state level data base to track the mental health care provided to high needs adults that would enable CMTs to track the care patterns so that interruptions in care or escalating needs for services are better identified and addressed. They also observed that many individuals who needed high intensity services often did not have a care provider who was primarily responsible and accountable for all aspects of the individual's care and with whom the individual was in regular contact. Focusing on the co-morbidity that affects many of these individuals, they suggested that many mentally ill individuals lacked information about treatment options and [too few providers offered coordinated evidence based integrated for the various conditions.] syntax?

One important variable in the mental health/criminal justice interface is homelessness. In his study of the relationship between hospital capacity, homelessness, and the crime and arrest rates of eighty-one U.S. cities, Markowitz also found that declines in public psychiatric hospital capacity have had a statistically significant negative effect on crime and arrest rates, in part,

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[48] 2006 CMHS Uniform Reporting System (URS) Tables, Virginia Mental Health National Outcome Measures (NOMS), 8/20/2007 p.1. http://download.ncadi.samhsa.gov/ken/pdf/URS_Data06/VA.pdf.

[49] New York State/New York City Mental Health-Criminal Justice Panel: Report and Recommendations (June 2008). Available at: http://www.omh.state.ny.us/omhweb/justice_panel_report/.

through the impact on homelessness.[50] Homelessness is related to higher incarceration rates among the mentally ill and studies have shown that mentally ill offenders are more likely than other inmates to have been homeless at the time of arrest and in the year before arrest. Citing a lack of community treatment programs and limited staffing for monitoring medication compliance, personal resources, and social supports, Markowitz argues that mentally ill homeless persons are at increased risk of police encounters and arrest for not only "public order" types of offenses, such as vagrancy, intoxication, or disorderly conduct, but also for more serious types of crimes like assault. [51]

These types of concerns have motivated some communities nationally and internationally to create pre-arrest diversion programs that seek to provide services to high need individuals before they are processed into the criminal justice system. Hartford, Carey, and Mendonca[52] recently conducted a literature review of these pre-arrest diversion programs to assess what is currently known about the best practices in this service arena. In terms of outcome, they concluded that active interventions improved treatment compliance and reduced the likelihood of recidivism. A detailed review of the six outcome studies that are currently available, also lead to the hypothesis that formal case finding procedures were important for the early identification of high risk individuals; that stable housing enhanced the possibility that an individuals with serious mental illness would remain in contact with their treatment manager and compliant with their medication; and that specific case management interventions improved compliance and reduced the likelihood of repeat contact with the criminal justice system.

In an earlier research report, Hartford, Carey and Mendonca[53] reported on an international survey of pre-arrest diversion programs and what the personnel involved believed to be the cornerstone of successful interventions. Based upon their review of the extant literature and a survey of practitioners from various countries, they concluded that leadership, a statutory mandate for coordination, and emergency drop-off centers were essential to ensure that coordination and communication did occur. The law enforcement communities further emphasized the importance of an emergency drop off center for law enforcement with a no-refusal policy for police cases as the basis of their ability to offer a different kind of response to mentally ill individuals prior to their being booked into the criminal justice system.

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[50] Markowitz, Fred E. (February 2006). "Psychiatric Hospital Capacity, Homelessness, And Crime And Arrest Rates," Criminology 44(1): 45–72.

[51] Markowitz at page 45, citing studies by Engel and Sliver (2001) and Lamb et al (2002). One reason persons with serious mental illness may end up in the criminal justice system is that with limited treatment options--low public hospital capacity coupled with absent or inadequate community-based services

> "disturbing behavior that might have been dealt with medically is now more likely to be treated as criminal behavior. For example, even though police may recognize some disruptive behavior as resulting from mental illness, they often have little choice but to use "mercy bookings" as a way to get persons into mental health treatment. Police are now one of the main sources of referral of persons into mental health treatment." right justification on this paragraph

[52] Hartford, Kathleen; Carey, Robert; and Mendonca, James. (April 2007). **"**Pretrial Court Diversion of People with Mental Illness," Journal of Behavioral Health Services and Research, 32(2):198-205.

[53] Hartford, Kathleen; Carey, Robert; and Mendonca, James. (2006). "Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey," Behavioral Sciences and the Law, 24(6):845-856.

Meeting the challenge of prevention and diversion, where appropriate, will require all parties--law enforcement, criminal justice, mental health and social services--to collaborate in the development of policies, training of personnel, and finding creative financing solutions. To take advantage of the opportunity to both *prevent* persons with serious mental illness from entering the criminal justice system and to divert others from repeatedly cycling through the criminal justice system, there are five key at risk groups that now or will soon require appropriate and effective community public mental health services:

1) The existing pool of people currently receiving some community services, but which are inadequate to maintain them in recovery;

2) Individuals on CSB waiting lists who cannot yet gain access to scarce services;

3) The growing population of persons in the community with serious mental illness;[54]

4) Those persons with serious mental illness who will be placed in community treatment as a result of diversion from the criminal justice system; and,

5) Individuals who meet the criteria for mandated outpatient treatment should that option become more widely used.

The CJ Task Force has provided Recommendations in this and the following chapters of this Report to aid in accomplishing these tasks. It also offers, first, the following four, overarching, Recommendations to meet the goal of improving coordination and oversight of mental health care to high-risk individuals:

Recommendation I.1. Legally responsible agencies should create criminal justice/mental health task forces/councils at state, regional and local levels to oversee and coordinate the effective development, enhancement and sustainability of jail diversion programs. [55]

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[54] As noted earlier in this Report, the increasing demand for community-based mental health services is anticipated to continue due to population growth and aging, plus decreasing availability of acute psychiatric hospital beds, increasing concomitant disorders and dual diagnoses, and veterans returning from combat.

[55] Note that by Executive Order No. 62, 2008, Governor Timothy Kaine established the Commonwealth Consortium for Mental Health/Criminal Justice Transformation (the "Commonwealth Consortium"), a copy of which is included in **Appendix D** of this Report. The Executive Order charges the Commonwealth Consortium "with the dual purpose of preventing unnecessary involvement of persons with mental illness in the Virginia criminal justice system, and promoting public safety by improving access to needed mental health treatment for persons with mental illness for whom arrest and incarceration cannot be prevented." The goals of the Commonwealth Consortium were stated as follows:

> **Goal I**: Transformation planning:
> The Consortium shall evaluate the viability of jail diversion models for persons with mental illness, and develop recommendations for improving access to mental health treatment for persons with mental illness who cannot be diverted from arrest and incarceration. Representatives from relevant stakeholder groups in each locality, including Community Criminal Justice Boards, Law Enforcement, Local and Regional Jails, Community Services Boards and Local Community

- **At the state level, the Secretary of Health and Human Services, the Secretary of Public Safety and the Chief Justice of the Supreme Court should develop a Coordinating Council on Mental Health and Criminal Justice (hereinafter the Coordinating Council) to assist in the development, oversight and coordination of regional and local diversion task forces.**

- **The Coordinating Council should oversee and approve the development and implementation of evidence-based and promising best practice programs, as well as the necessary policies and procedures to support their effective implementation.**

- **At the regional and/or state level, CCJBs or other capable and interested entities where the CCJB is not active or interested in participating in partnership with CSBs, should establish collaborative task forces, which include stakeholders from mental health, criminal justice, consumers/advocates, local government and business interests to develop locally feasible and acceptable community plans for jail diversion.**

Recommendation I.2. The General Assembly should amend the Virginia Code Section 9.1-178 to add one or more mental health representatives to CCJBs.

- **These representatives should include at least one consumer and one provider; and,**

- **An executive leadership position should be established to provide staffing for the state council and linkage between the work of the state council and local criminal justice/mental health collaboratives.**

Recommendation I.3. The Coordinating Council should establish a Criminal Justice/Mental Health Training Academy to coordinate, provide, develop and/or enhance appropriate training, cross-training and public education in the criminal justice/mental health interface area for stakeholders, agencies, individuals and systems. [56]

In outlining the steps that might be used in local community implement diversion programs, Steadman emphasizes the importance of data collection to the on-going viability of such programs.[57] Specifically, he underscore the relevance of rigorous data for use in applying for grants, educating policy makers and the community, increasing support for public funding,

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Corrections, Mental Health Services Consumers, and other public and private organizations shall be invited to participate in comprehensive transformation planning for their regions.

Goal II: Establish a Criminal Justice/Mental Health Training Academy for the Commonwealth: The Academy will provide an integrative locus for coordinating the training activities of currently disparate state and local, public and private organizations into a concerted program of cross-training for criminal justice and mental health personnel.

[56] See the Executive Order described in footnote 100 above, which provides for developing a Training Academy.

[57] Steadman, H.J. , *Practical Advise* (2007), see footnote 6 above.

defending against unexpected policy changes and improving the quality of the program over time.

Recommendation I.4. The DMHMRSAS, the DOC, and other appropriate state and local entities should collaborate in the development and implementation of systematic data collection in all diversion programs. This effort should be mandated at the state level and monitored through the Coordinating Council or other appropriate entity.

Furthermore, for prevention and diversion at any stage of a person with mental illness's interaction with the criminal justice system to be effective, there needs to be a substantial strengthening of community-based mental health services throughout the Commonwealth, which lack adequate outpatient services and are characterized as having long waiting lists. The CJ Task Force strongly urges that the Recommendations of the Access Task Force increasing access to services be implemented.

B. Initial Contacts with Law Enforcement.

A second key reform priority beyond prevention is the diversion of individuals with mental illness from the criminal justice system to the maximum extent and at the earliest point feasible consistent with the aims of criminal justice.

Diversion is a process where alternatives to criminal sanctions are made available to persons who have come in contact with law enforcement. In the context of minimizing the mental health/criminal justice interface, it can be defined as a program that identifies people with serious mental illness and concomitant disorders who came in contact with the justice system and redirects them from jail by providing linkages to community-based treatment and support services.[58] As such, the goal of diversion is the avoidance or reduction in jail or prison time through these linkages to community-based treatment.

In developing a jail diversion program, it is important to differentiate between pre-booking diversion and post-booking diversion.[59] The former occurs at the point of contact that the mentally ill person has with law enforcement and relies upon the effective interactions of these specially trained officers with the mentally ill individual and community mental health and substance abuse services. The latter involves programs that identify and divert individuals with mental illness after they have been arrested and/or at or after booking. Steadman reports that there are approximately 500 jail diversion programs in the U.S. and that 65 percent are of the post-booking kind with an emphasis on the monitoring of compliance after the individual had been returned to the community. Intrinsic to these programs is a process for screening individuals who are potentially suitable for diversion, the formal evaluation of them for assessing diversion options, negotiation with prosecutors, defense attorneys and the court to fashion a

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[58] See, e.g., *Jail Diversion Strategies for Persons with Mental Illness: A Guide for Mental Health Planning and Advisory Councils*, U.S. Department of Health and Human Services, Washington, D.C (2006). Available at: http://www.namhpac.org/PDFs/01/jaildiversion.pdf.

[59] CMHS National GAINS Center (2007), Practical Advise on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center, Delmar, NY, Author.

disposition outside of the jail, and the linking of these individuals with an array of available community services.

Based upon a review of the different types of diversion programs, Steadman, Morris and Dennis have identified six factors that seem to be consistently associated with program success.[60] They include:

- Interagency collaboration including social services, housing, mental health, health, local corrections, workforce development, Medicaid, and substance abuse services;
- Active involvement and meeting of all stakeholders with formal written agreements including Memorandum of Understanding and agreements concerning the sharing of information considering state and federal legal and ethical privacy and confidentiality concerns;
- Boundary spanning staff who are able to competently bridge the various systems and manage well cross system interactions;
- Strong leadership with network and coordination capabilities;
- Early identification, ideally within the first 24 or 48 hours following detention; and,
- A specialized case management program staffed by case managers with knowledge and experience with mental health and criminal justice.

In focusing on this research, the CJ Task Force recognizes that not all persons with mental illness are candidates for jail diversion. However, diverting those whose actions are less serious, are substantially related to a mental health crisis or serious mental illness, and who, without treatment are at risk of cycling repeatedly through the criminal justice system will benefit both the individual and the criminal justice system.

In seeking to apply these principles to Virginia, we have organized our recommendations specific to pre-trial diversion, using the conceptual model provided by the Sequential Intercept Model (the "Model"), a tool developed by the Department of Justice's GAINS Center to create a framework for discussion. (See Appendix A for a more complete description).[61] The Model

[60] Steadman, H.J., Morris, S.M., Dennis, D.L. (1995). "The Diversion Of Mentally Ill Persons From Jails To Community-Based Services: A Profile Of Programs." *American Journal of Public Health* 85(12): 1630-1635.

[61] The Gains Center is sponsored by the U.S. Department of Justice. Its website is: http://gainscenter.samhsa.gov/html. The Model, described in detail in *Appendix A*, anticipates that the highest numbers of persons should be diverted early before serious legal involvement. However, even when an individual is arrested there are opportunities at the initial detention and before booking. As the model shows, interventions are available at each step to filter appropriate candidates out of criminal justice and into treatment.

maps the progression of an accused from initial encounters with law enforcement, to arrest, to release into the community, and shows where the steps of the process occur (viz., law enforcement, courts, jails, prisons and probation/parole departments). The model emphasizes the importance of the "ultimate intercept," the filter with the greatest potential, which involves preventing the initial encounter with law enforcement. The next layers of interventions involve the contact made by law enforcement with the individual and their evaluation by emergency service personnel.

Although the Model, or elements of it, are being applied effectively in many communities in the U.S, in Virginia, the only explicit engagement of the mental health system into the routine criminal justice process is with the single the Mental Health Court *after* an individual is arrested and booked, a rather late intercept opportunity. Clearly, there are many opportunities being overlooked with the result that many who end up in jails and prisons should, instead, be in treatment in the community. Consequently, mental health advocates and policy makers must develop strategies targeting other, preferably earlier, possible intercepts that will either divert a person with a serious mental illness from the criminal justice system altogether, or maximize the likelihood of getting access to mental health services in jails or prisons and upon reentry to the community.

C. Description of the Initial Contact

Opportunities to intervene and provide mental health service options occur at several key points when persons with serious mental illness and law enforcement interact, including the initial contact with law enforcement and emergency services, post-arrest evaluation, treatment and jail diversion, recovery-oriented re-entry and community corrections and community support.[62]

The initial contact of a person with serious mental illness with law enforcement is critical.[63] A law enforcement encounter is often the first formal step experienced by a person with serious mental illness during the involuntary commitment process and always so when an arrest is executed. As a result, a key reason for using people with mental health training even for these initial encounters is to minimize trauma and to facilitate early engagement in treatment. It has been observed that persons with serious mental illness become resistant to seeking or accepting treatment if they fear this initial experience.

Educating law enforcement officers about mental illness and training them in techniques that ameliorate the unpleasant aspects of custody can have a positive effect not only in managing the encounter but in the longer term as well. However, the adverse impact of other routine police

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Note, also, that the Sequential Intercept Model was featured at the Commonwealth's Consortium on Mental Health/Criminal Justice Transformation ("Consortium") Conference held at Virginia Beach, VA, on May 13-14, 2008. The Consortium was established by Executive Order No. 62, 2008.

[62] The National GAINS Center in the Justice System has operated since 1995 as a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system. The Sequential Intercept Model is described more fully in **Appendix A** of this Report.

practices is difficult to overcome with training alone. For example, the physical discomfort of being transported to jail or another facility in handcuffs offsets some of the positive effects of increased law enforcement officer knowledge. Also, in emergency situations, of which many of these encounters present, persons with serious mental illness do not perceive the situation as objectively as they might otherwise. Although for some persons the destination may be a hospital, police detention, handcuffs, and transport in a police vehicle, all of which may cause some persons to believe they are under arrest.

The mental health response system selected by the CJ Task Force as exemplary is that of Montgomery County Emergency Services ("MCES"), operated by a Pennsylvania nonprofit entity under contract with the county. MCES uses an emergency mental health services model that requires a three-day training course for all officers followed by subsequent refresher trainings.

Although the extensive officer training is important, the most potent advantage of the MCES system, however, is that persons with serious mental illness taken into custody are brought to a single facility, where they undergo medical screening and treatment for physical conditions, appear at hearings, and are hospitalized, if necessary. Furthermore, MCES has access to a Mobile Crisis Intervention Service, including a psychiatric ambulance that meets Emergency Medical Services standards for initial transport. The MCES system has two principal benefits: 1) the one-stop shopping feature of its central facility reduces the disruption to persons with serious mental illness who sometimes must miss sleep and meals to travel to a hearing location; and 2) the central facility plus the Mobil Crisis Intervention Service alleviates the safety and time constraint problems that the mentally ill and law enforcement officers often face during multiple transports.

It may not be feasible for Virginia to adopt the MCES model to the extent it created a freestanding nonprofit emergency psychiatric hospital. However, it is feasible to provide some important aspects of this model in jurisdictions across the Commonwealth, including a 24-hour guaranteed therapeutic drop-off location and specialized training for officers who interact with persons with serious mental illness.

Virginia also needs to develop a process that will shorten the amount of time an officer spends in transporting and detaining a person with a serious mental illness awaiting evaluation and will avoid keeping officers from patrol for long periods of time. Virginia also needs a system, which promotes the ability to perform a thorough evaluation for a temporary detention order ("TDO") within a statutorily-mandated time period.[64] If access to medical and psychiatric hospital

[64] The civil commitment process usually begins with an Emergency Custody Order ("ECO"), which permits the detention of an individual with mental illness or substance abuse involvement for a brief period for a mental health assessment. Often the individual is in crisis and is brought to a hospital emergency department where the assessment occurs. This pre-screening assessment is conducted by a professional with one of Virginia's 40 CSBs, which have the statutory obligation to provide emergency mental health services.

During the TDO period, an independent examiner ideally conducts an extensive clinical evaluation of the individual to determine whether he or she meets the statutory criteria for involuntary inpatient admission or mandatory

facilities can be managed such that a consumer makes a single stop, medical screening and treatment will not push past the four-hour emergency custody order ("ECO") time limit, there will be no wait to designate a TDO facility, and the facility can accept custody of the person with a serious mental illness after a brief administrative delay for transfer.

D. Available Models

The CJ Task Force reviewed several models of jail diversion used in other jurisdictions at the pre-booking stage. No single model may be appropriate for Virginia or for any specific locality in Virginia. However, there are components from each model that can be effectively adopted and modified for any jurisdiction, regardless of size or demographics.

The key components in all models are reviewed community partnerships, trained personnel and a secure therapeutic location where the officer can transfer a person with serious mental illness. The following describes categories of diversion models used in different areas of the country:

1. In-house police models

The essence of in-house police models is the specialized training of the officers to handle cases involving persons with serious mental illness until the issues are resolved or until the individual is transferred to a mental health facility. Police are the first responders and make the decisions about whether and where to transport individuals for mental health assessments.

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a. Crisis Intervention Team or Memphis Model.

The Crisis Intervention Team ("CIT") approach employs specially trained uniformed officers to act as primary or secondary responders to every call in which mental illness is considered a factor. The Memphis Model CIT has been successfully adapted in several Virginia communities (Charlottesville, Fairfax County, and the New River Valley) and many others are working to adopt CITs, including the northern Shenandoah Valley (Northwestern Community Services Board), the Mt. Rogers CSB Service area and Portsmouth.

b. Comprehensive Advanced Response

The Comprehensive Advanced Response model differs from the CIT model in that it mandates advanced training for *all* officers within the department rather than a specialized team. This model may be more effective for smaller communities with fewer officers and fewer incidents involving persons with serious mental illness.

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outpatient treatment. The Virginia Code provides for a 48-hour period for a TDO. The Commission's Task Force on Civil Commitment recommended increasing that time period to four days.

2. Co-response models

Co-response models employ a partnership of police officers and mental health professionals in handling cases involving persons with serious mental illness. The mental health professionals partnering with the police can either be housed within the police department or outside with another agency or entity.

a. Mental health professionals *within* the department.

In this co-response model, civilian mental health professionals serve in special units located within the police department and are under the chief 's supervision. Depending on community size, the number of officers and the number of calls involving persons with serious mental illness, these mental health professionals may either ride along with officers in special teams or respond when called by an officer. The civilian employees are not sworn officers but respond to the scene either with sworn officers or after the scene has been secured by sworn officers.

b. Mental health professionals *outside* the department (Mobile Crisis Teams).

Another co-response model is that of Mobile Crisis Teams ("MCT"s"), which are composed of civilian licensed mental health professionals employed and supervised by a mental health agency separate from the police department. MCTs are called once law enforcement officers have secured the scene and have determined that the incident involves a person with a serious mental illness. In some jurisdictions, such as those served by the Montgomery County Emergency Services ("MCES") ascribe to this program. MCTs are authorized to provide transport to a mental health facility if it appears the person might meet the criteria for civil commitment, or may counsel and assist the person in obtaining community treatment and services.

A study by Steadman, et al. reviewed 100 police dispatch calls involving an emotionally disturbed person in three cities with different jail diversion programs—in Birmingham, Knoxville and Memphis.[65] Memphis used the in-house police response model—the CIT model—while Birmingham and Knoxville used within the police department mental health professionals and outside mental health professionals in variations of the co-response model.[66]

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[65] Steadman HJ, Deane MW, et al. (2000). "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies," Psychiatric Services, 51:645-649. This study compared three models of police responses to incidents involving people thought to have mental illnesses to determine how often specialized professionals responded and how often they were able to resolve cases without arrest. The key findings showed that, although all three programs resulted in relatively lower arrest rates when a specialized response was made, time delays associated with waiting for mental health co-responders likely greatly reduced the frequency at which they were called. In addition, the strong linkage of the Memphis CIT model with a no-refusal drop-off center increased the likelihood of a specialized response.

66 The three programs in more detail are:

In general, police-based response programs seem to have the weight of research in support. A key advantage to police-based programs seems to be the higher frequency of a specialized response. Steadman, et al. examined the frequency at which a specialized, mental health-trained responder in response to a call involving a "mental disturbance" and the nature of the outcome of that response. All three programs studied resulted in relatively low arrest rates when a specialized response was made. However, there were significant differences in how frequently specialized responses were made.

Overall, there was a specialized response a little more than half the time (54%) in cases classified as involving a person suspected of having a serious mental illness. However, this average masks considerable differences. The Memphis CIT program, with police officers trained in mental health, had the highest specialized response rate at 95%. The two co-response programs had significantly lower specialized responses, with Birmingham at 28% and Knoxville at 40%. One reason for these discrepancies cited is that the specialized co-responder units' slow response times created a disincentive for law enforcement to call upon their services.

If a specialized response was made, however, arrest rates were low for all three programs (Memphis (2%), Birmingham (13%), Knoxville (5%). Rather than arrest, the most common responses were resolving the situation at the scene or, when that failed, transporting the individual to a treatment facility. Again, there were significant differences in the non-jail dispositions of such incidents, perhaps reflecting a difference in the qualifications of the mental health responders and, in part, the availability of community-based treatment facilities. Birmingham's co-response program with civilian community service officers resolved more incidents on the scene (64%). In contrast, both the Memphis CIT program and the Knoxville MCT program transported more persons with serious mental illness to a treatment/crisis stabilization center (75% and 78%, respectively).

Police-based specialized response models for cases involving persons with serious mental illness, whether involving specially trained police officers or having police-based mental health responders, tend to be the most common. A 2003 Police Executive Research Forum surveyed law enforcement agencies that utilize police-based specialized response models for

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- Memphis' CIT Program. Memphis police utilize the CIT model employing specially trained uniformed officers as primary or secondary responders to every call in which mental illness is deemed a factor.
- Birmingham's Co-response Programs: Birmingham police use a co-response model whereby civilian community service officers, trained in social work or a related field, employed by the police department provide crisis intervention and follow-up services. They are available during weekdays and evenings and operate on an on-call basis overnight and on weekends and holidays. These community service officers are not sworn police officers, do not carry weapons, and cannot make arrests.
- Knoxville's MCT Co-response Program: Knoxville utilizes the MCT co-response model, which is primarily a specialized non-law enforcement model in which teams composed of civilian licensed mental health professionals are employed and supervised by a mental health agency separate from the police department. These mobile teams are available 24/7 and cover a five-county area.

cases involving persons with serious mental illness.[67] Of the 28 agencies interviewed, 22 used the Memphis CIT model and 6 used the police-based mental health co-responders. However, the study also found that communities often combine elements from different models to suit their jurisdiction, which, given the diversity of jurisdictions in terms of size and availability of mental health professionals within Virginia, selecting the best elements of the various response models may be the best option.

E. Diversion at the Initial Contact: Goals and Vision

The CJ Task Force encourages Virginia to develop a collaborative, community supported system that utilizes specially trained officers, acting in the course of their regular patrol duties, with ready access to a designated therapeutic drop-off location which allows officers to return quickly to their other duties. The basic goals of such an initial law enforcement contact system are to:

- Improve safety for officers and individuals with mental illness;
- Increase police understanding of mental illness;
- Improve the interrelationship between police, mental health community, and persons with serious mental illness and their families within the bonds of state and federal privacy and confidentiality laws; and,
- Provide reasonable options for redirecting individuals from the criminal justice system to the health care system *before* any criminal charges are brought.

1. Core elements

a. Community Partnerships

The first step in creating a successful program at the initial law enforcement contact stage is convening mental health care providers, law enforcement/criminal justice personnel, consumers, family members, advocates, and other community members to develop strong, formalized collaborative partnerships. Such collaborations are integral to the planning and execution of successful jail diversion programs at all stages of the Mental Health/Criminal Justice Intercept Interface. When formalized (as through a Community Criminal Justice Board, under the auspices of local CSBs or under the direction of other non-profit organizations like the National Alliance on Mental Illness ("NAMI"), the Mental Health Association ("MHA"), or Virginia Organization of Consumers Asserting Leadership ("VOCAL")), these partnerships enhance mental health and criminal justice systems interoperability through strengthened relationships, improved communication and understanding, and increased cross-training and education. Furthermore, these partnerships provide an

[67] Reuland, M. (2004). *A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness,* National GAINS Center.

ongoing forum for creating inter-agency and inter-jurisdictional processes that assure the best responses to individuals and address developing issues before they become intractable barriers, assuring that all interfacing systems operate in the most cost-effective and efficient way.

Specifically, these community partnerships should include representation from the following three "strands" of entities

(1) Criminal Justice System

(a) Police Chiefs and Sheriffs – Providing leadership and demonstrating support; developing and approving necessary policy and procedural changes;

(b) Supervisors – Providing administrative oversight to ensure top down and bottom-up issues are resolved within their agencies;

(c) Patrol officers – Intervening with mental health crisis situations and providing input and insight for leadership about what is actually happening "on the ground";

(d) Hospital Security Staff;

(e) Attorneys – Prosecutors, defense attorneys, civil commitment attorneys;

(f) Judges – Including Special Justices;

(g) Corrections staff;

(h) Probation/parole officers– Including Community Corrections; and,

(i) Magistrates.

(2) Community Stakeholders

(a) Persons with mental illness, especially those who have had interactions with law enforcement;

(b) Invaluable resource. No one knows the effects of detention and arrest better than those who have lived the experience;

(c) Forensic Peer Specialist (FPS). This is a specialized position for trained peer staff that have a history of mental

illness and incarceration. FPSs provide recovery-oriented services directly to peers with similar experiences;

(d) Family members:

(1) Families often deal with law enforcement and mental health treatment issues for years on behalf of their family member; and,

(2) A successful diversion program should include a mechanism for providing support to family members at every intercept.

(e) Advocates and Advocacy groups—Including NAMI and MHA and any other local mental health advocacy group.

Mental Health Providers—Public, Private, For-profit and Non-profit Sectors

(a) Clinicians;

(b) Hospitals—ER Staff, Administrators, Psychiatric Unit Personnel;

(c) Administrators from relevant public and private service providers; and,

(d) EMS/Ambulance Services.

Membership from among these three strands in a community partnership provides the ongoing expertise, leadership and systems knowledge for the successful development, implementation and sustainability of programs at all stages of the Mental Health/Criminal Justice Interface. Importantly, by recognizing and maintaining the discrete nature of the strands, each sub-group has a ready forum to broach and resolve sensitive issues internally, which can then be discussed among the wider group, as necessary.

The community partnership should develop strategies to measure, collect and present data in order to demonstrate the program's efficacy and provide feedback regarding necessary course corrections.

b. Training

The second major element in successful diversion at the time of initial law enforcement contact is training. Training that includes consumers (as in programs in Charlottesville, Fairfax County and New River Valley) is particularly effective in countering the stigma associated with mental illness and precipitating improved

communication between the public employees and consumers. This multi-faceted training component includes:

- Basic training of all officers on mental illness including recognizing indicators and de-escalation techniques;

- An advanced DCJS certified program for select, or all, patrol officers that covers everything from mental health diagnoses, psychopharmacology, suicide and concomitant disorders to understanding necessary changes in policies and response protocols, community resources and linkages as well as intensive role play exercises which provide officers with hands-on experience and self-confidence in de-escalating mental health crisis situations;

- Training of dispatchers that enables them to recognize when mental health is at issue, begin the process of de-escalation with the caller when appropriate and dispatch a trained officer to the scene;

- A Train-the-Trainer program which identifies core mental health and law enforcement faculty, provides skilled staff to lead them through the development of their own officer training modules, emphasizes collaborative Mental Health and Law Enforcement teaching practices and guides faculty in the development of their own role playing scenarios, allowing community programs to become self-sustaining;

- Continued in-service instruction opportunities for officers focusing on special populations, new and promising intervention practices, protocol changes, or other timely topics;

- Education on state and federal privacy laws related to sharing mental health information;

- Public outreach and education to raise awareness of the program; and,

- Cross training of mental health emergency services and law enforcement to enhance understanding of the roles, duties, expectations and limitations each of these strands face when handling a crisis situation.

c. Guaranteed therapeutic drop-off location

Fundamental to the success of diverting persons with serious mental illness at the initial police contact is an available, guaranteed, efficacious and therapeutic (not law enforcement based) drop-off facility. Such receiving facilities serve as mental health crisis triage centers and can serve both acute and non-acute clients by providing a full range of medical screening and treatment, clinical assessment, access to in-patient services, crisis stabilization and linkage to community-based

services. The drop-off process should involve minimal officer turnaround time, be available on demand and provide services or linkage to services 24/7. A drop-off center can also provide an extraordinary opportunity for on-site peer service and support.

These core elements comprise the necessary components for successful intervention at the initial law enforcement contact.

2. Issues that must be addressed prior to implementing pre-booking diversion

a. Commitment Criteria

The Commission's Civil Commitment Task Force reviewed and made recommendations concerning the Commonwealth's commitment criteria, but there is an overlap with the CJ Task Force's focus on this issue. Changes may be needed to the current law to ensure that persons whose crimes are largely the result of their mental illness are hospitalized for treatment, if necessary, rather than jailed, and to provide that imminent risk of arrest constitutes either an imminent danger to an individual or results in a judgment that the person is substantially unable to care for him or herself.[68]

b. Officer Discretion

Another area where Virginia's mental health law should be clarified is that of law enforcement's discretion to take individuals into custody for a mental health evaluation instead of arresting them in situations where a person is suspected of committing a criminal offense. In such instances, when the officer has probable cause to believe that the person meets the criteria for and ECO under the Virginia Code's civil commitment provisions, the officer should have the discretion to take the person into custody and transport him or her to an appropriate location for an assessment of the need for hospitalization or treatment. This discretion should be available to law enforcement without prior authorization and without formally

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[68] Note that the 2008 General Assembly modified the Virginia Code replacing the phrase "substantially unable to care for self" with the phrase **"suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs**." The legislative history confirms that the intent was not to limit harm to physical harm but to include other sorts of harm as well. Initial consensus guidance on interpreting this language includes the following example: Engaging in illness-related criminal behavior that would be highly likely to lead to arrest and incarceration if the police were to decide when confronted with such behavior to initiate the criminal process. See *Understanding and Applying Virginia's New Statutory Civil Commitment Criteria* by Bruce J. Cohen, Richard J. Bonnie, and John Monahan, University of Virginia's Institute for Law, Psychiatry and Public Policy, June 2008).

tendering criminal charges. The Virginia Code should be modified to make this option explicit.

c. Coterminous diversion

Coterminous diversion occurs when a person with serious mental illness who has possibly committed a crime and is in police custody is taken to a mental health facility for assessment and the criminal charges are either dropped or held in abeyance conditional to the individual's agreement to mental health treatment. A statutory change may be required to allow charges to be held in abeyance in cases involving persons with serious mental illness.

d. Transportation

Officers and deputies are authorized under the Virginia Code to transport persons with serious mental illness to locations where treatment will be provided. There are three situations where law enforcement could be called to provide transportation for a person with serious mental illness. In all three situations, officers and deputies must consider the need for the use of handcuffs, leg restraints, waist belts, and paddy wagon type vehicles, etc. Decisions on the type of vehicle and manner of restraint should be discretionary for each department and each official and must be made only after careful consideration of the totality of the circumstances, agency policy, and the demeanor of the individual being transported.

(1). Response to calls for service for persons with serious mental illness

Officers and deputies responding to a call for service where a person exhibits symptoms of a mental illness and has committed a minor crime or may be a danger to him or herself or others should be allowed to transport the person to the therapeutic drop off center where they can be evaluated for a TDO. The method and manner of transportation should be determined as described above.

(2). Response to detain a person with serious mental illness when an Emergency Custody Order has been issued

Officers and deputies responding to serve an ECO should be allowed to transport the person to the therapeutic drop-off center. The method and manner of transportation should be determined as described above.

(3). Response to transport a person with serious mental illness from the therapeutic drop off center to a secure rehabilitation facility

Officers and deputies should be allowed to transport persons with serious mental illness when a TDO has been issued from the location of examination to the secure treatment facility. The method and manner of transportation should be determined as described above.

F. Law Enforcement and Emergency Services: Recommendations

Policy Considerations

Recommendation I.5. The Coordinating Council and the participating agencies should take the necessary steps to implement evidence-based or promising best practices throughout the Commonwealth. Such programs should include, at a minimum:

- **Appropriate methods for selection and training of officers and/or mental health professionals for addressing mental health crisis response;**

- **Support for the use of specially trained officers to allow them discretion to seek treatment for appropriate individuals rather than pressing charges and to make community referrals in situations that do not rise to the level of an ECO; and,**

- **A therapeutic drop-off process, which can be effectively used to reduce the need and preference for arrest and booking.**

Regulatory Considerations

The DMHMRSAS may need to enact regulations to meet the requirements of such new programs and legislation.

Procedural Considerations

Recommendation I.6. The DMHMRSAS and the DCSJ should jointly develop protocols for the primary officer in any encounter involving an individual with suspected mental illness as well as for specialized responders, whether civilians or police officers.[69]

Recommendation I.7. The DMHMRSAS and the DCSJ should jointly develop protocols for when an officer with specialized training in mental health and crisis response should be dispatched to a scene.

Training Considerations

As discussed above, crisis response training is an essential core element in any successful diversion model, and consumers are an important part of the training team. Consideration of the number of officers trained will depend on whether dispatchers send specially trained of untrained officers as first responders on the scene. If untrained officers are to be dispatched, great consideration should be given to a policy of providing all officers with education about mental illness and training in de-escalation techniques. This is typically done in a two or three day training course.

[69] Typically, when a police officer is the responder, a specially trained officer is in charge of a mental health call because of his expertise, regardless of rank.

Recommendation I.8. The Coordinating Council and its participating agencies should take the necessary steps to assure that targeted crisis response training is provided to the following groups in order to enhance community capability to support mental health crisis response:

a. Medical Crisis Responders

b. Dispatchers

c. All Law Enforcement Officers (see statutory change recommended below)

d. Magistrates

e. Consumers/Family/Household

f. The community at large

Recommendation I.9. The General Assembly should amendVirginia Code § 9.1-102 to require the Department of Criminal Justice Services to establish compulsory minimum entry-level, in-service and advanced training standards for law enforcement personnel in recognizing, communicating with, facilitating the safe disposition of incidents involving, and obtaining evaluation and treatment of individuals with mental illness;

Resource Considerations

Recommendation I.10. Local or regional criminal justice/mental health collaboratives should develop guaranteed, secure therapeutic drop-off locations for individuals in crisis, including person under an ECO or TDO. Such facilities should be suitable to local needs and resources in each locality or region and may include existing facilities provided that security issues are addressed. At a minimum, such a drop-off locations would reduce the amount of time necessary for first response law enforcement to remain on scene during an ECO.

Legislative Considerations

In order to implement the changes contemplated for providing more mental health interventions at the initial contact of a person with serious mental illness with law enforcement, several statutory amendments are recommended.

Law enforcement custody

If law enforcement elects a mental health intervention rather than the arrest of a person with a serious mental illness, the authority to take that individual into custody is provided under Virginia Code § 37.2-808, which sets forth the requirements for an ECO. However, a major *disincentive* for utilizing this avenue is the statutory requirement for law enforcement to retain

custody of that individual for up to the four-hour limit of the ECO. As a practical matter, an officer can return to his duties more quickly by arresting an individual and transporting him to jail than by transporting an individual for an evaluation using the ECO. As a result, an essential component of a successful diversion program is a 24-hour, secure, therapeutic drop-off location where law enforcement officers can transport an individual and quickly return to their other duties. Without access to such facilities, neither clarifying the discretion of officers to divert nor providing improved mental health training will be sufficient to stem the bias toward arrest.

A further advantage to minimizing the period of police involvement is that persons with serious mental illness may believe they are in a criminal justice situation (viz., being arrested) even if the custody is purely civil. Decreasing the police presence at the mental health facility should serve to decrease the risk of "perceived criminalization" on the part of the person with serious mental illness.

Recommendation: I.11, To facilitate an officer's ability to assist appropriate individuals in obtaining necessary services rather than arresting the individual, the General Assembly should amend the Virginia Code § 37.2-808 to permit custody to be transferred to the facility. [This authority was conferred in the reform package adopted by the General Assembly in 2008.]

Law enforcement discretion

For diversion at the initial contact with law enforcement to work effectively, law enforcement officers must have the discretion to seek mental health treatment for appropriate individuals rather than pursuing criminal charges. Although officers may have such discretion under current law, Virginia law can be amended to explicitly provide officers with such discretion to divert individuals from the criminal justice system when appropriate.

Recommendation I.12. The General Assembly should further amend the Virginia Code § 37.2-808 (G), as amended in 2008, as follows:

G. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization. Such evaluation shall be conducted immediately. <u>If a person is committing a criminal offense and the officer has probable cause to believe that the person meets the criteria for emergency custody as stated in this section, the officer may take the person into custody and transport the person to an appropriate location to assess the need for hospitalization or treatment without prior authorization and without formally tendering criminal charges against the person.</u> <u>*The law enforcement officer may transfer custody of the person to the appropriate location to which the individual is transported if the location is willing to accept custody of the person and can provide security adequate to protect the individual and others from harm [in accordance with regulations adopted by the Board.]*</u>

Training Considerations

Mental Health training of law enforcement is a necessary component of diversion programs. Law enforcement officers and dispatchers must be able to recognize when mental health is, or may be, an issue and to effectively use de-escalation techniques.

CHAPTER II. POST-ARREST TREATMENT AND JAIL DIVERSION

The second reform priority, enrichment of appropriate mental health services for individuals with mental illness while detained, incarcerated, or under community supervision, applies to the next three chapters of this Report.

A. A Unified Vision

The next two points in the criminal justice system for possible mental health interventions occur during the post-arrest period and include 1). the initial detention period and hearing and 2). diversion after arraignment and/or treatment in jail during the post-booking phase. Diversion at these points requires the integration of jail corrections and treatment activities to encourage post-booking diversion from incarceration. In addition, diversion goals *after* booking include minimizing further prosecution for acts attributable to the active mental illness of persons with serious mental illness for whom *pre*-booking diversion and other crisis supports were not provided.

The CJ Task Force envisions that through the combined efforts of state and local planning and resource granting sources, each locality in Virginia will adopt sets of conceptual and operational policies supporting jail diversion of individuals with mental illness adapted to the characteristics of that community and will implement them to provide the greatest positive impact in the shortest amount of time.

Given the complexities of implementing a meaningful post-arrest treatment and jail diversion program, the scope of each community's public mental health and social services agencies' legally mandated responsibilities should include the provision of care to the population of persons with serious mental illness who are in the custody of the local criminal justice system.

B. Earliest Feasible Release

Jailing persons with serious mental illness is a costly policy choice. Persons with serious mental illness remain in jail, on average, 6.5 times longer than those who are not symptomatic for mental illness. One key goal of the CJ Task Force is that all eligible persons with serious mental illness who have been subject to arrest and jailing will be released to community treatment as soon as feasible. To accomplish this, the magistrate hearing (at which criminal charges are formally considered and applied) should serve as an initial mental health diversion readiness and processing stage, prior to, or in lieu of, the booking of an arrested person with serious mental illness into jail.

C. Early Access to Treatment

Similarly, law enforcement personnel, including police and sheriffs' departments, local pretrial and probation officers, jail administrators and local correctional personnel must be trained to accept that persons with serious mental illness are part of the population that they serve, and that

guaranteeing an expeditious, efficacious path to treatment for those in need can be best accomplished through joint efforts of public safety and human services agencies and programs.

Consequently, the CJ Task Force urges that arrest and subsequent placement in jail can begin to serve as a point of access to treatment for persons with serious mental illness, especially for those individuals whose access to treatment services was impeded while in the community.[70] This will require training, coordination and improved access to mental health services. This training focus must be applied at the judicial level as well as with law enforcement. But Virginia need not reinvent the wheel.

According to the Council of State Governments, there are well over 150 *post*-booking jail diversion programs in operation in the United States.[71] Many of these programs have been constructed as specialized "mental health courts" or "mental health dockets," using the structure and power of the criminal court as the vehicle for diverting persons with serious mental illness from prolonged incarceration to community-based treatment. The court's authority is used to require active participation in mental health treatment and to promote recovery. Although post-booking diversion at the court-hearing stage are increasingly being employed, there is more limited information available in the mental health and criminal justice literature regarding programs and procedures that are more efficient at promoting earlier diversion to treatment directly from arrest.

The relative lack of focus on *post-booking/pre-court* diversion is understandable, perhaps it is because the efforts of specialized, problem-solving courts, such as drug courts and, increasingly, mental health courts, have overshadowed diversion efforts at the post-booking/pre-court stage while persons are in jail. Typically, providing mental health services in jails for persons after booking but before a court hearing has evolved only as a "side line" of jail operations. While many jails have, in fact, implemented specialized programs for persons with serious mental illness in their jails, and some have attained national prominence, provision of mental health services prior to court hearings remains a function outside the primary mandate of criminal confinement for which jails are constructed and operated and remain clinically inadequate.

Although providing mental health services in jails is not a principal mission, Virginia jails have responsibility for housing more persons with serious mental illness each day than do all of the state hospitals operated by the DMHMRSAS. They have become the primary *de facto* public mental health facilities in Virginia. A Senate Finance Committee Report revealed that, while there were 1,503 residents of state mental hospitals in 2005, there were 8,656 adults with serious mental illness incarcerated in Virginia's jails and prisons (4,006 in local and regional jails and

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[70] This represents a modification of the Gains Sequential Intercept Model.

[71] Council of State Governments Consensus Project Newsletter, April 2007. The Newsletter reports that the Consensus Project now has available detailed, web-based profiles for approximately 150 mental health courts and 100 specialized police-based response programs. Available at: http://consensusproject.org/updates/newsletters/2007-CP-newsletters/2007Apr-newsletter#infonet.

4,650 in prisons).[72] As a result, promoting both improved access to treatment services for persons with serious mental illness in the criminal justice system as well as expanded jail diversion programs is important not only to provide access to mental health interventions for as many persons with serious mental illness as possible but to relieve the pressure on jail and prison capacity.

D. Initial Detention/ Initial Court Hearings Recommendations

Recommendation II.1. The General Assembly and local governments should assure that the jails of the Commonwealth are sufficiently resourced to meet the basic standards for provisions of mental health services that have been established by national jail accreditation organizations, such as the American Correctional Association.[73]

Recommendation II.2. Regional and local task forces should assure that provision of mental health services in each local and regional jail are sufficiently linked with local community mental health and social services agencies, and with state hospital forensic programs, to provide for continuity of treatment for jail inmates during incarceration, and at the point of diversion to community treatment.

The CJ Task Force is not suggesting that the Commonwealth's jails become mental hospitals or that they supplant the historical role of state hospital forensic programs as providers of emergency treatment services. In addition, it is clear that jails are not the appropriate overseers of community-based treatment or supportive aftercare. However acknowledging that the large numbers persons with serious mental illness find themselves in jails for long periods of time, often repeatedly, is critical to efforts to improve their care and to end repeated incarcerations based largely on their mental illness. It also suggests the importance for jails to provide a therapeutic context to identify persons with serious mental illness who may be eligible for post-booking, pretrial release to community treatment, or early release to treatment following trial. Strengthening connections to family and community can also be accomplished at the pre-booking stage by making communication more readily available and at no cost. Linkage to community support can be initiated while in the jail by allowing trained facilitators, including peer support specialists, from the community to conduct support groups within the jail. Connection with peers is often sustained in situations even where ongoing use of mental health services has not been successful.

Recommendation II.3. The Coordinating Council should periodically review models for jail diversion programs, including all worthwhile formats for mental health specialty courts and other pretrial diversion options, and implement those suitable to the needs of the Commonwealth, based on available resources and predicted effectiveness.

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[72] Morris, James J. (2006). *Mental Health Treatment Needs of Individuals with Mental Illness in the Virginia Justice System*, Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse, Office of Forensic Services. Available at: www.dmhmrsas.virgini.gov/documents/OMH-CMHLRMorris101206.pdf.

[73] The American Correctional Association's Health Care standards are addressed in separate manuals for prisons, jails and juvenile confinement facilities. See http://www.aca.org/standards/healthcare/.

Recommendation II.4. The Coordinating Council and the regional and local task forces should consider the impact of all interventions and programs on DMHMRSAS state forensic hospital programs.

CHAPTER III. EVALUATION AND TREATMENT DURING CRIMINAL PROCEEDINGS

A. General Description

Although a primary goal of the CJ Task Force is to promote the diversion of as many persons with serious mental illness as feasible from criminal justice involvement *prior* to trial, not all eligible criminal defendants will be diverted at this stage. Those who are unable or unwilling to engage in treatment, or to participate in diversion programs, are not likely to be candidates for pretrial diversion, nor will persons with serious mental illness who have been charged with serious offenses, particularly those of a violent nature, regardless of their having a mental illness. For those persons with serious mental illness who must remain incarcerated, prior to trial and subsequent to conviction and sentencing, the availability of adequate mental health treatment services onsite is a crucial matter, particularly for inmates whose symptoms do not warrant inpatient psychiatric hospitalization.

A key recommendation at this stage is the furtherance of the role of specialized mental health courts at the trial and sentencing phases for persons with serious mental illness. Many, if not the majority, of specialized mental health courts or dockets in operation in the U.S. today operate primarily within a model that requires a defendant with mental illness enter a plea of guilty for the offense(s) charged, before he or she is formally admitted as a mental health docket client. Persons with serious mental illness, who agree to so plead, and to participate in the treatment and supervision plan imposed by the court, are offered an early release from confinement, contingent upon their continuing participation in court-ordered treatment as a condition of probation. In some instances, and consistent with the approach used in drug courts, the defendant is required to enter a guilty plea, but his conviction is held in abeyance, pending the successful adherence to his treatment and supervision plan for a designated time period. At the end of successful completion of that period, the defendant is returned to court, and his charges are dismissed. For those defendants who are subject to such courts, the benefits include not only avoiding jail time but also the elimination of the offense from one's criminal history.

B. Treatment needs by population/illness

As noted elsewhere in this Report, persons with mental illness not only are overrepresented in U.S. jails and prisons but concomitant substance abuse disorders also present a treatment challenge. The overcrowded and stressful conditions in jail and prison are particularly overwhelming for persons with serious mental illness, which often leads to higher disciplinary rates for these inmates. In addition, those who are mentally ill are also more likely to become victims of violent crime or sexual attacks while incarcerated due to their heightened vulnerability. Jails, perhaps due to the shorter average length of stay and limits on local funding, are generally even less well-equipped to handle the needs of the mentally ill inmates than prisons.

As noted throughout this Report, differences in the primary missions of criminal justice and the mental health systems pose challenges for developing a coordinated response to the goals of

minimizing the engagement of persons with serious mental illness with law enforcement and the courts and promoting their continued recovery. Without a coordinated strategy, however, the results are that many mentally ill inmates become "frequent flyers" because they are arrested, usually for offenses arising from their mental illness such as parole violations, processed through the criminal justice system with inadequate attention to their mental illness, and released back into the community without a treatment plan in place. As a result, many return to the criminal justice system. In Los Angeles County, for example, 90 percent of Los Angeles County jail inmates with mental illness are repeat offenders; an estimated 31 percent have been incarcerated 10 or more times. A study of the Lucas County, Ohio jail found that 72 percent of people with mental illness were re-arrested within 36 months of release.[74]

In addition, 49 percent of federal prisoners with mental illness have three or more prior probations, incarcerations, or arrests compared to 28 percent of federal prisoners who do not suffer mental illness.[75] No one benefits in failing to have effective policies and programs in place for persons with serious mental illness.

While there are some model programs for treating persons with serious mental illness while in jail across the state, Virginia has no standardized policy or protocols for providing services and practices vary considerably. Not only are protocols for evaluation often lacking in jails but, also, there is no statutory time limit within which a mental health assessment must be completed. As a result, jails often narrowly focus on evaluating the person's suicide risk and provide treatment for only the most ostentatious and serious symptoms.

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[74] Jails and Mental Illness Fact Sheet, Criminal Justice/Mental Health Consensus Project, Council of State Governments, at http://consensusproject.org/resources/fact-sheets/fact_jails.

[75] Ditton, P.M. (1999). *Mental Health and Treatment of Inmates and Probationers* (Bureau of Justice Statistics, NCJ-174463). Washington, D.C.: U.S. Department of Justice. Available: http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf. See also Lovell, David, M.S.W., Gregg J. Gagliardi, and Paul D. Peterson. (2002). "Recidivism and Use of Services Among Persons With Mental Illness After Release From Prison," Psychiatric Services 53:1290-1296. In this study nearly 350 mentally ill offenders who had left Washington State prisons were identified. Men and women differed with regard to offenses, diagnoses, rates of drug abuse, and use of mental health resources. Although most subjects (73 %) received post-release social or mental health services, few received clinically meaningful levels of service during the first year after release. Charges for new crimes or supervision violations were common (70 % of subjects), but only 10 percent committed new felonies against persons, and 2 percent committed very serious crimes. Youth, frequency of past felonies, and variables such as misbehavior in prison were associated with new offenses. As the authors note:

> "Persons with mental illness who are incarcerated are often without housing, family, or friends. Stable connections with treatment providers may also be uncommon. For many, life on the street or in shelters is punctuated by arrests and jail stays, and imprisonment is little more than an extended break in this pattern. The vast majority of their offenses, such as public intoxication, trespassing, possession of drugs, and aggressive panhandling, are more a reflection of a marginal urban existence than a violation of the basic rights of other citizens." Page 1296. (justify right margin)

C. Available Post-Booking Models: Assessment and Specialty Courts

For persons with serious mental illness who cannot be diverted from jail, a prompt and complete evaluation is necessary to properly identify the individual needs and to develop a service plan that will meet both the clinical needs of the inmate and provide safety for the jail staff. Numerous clinical tools are available and used in jurisdictions throughout the nation. To maximize the utilization of mental health evaluations, some jurisdictions employ behavioral health care professionals to provide these services in jails.

In addition, specialty courts have emerged as a focused judicial response to diverting many persons with serious mental illness to treatment instead of prison. Such programs, discussed in more detail below, have been shown to reduce recidivism and prevent the stigma of a criminal conviction.

D. Intake Procedures: Access

Once persons are placed in jail a number of activities must occur for the protection of the persons, the staff and to insure that persons with mental illness or substance abuse disorders are provided specialized and appropriate treatment or diversion. In addition, it is particularly important to establish a comprehensive, standardized, objective, and validated intake process to assess the individuals' strengths, risks, and needs upon admission. The intake procedures and access to treatment, at a minimum, should include the following:

- **Individualized Programming Plan**

  Using information obtained from the assessment, identification of programs necessary during incarceration to insure safe and successful transition to the community.

- **Physical Health Care and Mental Health Care**

  Facilitation of community provider access to jails and promote prompt service delivery consistent with community and public health standards.

- **Substance Abuse and Mental Health Treatment**

  Provision of prompt and effective substance abuse and mental health treatment to inmates.

E. Adjudication Approaches

1. Specialty Courts

One approach courts have taken to address defendants with serious mental illness and/or substance abuse disorders is that of establishing **specialty courts that formally engage mental health professionals to determine the appropriate intervention to minimize repeated engagements with the criminal justice system. For all of these to**

work, a threshold mandate is to have formal evaluation and standardized protocols while the individual is in jail to properly develop a service plan that will meet the clinical needs of the inmate and provide safety for the jail staff. There are numerous evaluation tools available, which could be used and models for adjudication for persons with serious mental illness.

It is not unusual for specialized mental health teams to be established to work with persons with serious mental illness and the courts. These teams often include behavioral health care professionals, court personnel, advocates, Public Defenders, Commonwealth attorneys and jail staff. This allows a complete packet of information to be developed and presented to the court.

Most drug courts and mental health courts are not full-time courts but are special docket courts where cases involving drug-involved or mentally ill defendants are heard on particular days. There are several variations of such courts, which will be discussed below, but the advantages to such courts are as follows:

- Increased judicial specialization increases the ability of the Court to consider the relevant medical/psychiatric factors from a fully informed viewpoint;

- Opportunity for deferred sentencing, if the mentally ill or addicted defendant is convicted, with conditions of completing stipulated treatment, and maintaining appropriate safe compliance, imposed by the court; and,

- Availability of procedures allowing courts to impose sentences, when appropriate, allowing for conditional release to the community.

a. Drug Courts

The first drug court was established in 1989 in Dade County, Florida. Numerous evaluations have demonstrated that drug courts result in economic savings to the community, reduce jail time, and produce successful outcomes in reduced crime related to drugs and reduced recidivism. The approach of drug courts is to divert defendants to supervised drug treatment instead of incarceration, closely monitoring the participants and overseeing the rewards and sanctions based on compliance to the program. Upon an individual's successfully completing the court-ordered treatment, the judge may reduce or dismiss the initial charge.

b. Mental Health Courts

Mental health courts, using a model similar to drug courts, have also been established. The first was launched in Broward County, Florida in 1997. As is the case with drug courts, the goal of mental health courts is diverting eligible persons with serious mental illness to treatment as well as reducing recidivism for persons with serious mental illness who commit a crime.

There has been a rapid growth in mental health courts across the U.S. to more than 150 with many others being planned.[76] Although the empirical evidence for mental health courts is not yet as developed as with drug courts, initial results have fueled their rapid growth as part of a trend of problem solving courts and a desire to reduce inappropriate incarceration and recidivism of this population.[77] The trend has not been embraced in Virginia, however, with the Norfolk Mental Health Court, begun in 2002, the only example.

Although, several elements have been identified as important to the success of mental health courts; including interagency planning and administration, identifying the appropriate target population, informed choice, treatment supports and services,[78] because of significant program differences, no single model for mental health courts has emerged. Eligibility, plea agreements, supervision, incentives, sanctions for noncompliance, and completion standards vary widely. Some courts admit into diversion programs only those charged with misdemeanors, others include some felony charges and many exclude those charged with domestic violence, crimes against children, driving while intoxicated, or violent felonies.

Mental health courts are not without controversy. Although the diversion model employed by mental health courts is similar to that used in most drug courts, some mental health consumers and some in the legal system have raised concerns about its application to persons with serious mental illness. These concerns are generally focused on the use of the court's coercion of individuals to plead guilty to a crime in exchange for access to proper treatment. Some argue that better access to community-based mental health services would help to limit criminal justice involvement and these after-the-fact mechanisms to get persons into treatment are inefficient and potentially saddle individuals, already saddled with the stigma of mental illness with the additional stigma of having a criminal record. However, these concerns generally have been outweighed

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[76] Thompson, Michael; Osher, Fred; and Tomasini-Joshi, Denise. (2008). *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court*, Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus Project, New York, page vii.

[77] Steadman, Henry J. and Redlich, Allison D. (February, 2006). *An Evaluation of the Bureau of Justice Assistance Mental Health Court Initiative*, www.ncjrs.gov/pdffiles/nif/grants/213136.pdf.

[78] Thompson et al. This report identifies ten characteristics of a successful Mental Health Court:

- Planning and Administration
- Target Population
- Timely Participation Identification and Linkage to Services
- Terms of Participation
- Informed Choice
- Treatment Supports and Services
- Confidentiality
- Court Team
- Monitoring Adherence to Court Requirements
- Sustainability

by initial research showing the benefits of such diversion programs in reducing recidivism and the costs associated with time spent in jail.[79]

2. Special Teams

Not all jurisdictions adopt the specialty court or docket model to adjudicate persons with serious mental illness. Instead, many utilize a special teams approach for mental health defendants providing specialized input to the courts in crafting a conditional release plan. Special teams may consist of a public defender, pretrial services, and mental health professionals, who work cooperatively with the prosecutor to develop a conditional release plan and present it to the judge, with an order for the judge's signature.

An example of a special teams approach is the Jericho Program in Shelby County, Tennessee, which includes the city of Memphis.[80] Jericho has, as its core strategy, the development of comprehensive transition plans and "boundary spanners" that bridge the gaps between mental health, criminal justice and other interested parties. Jericho has become a "name-brand" program, recognized by judges aware of the success rate of the program. Under a special teams approach, persons, even some charged with violent crimes, may be included in consideration of conditional release plans.

F. Barriers

It is the CJ Task force's view that greater access to community-based services would not only prevent many individuals with serious mental illness from entering the criminal justice system in the first place but would allow many to be diverted to community-based treatment post booking or post sentencing as well. However, once engaged with the criminal justice system, persons

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[79] Ridgley, Susan M.; Enberg, John; Greenberg, Michael D.; Turner, Susan; DeMartini, Christine; and Dembosky, Jacob W. (2007). *Justice, Treatment and Cost: An Evaluation of the Fiscal Impact of the Allegheny County Mental Health Court*, Rand Corporation (Santa Monica, CA), for the Council of State Governments. This study represents the "first-of-its-kind study of the fiscal impact of a mental health court program." A downloadable copy of this report can be found at: www.rand.org/pubs/technical_reports/2007/RAND_TR439.pdf.

[80] *Mental Health in Tennessee's Courts: A Procedural Manual for Judges, Defense Attorneys and District Attorneys.* (July 2006). Tennessee Department of Mental Health and Developmental Disabilities, pages 93-94:

> The Jericho Project targets individuals with serious mental illness and co-occurring substance use whose level of criminal justice involvement makes them ineligible for prebooking diversion through other available programs/resources in the area. . . (justify right margins in both paragraphs)
>
> The Jericho Project offers courts quality alternatives to pretrial detention utilizing an array of supervised, conditional release strategies**.** At the heart of these strategies is the *Community Linkage Plan (CLP)*, a comprehensive transition plan developed by boundary spanners and tailored to the individual needs of the detainee. Based on the GAIN Center's APIC best practice transition planning model, CLPs address critical domains of service (access to treatment, safe housing, bridge medication, restoration of benefits, transportation, supervision, etc.) with an emphasis on evidence-based integrated treatment for co-occurring disorders. . . Success during supervised release frequently improves ultimate case disposition, with impact ranging from full suspension of sentence to reduced (or dismissal) of charges. Evaluation data indicates reduced caselag and recidivism, plus increased quality of life and treatment compliance.

with serious mental illness do not have easy access to Virginia's CSB services, making diversion or conditional release plans difficult to put in place. This is, in part, because the long waiting lists seen at most CSBs for receiving voluntary services. In addition, once a person is engaged with criminal justice system it is expected that the criminal justice system, not CSBs, is statutorily responsible for providing the recommended services. There is no statutory framework in Virginia, a requirement that CSBs work with law enforcement to facilitate diversion programs and, without substantial additional resources, would result in the fact that most communities simply could not serve additional consumers diverted from the criminal justice system. There are additional barriers as well.

1. **Lack of funding and resources in jails**

   Lack of mental health treatment resources in the criminal justice system results in jails providing only the most minimal care for persons with special needs. While jail staff routinely screens persons for suicidal ideation, they are not equipped to provide complete psychiatric assessments.

2. **Fragmentation among mental health system and corrections**

   The fragmented public policies in how persons with mental illness are screened, diagnosed and treated, often result in repeated and costly encounters with law enforcement and engagement with the criminal justice system. The lack of coordination is evident in several areas. As a threshold issue, even when there are indications that mental illness may be a significant factor in an arrest, whether an individual is screened, diagnosed and treated for mental illness is largely determined by what jurisdiction he/she is in and whether mental health professionals are available.

   Even when a diagnosis is made and medications are deemed warranted, because criminal justice and mental health agencies have separate pharmacies with different formularies, persons with serious mental illness do not have access to the same medications. This difference is important for persons released from jails or prisons without reentry planning to connect those individuals with community-based providers and without an adequate supply of medication to last until such a connection is made. Even then, for many, the medications that may have been working well while incarcerated may not be available through the DMHMRSAS formulary and a different medication regime, with different benefits and side effects, is often prescribed.

   In contrast to persons released from jails or prisons, persons with serious mental illness released from state psychiatric facilities are the statutory responsibility of the DMHMRSAS and the local CSB and, as a result, have access to Community Resource Pharmacies so continuity of their medications is possible.[81] A person with serious mental

[81] Community Resource Pharmacies, which are overseen by DMHMRSAS, provide medications for individuals who have been discharged or diverted from a state hospital or training center and who are unable to pay for medications that have been prescribed to treat or prevent a recurrence of the condition for which they received state facility services.

illness released from a jail or prison may access to medications through the Community Resource Pharmacies only after he or she has met with a CSB professional. Given this lack of coordination between criminal justice and community mental health providers in planning for release, the high rate of recidivism among this group is not surprising.

3. Lack of Housing

Many persons with serious mental illness who could be diverted pre-trial or post-trial cannot be released due to the unavailability of appropriate housing. They may remain in jail not because they are a public safety threat or a flight threat but because they are homeless. Even if a specialty court was available and an individualized treatment plan or conditional release was developed, without housing, persons with serious mental illness cannot be released.

4. Risk of Violence

Often there is public concern that persons with serious mental illness pose an unusually high risk of violence to the public and, as a result, should not be candidates for diversion. Although it is true that when a perpetrator of a violent crime is someone with a mental illness that fact is heavily reported in the media, it is not the case that persons with serious mental illness are more likely to commit serious crimes. In fact, persons with serious mental illness are much more likely to be *victims* of violence than *perpetrators* of violence. A North Carolina study found that people with mental illness are almost three times as likely to be victims of violent crime than people without mental illness.[82] However, persons addicted to drugs and alcohol may be at a higher risk of violence and, since the number of people with concomitant disorders is so prevalent, proper evaluations are required to insure that the public and the individual are protected.

5. Negotiated Release Plans

If a person with serious mental illness progresses toward trial, some diversion programs provide for the development of a release plan negotiated by the public defender, the prosecutor, mental health service providers, pretrial services and the individual. This release plan is then presented to a judge typically by the special defense team. For such diversion plans to work, however, education about mental illness for court diversion teams and judges is essential.

Broadly, criminal justice diversion programs and the negotiated release plans are characterized as leveraging the power of the court, and the threat of incarceration, to get the adherence of a person with serious mental illness to a community-based treatment plan. As noted elsewhere in this Report, there is an ongoing discussion among

[82] Hiday, Virginia; Swartz, Marvin S.; Swanson, Jeffery W.; Borum, Randy; and Wagner, H. Ryan, (1998)."Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services* 50: 62-68. This study of 331 involuntary mental health outpatients found the rate of violent criminal victimization was two and a half times greater than in the general population - 8.1 percent compared to 3.1 percent.

consumers, advocates, lawyers and treatment professionals about whether this leverage muddies the idea of an "agreement." Whether such a diversion outcome is based on coercion, many individuals "choosing" treatment instead of jail tend to respond positively to it, even stating that they plan to continue treatment after the release conditions are lifted.[83] Not all researchers agree. Although many studies show that leveraged treatment for substance abuse disorders is effective, these cannot be directly translated to success for leveraged mental health treatment,[84] there is a question about the longer-term results of leveraged treatment. A pilot program in Virginia Beach indicates that some individuals discontinued their medications after the conditional release period expired. Additional study is needed.

G. Analysis of Options

Crucial to any diversion program is an enhanced array of mental health services as well as easy access to them. Unfortunately, Virginia does not have sufficient mental health resources to meet the needs for community-based treatment of persons with serious mental illness. There are, however, a few good, workable models in Virginia that put together the resources needed for an effective diversion program. For example, the Fairfax County Mental Health Facility and the Norfolk City Mental Health Court have diversion programs that address the housing and treatment needs from criminal justice to treatment and from jail to treatment. These programs and others should be evaluated and that information should be used to develop programs throughout the Commonwealth.

H. Mental Health Interventions During Criminal Proceedings: Recommendations.

Policy Considerations

Recommendation III.1. The Coordinating Council should establish a standardized mental health screening and/or assessment procedure to identify individuals with mental illness or concomitant disorders upon booking with the goal of providing appropriate diversion, creating formal service plans developed, and providing appropriate jail mental health services and appropriate community linkage upon release. (See, also, III.6 below).

Recommendation III.2. The Virginia Supreme Court should support specialized judicial approaches for persons with mental illness, substance abuse disorders, or concomitant disorders pending criminal charges.

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[83] Farabee, D.; Shen. H.; and Sanchez, S. (2002). "Perceived Coercion And Treatment Need Among Mentally Ill Parolees." Criminal Justice and Behavior 29:76–86.

[84] Steadman, Henry J. and Allison D. Redlich. (2005). An Evaluation of the Bureau of Justice Assistance Mental Health Court Initiative, National Institute of Justice, Document No.213136. Available at: http://www.ncjrs.gov/pdffiles1/nij/grants/213136.pdf.

Recommendation III.3. Regional and local criminal justice/mental health task forces should establish an adjudication approach suitable to the locality for individuals with mental illness and/or with substance abuse disorders who qualify for diversion at the pre-trial or post-conviction stage.

Legislative Considerations

Recommendation III.4. Local or regional jails and CSBs should enter into necessary agreements to assure that CSB Mental Health and Substance Abuse Services staff are available to properly identify and evaluate the needs of inmates with mental illnesses and/or substance use disorders.

Recommendation III.5. The General Assembly should amend the Code of Virginia so that seriously mentally ill inmates have the same access to a licensed psychiatric hospital when they cannot be stabilized in the jail setting as they would if they were not incarcerated.

Procedural Considerations

Recommendation III.6. The Coordinating Council and its participating agencies should take the necessary steps to assure that prisons and regional and local jails utilize a standardized evaluation tool to determine presence of a mental illness or co-occurring disorder and the consequent service and support needs for persons with serious mental illness in jail or prison.

Training Considerations

Recommendation III.7. The Coordinating Council and its participating agencies should establish a Criminal Justice/Mental Health Training Institute to support better understanding of 1) the use of the standardized evaluation tool, 2) mental illness and methods for managing inmates with mental illnesses, 3) the service needs of inmates with mental illnesses and concomitant substance abuse disorders, and 4) procedures used in jail or prison to facilitate their success in the community.

CHAPTER IV. RECOVERY-ORIENTED RE-ENTRY

A. Introduction

Some persons with serious mental illness will spend time in jails or prisons. For those who are incarcerated for misdemeanors or other lesser offenses (including those who are hospitalized under these conditions), because their serious mental illness poses a high risk for recidivism, support for their re-entry into their communities is critical. Support for the re-entry of this population should be differentiated from the ongoing Department of Corrections supervision of more serious offenders discussed in Chapter V of this Report, by having a treatment-oriented, recovery management perspective. Because there is no statutory designation of an agency responsible for such re-entry assistance, and little state or local financial support, much of this burden falls on community not-for-profit organizations. Although the efforts of not-for-profits providing re-entry support are laudable, some areas of the state have more robust programs than others and this spotty coverage leads to many preventable re-incarcerations and hospitalizations of persons with serious mental illness.

As a result, one of the CJ Task Force's reform priorities is to broaden and strengthen re-entry support for individuals being released from local jails, state prisons, and juvenile correctional centers throughout the Commonwealth. Recovery-oriented re-entry programs are divided into those that address 1). the preparation for release and 2). those that address the issues faced upon reentry.

- *Pre-release preparation* addresses the challenge for correctional and hospital facilities across Virginia to provide adequate services to prepare this population for release while under their care and to link these offenders with appropriate community-based services upon their release from confinement. The CJ Task Force supports the development of comprehensive collaborative case management services for these individuals starting during their confinement and continuing through the first year of release with an emphasis on treatment-focused discharge planning. This discharge planning and continuity of care are vital factors in the successful re-entry of offenders with mental illness into the community.

- *Reentry support* focuses on the range of issues offenders with serious mental illness face when they are released to the community and the challenge for Virginia's community corrections and community resource agencies to provide intensive services for this population. The CJ Task Force recommends that all offenders with serious mental illness be provided treatment-oriented community supervision with an emphasis on a wrap-around approach involving multi-agency and multidisciplinary participation.

B. Challenges Facing Offenders with Mental Illness

Criminal offenders with serious mental illness returning to their communities following release from incarceration often face a multitude of challenges. These obstacles typically surface in one of five areas: housing, employment, health, substance abuse and community connections.

1. Housing

Upon release, many former prisoners are able to live, at least temporarily, with family members, but those who cannot do so usually have limited housing options. Housing for the offender population, in general, is difficult to obtain for those returning to the community after confinement. For those with serious mental illness, this can be even more of a challenge. Many landlords will not consider anyone with a criminal record. Lack of guaranteed housing for offenders with mental illness immediately upon release results in increased stress often increasing mental illness symptoms and reducing the likelihood that medications will be taken appropriately. And, as noted elsewhere in this Report, homelessness is a significant risk factor for recidivism. It is not surprising that this population is at a high risk of recidivism. In addition to the lack of housing, offenders with serious mental illness are frequently released into communities before being sufficiently connected with family members and local agencies.

2. Employment

Finding work is another major hurdle for offenders returning to their community. According to a 2006 Bureau of Justice Statistics report, 31% of inmates with mental health problems are unemployed at the time of their arrest and connecting them to jobs upon release is no easy task.[85] Many employers will not consider anyone who has a criminal record, seriously limiting opportunities for stable employment and serious mental illness adds to the challenges of finding employment.

3. Health Care/Mental Health Care

Not only is access to mental health resources to support offenders returning to their communities limited, access to other health care resources is often lacking as well. Former prisoners with serious mental illness often have chronic and/or infectious diseases and return to communities with insufficient health care facilities or the in ability to pay for such services. Without employment, most do not have access to private health insurance. In addition, unless an inmate is over 65, he/she does not have access to Medicare. And, even if an individual's mental illness was serious to qualify him/her for SSI and Medicaid prior to incarceration, such eligibility lapses after 30 days and time lags in re-qualifying after release can take 90 days or more. Without aggressive efforts to re-quality individuals prior to release there will certainly be significant gaps in coverage and care. Although on paper such individuals have access to CSB services for their mental health needs, it is not unusual for a new client seeking mental health assistance to

[85] James and Glanz, footnote 8.

have waits of three weeks or more for an initial, non-emergency interview, which risks discontinuation of medications and relapse, among other health emergencies.

The gaps in health care/mental health care coverage are compounded by individuals being released from incarceration with only minimal amounts of psychotropic medications. Given the barriers to getting access to health care facilities the result is a near guarantee that medications will not be obtained in time to maintain the person's condition.

4. Substance Abuse Disorders

An estimated 75 to 80% of inmates with serious mental illness also have a history of substance abuse and most identify drug and alcohol abuse and the primary cause of their legal problems. While substance abuse treatment is available in many prisons and jails, without appropriate case management and access to substance abuse treatment in their communities, a high percentage lapse to their previous habits.

5. Community Connectivity

Inadequate connectivity with community resources is often the principal reason for prisoners to falter upon their release from incarceration. Although CSB participation in pre-release planning occurs in some jurisdictions, they are not statutorily required to do so. Since that is so, CSB participation is lacking in almost one-third of Virginia localities. Jails, prisons and community corrections programs do not have adequate staff or resources to initiate and sustain re-entry either. As a result, this poor coordination between the Department of Corrections, the local jails and the CSBs short-circuits the continuity of care needed by these offenders

C. Current Re-entry and Jail-based / Prison-based Programming in Virginia

The goal of offender re-entry programming is to reduce crime by implementing a seamless plan of mental health services and treatment supervision tailored to each offender. Such re-entry programming is delivered through state and local collaboration, from the time of their entry into prison or jail through their transition, reintegration and aftercare in the community.

The re-entry support includes intensive workshops beginning 90 days prior to release and includes such topics as life skills, conflict resolution, employability, conflict resolution, substance abuse, and domestic violence. Some programs offer workshops for a short period after release as well as employment and housing assistance.[86]

One segment of re-entry programming in Virginia is administered through the Virginia Department of Corrections' Virginia Serious and Violent Offender Re-entry Initiative ("VASAVOR") and the Virginia Department of Criminal Justice Services' Offender Re-entry

[86] In 2002, the Department of Corrections implemented a pilot program to provide re-entry transition services in partnership with local jails.

and Transition Services ("ORTS") programs. VASAVOR programs target high-risk offenders who are returning to communities from the state prison system. ORTS programs are currently in place in 95 of Virginia's 134 localities and target a wide range of offenders returning to the community. Neither, however, has a particular focus on persons with serious mental illness.

The ORTS Coalition, a network of nine non-profit organizations and local government programs that have been providing re-entry and transition services since the 1970's, administers these services.[87] These programs are supported through a variety of sources: state and local government, private foundations, the United Way as well as donations from corporations, churches and private individuals. There are currently over 1,200 trained volunteers across Virginia supporting re-entry services for offenders returning to their communities from incarceration. This re-entry work is being carried out in five regional jails, 13 local jails, two detention facilities, one work release center and 28 state correctional units. More than 15,000 inmates and former offenders were served by this coalition during FY 2006. In this process 1,521 re-entry participants secured full time jobs, 1,270 were assisted in finding housing, 2,097 were assisted in receiving clothing and 7,570 were referred to educational and support groups. These ORTS programs utilize a wide range of community resources ranging from the offender's family and peer groups to CSBs, employers, faith-based groups and governmental agencies to structure successful transitions to the community. Strengthening these programs to provide additional support to individuals with serious mental illness may be an important vehicle for their successful re-entry.

D. Barriers to Treatment-Oriented Re-entry

Successfully transitioning offenders with serious mental illness from incarceration into the community is often difficult. There are many barriers to providing continuity of care for this target population as they return home. Unfortunately, many of the barriers are resource-based and there is simply not enough funding (for CSBs, probation offices and state-funded mental health agencies) to adequately manage the return of these individuals into the community.

The availability of transitional housing is a major barrier for the re-entry of persons with serious mental illness. It is not unusual for these individuals to be placed into inexpensive motels as an alternative to transitional housing. The uncertainty of their living status often increases stress, which may result in increased symptoms and acting out and possibly ultimate failure in the community. There is an inadequate weighing by courts that stress is a particularly potent trigger for this population. They are at a high risk of relapse and recidivism if not released to a stable environment.

The absence of smooth linkages between jails, prisons and Virginia's mental health infrastructure undermines the success of re-entry programs. CSBs, who are not statutorily required to do so, often do not participate in pre-release planning for offenders with mental

[87] Formerly known as PAPIS (Virginia's Pre-release and Post-incarceration Services), ORTS is a coalition of agencies that offers transition services to local and state institutions and released offenders across the State of Virginia. The overall goal is to reduce criminal activities and recidivism by adult offenders released to the community.

illness. Once released, however, these offenders routinely become CSB responsibilities—too often in times of relapse or crisis. Because the hand-off from corrections to CSBs is not systematic or facilitated, many newly released individuals are left to navigate the mental health system on their own. Furthermore, because of high client volume, generally, CSBs frequently do not view the jail and or prison population as a high priority. This lack of case management, coupled with the long waiting lists at CSBs for new clients, means newly released persons with serious mental illness may wait as long as three to four weeks for an initial, non-emergency interview. Such delays often lead to discontinuance of medications followed by relapse. A statutory mandate for CSB participation in pre-release planning coupled with targeting funding would be important improvement to the successful re-entry to the community of persons with serious mental illness.

Other factors undermine successful re-entry including the failure to release individuals with adequate amounts of the medications they have been using to manage their mental illness. This is, in part, no doubt a cost issue for jails and prisons. Without adequate and clinically appropriate medications, persons with serious mental illness are at risk for returning to those same jails or prisons. Furthermore, concerns about mental health records privacy and confidentiality often result in restricted communication between prisons, jails, probation offices, CSBs, service providers and re-entry programs producing a disconnect between the very agencies assigned the responsibility for their care.

While re-entry programs exist in approximately 70 percent of Virginia's localities, a uniform, comprehensive statewide re-entry system should identify the relative responsibilities of the mental health system and criminal justice, the scope of services that must be available and providing coordination is not in place. As part of this, the CJ Task Force believes that each jail and prison should have a full-time release/re-entry planner to ensure that the individual is linked to services upon release. Broader collaborations between the jail and the community-based mental health support agencies should be established to ensure a smooth and seamless transition to the community. Transitioning offenders with mental illness from incarceration into the community would be well served by such an organized system

E. Recovery-Oriented Reentry Recommendations

Policy Considerations

Recommendation IV.1. The Coordinating Council should work with jails and prisons to establish an overarching policy promoting re-entry client support for all MH/SA clients to optimize each client's chances of successful community reintegration.

Basic services should include: developing a client-centered plan, identifying and making formal client connections with local resources who will ensure: continuity of SM/AH care, stable housing, stable and sufficient sources of income, and community support services designed to help clients avoid re-incarceration.

Client support services should start while individuals are incarcerated and continue through at least the first year of probation, with close involvement of, and monitoring by, state probation

offices and likewise the same would happen in local and regional jails and with involvement of local community corrections. The provision and timing of re-entry client support services should be automatically triggered by the client's release date, e.g., planning begins one month before release.

Case managers should approve re-entry plans involving family members only when the family member has been directly involved in the re-entry planning process, and that process has occurred at least two full days before the client's release.

As a part of re-entry planning, a consumer advocate should educate the client about peer support and peer-run programs in the community and invite the client to participate.

Legislative Considerations

Recommendation IV.2. The General Assembly should amend the Virginia Code to designate and fund CSBs as the accountable organization for re-entry client support in the Commonwealth.

CSBs should be charged with re-entry client support planning conducted at the facilities, with input and participation by the client, jail/hospital personnel who have worked with the client, the local probation office, a consumer advocate, and, if desired by the client, family members/friends and advocates.

Recommendation IV.3. The General Assembly should amend the Virginia Code to require that, upon release from jail or prison, the responsible correctional authority provide persons with serious mental illness at least seven days' supply of the medication they were prescribed in the facility and a prescription for at least one month more, to ensure continuity of mental health care.

Training Considerations

- Family members/close friends of the client need to be oriented to how to provide positive support to the client during and after re-entry.

- The client should receive coaching in putting together and taking responsibility for his/her re-entry plan. This includes: awareness of core public and private resources; eligibility for public benefits; transitional housing sources; employment; treatment resources, planning for wellness, and the like.

- Jail/prison/hospital staff: should be trained not to release persons with serious mental illness to the streets, which can result in instant homelessness and panicky behavior that can prompt criminal and/or substance abusing behavior.

CHAPTER V. COMMUNITY CORRECTIONS AND COMMUNITY SUPPORT

A. Overview

This Chapter addresses the challenges facing offenders with serious mental illness who have been incarcerated in prisons for more serious offenses and who are released into communities under DOC community corrections supervision. In October 2007, the total caseload of those under community supervision in the Commonwealth was 58,154 with 6,894 active parolees and 51,260 active probationers.[88]

As is the case for the re-entry support needed for persons released from jails or prisons for lesser offenses, the transition of this population to the community requires attention to those same community barriers—linkages to housing, employment and mental health services. In addition, however, it also requires a thorough understanding of correctional officers and courts setting the terms of release on the particular challenges persons with serious mental illness have with compliance as well as the resources to successfully support compliance. Treatment-oriented supervision through community corrections and community support focuses on implementing a supervision strategy to concentrate community supervision resources during the period immediately following the person's release from prison or jail and to adjust supervision strategies as the needs of the individual released, the victim, community or family change.

Community corrections for persons with serious mental illnesses is a challenge for already overburdened community corrections officers.[89] Critically important is connecting inmates to employment, facilitating the person's sustained engagement in treatment, mental health and supportive health services and finding stable housing. The availability of a wide range of options for community corrections officers to use in reinforcing positive behavior and addressing violations or noncompliance with conditions of release is integral to success.

B. Goals and Vision

The DOC's stated goal for community corrections is public safety, which it defines as the:

> quality of life that allows our citizens to feel secure in their everyday lives by being free from danger, injury and damage caused by those who choose not to

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[88] Virginia Department Of Corrections, Division of Operations and Community Corrections, Population Summary, October 2007. Available at: http://www.vadoc.virginia.gov/about/facts/research/new-popsum/2007/oct07popsummary.pdf. Probationers include adult offenders whom courts place on community supervision generally in lieu of incarceration. Parolees include those adults conditionally released to community supervision whether by parole board decision or by mandatory conditional release after serving a prison term. They are subject to being returned to jail or prison for rule violations or other offenses.

[89] According to the Department of Corrections Strategic Plan, the average P&P Officer workload per offenders under supervision for FY2006 was 73.8. Available at: http://www.vaperforms.virginia.gov/agencylevel/stratplan/spReport.cfm?AgencyCode=799.

> obey the law. Our approach to this goal through professional supervision of offenders under our purview is "A Balanced Approach." This practice emphasizes the dual role of providing supervision and services for probationers and parolees.[90]

Part of assuring the public's safety is to provide services for probationers and parolees that will maximize their ability to comply with the terms of their release. For those who are released with severe mental illness, the goal of community corrections and community support must be to strengthen the links between jail-based and prison-based services and the community health services needed during detention and upon release. The CJ Task Force believes that systematically integrating community supervision with mental health treatment programs, utilizing a wrap-around approach with multidisciplinary and multi-agency participation the most effective means to accomplish this goal. This integration, in addition to the establishment of formal mechanisms for requiring it, will ensure additional training of both DOC probation officers and community corrections officers about mental health as well as mental health workers about the requirements of community supervision.

As stated in Chapter V, which addressed those incarcerated for lesser offenses, the CJ Task Force urges that all offenders with serious mental illness will be so identified *before* their release from incarceration and that planning for a smooth transition begins prior to release. Persons scheduled to be released from jails or prisons should be matched with individuals and agencies, which can assist them upon their release. These contacts should include peer support resources available in the community to which they will be released. Treatment opportunities should be provided immediately upon their release along with treatment-oriented community supervision using a wrap-around approach involving multi-agency and multidisciplinary participation.

C. Barriers

Barriers to care are the norm in the correctional system and are also common upon re-entry to the community. First, jail and prison personnel, probation officers and community corrections staff do not receive the training they need to understand the symptoms and effects of mental illness or has to work with offenders with mental health disorders, particularly those on psychotropic medications. Often such offenders who are acting out are handled as non-compliant and placed into more restrictive levels of incarceration or supervision, which in turn, exacerbates their situation.

Re-entry to the community presents its own set of barriers. Although a Memorandum of Understanding ("MOU") in Virginia among the DOC, DMHMRSAS, and the executive director of CSB/BHA to coordinate discharge planning and post-release planning for inmates with mental health and/or substance abuse problems was developed in 2005, there remains inadequate coordination between the Department of Corrections, local community corrections, jails and

[90] See http://www.vadoc.virginia.gov/community/.

CSBs, and there is no robust system to ensure that services in corrections are translated to the community.

In addition to the MOU, there is some infrastructure in place to promote coordination, which could be made more effective. Each community in Virginia has a Community Criminal Justice Board ("CCJB") that helps plan criminal justice programming in their community.[91] However, while each CCJB is mandated to include a representative from the local CSB, there is no mandate to have a CSB *mental health representative*, or a community mental health representative, or a consumer who may have the best knowledge of a client's needs in the community. As a result, it is the view of the CJ Task Force that this inter-agency planning is not as effective as it could be.

In addition to the missed opportunities promoting smoother re-entries by failing to have a mental health professional as a mandated participant of the CCJB,[92] privacy and confidentiality concerns often result in restricted communication between prisons, jails, probation offices, CSBs and other service providers producing a disconnect between the very agencies assigned the responsibility for services and support. However, as the Commission's Working Group on Health Privacy and the Civil Commitment Process has found, such concerns may be more a function of a lack of understanding of the federal Health Insurance Portability and Accountability Act ("HIPAA"), Virginia's Health Records Privacy Act, and Virginia common law than any real barrier.[93]

As emphasized in Chapter IV's discussion of community service needs upon re-entry, the lack of housing as well as transitional housing presents a major hurdle for offenders with mental illness under community supervision. There are also barriers in accessing appropriate mental health care in the community related to appropriate medications. The DOC and DMHMRSAS use separate state level pharmacies for offenders with mental illness who are in need of medication. The DOC does not include some of the newer medications resulting in some newly released offenders being faced with unfamiliar medications.

Together, these barriers to community-based mental health care upon re-entry increase the likelihood of poor mental illness management and relapse, which often leads to recidivism. And such individuals are swept into the criminal justice cycle all over again.

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[91] The statutory mission of CCJBs is set forth in the Code of Virginia §53.1-185 and includes advising communities on the development and operation of local pretrial services and community-based probation programs and services for use by the courts in diverting offenders from local correctional facility placement.

[92] Although the CJ Task Force agreed on the importance of improved training about mental illness for the DOC, community corrections officers and members of the CCJBs, not all members of the CJ Task Force were in favor of requiring a mental health professional to be a member of CCJBs.

[93] A copy of the Commission's Working Group on Health Privacy and the Civil Commitment Process can be found on the Supreme Court's website at: www.courts.state.va.us/cmh/home.html.

D. Community Corrections / Community Support System in Virginia

A major challenge in coordinating plans for persons with serious mental illness who are reentering the community under community supervision is the catchment areas for the corrections systems and the mental health authorities differ and are operated not only by different levels of government also by quasi-governmental, non-profit, and private entities. These differences in how corrections and mental health services are organized complicate establishing tightly coordinated systems throughout the Commonwealth.

For example, offenders with mental illness may be released from corrections to one of two community corrections systems in Virginia overseen by either local or state governmental entities. Mental health services are provided by local entities, CSBs, that operate quasi-independently from city or county governments and some non-profit and for-profit providers.

Local responsible offenders, i.e., those individuals who have been convicted of offenses for which they serve their sentences in local and regional jails, are released to one of 39 community corrections agencies, which are grant-funded by the Virginia Department of Criminal Justice Services. Periods of supervision for local probationers typically range from six to twelve months. For FY 2006, local community corrections placements totaled 37,823 offenders. *State* responsible offenders are those individuals who have been convicted of offenses for which they serve their sentences in state correctional facilities. These offenders are released to one of 43 state probation offices, which fall under the umbrella of the DOC. Periods of supervision for state probationers can range from one year to more than ten years.
Mental health services are organized through Virginia's forty CSBs, which are local public mental health, mental retardation, and substance abuse authorities.[94] While CSBs are agents of the local governments that established them, most CSBs are not city or county government departments. These services are provided through a broad and diverse network of CSBs and their directly-operated and contractual programs. CSBs exist to provide individualized, effective, flexible, and efficient treatment, habilitation, and prevention services in the most accessible and integrated yet least restrictive setting possible. CSBs draw upon all available community resources along with people's natural support systems e.g., family, friends, work) to ameliorate the effects of mental health impairments and substance abuse disorders, and encourage growth and development. CSBs serve as the single points of entry into publicly-funded mental health, mental retardation, and substance abuse services for their service areas, including access to state mental health and mental retardation facility services through pre-admission screening, case management, and coordination of services.

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[94] Virginia's CSBs (and Behavioral Health Authorities ("BHA"s)) are local government agencies created by the Code of Virginia in 1968. Under the Code, every local government jurisdiction form or, with other local governments, form a CSB/BHA. CSB/BHAs have the responsibility for delivering community-based mental health, mental retardation, and substance abuse services to citizens with those disabilities. Emergency services and case management are mandated services. CSB/BHAs have agreements with local human services agencies and with public safety agencies. (cumulative and redundant?)

In addition to Virginia's CSB system, there are numerous non-profit and for-profit providers that play an important role in the delivery of services to this population.

E. Analysis of Options

While Virginia has an extensive community corrections and community support system in place, a close examination reveals the need for better inter-agency communication and exchange among those agencies that work with offenders with mental illness. While agreements are in place for interagency cooperation between community corrections and community support agencies, there is still some way to go to achieve the goal of having a "fully implemented wrap-around approach with multi-disciplinary and interagency participation." Equally important, because mental health has not been a primary focus in the training of community corrections personnel, most professions working in community corrections do not have the skills to recognize and effectively supervise those with serious mental illness.

In Virginia there is a wide array of agencies working with offenders with mental illness. The degree of cooperation and buy-in into inter-agency participation varies across each of the more than130 localities in Virginia, often a factor of management style and availability of resources. It would be a useful analysis to investigate whether those jurisdictions with greater coordination between community corrections and the mental health community had lower rates of failures among parolees and probationers with serious mental illness. Even without that data, the CJ Task Force believes that department heads and agency directors should be provided with background and training in the benefits of the wrap-around approach inclusive with the multi-disciplinary and interagency participation concept and should be encouraged to fully implement this philosophy across their organizations.

In addition to the targeted training related to mental illness and the challenges of supervising persons with serious mental illness, community corrections and community support agencies, training for jail and prison staff should be instituted that includes the use of a universal screening tool and associated training to improve the identification of inmates with mental illness. Specific training on working with offenders with serious mental illness for community corrections personnel is also needed. Likewise, community support agencies need intensive training on providing recovery-oriented, client-centered services for this population.

F. Community Corrections: Recommendations

Policy Considerations

Recommendation V.1. The Department of Corrections should require identification, of inmates with mental illness and the development of, appropriate follow up plans for these inmates *prior to release* to the communities.

Recommendation V.2. The Coordinating Council and each regional or local task force should take the necessary steps to assure that offenders with mental illness released to the community are provided with intensive, treatment-oriented community supervision and support using a wrap-around approach involving multi-agency and multidisciplinary

participation immediately upon release to the community. **Purchase of services funds should follow the client.**

Recommendation V.3. Pre-release planning conducted by jails and prisons should include a review of a client's eligibility for federal and state benefits, including Medicaid, and assurance that those benefits are reinstated, if applicable.

Legislative Considerations

Recommendation V.4. The General Assembly should designate the CSBs as the accountable entities for initiating, coordinating and monitoring client support services for at least the individual's first year post-incarceration, and should provide the necessary funding for them to carry out this responsibility.

Recommendation V.5. The DOC and DMHMRSAS should collaborate to combine the purchasing power of both systems and operate a single state pharmacy or contract with a private vendor to provide the most appropriate medications for each individual.

Training Considerations

Recommendation I.3 in Chapter I of this Report focuses on the need for training across disciplines to mitigate the professional and agency divides that lead to so many individuals with serious mental illness entering the criminal justice system. In the context of planning for reentry to communities, such training should include the following:

- Jail and prison staff should be trained in the use of a universal screening tool to identify inmates with mental illness;
- State and local probation officers should be educated about mental illness and on supervising clients with mental health/substance abuse issues;
- Staff of transitional housing facilities should be trained in working productively with clientele who have serious mental illness and substance abuse disorders; and,
- CSB staff should receive training on providing recovery oriented, client-centered services.

Resource Considerations

Recommendation V.6. The General Assembly should define the respective roles and responsibilities of CSBs and the criminal justice, community corrections, and probation systems in developing and overseeing community-based services

Evaluation and measurement should focus on client MH/SA treatment and compliance, client criminal justice system contact, unplanned use of hospital resources for MH/SA needs; and cost comparisons with either baseline (pre-program) or a control group not receiving the new case management approach—all measured against the outcomes achieved by clients.

CONCLUSION

It is well documented that persons with serious mental illness are disproportionately represented in the jails, courts, and prisons of the Commonwealth of Virginia, a problem that is by no means unique to this state. It is generally believed that gaps in community-based services lead to avoidable (and sometimes dangerous) encounters with law enforcement, repeated arrests for generally minor crimes, and contribute to the growing demand for prison capacity.

The CJ Task Force has reviewed the literature and examined evidence-based programs in Virginia and across the country as a foundation for making a series of Recommendations for all branches of government to use the Commonwealth's limited resources more efficiently and effectively. This can be done by:

- identifying opportunities for preventing initial encounters with law enforcement;
- directing, as appropriate, persons with serious mental illness to treatment in the pre-booking and post-booking stages of the criminal justice system; and,
- improving the conditions of release from jails and prisons to minimize recidivism.

Repeated encounters between law enforcement and persons with serious mental illness result in high costs to the criminal justice system, increased risks to the individuals, the public and law enforcement, and criminal records for persons with serious mental illness. Already stigmatized because of their mental illness, a criminal record for persons with serious mental illness makes finding appropriate housing and employment even more challenging. A pernicious cycle ensues.

Fundamentally, the consensus of the CJ Task Force that inadequate community-based mental health services and supports undermine the ability of many persons with serious mental illness to maintain themselves in their community and lead to behaviors and/or circumstances such as homelessness that bring them to the attention of law enforcement. The Recommendations contained in this Report identify opportunities to minimize encounters with law enforcement as well as the adverse and unproductive consequences. All effective interventions hinge on increasing access to community-based mental health services and other supportive services.

APPENDIX A

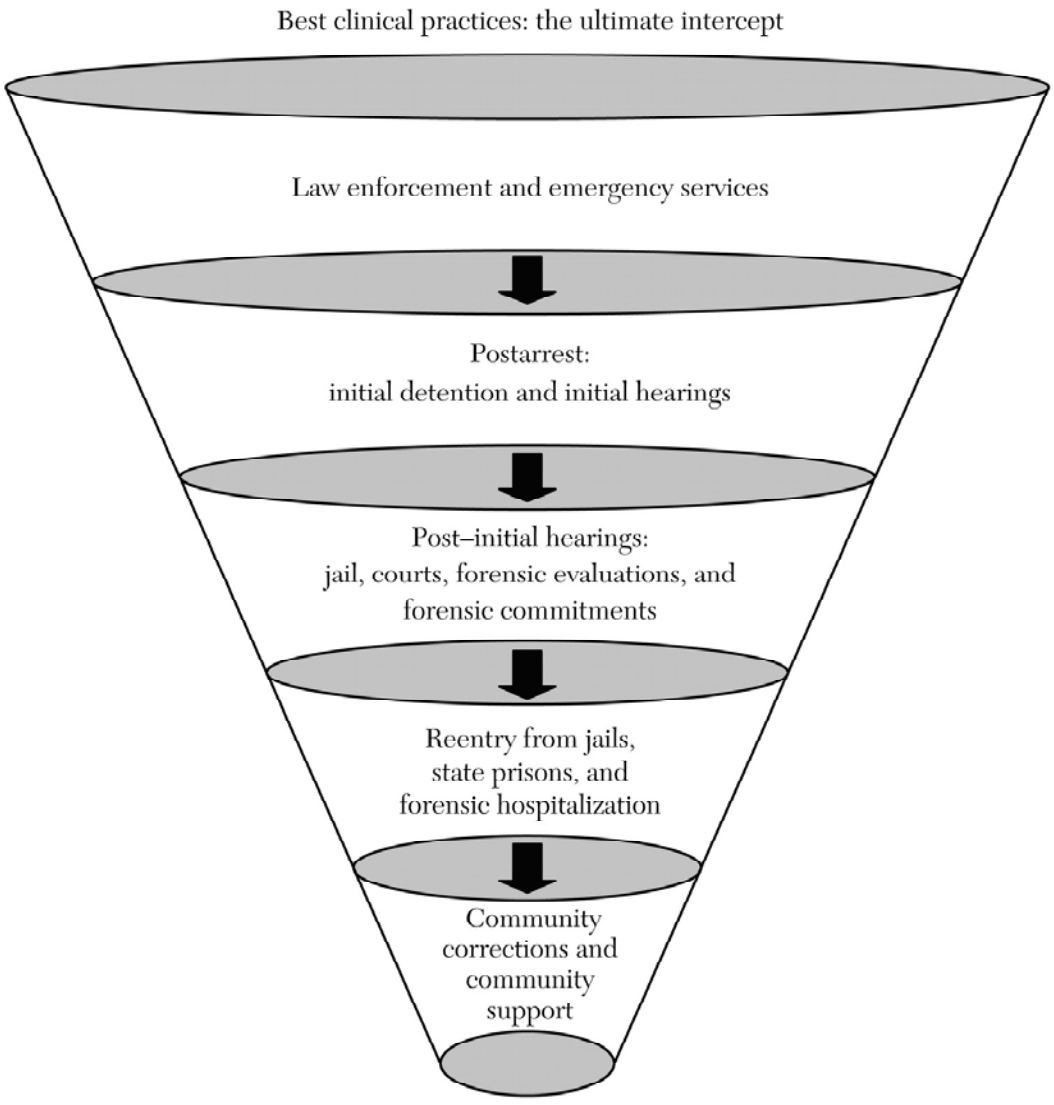
The Sequential Intercept Model of the Criminal Justice System

II. Overview of the Sequential Intercept Model

The Sequential Intercept Model was developed by the GAINS Center to provide a framework for a description of "intercept points," where a person with mental illness may be diverted to mental health treatment in the community or, if it is the least restrictive alternative, to the hospital.

Figure 1

The Sequential Intercept Model viewed as a series of filters



From Mark R. Munetz and Patricia A. Griffin. (April 2006). *Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness*, Psychiatric Services 57:544-549.

III. Diversion Activities at Intercept Stages

For reference, the Intercepts are numbered 1 through 5 beginning with Law Enforcement and Emergency Services and concluding with Community Corrections and Community Support. Not every criminal justice system fits comfortably into the exact flow of activities as another. The model is easily adaptable to these differences.

A. The "ultimate intercept" lies completely outside the criminal justice system

B. Intercept 1: Law Enforcement and Community Services

IV. Common Elements of the Intercept Stages

The Sequential Intercept Model is a tool used to identify phases of the criminal justice process and the locus of activities where people with mental illness may be "intercepted" and diverted into the mental health system. Subsequent sections of this task force report describe these activities in detail for each intercept phase. However, there are certain over-arching elements that apply to the planning, design and implementation of all options and recommendations at all intercepts.

A working partnership among the heads of all agencies affecting the mental health system and criminal justice process for persons with serious mental illness is the foundation of a successful system in a given locality. Mental health service providers, law enforcement, judges, attorneys, pretrial services, corrections, and the like must combine with persons with serious mental illness, family members, nonprofits and advocates to develop a system that accommodates a timely response with a goal of engaging the person with mental illness in treatment and recovery.

Multidisciplinary Planning and Implementation

The planning period for an integrated mental health/criminal justice system may take one to two years. Implementation may occur in a phased approach—either by putting in place pilots of many elements of the system or beginning with a full-scale version of a single element. For example, the Fairfax County Police Department went forward with its Crisis Intervention Team training using its existing training funds without waiting for program and budget approval from the county.

Part of the planning involves determining where the need for improvement exists and developing data to support the need and to define the resources required to close the gap between the current amount and quality of services and the newly designed system.

Developing a "picture" of the current and planned systems provides a way to attach measures to processes and interfaces among agencies and organizational components to provide baselines and metrics to determine progress toward the goal.

Monitoring and Continuous Improvement

After initial implementation of the system in any locality, the agency heads must continue to cooperate actively by convening regular meetings of the partnership and appointing an inter-agency working group to discuss issues, concerns and problems in a timely fashion. The work group should then report to the partnership at regularly scheduled meeting.

C. Participation of Persons with Serious Mental Illness

Peer Participation

Peer participation is essential in every phase of the mental health/criminal justice process including planning and design for improvement, plus participation at every intercept stage. Planning and participation currently exist, at least partially, across Virginia. Peer participation in both contexts can begin immediately, even if a community is not fully committed to an organized program of diversion services, or if it has consumer and family participation only in some phases.

Peer involvement in planning and in providing direct services to persons with serious mental illness have broad national support as key ingredients in progressive, recovery-oriented system change. People who have had difficulty using mental health services and those who have been in the criminal justice system often can connect with their peers who are at a more solid stage of recovery.

Peers working in the system are real bearers of hope, and become positive role models for those facing the many challenges of re-establishing a life in the community. Giving back and helping others become important facets of their own recovery process. Peer provider jobs are excellent work for many persons with serious mental illness.

Community for peers is a critical element in the new vision Virginia is developing for persons with mental illness. In the foreseeable future, Virginia's mental health and criminal justice systems will not be able to provide all the support and structure needed to keep people with mental illness out of jail. Peer community is growing, formally and informally, across the Commonwealth through VOCAL and a number of local peer-run organizations and networks. DMHMRSAS is supporting peer provider training and WRAP planning. Peers working at each intercept -- crisis intervention, pre-trial diversion, support in jail or prison, release planning and re-entry -- can connect persons with serious mental illness to community peer support. They can introduce those being released to the appropriate drop-in center, WRAP group, peer-run employment program, or individual mentor. They can teach from first-hand experience how to navigate such systems.

Forensic Peer Specialists

Forensic Peer Specialists ("FPS"s) are persons with serious mental illness who have been subjects of the criminal justice system. FSP programs serve dual purposes. First, such programs are designed to integrate persons with mental illness with a forensic background into the community by providing meaningful work, thereby guiding other individuals, through and out of the criminal justice system. The FPS is conversant in the culture of incarceration, more easily trusted by persons with serious mental illness who have been in the system, and able to help confront traumatic history. Secondly, of course, is the ability of FPSs to provide substantive information and support for other persons with serious mental illness as they navigate the criminal justice system.

The federal Center for Mental Health Services ("CMHS") supports a variety of programs aimed at facilitating mental health services for persons in contact with the criminal justice system. Through its National GAINS Center for Systemic Change for Justice-Involved Persons with Mental Illness, CMHS has sponsored efforts to promote the use of FSPs noting on its website that "Forensic Peer Specialists are an untapped and valuable workforce that can assist programs in achieving positive outcomes."[95]

The Howie T. Harp Peer Advocacy Center in New York City[96] has in place an FPS program that successfully trains and places FPSs in jail diversion, housing, vocational,

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[95] The work of the National GAINS Center in the Justice System and the Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion are informed by the National GAINS Center, which has operated since 1995 as a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system. The TAPA Center for Jail Diversion and the Center for Evidence-Based Programs in the Justice System, funded by the Center for Mental Health Services (CMHS) in 2001 and 2004 respectively, comprise the National GAINS Center.

The GAINS Center's primary focus is on expanding access to community-based services for adults diagnosed with concomitant mental illness and substance abuse disorders at all points of contact with the justice system. The Center emphasizes the provision of consultation and technical assistance to help communities achieve integrated systems of mental health and substance abuse services for individuals in contact with the justice system. To achieve this, the Center builds on its acronym:

G - gathering information

A - assessing what works

I - interpreting/integrating the facts

N - networking

S - stimulating change

[96] **Howie T. Harp Peer Advocacy Center** (HHAC)

HHAC is a consumer operated advocacy and service organization that provides comprehensive training to people with psychiatric histories, including those who have been homeless, who have had problems with substance abuse, or have a history of incarceration. Current criminal justice programs include a training program for service providers on serving people with mental illness returning to their communities from state prison and a forensic peer specialist training program in which graduates of the program are prepared to obtain permanent positions as: peer advocates, peer counselors, case managers, entitlement specialists and other entry-level positions within the field of human services. For more information go to: http://www.Howietheharp.org.

and substance abuse programs. Training there includes identifying and modifying adaptive prison behaviors and attitudes, and specialized training in navigating the criminal justice system.

Access to meaningful employment

For a state to provide FPSs, it must ensure there are limited barriers to training and hiring people with criminal records, even if they are currently on probation. Among the benefits of the FPS program is the access to employment by persons with serious mental illness who might otherwise be prevented from working a meaningful job. Employment is one of the top priorities of persons with serious mental illness who are in the recovery process. It contributes to the other two priorities – wellness and housing.

D. Family Involvement

NIMH studies have shown that family support is the most significant factor in the recovery of a person with serious mental illness.[97]

The beginning of family involvement

Serious mental illnesses such as schizophrenia, bi-polar disorder, and depression typically "bloom" in the late teens through mid-twenties. [cite?] These are the ages in which "first psychotic breaks" are frequently reported, (viz., the period between late high school and college or first fulltime employment). Because young people in this age range frequently lack health insurance, they tend to seek health care only when a crisis arises.[98] These young adults entering the early stages of very serious mental illnesses are less likely than children to receive a routine screening for mental illness.

The advantages of family involvement

A family member can usually explain to law enforcement, health care personnel or court personnel the medical and social history of a person with serious mental illness, often providing useful contact information and background on the person's psychiatric symptoms, history, and previous treatment. Importantly, the family may know and have paperwork on whether or not their loved one has been formally diagnosed with a serious brain disease and whether prescribed treatment is being followed. The amount and detail of this information increases with the amount of time the person has been ill in particular when the person with a serious mental illness has been living with the family.

When the family member has served as a caregiver for a person with a serious mental illness (e.g., provided housing, financial support, informal case management,

[97] See, for example, Clark, R.E. (2001). "Family Support And Substance Use Outcomes For Persons With Mental Illness And Substance Use Disorders," Schizophrenia Bulletin 27(1):93-101.

[98] Note high school graduates who do not go to college or who are in college but over the age of 23 no longer qualify as dependents on their parents' group health insurance.

transportation to appointments), they probably know a great deal about that person's mental health status. Yet, even though the family member may actually be living with the person with a serious mental illness, they are precluded from direct communication about their case with law enforcement, court, and health care personnel unless the person with a serious mental illness has given prior permission. {cite?]

Barriers to participation

If an emancipated young adult has not signed an advanced health directive allowing a family member to be contacted and involved in his or her health care planning and a psychotic break occurs, valuable information may not be transmitted to the various players who must make rapid decisions in a crisis criminal justice situation with a person with mental illness. [doesn't this depend on the young person's age (viz., 18 years old?)]

When families meet barriers to treatment of a loved one

Family members attending the NAMI "Family to Family" programs in Virginia consistently cite the difficulty they face in trying to obtain help for their seriously ill child, sibling, or spouse from mental health professionals and law enforcement– *before* the person goes into crisis. Many report instances of their loved one being seriously psychotic, but when the police arrive, the psychotic symptoms may be viewed as insufficient to book a person as a threat to self or others. Other families, fearing for their own safety when a family member becomes psychotic or "out of touch," ask the family member to leave the home. A substantial number of these persons eventually end up "living on the street" -- a condition not legally considered to be a threat to self by law enforcement or public health or mental health officials. And while emergency room hospital personnel may sympathize with a person presenting with psychotic symptoms and even offer medication, frequently psychiatric beds are lacking to stabilize the person long enough to ensure the prescribed medication is actually effective and clinically appropriate.[99] Hospitalization is especially problematic for those lacking medical insurance since private hospitals, which are a major provider of mental health care, are reluctant to take patients without health insurance who are not under a court-ordered civil commitment or under the custody of the criminal justice system.

Preparation for reentering the community

So, should family members be involved? Take the family totally out of the equation and what is lost? First loss: immediate and in depth information about the person with a serious mental illness at the time of crisis, including, potentially, whether or not the person is not properly taking his or her prescribed medications. Also, family may have knowledge about threats, ideations, or writings the person has discussed that reflect potential threats to others or to themselves. Most important, the absence of family involvement deprives the various decision makers in the criminal justice process of

[99] Some anti-psychotics take several weeks to reach optimal effects.

timely and valuable information, at the time of crisis, pre-booking, court hearings, treatment planning, and discharge/re-entry planning. As family is often suggested by the criminal justice system as the first-best- post-incarceration resource, the frequent, intentional non-involvement of the family up to this point is baffling to parents, siblings and spouses. [need to restructure the last sentence, unclear.]

The discord among purposes

The prior permission requirement for engagement of family members is intended to protect the seriously mentally ill individual's right to self-determination, to honor HIPAA and other regulations[100] and to avoid potential abuse by family members who may not have the persons with a serious mental illness' best interests at heart. However, as applied, the prior permission requirement and misunderstandings of HIPAA and other such laws also *protect* the rights of the seriously mentally ill individual to make uninformed or irrational decisions about their own current and future criminal justice and mental health treatment and care. Such prior permission requirements, if comparably applied to a person with serious Alzheimer's Disease, would require families to wait for that person with such a serious brain disease to decide whether and how best to have their treatment provided.

Virginia's current laws and, more importantly, the practices of many law enforcement, court, and health professionals in involving families only when an individual clearly requests such involvement, while well-intended, have had the effect of creating barriers between families and their ill family members, and rifts between families and the criminal justice, court, and treatment communities. This is unfortunate since families can be a resource of immeasurable value when brought into a criminal justice crisis situation and subsequent mental health evaluation, treatment planning and reentry/case management phases.

[100] The Commission's Task Force on Privacy and Health Information addresses some of the common misperceptions of the requirements of HIPAA and other privacy and confidentiality laws.

APPENDIX B

CRIMINAL JUSTICE TASK FORCE RECOMMENDATIONS

CHAPTER I. COORDINATION, PREVENTION AND INITIAL CONTACTS WITH LAW ENFORCEMENT

Recommendation I.1. Legally responsible agencies should create criminal justice/mental health task forces/councils at state, regional and local levels to oversee and coordinate the effective development, enhancement and sustainability of jail diversion programs.

- **At the state level, the Secretary of Health and Human Services, the Secretary of Public Safety and the Chief Justice of the Supreme Court should develop a Coordinating Council on Mental Health and Criminal Justice (hereinafter the Coordinating Council) to assist in the development, oversight and coordination of regional and local diversion task forces.**

- **The Coordinating Council should oversee and approve the development and implementation of evidence-based and promising best practice programs, as well as the necessary policies and procedures to support their effective implementation.**

- **At the regional and/or state level, CCJBs or other capable and interested entities where the CCJB is not active or interested in participating in partnership with CSBs, should establish collaborative task forces, which include stakeholders from mental health, criminal justice, consumers/advocates, local government and business interests to develop locally feasible and acceptable community plans for jail diversion.**

Recommendation I.2. The General Assembly should amend the Virginia Code Section 9.1-178 to add one or more mental health representatives to CCJBs.

- **These representatives should include at least one consumer and one provider; and,**

- **An executive leadership position should be established to provide staffing for the state council and linkage between the work of the state council and local criminal justice/mental health collaboratives.**

Recommendation I.3. The Coordinating Council should establish a Criminal Justice/Mental Health Training Academy to coordinate, provide, develop and/or enhance appropriate training, cross-training and public education in the criminal justice/mental health interface area for stakeholders, agencies, individuals and systems.

Recommendation I.4. The DMHMRSAS, the DOC, and other appropriate state and local entities should collaborate in the development and implementation of systematic data collection in all diversion programs. This effort should be mandated at the state level and monitored through the Coordinating Council or other appropriate entity.

Recommendation I.5. The Coordinating Council and the participating agencies should take the necessary steps to implement evidence-based or promising best practices throughout the Commonwealth. Such programs should include, at a minimum:

- **Appropriate methods for selection and training of officers and/or mental health professionals for addressing mental health crisis response;**

- **Support for the use of specially trained officers to allow them discretion to seek treatment for appropriate individuals rather than pressing charges and to make community referrals in situations that do not rise to the level of an ECO; and,**

- **A therapeutic drop-off process, which can be effectively used to reduce the need and preference for arrest and booking.**

Recommendation I.6. The DMHMRSAS and the DCSJ should jointly develop protocols for the primary officer in any encounter involving an individual with suspected mental illness as well as for specialized responders, whether civilians or police officers.[101]

Recommendation I.7. The DMHMRSAS and the DCSJ should jointly develop protocols for when an officer with specialized training in mental health and crisis response should be dispatched to a scene.

Recommendation I.8. The Coordinating Council and its participating agencies should take the necessary steps to assure that targeted crisis response training is provided to the following groups in order to enhance community capability to support mental health crisis response:

a. Medical Crisis Responders

b. Dispatchers

c. All Law Enforcement Officers (see statutory change recommended below)

d. Magistrates

e. Consumers/Family/Household

f. The community at large

Recommendation I.9. The General Assembly should amendVirginia Code § 9.1-102 to require the Department of Criminal Justice Services to establish compulsory minimum entry-level, in-service and advanced training standards for law

[101] Typically, when a police officer is the responder, a specially trained officer is in charge of a mental health call because of his expertise, regardless of rank.

enforcement personnel in recognizing, communicating with, facilitating the safe disposition of incidents involving, and obtaining evaluation and treatment of individuals with mental illness;

Recommendation I.10. Local or regional criminal justice/mental health collaboratives should develop guaranteed, secure therapeutic drop-off locations for individuals in crisis, including person under an ECO or TDO. Such facilities should be suitable to local needs and resources in each locality or region and may include existing facilities provided that security issues are addressed. At a minimum, such a drop-off locations would reduce the amount of time necessary for first response law enforcement to remain on scene during an ECO.

Recommendation: I.11, To facilitate an officer's ability to assist appropriate individuals in obtaining necessary services rather than arresting the individual, the General Assembly should amend the Virginia Code § 37.2-808 to permit custody to be transferred to the facility. [This authority was conferred in the reform package adopted by the General Assembly in 2008.]

Recommendation I.12. The General Assembly should further amend the Virginia Code § 37.2-808 (G), as amended in 2008, as follows:

G. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization. Such evaluation shall be conducted immediately. If a person is committing a criminal offense and the officer has probable cause to believe that the person meets the criteria for emergency custody as stated in this section, the officer may take the person into custody and transport the person to an appropriate location to assess the need for hospitalization or treatment without prior authorization and without formally tendering criminal charges against the person. *The law enforcement officer may transfer custody of the person to the appropriate location to which the individual is transported if the location is willing to accept custody of the person and can provide security adequate to protect the individual and others from harm [in accordance with regulations adopted by the Board.]*

CHAPTER II. POST-ARREST TREATMENT AND JAIL DIVERSION

Recommendation II.1. The General Assembly and local governments should assure that the jails of the Commonwealth are sufficiently resourced to meet the basic standards for provisions of mental health services that have been established by national jail accreditation organizations, such as the American Correctional Association.

Recommendation II.2. Regional and local task forces should assure that provision of mental health services in each local and regional jail are sufficiently linked with local

community mental health and social services agencies, and with state hospital forensic programs, to provide for continuity of treatment for jail inmates during incarceration, and at the point of diversion to community treatment.

Recommendation II.3. The Coordinating Council should periodically review models for jail diversion programs, including all worthwhile formats for mental health specialty courts and other pretrial diversion options, and implement those suitable to the needs of the Commonwealth, based on available resources and predicted effectiveness.

Recommendation II.4. The Coordinating Council and the regional and local task forces should consider the impact of all interventions and programs on DMHMRSAS state forensic hospital programs.

CHAPTER III. EVALUATION AND TREATMENT DURING CRIMINAL PROCEEDINGS

Recommendation III.1. The Coordinating Council should establish a standardized mental health screening and/or assessment procedure to identify individuals with mental illness or concomitant disorders upon booking with the goal of providing appropriate diversion, creating formal service plans developed, and providing appropriate jail mental health services and appropriate community linkage upon release. (See, also, III.6 below).

Recommendation III.2. The Virginia Supreme Court should support specialized judicial approaches for persons with mental illness, substance abuse disorders, or concomitant disorders pending criminal charges.

Recommendation III.3. Regional and local criminal justice/mental health task forces should establish an adjudication approach suitable to the locality for individuals with mental illness and/or with substance abuse disorders who qualify for diversion at the pre-trial or post-conviction stage.

Recommendation III.4. Local or regional jails and CSBs should enter into necessary agreements to assure that CSB Mental Health and Substance Abuse Services staff are available to properly identify and evaluate the needs of inmates with mental illnesses and/or substance use disorders.

Recommendation III.5. The General Assembly should amend the Code of Virginia so that seriously mentally ill inmates have the same access to a licensed psychiatric hospital when they cannot be stabilized in the jail setting as they would if they were not incarcerated.

Recommendation III.6. The Coordinating Council and its participating agencies should take the necessary steps to assure that prisons and regional and local jails utilize a standardized evaluation tool to determine presence of a mental illness or co-occurring disorder and the consequent service and support needs for persons with serious mental illness in jail or prison.

Recommendation III.7. The Coordinating Council and its participating agencies should establish a Criminal Justice/Mental Health Training Institute to support better understanding of 1) the use of the standardized evaluation tool, 2) mental illness and methods for managing inmates with mental illnesses, 3) the service needs of inmates with mental illnesses and concomitant substance abuse disorders, and 4) procedures used in jail or prison to facilitate their success in the community.

CHAPTER IV. RECOVERY-ORIENTED RE-ENTRY

Recommendation IV.1. The Coordinating Council should work with jails and prisons to establish an overarching policy promoting re-entry client support for all MH/SA clients to optimize each client's chances of successful community reintegration.

Recommendation IV.2. The General Assembly should amend the Virginia Code to designate and fund CSBs as the accountable organization for re-entry client support in the Commonwealth.

Recommendation IV.3. The General Assembly should amend the Virginia Code to require that, upon release from jail or prison, the responsible correctional authority provide persons with serious mental illness at least seven days' supply of the medication they were prescribed in the facility and a prescription for at least one month more, to ensure continuity of mental health care.

CHAPTER V. COMMUNITY CORRECTIONS AND COMMUNITY SUPPORT

Recommendation V.1. The Department of Corrections should require identification, of inmates with mental illness and the development of, appropriate follow up plans for these inmates *prior to release* to the communities.

Recommendation V.2. The Coordinating Council and each regional or local task force should take the necessary steps to assure that offenders with mental illness released to the community are provided with intensive, treatment-oriented community supervision and support using a wrap-around approach involving multi-agency and multidisciplinary participation immediately upon release to the community. Purchase of services funds should follow the client.

Recommendation V.3. Pre-release planning conducted by jails and prisons should include a review of a client's eligibility for federal and state benefits, including Medicaid, and assurance that those benefits are reinstated, if applicable.

Recommendation V.4. The General Assembly should designate the CSBs as the accountable entities for initiating, coordinating and monitoring client support services for

at least the individual's first year post-incarceration, and should provide the necessary funding for them to carry out this responsibility.

Recommendation V.5. The DOC and DMHMRSAS should collaborate to combine the purchasing power of both systems and operate a single state pharmacy or contract with a private vendor to provide the most appropriate medications for each individual.

Recommendation V.6. The General Assembly should define the respective roles and responsibilities of CSBs and the criminal justice, community corrections, and probation systems in developing and overseeing community-based services

APPENDIX C

ACRONYMS

ACT	Assertive Community Treatment
BHA	Behavioral Health Authority
CCJB	Community Criminal Justice Board
CSA	Comprehensive Services Act
CSBs	Community Service Board
CIT	Crisis Intervention Teams
CLE	Continuing Legal Education
CRP	Community Resource Pharmacy
DCJS	Department of Criminal Justice Services
DOC	Department of Corrections
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation, and Substance Abuse Services
ECO	Emergency Custody Order
FPS	Forensic Peer
FERPA	Family Educational Rights and Privacy Act
HIPAA	Health Insurance Portability and Accountability Act
IE	Independent Examiner
ICAAC	The Interagency Civil Admissions Advisory Council
JIRC	Judicial Inquiry Review Commission
JLARC	Joint Legislative Audit and Review Commission
MCES	Montgomery County Emergency Services
MCT	Mobile Crisis Team
MOT	Mandatory Outpatient Treatment
NAMI	National Alliance on Mental Illness
NGRIS	Not Guilty by Reason of Insanity
NIMH	National Institute of Mental Health
OIG	Office of the Attorney General
ORTS	Offender Re-entry and Transition Services
PACT	Program of Assertive Community Treatment
	Person with Mental Illness
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SIM	Sequential Intercept Model
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
TDO	Temporary Detention Order
VACSB	Virginia Association of Community Service Boards
VOCAL	Virginia Organization of Consumers Asserting Leadership
WRAP	Wellness Recovery Action Plans

APPENDIX D

The Commission's Preliminary Report

In December 2007, the Commission issued its Preliminary Report (the "Blueprint"), which contained a blueprint for action based on the work of the five Commission Task Forces including an earlier draft of this CJ Task Force Report. The following contains the Commission's Blueprint provisions involving the intersection of the criminal justice and mental health systems.

A Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform December 21, 2007

IV. REALIGNING THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS

The Commission's main goals with respect to the criminal justice system are to minimize the engagement of individuals with serious mental illness from the criminal justice system to the maximum extent consistent with the aims of criminal justice and to increase access to appropriate [delete space]mental health services for individuals with mental illness while detained, incarcerated or under community supervision.

IV-A Mental Health/Criminal Justice Coalitions
The Commission recommends creation of, and support for, mental health/criminal justice coalitions (including participation by persons with mental illness, family members, interested community partners and advocates) at state, regional and local levels to facilitate *diversion of persons with mental illness from the criminal justice system* and the delivery of mental health services to persons with mental illness incarcerated or under criminal justice supervision throughout the Commonwealth.

IV-A-1 State Coordinating Council.

At the State level, the Commission recommends that the Secretary of Health and Human Resources, the Secretary of Public Safety, and the Chief Justice of the Supreme Court should work cooperatively through a Coordinating Council on Mental Health and Criminal Justice ("Coordinating Council") The duties of the Coordinating Council should include identifying and advocating for policies, laws and programs that facilitate diversion and access to services and supporting and overseeing the efforts of local and regional partnerships.

IV-A 2 Local and Regional Partnerships. At the regional or local level, the Commission recommends that the CCJB(or a comparably constituted entity) should plan, implement and monitor diversion and treatment at every point in the criminal process—including crisis response, pre-trial proceedings, adjudication, sentencing, incarceration, forensic hospitalization, re-entry planning, and community supervision upon release. These partnerships should be multi-disciplinary and should include representatives with experiences and expertise in mental health, including public and private providers, consumers, family members and mental health advocates. If CCJBs serve as the coordinating entity, Va. Code § 9.1-178 should be amended to add at least two representatives with mental health expertise or experience.

IV-B Training

The Commission recommends that the Coordinating Council establish a Criminal Justice Mental Health Training Academy ("Training Academy") to facilitate training for law enforcement, court, jail, prison and mental health professionals at the nexus of mental health and criminal justice and to oversee public education and outreach efforts throughout the Commonwealth. The DCJS, the Supreme Court, and DMHMRSAS should support this Training Academy jointly, with direction by the Coordinating Council.

IV-C Programs and Services

The Coordinating Council should conduct a continuing review of programs, in the Commonwealth or elsewhere, aiming to facilitate diversion of persons with mental illness from the criminal justice system, to deliver services to persons with mental illness in the criminal justice system and should assess their effectiveness and cost. Based on these assessments, the Coordinating Council should take necessary steps to help communities implement evidence-based or other promising practices, services and programs.

IV-D Initial Contact with Persons in Crisis

Law enforcement officers should be trained to recognize signs of mental illness, to respond to crisis situations, to collaborate with mental health agencies, and, when appropriate, to take the person to a treatment facility rather than pressing criminal charges. In order to facilitate therapeutic referrals, each CSB region should establish one or more secure therapeutic drop-off centers with authority to take custody of the individual from law enforcement officers.

IV-E Post-Arrest Evaluation and Treatment in Jail

Each CSB should have staff available to evaluate the needs of all inmates at the earliest point of entry in jail in order to assess those who might be appropriately released pre-trial and to determine what services are needed for those who cannot otherwise be released. Standardized screening and evaluation tools should be used throughout the Commonwealth to determine the presence of a mental illness and concomitant disorders. Jail staff should be trained to administer initial screening tools. Inmates should have access to the same level of care and medications as individuals being served in a state psychiatric hospital or by a CSB. All jails should have sufficient resources to meet the basic standards for mental health services established by national jail accreditation organizations, such as the American Correctional Association. The mental health services in the jail should be linked with services in the community to facilitate continuity of treatment during incarceration and at the point of diversion from the jail. Expeditious placement in a licensed psychiatric hospital should be available for inmates who meet civil commitment criteria and would be otherwise hospitalized but for their incarceration, or who otherwise cannot be safely stabilized in a jail.

IV-F Therapeutic Leverage in Adjudication

The local CCJB or other designated entity, specifically including judges from circuit and district courts, should explore ways of linking the mentally ill defendant's adherence to treatment with the disposition of the criminal case, including formal pre-plea or post-plea diversion agreements, and prescribed treatment as a condition of bond or probation. Any local initiatives exploring mental health courts or other specialized dockets should be carefully studied by the Coordinating Council.

IV-G Recovery-Oriented Re-entry

Jails and prisons and CSBs should work together to facilitate successful community integration for all individuals with mental health and co-occurring disorders. Pre-release planning should include review of the individual's eligibility for federal and state benefits. CSBs should be responsible for overseeing the community re-entry of persons with mental illness from the criminal justice system and should be given sufficient resources to provide appropriate and effective treatment, peer support and other needed services. Protocols for communication and oversight among CSBs, jails, prisons and courts should be developed under the guidance of the State Coordinating Council which is based, whenever possible, upon existing formal agreements and contractual relationships. Upon release, individuals should be provided with a reasonable supply of medications prescribed in the jail or prison to cover the period before medical treatment in the community can begin.

APPENDIX E

Executive Order 62 (2008)

ESTABLISHING THE COMMONWEALTH CONSORTIUM FOR MENTAL HEALTH/ CRIMINAL JUSTICE TRANSFORMATION

National surveys have shown that 16% of all jail inmates have some form of mental illness. The 2005 Virginia Jail Survey yielded a similar prevalence in the Commonwealth of jail inmates with mental illness. These findings suggest that persons with mental illness are far too often subject to arrest and incarceration in Virginia for minor "nuisance" offenses related to their symptoms, and that many jail inmates with mental illness do not receive adequate mental health treatment in our jails, or when they return to the community. This lack of treatment access can lead to continuing acute illness or relapse, as well as engagement in criminal activity, including violent acts.

During the past decade, Virginia lawmakers and Executive Branch agencies have spearheaded efforts aimed at identifying the needs of persons with mental illness who become involved with the criminal justice system. It is imperative that Virginia address the pressing public safety and treatment access challenges posed by the lack of adequate mental health treatment for persons with mental illness in the criminal justice system. Doing so will require that there be a coordinated effort across all branches of state government, as well as the active and direct development of community-based solutions to this serious social problem.

By virtue of the authority invested in me by Article V of the Constitution of Virginia and Section 2.2-134 of the Code of Virginia, I hereby direct the Office of the Secretary of Health and Human Resources and the Office of the Secretary of Public Safety to lead the Commonwealth Consortium for Mental Health/Criminal Justice Transformation, with the dual purpose of preventing unnecessary involvement of persons with mental illness in the Virginia criminal justice system, and promoting public safety by improving access to needed mental health treatment for persons with mental illness for whom arrest and incarceration cannot be prevented.

The Commonwealth Consortium shall be chaired by the Secretary of Health and Human Resources and the Secretary of Public Safety, or their designees. The Office of the Attorney General and the Secretary of Finance shall provide key leadership and guidance to the Consortium. The Virginia General Assembly and the Supreme Court of Virginia have been invited to participate as partners in the Consortium. Membership of the Consortium shall include Commissioners or Directors of the following state government agencies (or their designees) that have a current or potential central role in improving access to treatment for persons with mental disorders in the criminal justice system:

- Board for People with Disabilities
- Commonwealth Attorney's Services Council
- Department of Corrections
- Department of Correctional Education

- Department of Education
- Department of Health
- Department of Housing & Community
- Department of Juvenile Justice
- Department of Medical Assistance Services
- Department of Planning & Budget
- Department of Health Professions
- Department of Rehabilitation Services
- Department of Social Services
- Department of Veterans Services
- Governor's Office for Substance Abuse Prevention
- Office of the Comprehensive Services Act (CSA)
- Virginia Criminal Sentencing Commission
- Virginia Employment Commission
- Virginia Indigent Defense Commission
- Virginia Office of Protection and Advocacy (VOPA)
- Virginia State Crime Commission
- Virginia State Police

The following additional organizations shall be invited to serve as members of the Commonwealth Consortium:

- Mental Health America of Virginia (MHAV)
- NAMI Virginia and its state regional affiliates
- University of Virginia, Institute of Law, Psychiatry and Public Policy
- Virginia Association of Chiefs of Police
- Virginia Association of Community Services Boards (VACSB)

- Virginia Association of Counties
- Virginia Association of Regional Jails
- Virginia Bar Association
- Virginia Community Criminal Justice Association (VCCJA)
- Virginia Council on Juvenile Detention
- Virginia Municipal League
- Virginia Sheriffs' Association
- Virginia Hospital and Healthcare Association
- VOCAL Virginia

The Consortium shall have the following goals:

Goal I: Transformation planning:
The Consortium shall evaluate the viability of jail diversion models for persons with mental illness, and develop recommendations for improving access to mental health treatment for persons with mental illness who cannot be diverted from arrest and incarceration. Representatives from relevant stakeholder groups in each locality, including Community Criminal Justice Boards, Law Enforcement, Local and Regional Jails, Community Services Boards and Local Community Corrections, Mental Health Services Consumers, and other public and private organizations shall be invited to participate in comprehensive transformation planning for their regions.

Goal II: Establish a Criminal Justice/Mental Health Training Academy for the Commonwealth:
The Academy will provide an integrative locus for coordinating the training activities of currently disparate state and local, public and private organizations into a concerted program of cross-training for criminal justice and mental health personnel.
This Executive Order shall be effective upon its signing and shall remain in full force and effect until December 31, 2009, unless sooner amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 23rd day of January 2008.

Timothy M. Kaine, Governor

Attest:

Secretary of the Commonwealth