# Virginia Judges Leading Change
# A Behavioral Health Summit

## October 30-Nov 1, 2023

*Williamsburg Lodge*

## Agenda

**Registration, October 30, 2023**

| | |
|---|---|
| **4:00 PM – 7:00 PM** | **Registration** |
| **6:00 PM – 7:00 PM** | **Welcome and Reception**<br>Welcome the teams, guests, and faculty to the first Virginia Behavioral Health Summit and make brief remarks<br><br>*Speakers:*<br>**Judge Leifman and Planning Team** |
| | **Dinner on Your Own** |

**October 31, 2023**

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| **7:30 AM – 4:30 PM** | **Registration** |
| **7:30 AM – 8:30 AM** | **Breakfast** |
| **8:30 AM – 8:45 AM** | **Welcome and Opening Remarks**<br>Welcome the attendees and representatives from the Virginia Behavioral Health Commission and thank the State Justice Institute for funds to support this summit<br><br>*Speaker*:<br>**Hon. S. Bernard Goodwyn**<br>Chief Justice, Supreme Court of Virginia |
| **8:45 AM – 10:00 AM** | **Plenary Session – Judicial Leadership: The Story of Miami-Dade County, Florida**<br>Opening the summit with an inspiring keynote address of what judicial leadership can accomplish to improve the community and court response to individuals with mental illness. Miami-Dade County, with a population of 2.8 million, is the seventh largest county in the nation and is a leader in addressing the complex community challenges involving law enforcement, behavioral health, and the justice system, as well as in devising evidence-based, cost-effective solutions for individuals with mental illness.<br><br>*Speaker:*<br>**Hon. Steve Leifman**<br>Associate Administrative Judge Miami-Dade County Court |
| **10:00 AM – 10:15 AM** | **Break** |

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|---|---|
| **10:15 AM – 11:00 AM** | **Plenary Session – The Sequential Intercept Model (SIM)**<br>The SIM was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.<br><br>*Speaker:*<br>**Debra A. Pinals, M.D.**<br>Clinical Professor, University of Michigan Law School, MDHHS Medical Director for Behavioral Health and Forensic Programs |
| **11:00 AM – 11:30 AM** | **Brief Remarks–Wellness in Law**<br>Highlights of progress made in the "well-being in law movement with special focus on the promotion of well-being and prevention of behavioral health concerns among judges and court personnel.<br><br>*Speaker:*<br>**Hetal M. Challa, Esq.**<br>Wellness Coordinator, Office of the Executive Secretary of the Supreme Court of Virginia |
| **11:30 AM – 1:00 PM** | **Lunch and State Team Meetings** |
| **1:00 PM – 2:15 PM** | **Plenary Session – Early Intervention, Deflection, and Diversion: Public Health System Community Services (Intercept 0) and Law Enforcement (Intercept 1)**<br>Using SIM as a framework, this multidisciplinary panel will share practical solutions and evidence-based practices pre-arrest in the public health system and communities including law enforcement alternatives, such as Crisis Intervention Training, a continuum of crisis services, and involving civil commitment practices and assisted outpatient treatment. Early intervention with crisis mobile teams and diversion from the criminal justice system are the preferred strategies for as many persons with serious mental illnesses as feasible. "988 implementation strategies" will also be addressed.<br><br>*Speaker:*<br>**Margie Balfour MD, PhD**.<br>National Council of Mental Wellbeing, Chief of Quality and Clinical Innovation, Connections Health Solutions, University of Arizona<br>*Panelists:*<br>**Lt. Donald Green and Officer Wire**<br>Henrico Crisis Intervention Trained Officers |
| **2:15 PM – 2:30 PM** | **Break** |
| **2:30 PM – 3:15 PM** | **Plenary Session – Certified Community Behavioral Health Clinics**<br>A Certified Community Behavioral Health Clinic (CCBHC) model is designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth. |

*Speaker*:
**Brett Beckerson**
National Council for Mental Wellbeing

*Panelists:*
**Laura Davis, LCSW, LSATP**
Chief CQI Officer, CCBHC Project Director, Mount Rogers CSB
**Melanie Adkins, LPC**
CCBHC Project Director/Senior Director for Clinical Services, NRVCS
**Dawn Farrell-Moore, LCSW, CSAC**
Director Grants, Research, Evaluation & Planning, RBHA

**3:15 PM - 4:30 PM** — **Plenary Session – Diversion (Intercept 2), and Behavioral Health Dockets (Intercept 3) Virginia Solutions Aligned with Task Force Recommendations**
Using the SIM as a framework, this judicial panel will share experience implementing and presiding practical solutions and evidence-based practices to reduce incarceration by diversion and linking participants to treatment.

*Speaker:*
**Debra A. Pinals, M.D.**

*Panelists:*
Diversion to Treatment
**Hon. Jacqueline Talevi, Judge**, Roanoke County General District Court

Behavioral Health Dockets
**Hon. Mansi Shah, Judge,** Richmond General District Court
**Hon. R. Frances O'Brien, Judge**, Arlington General District Court

Cross-Designation from JDR courts
**Hon. Jacqueline Talevi, Judge**, Roanoke County General District Court

**4:30 PM - 5:30 PM** — **Court Team Meetings**
Each of the court teams will work on action plans.

**November 1, 2023**

**7:30 AM – 12:00 PM** — **Registration**

**7:30 AM – 8:30 AM** — **Breakfast**

**8:25 AM – 8:30 AM** — **Welcome and Morning Announcements**

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| **8:30 AM –9:45 AM** | **Plenary Session – In-Jail Behavioral Health Program**<br>Jail health care providers are required to provide behavioral health and medical services to detainees needing treatment. Access to individualized behavioral health services includes integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.<br><br>*Speakers:*<br>**Dr. Kevin L. Cuffee**<br>Resident in Counseling, Human Services VA Beach<br>**Hon. Ken Stolle,**<br>Sheriff VA Beach Jail |
| **9:45 AM – 10:00 AM** | **Break** |
| **10:00 AM – 11:15 AM** | **Plenary Session – *Reentry (Intercept 4) and Community Corrections (Intercept 5)***<br>Building on the earlier panels, and again using the SIM as a framework, this panel will highlight effective practices and models within the justice system to address behavioral health conditions. The goal is to consider the implementation of procedures to identify the extent to which behavioral health impacted a current criminal conviction or probation violation, not necessarily in relation to intent, but to address an underlying impact on behavior. This should improve the decisional process for imposition of sentences and terms of probation for non-violent criminal offenders who, with proper counseling or mental health treatment and a concrete plan, will reasonably be expected to avoid future criminal behavior, successfully complete probation, and achieve rehabilitation while paying their debt to society for the crime committed.<br>The purpose of the procedures is to determine, either at the time of sentencing or when considering a probation violation, whether the Court should order special conditions of probation that could foster a greater probability of the successful completion of probation.<br><br>*Speaker*:<br>**Michelle O'Brien, JD**<br>Principal Court Management Consultant, National Center for State Courts<br><br>*Panelists:*<br>**Hon. Daniel S. Fiore, II, Judge**<br>Arlington Circuit Court<br>**Suzanne Somerville**, LCSW, Arlington CSB, Bureau Director Behavioral Healthcare Division<br>**Kristina Centanni**, DOC, District 10, Senior Probation & Parole Officer, Substance Abuse & Mental Health Team |

# Virginia Judges Leading Change
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|---|---|
| **11:15 AM –12:15 PM** | **Improving Court Response to those with Mental Illness Task Force Recommendations**<br>The Task Force led by an Executive Committee, joined by 40 additional judges, court, and behavioral health experts, and funded by the State Justice Institute spent two years developing tools, resources, best practices, and policy recommendations for the state courts to help in their efforts to effectively respond to the needs of court-involved individuals with serious mental illness. This work culminated in the Task Force's Final Report and Recommendations, released at the Task Force press conference event on October 25, 2022.<br><br>*Speakers:*<br>**Michelle O'Brien**<br>Principal Court Management Consultant, National Center for State Courts<br>**Paul DeLosh**<br>Director, Judicial Services Department, Office of the Executive Secretary of the Supreme Court of Virginia |
| **12:15 PM – 12:30 PM** | **Peer Voice of Lived Experience (Lunch Speaker)**<br>A peer recovery specialist sharing their experience<br><br>*Speaker:*<br>**Chris Pittman, CPRS**<br>Substance Abuse and Addiction Recovery Alliance (SAARA) of Richmond |
| **12:15 PM - 1:15 PM** | **Lunch & Regional Team Meetings** |
| **1:15 PM -2:00 PM** | **Team Reports and Closing Remarks**<br>Selected court teams will report back to the full group on action plans.<br><br>*Facilitators:*<br>**Danny Livengood**, Specialty Dockets Training Coordinator, Department of Judicial Services<br>**Liane Hanna,** Specialty Dockets Compliance Analyst, Department of Judicial Services |
| **2:00 PM** | **Adjourn** |

# Improving Court and Community Responses to those with Mental Illness: A focus on the Sequential Intercept Model

DEBRA A. PINALS, M.D.

ADJUNCT CLINICAL PROFESSOR OF PSYCHIATRY
DIRECTOR, PROGRAM IN PSYCHIATRY, LAW AND ETHICS
UNIVERSITY OF MICHIGAN

SENIOR MEDICAL AND FORENSIC ADVISOR,
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

# Overrepresentation of SMI & SUD in Justice System

More than half of those incarcerated have some type of mental health history, even more have a substance use history

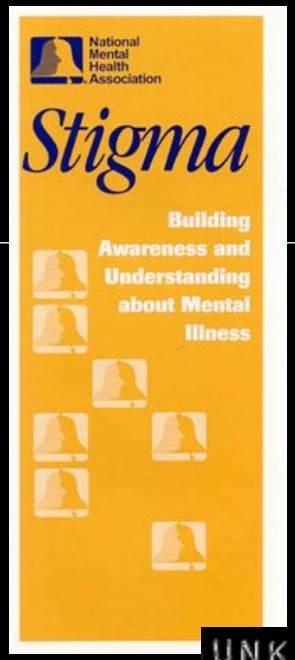
Of those with MH issues, three-quarters have a co-occurring substance use problem (James & Glaze, 2006)

10-15% of jail and prison inmates have a form of mental disorder that requires treatment (Hoge, Buchanan, Kovasznav, & Roskes, 2009)

Those with co-occurring disorders are at at high risk for re-incarceration

# Impact of Stigma

- Reduced access care
- Reduced access to housing, employment, etc
- Discrimination, isolation
- Lack of parity in healthcare coverage
- Belief that persons with mental illness and substance use are not sufficiently held responsible for their actions
- Belief that persons with MI are less competent and more dangerous




# Intangible consequences

Ostracism

Isolation

Public Humiliation

The exacerbation of trauma that may accompany incarceration

Courtesy of Hudson-Price 2014

# A Systems Approach to Behavioral Health and Justice Involved Individuals

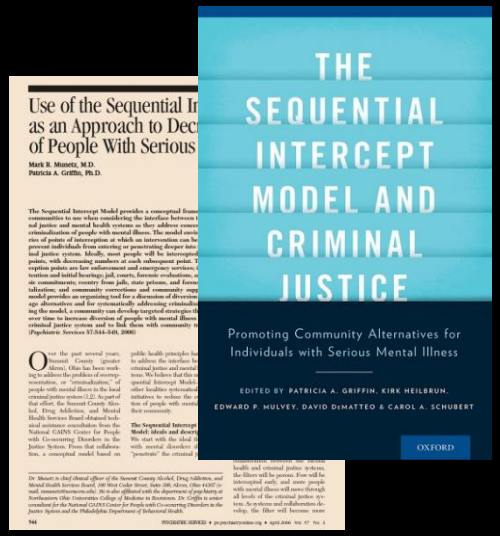
OPPORTUNITIES FOR DIVERSION AND ALTERNATIVE PATHWAYS WHEN SAFE AND APPROPRIATE

# Sequential Intercept Model

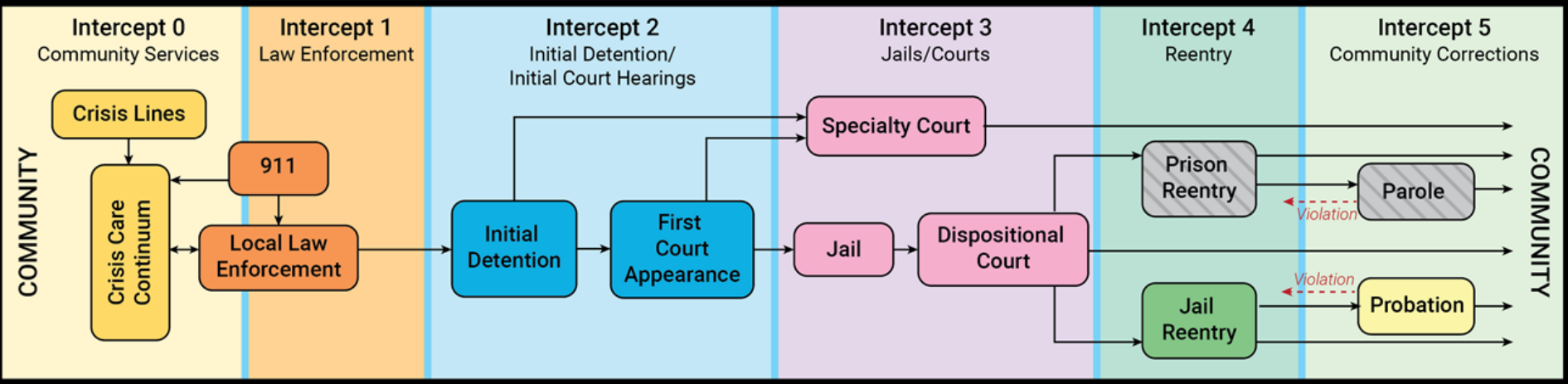
People move through the criminal justice system in predictable ways

Illustrates key points, or intercepts, to ensure:

- Prompt access to treatment
- Opportunities for diversion
- Timely movement through the criminal justice system
- Engagement with community resources



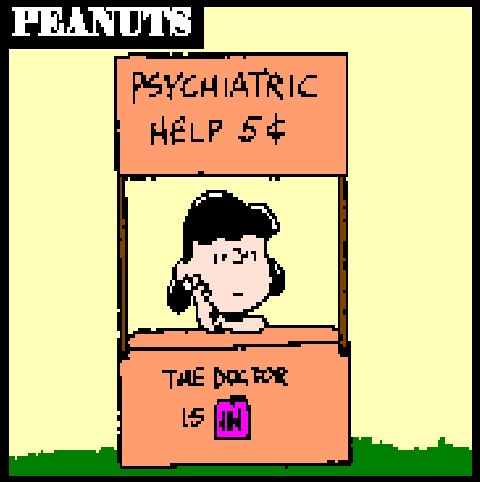
# Potential Intercepts in the Criminal Justice Process where Mental Health and Substance Use needs can be Identified: A Broad Overview




SAMHSA's National GAINS Center, Delmar, NY 2017;
Adapted from Munetz and Griffin, *Psychiatr Svcs*, 2006

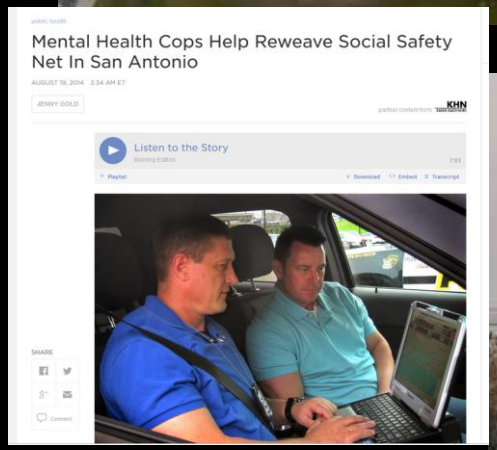
# Intercepts 0 and I:

Mental Health Services and Law Enforcement

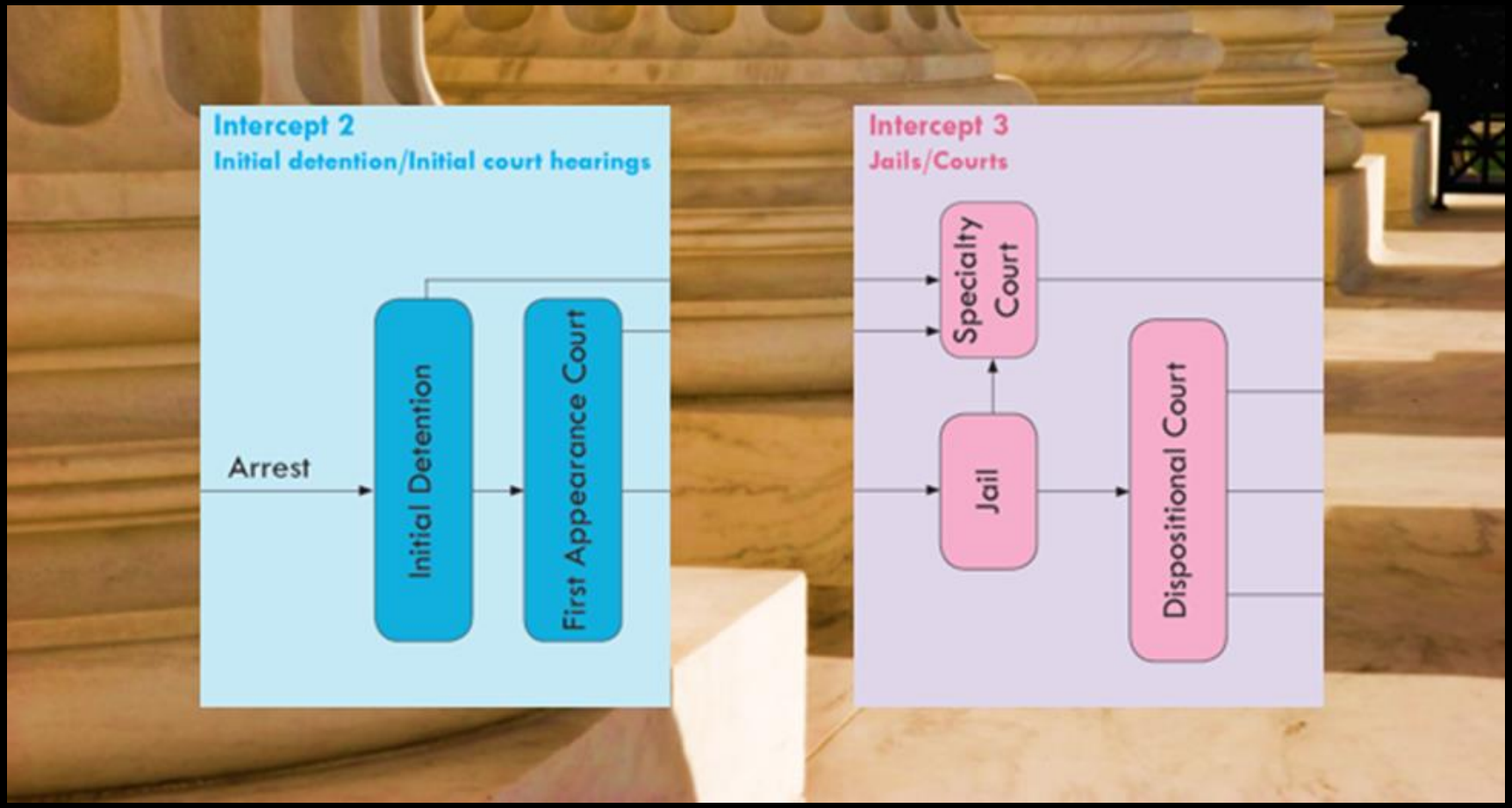


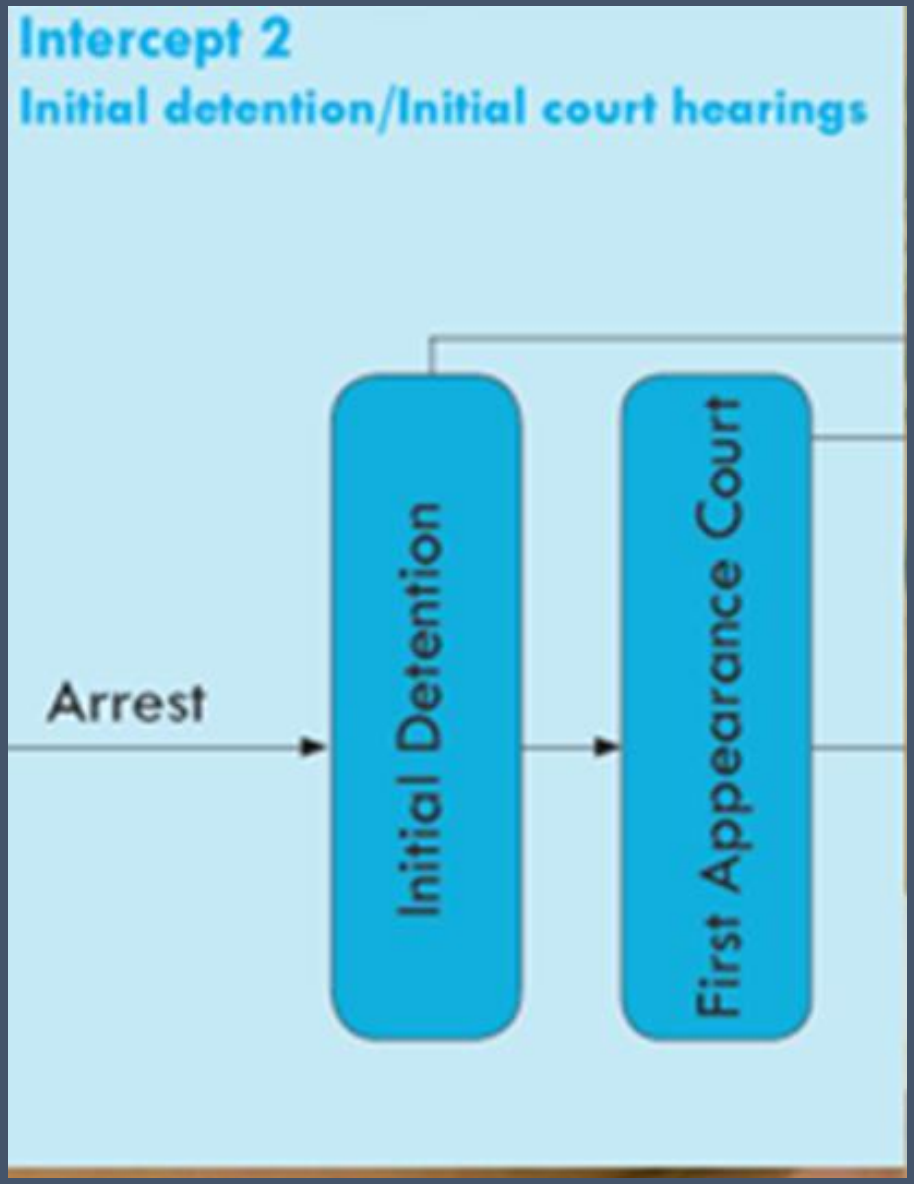

# Intercept 0/1: Prevention and Intervention

- Crisis warm lines
- Peer support in emergency rooms
- Crisis drop off centers
- CIT
- Law Enforcement Assisted Diversion
- Non law enforcement strategies of response
- Police mental health collaboration
  - Co-responders




# Intercepts 2 and 3



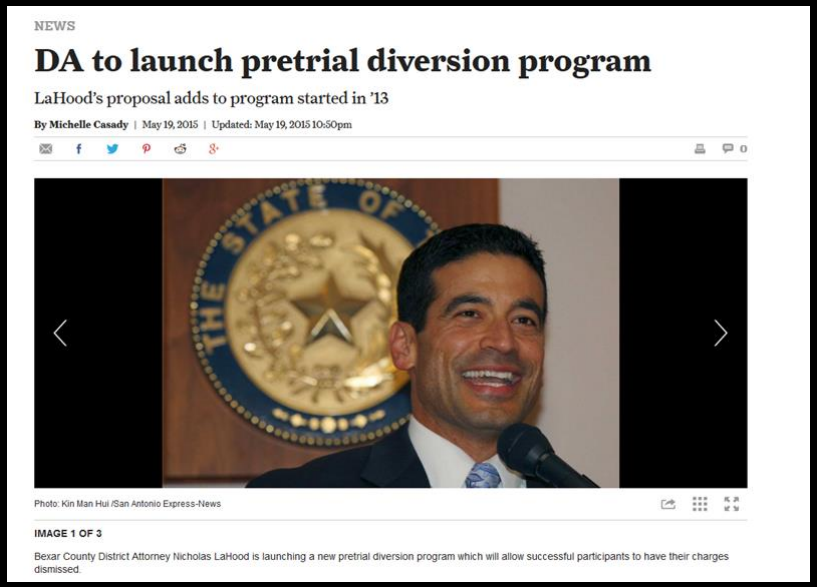

Intercept 2
Initial detention/Initial court hearings
Arrest
Initial Detention
First Appearance Court

# Intercept 2

# Legislative and Program Strategies

Bail Reform

Pretrial Services



NEWS

## DA to launch pretrial diversion program

LaHood's proposal adds to program started in '13

By Michelle Casady | May 19, 2015 | Updated: May 19, 2015 10:50pm

Photo: Kin Man Hui /San Antonio Express-News

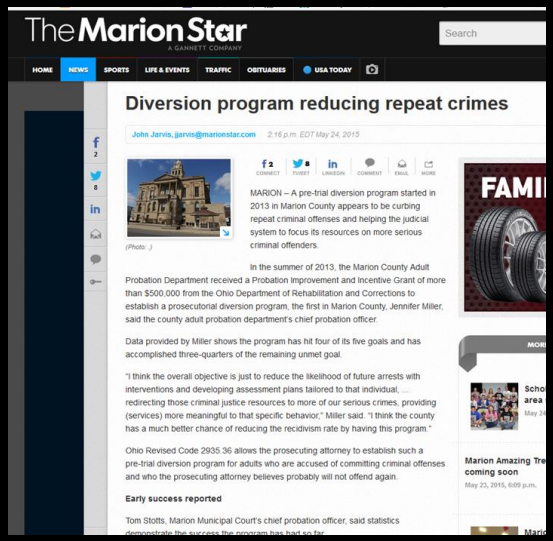
IMAGE 1 OF 3

Bexar County District Attorney Nicholas LaHood is launching a new pretrial diversion program which will allow successful participants to have their charges dismissed.

# PRE-TRIAL DIVERSION

http://www.lectlaw.com/def2/p068.htm

Also known as adjournment in contemplation of dismissal or conditional dismissal. A program in which a defendant essentially is put on probation for a set period of time and his or her case does not go to trial during that time. If the defendant meets the conditions set by the court, then the charge will be dismissed.



The Marion Star

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## Diversion program reducing repeat crimes

John Jarvis, jjarvis@marionstar.com 2:16 p.m. EDT May 24, 2015

MARION – A pre-trial diversion program started in 2013 in Marion County appears to be curbing repeat criminal offenses and helping the judicial system to focus its resources on more serious criminal offenders.

In the summer of 2013, the Marion County Adult Probation Department received a Probation Improvement and Incentive Grant of more than $500,000 from the Ohio Department of Rehabilitation and Corrections to establish a prosecutorial diversion program, the first in Marion County, Jennifer Miller, said the county adult probation department's chief probation officer.

Data provided by Miller shows the program has hit four of its five goals and has accomplished three-quarters of the remaining unmet goal.

"I think the overall objective is just to reduce the likelihood of future arrests with interventions and developing assessment plans tailored to that individual, ... redirecting those criminal justice resources to more of our serious crimes, providing (services) more meaningful to that specific behavior," Miller said. "I think the county has a much better chance of reducing the recidivism rate by having this program."

Ohio Revised Code 2935.36 allows the prosecuting attorney to establish such a pre-trial diversion program for adults who are accused of committing criminal offenses and who the prosecuting attorney believes probably will not offend again.

**Early success reported**

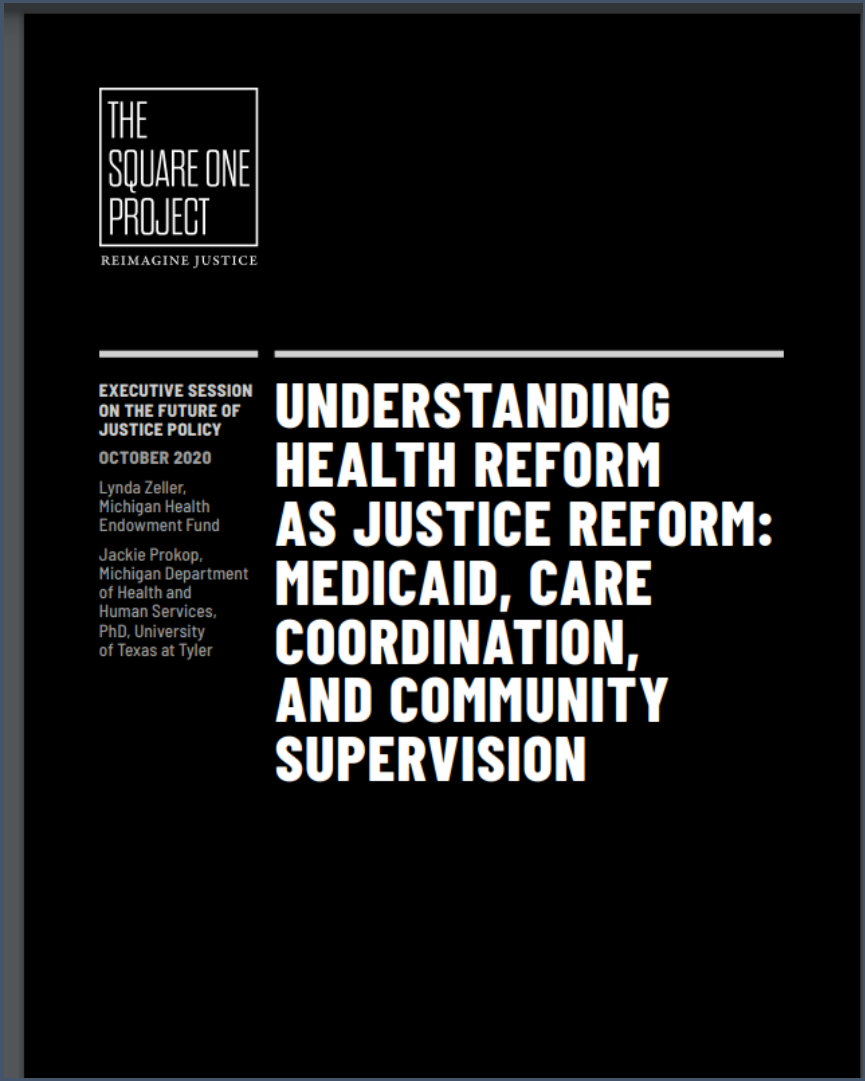
Tom Stotts, Marion Municipal Court's chief probation officer, said statistics

# Importance of Intercept 2 Diversion

2013 study of pretrial detention in Kentucky (N=155,000)

- Detention of low and moderate risk defendants increases their rates of new crimes
- When held 2-3 days, low risk defendants 40% more likely to commit crimes before trial
- When held 8-14 days, low risk defendants are 51% more likely to commit crimes 2 years after case disposition

Lowenkamp, C. T., VanNostrand, M., & Holsinger, A. (2013). The hidden costs of pretrial detention. Houston, TX: Laura and John Arnold Foundation.




# Incercept 2 and Jail Healthcare

Various models:

- Contracted with local, private or public provider
- Expanding linkages for fast paced returns to community

Quality of Care Enhancements

- Accreditation
- Partnership with state and others

Recent advancements

- MAT for opioid use disorders
- Focus on linkages
- Attention to Medicaid

Intercept 3

Jails/Courts

Specialty Courts?

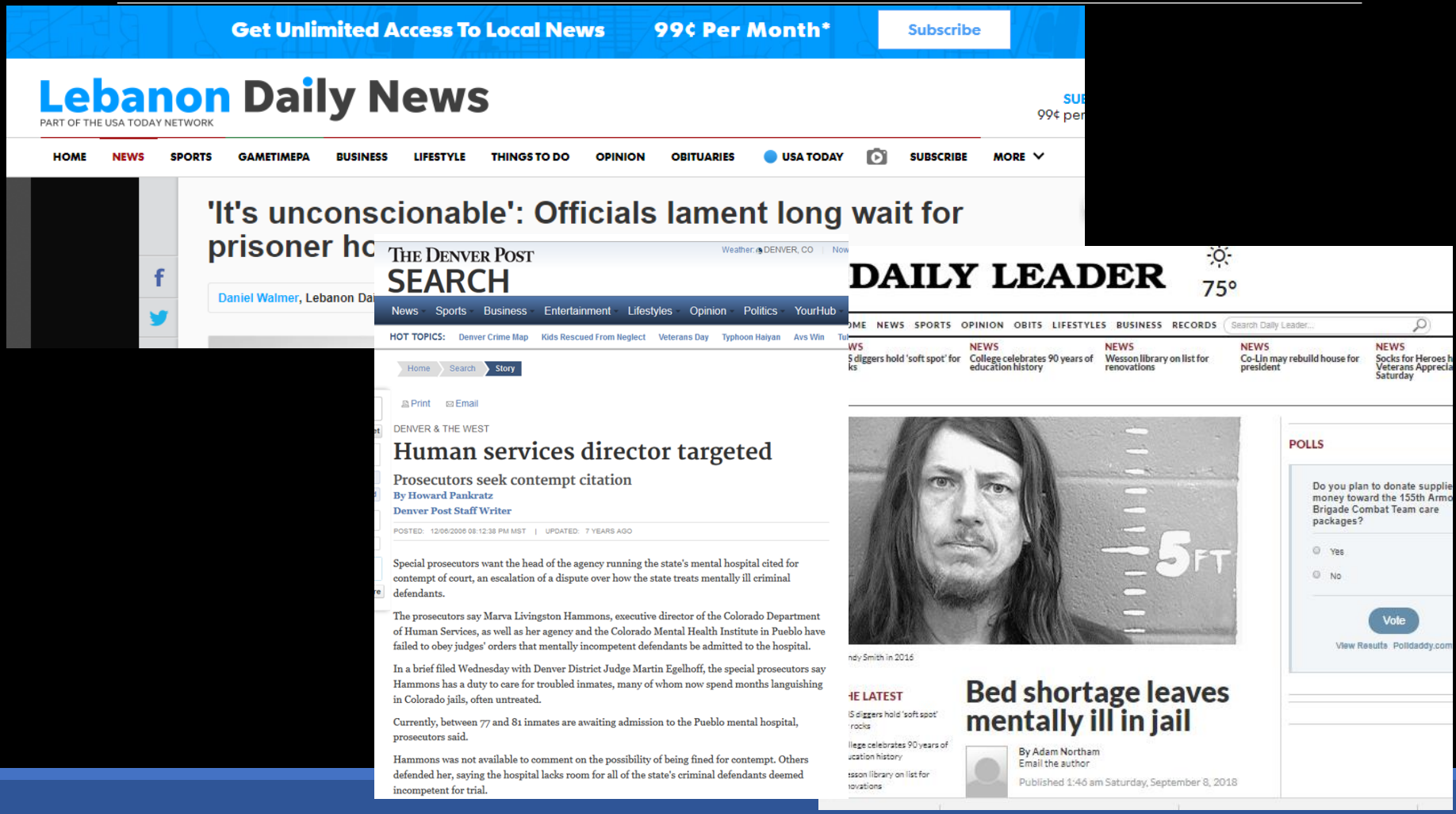
Other Court Programs?

Jail-Based:

**Diversion?**

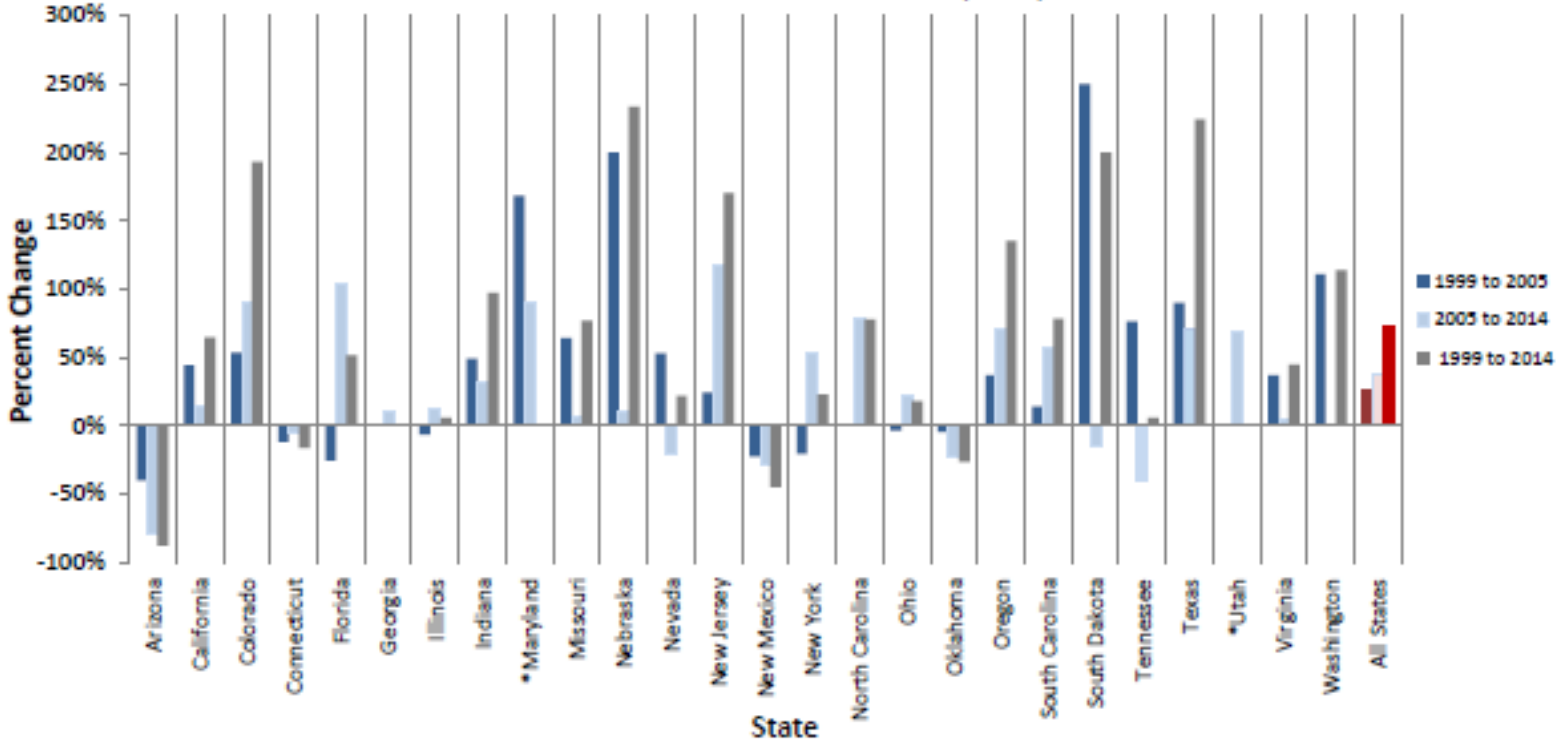
**Mental Health & Substance Use Services?**

# Evaluation and Restoration: Legal Challenges Increasing mostly for “restoration beds”



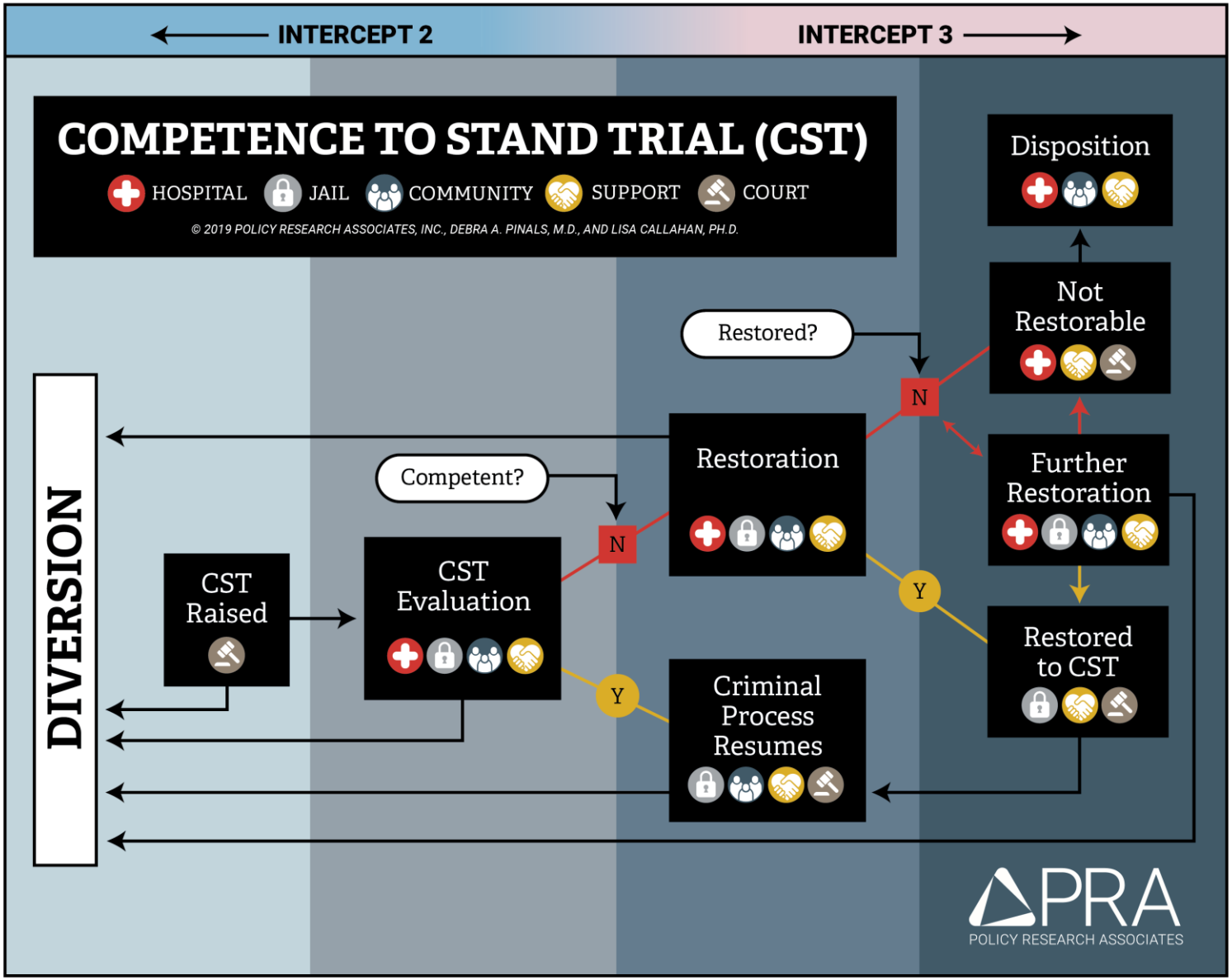
## Graph 18: Percent Change in Inpatient Incompetent to Stand Trial Population, 1999-2014

Based on the 26 States with Numerical Data for 1999, 2005, and 2014



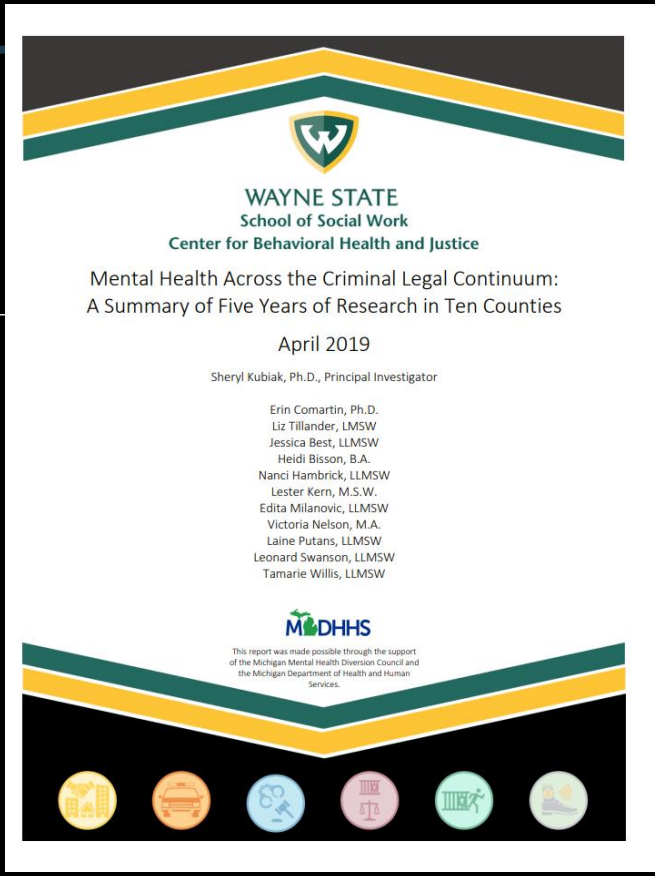

*Notes: 27 states had numerical data . However, NH was removed since it had 0 IST patients for 1999, 2005, and 2014.
GA had a percent change of 302% for *1999-2005* and 344% for *1999-2014*.
MD had a percent change of 409% for *1999-2014*.
UT had a percent change of 629% for *1999-2005* and 1129% for *1999-2014*.

Sources: 2017 NRI Inpatient Forensic Services Study, and 1995-2015 State Mental Health Agency Profiling System


INTERCEPT 2
INTERCEPT 3
COMPETENCE TO STAND TRIAL (CST)
HOSPITAL
JAIL
COMMUNITY
SUPPORT
COURT
© 2019 POLICY RESEARCH ASSOCIATES, INC., DEBRA A. PINALS, M.D., AND LISA CALLAHAN, PH.D.
Disposition
Not Restorable
Restored?
N
Restoration
Further Restoration
Competent?
N
CST Raised
CST Evaluation
Y
Restored to CST
Y
Criminal Process Resumes
DIVERSION
PRA
POLICY RESEARCH ASSOCIATES

# Jails and Courts

- In-jail services
  - Assessment of in-custody needs
  - Access to medications, mental health services, and substance use services
  - Communication with community-based providers
  - Health Information Exchange




"Individuals receiving an in-reach or diversion service while in jail were twice as likely to receive a mental health service in the community" Kubiak et al, 2019

# Specialty Court Services: Goals and National Outcomes

Reduced arrest rates

Reduced days incarcerated

Improvements in recovery from illness and substance use conditions

Improved linkages to services

# Historical Perspective

| Type | Year Started | Current Estimated # |
|---|---|---|
| Drug Courts | 1989 | 2700 |
| Mental Health Courts | 1997 | 350 |
| Veterans Treatment Courts | 2008 | 200 |


Sources: NADCP 2014; Steadman et al. 2014

# Intercept 4-5: Re-entry Efforts and Community Supervision

# By the end of 2011…..

- 2,239,800 people were incarcerated in state or federal prisons or local jails.
- 4,814,200 people were supervised by probation or parole

Bureau of Justice Statistics 2012

# Post Release Outcomes

Individuals with serious mental illness convicted of felonies show poor follow up with treatment services and by year 3, nearly 40% had been re-arrested

(Lovell et al., 2002; see also McGuire and Rosenheck 2004)

# Post Release Outcomes

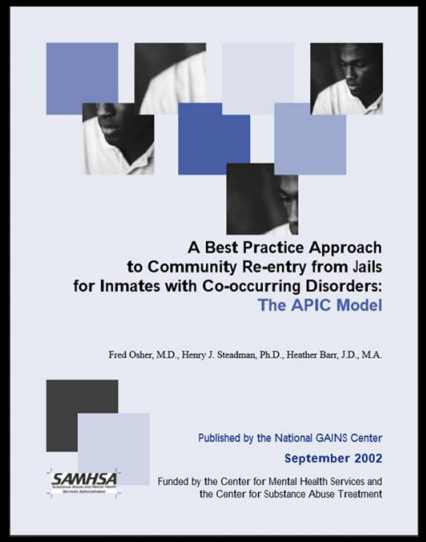
Risk of death of released prison inmates is 12.7 times higher within 2 weeks of release than for state population residents

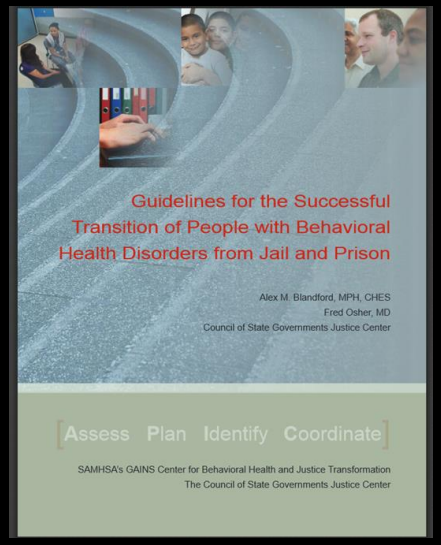
- Leading causes include Drug Overdose, Suicide, Homicide, and Cardiovascular (Binswanger et al. 2007)

North Carolina Inmates Released compared to general North Carolina residents:

- 2 weeks post-release 40x higher opioid overdose risk
- 1-year post-release- 11x higher opioid overdose risk
- Complete follow up: 8.3 x higher opioid overdose risk

(Ranapurwala et al. 2018)




**10 Guidelines following the APIC framework including:**

Assess

- Screening for behavioral health needs and risk
- Assessments after positive screenings

Plan

- Individualized treatment planning with appropriate treatment levels and dosing to match risk in collaborative programs
- Collaborative responses between behavioral health and justice systems

Identify

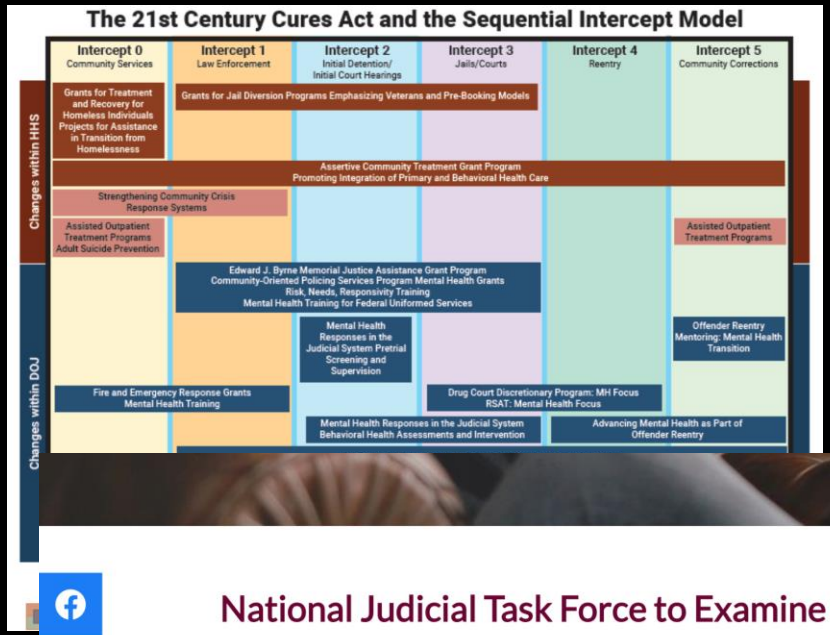
- Anticipate critical periods especially time surrounding release
- Policies and practices that enhance continuity of care

Coordinate

- Support “firm but fair” adherence to treatment and supervision conditions
- Develop Information sharing mechanisms
- Support cross training
- Support data analysis

# Evolving themes

- Enhancing trauma awareness in practices and recovery principles
- Refining target populations
- Enhancing focused treatments for CODs, including Medication Assisted Treatments for substance use
- Focus on addressing criminogenic risks and needs and responsivity factors
- Integrated behavioral health and physical health opportunities
- Linkages across services, agencies
- Attention to funding and finances





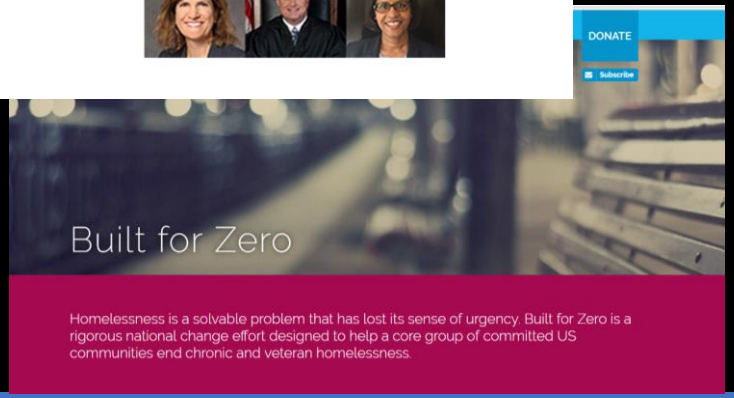
# National Judicial Task Force to Examine State Courts' Response to Mental Illness

In March 2020, the Conference of Chief Justices and Conference of State Court Administrators established the Task Force to assist state courts in their efforts to more effectively respond to the needs of court-involved individuals with serious mental illness.

Led by an Executive Committee, joined by 40 additional judges, court, and behavioral health experts, and funded by the State Justice Institute, the Task Force will spend the next two years developing tools, resources, best practices, and policy recommendations for the state courts.


## Contact Us

Subscribe to the semi-monthly Behavioral Health Alerts resource newsletter.

# Conclusions: Examining the Intercepts

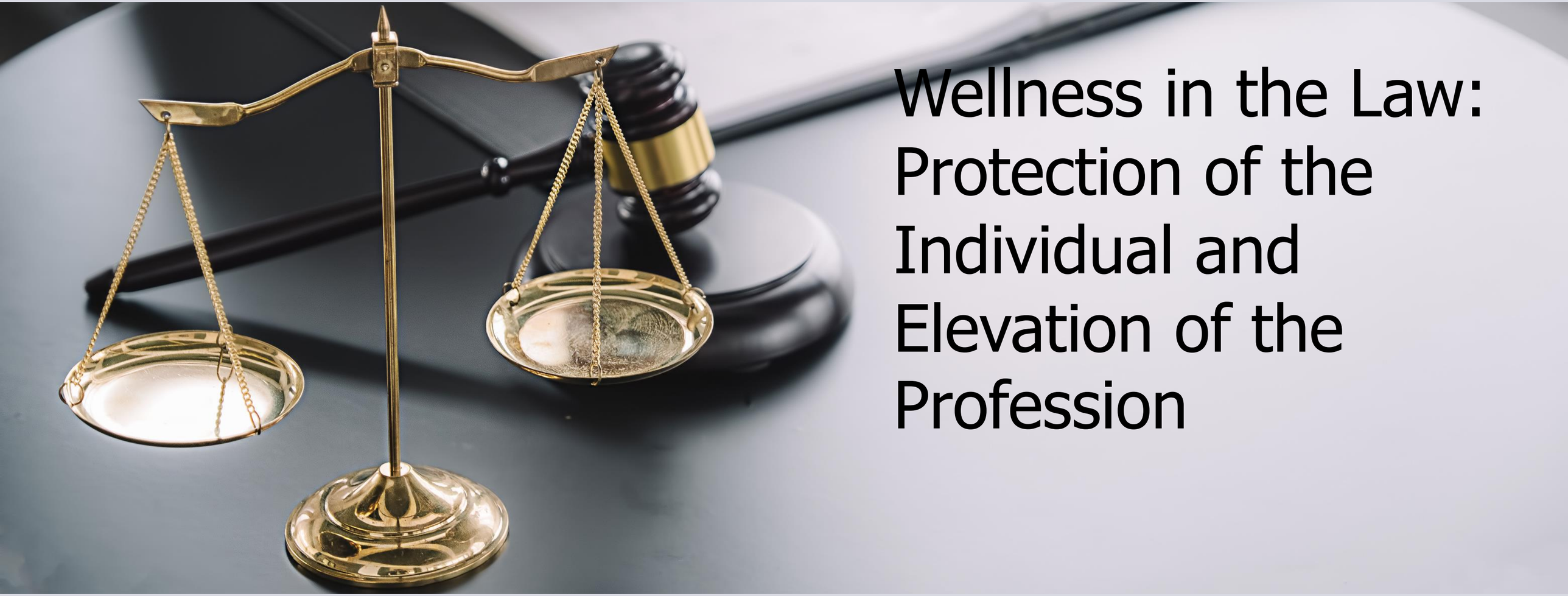
Duration of Intercept may be brief but offers significant opportunities

Intercept interventions can take many shapes and sizes

# Thank you!

Virginia Lawyers'
Wellness Initiative

Hetal Challa, Esq. Wellness Coordinator
Supreme Court of Virginia, Office of the Executive Secretary



# Wellness in the Law: Protection of the Individual and Elevation of the Profession

Virginia Lawyers'
Wellness Initiative

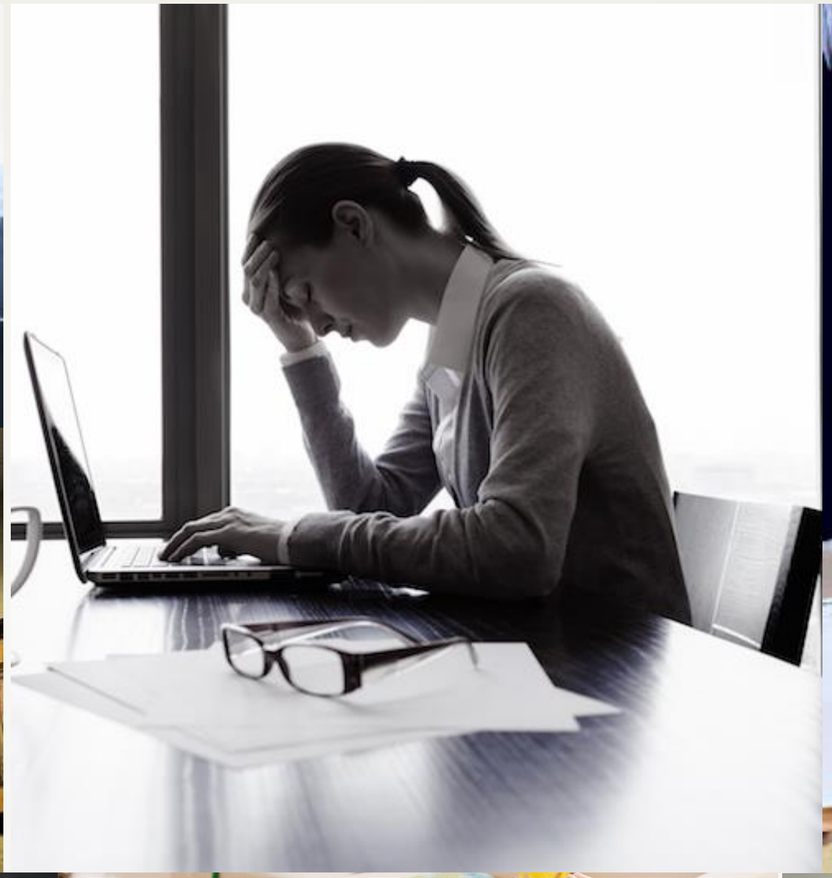
# Introduction

Conversation Connection Collaboration


Virginia Lawyers'
Wellness Initiative

# Learning Objectives

- Explain the background of studies, and the evolution of the Virginia Lawyers' Wellness Initiative (VLWI).
- Summarize key advancements of the VLWI.
- Understand the inherent occupational risks of the legal profession.
- Recognize how prioritizing your well-being protects you from potential impairment and ultimately elevates the legal profession.

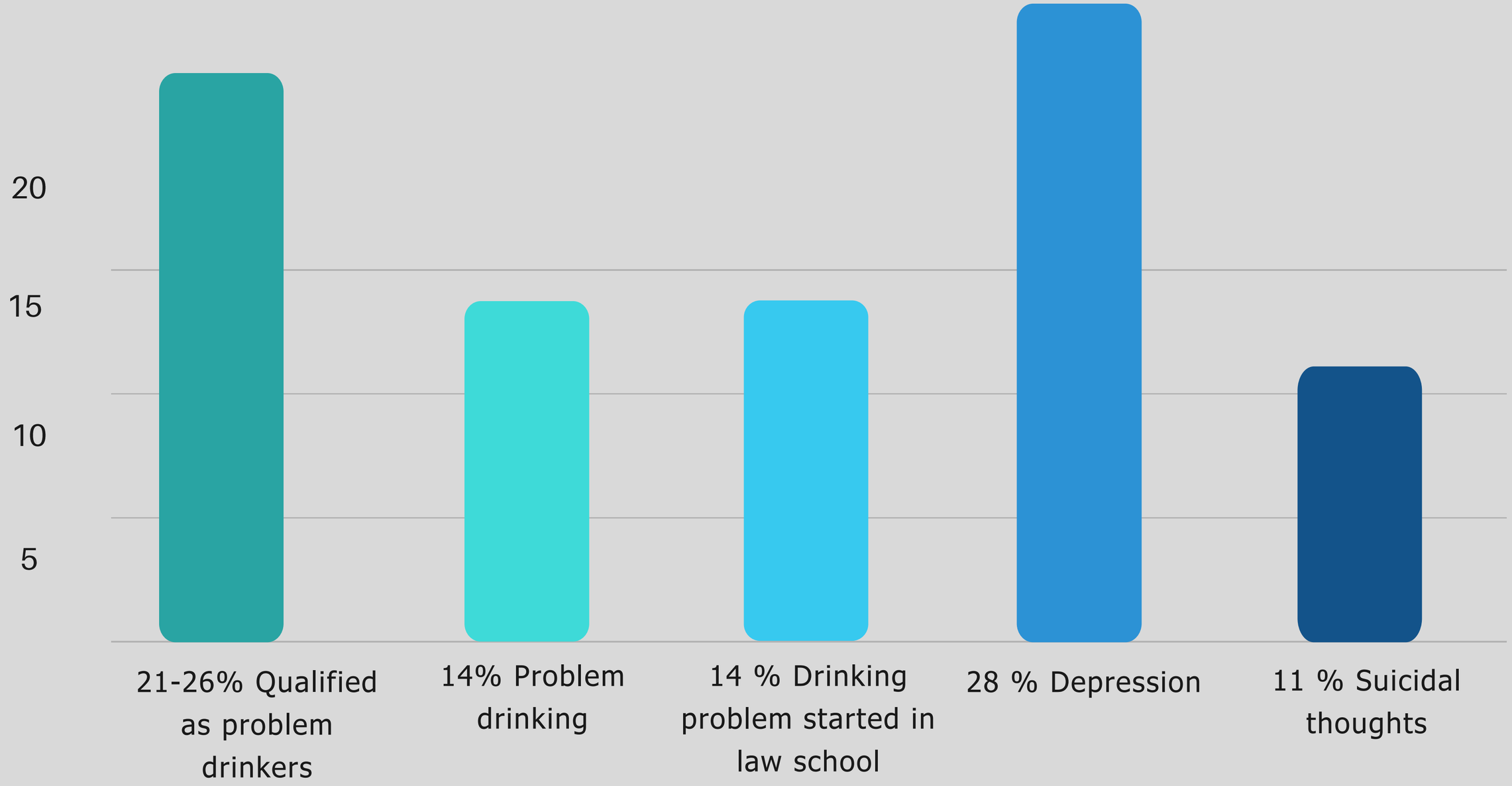


Virginia Lawyers'
Wellness Initiative

# Stress in the Legal Profession

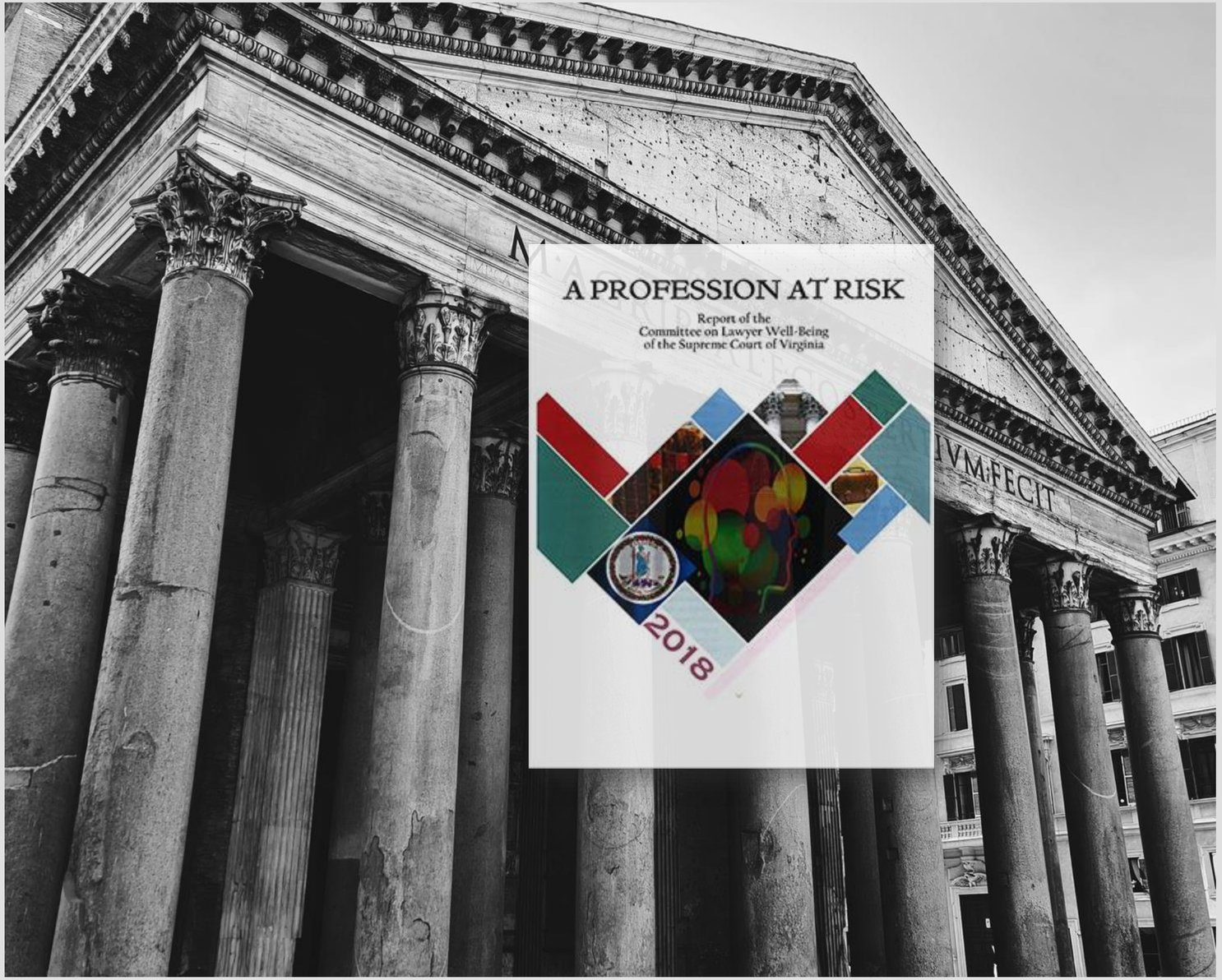
- Hazelden Study-National Landmark Study (with American Bar Association)
- High incidence of depression, anxiety, substance abuse, suicide ideation
- Statistics are meant to provide context

# Hazelden Betty Ford and American Bar Association National Studies



# State Response to Crisis

- Education
- Stakeholder Collaboration
- Hiring of Wellness Coordinator
- Funding for the Virginia Judges and Lawyers' Assistance Program
- De-stigmatization



Virginia Lawyers'
Wellness Initiative

# About the VLWI

Coordination of education, outreach, and assistance to judges, lawyers, law students, and other legal professionals, regarding wellness initiatives, with a particular focus on behavioral health and substance abuse issues

Virginia Lawyers'
Wellness Initiative

# About VJLAP

- Confidential and not affiliated with the Virginia State Bar
- Open to more than just judges and lawyers, to include all legal professionals and their families
- Free
- 24/7 hotline
- 1-877-545-4682
- www.vjlap.org
- Early intervention is key

Virginia Lawyers'
Wellness Initiative

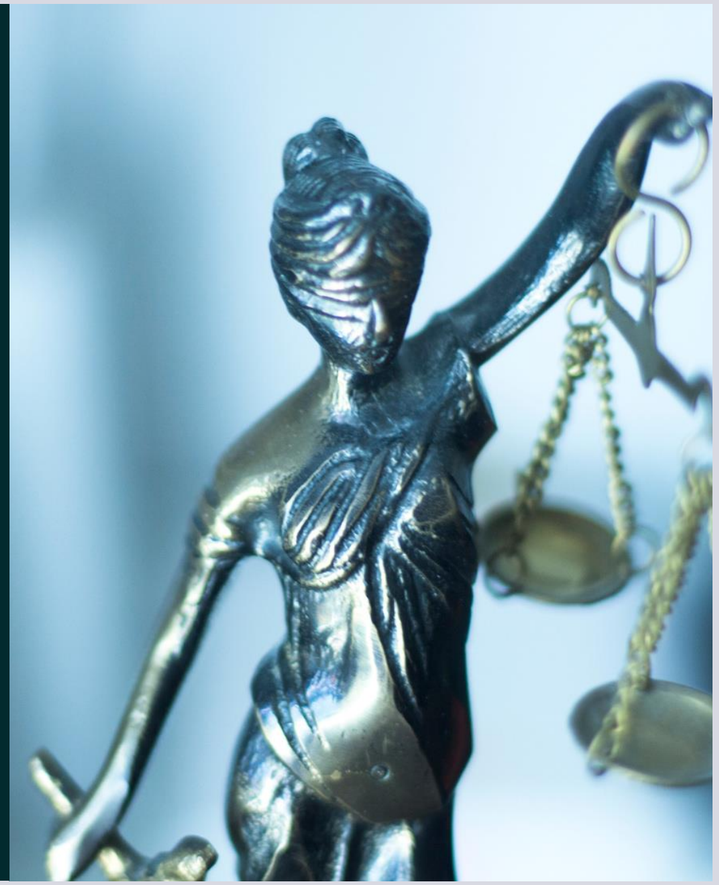
# Vision & Mission

## Vision

- Decrease the stigma surround mental health, particularly help-seeking behaviors
- Build tools to minimize stress, manage existing symptoms, and prevent impairment
- Improve the culture and integrity of the legal profession

## Mission

- To get in front of as many legal professionals as possible, to educate and build awareness
- Recommend policy changes
- Encourage organizations to support employee well-being



Virginia Lawyers'
Wellness Initiative

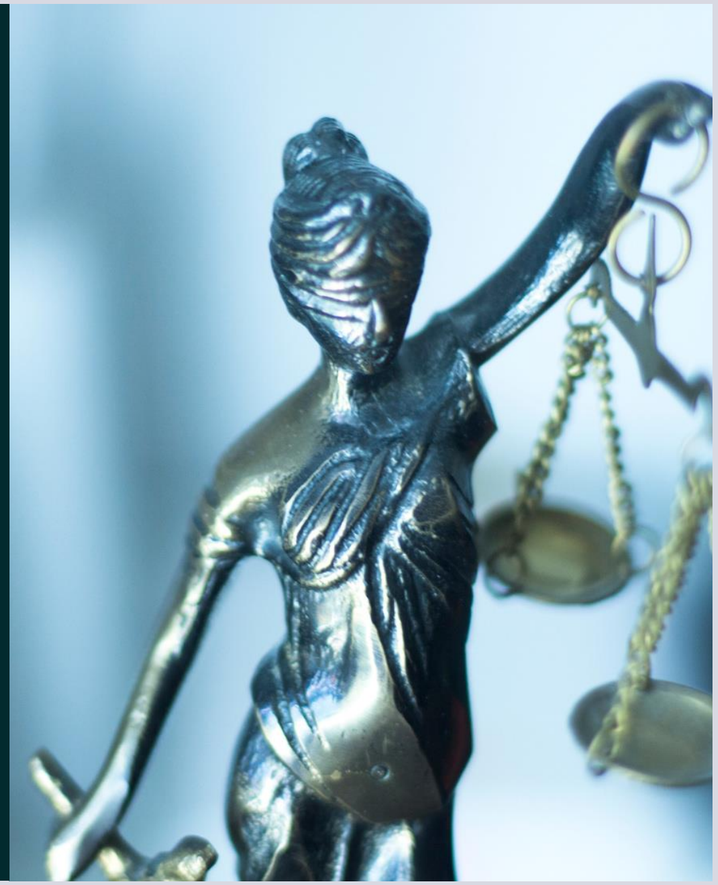
# Occupational Risks

## Risks

- Adversarial
- Sedentary
- Managing long and unusual hours
- Working indoors
- Sleep deprivation
- Vicarious Trauma
- Isolation
- Need to display confidence and conceal vulnerability

## Recommendations

- Practice civility
- Move more
- Maintain reasonable work hours
- Take a walk daily for Vitamin D
- Prioritize sleep hygiene
- Education, counseling or VJLAP
- Stay connected with others
- Seek strong mentors, find a support network



Virginia Lawyers'
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## Progress made:

- Increase in free VACLE wellness modules for credit
- Updates to Character and Fitness student application
- Increase in funding and expansion of VJLAP
- More education in law schools to change the culture
- Education and outreach for all legal professionals
- Judicial coaching program

Virginia Lawyers'
Wellness Initiative

# Ethical Considerations

## Communication with VJLAP Protected

Rule 8.3 (d) and Comment [5] recognize the importance of confidentiality in encouraging help-seeking behavior, and grant lawyer-client privilege to these communications.

Virginia Lawyers'
Wellness Initiative

# Report of the Committee on Lawyer Well-Being

"The wellness of legal professionals is inseparable from the duty of such professionals to provide competent services to the public and ensure its protection."

Virginia Lawyers'
Wellness Initiative

# Well-Being as a Part of Competence

"A lawyer's mental, emotional, and physical well-being impacts the lawyer's ability to represent clients and to make responsible choices in the practice of law. Maintaining the mental, emotional, and physical ability necessary for the representation of a client is an important aspect of maintaining competence to practice law."

-VA RPC Rule 1.1 Comment [7]

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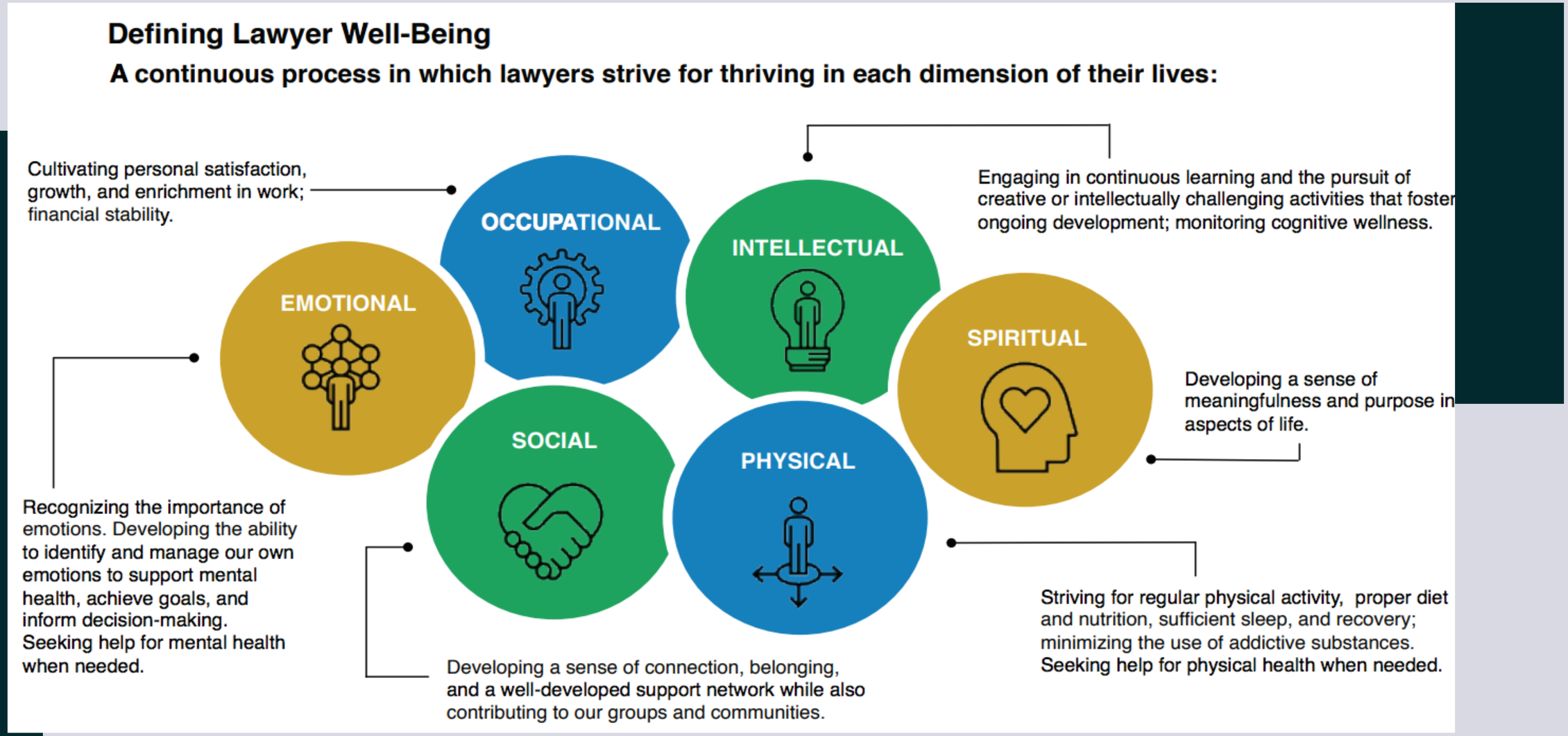
Wellness Initiative

# Dimensions of Wellness



Virginia Lawyers'
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# Conclusion

Conversation Connection Collaboration


Virginia Lawyers'
Wellness Initiative

# Connect with me


804-317-7861

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www.vacourts.gov

Early Intervention, Deflection, & Diversion
Intercept 0 (Community Services) &
Intercept 1 (Law Enforcement Collaboration)

# Roadmap to the Ideal Crisis System: Lessons from Arizona


**Margie Balfour, MD, PhD**
Connections Health Solutions
Chief of Quality & Clinical Innovation
Associate Professor of Psychiatry, University of Arizona
margie.balfour@connectionshs.com

connections

# Most communities in America…


"I'm having chest pain."




"I'm suicidal."



# SAMHSA's Vision

**"Someone to contact"**

988 SUICIDE & CRISIS LIFELINE

**"Someone to respond"**
(mobile crisis)

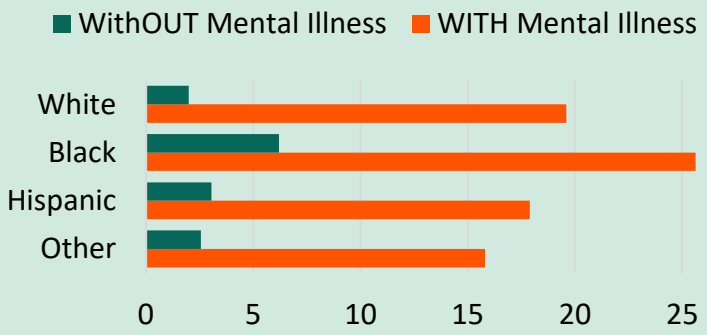
**"A safe place for help"**
(specialized facilities and stabilization services)

# 911: What happens after the call?

## Police-Involved Deaths

- **One Quarter** of police involved shooting deaths involve mental illness
- Half occur in the person's home
- Black Americans with Mental Illness have the highest rates of death
- …and are less likely to call 911 for help with a mental health emergency

**US Death Rate by Police per million**




## Jails: The New Asylums

- **The "Divert to What?" Question**
- Prevalence of mental illness in our jails & prisons is 3-4x that of the US population
- Inmates with mental illness
  - Often do not get needed treatment
  - Incarcerated 2x as long at 2x the cost
  - 3x more likely to be sexually assaulted in jail
  - More likely to be homeless, unemployed, re-arrested upon release


## ED Boarding

- 62% of EDs report they have no psychiatric services available
- Without treatment, inpatient is the default disposition, and people wait for hours for transfer to a psych hospital

  - Increased risk: Assaults, injuries, self-harm
  - Increased cost: $2300/day
  - Poor patient experience: Nontherapeutic environment with untrained staff

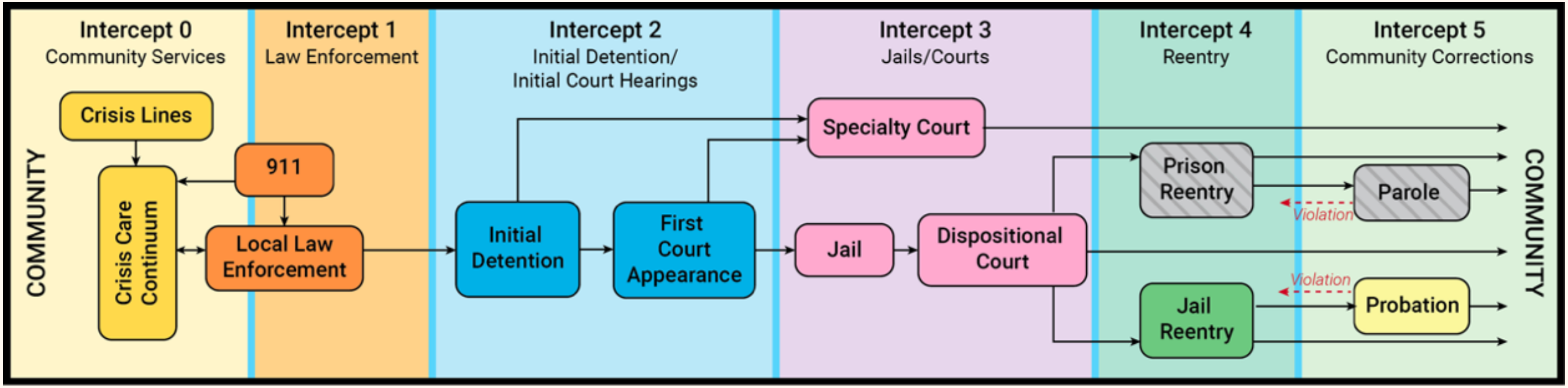


Saleh AZ, Appelbaum PS, Liu X, Scott Stroup T, Wall M.(2018) Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry* 58:110–6
Steadman HJ et al. (2009) Prevalence of serious mental illness among jail inmates. *Psychiatric Services*. 60(6):761-5.
Glaze LE, James DJ. (2006) Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics.

Nordstrom K et al.. West J Emergency Med. 2019 Jul 22;20(5):690-695.
Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int*. 2012;2012:360308.

# The Sequential Intercept Model

## Intercepts 0 and 1 focus on *preventing police interactions & arrest*



# The conditions are right for an unprecedented expansion in crisis care

# Roadmap to the Ideal Crisis System

National Council for Mental Wellbeing report to help communities develop crisis systems.

## Crisis Roadmap Vision

A BH Crisis System is an **essential community service** just like police, fire, & EMS.

A crisis **system** is more than a single crisis program.

The Roadmap complements the SAMHSA Crisis Best Practice Toolkit





**Download the Report**

**CrisisRoadmap.com**

# Key Feature: Systems Thinking

# 3 Key Ingredients for a SYSTEM

## Accountability

- Who is *responsible* for the system?
- Governance and financing structure
- System values and outcomes
- Holding providers accountable

## Collaboration

- Broad inclusion of potential customers, partners, & stakeholders
- Alignment of operational processes & training towards common goals
- Culture of communication & problem solving (“figure out how to say yes”)

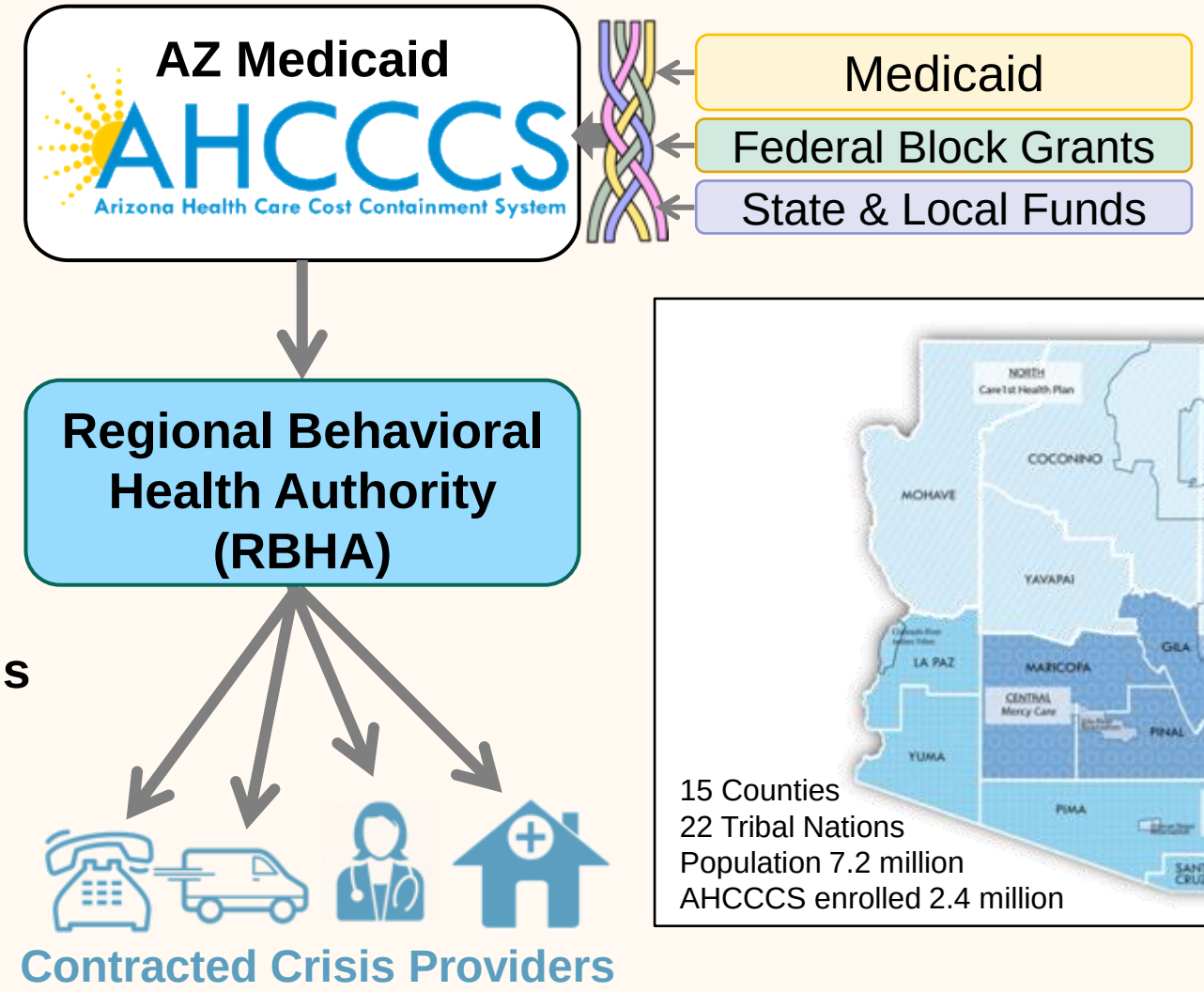
## Data

- Are we achieving desired outcomes?
- Performance targets & financial incentives
- Continuous quality improvement
- Data driven decision making

# Arizona Crisis System Financing & Governance Structure

***creates the foundation for an organized, coordinated, & sustainable system***

- A **"braided" funding** model maximizes the impact of multiple funding streams, creating a sustainable system that can serve everyone regardless of payer.
- A single **"accountable entity"** creates the structure for strategic planning and oversight.
- Contracted services are **aligned towards common goals** that are both clinically desirable & fiscally responsible:
  - **DECREASE ER, Hospital, Jail**
  - **INCREASE community stabilization**







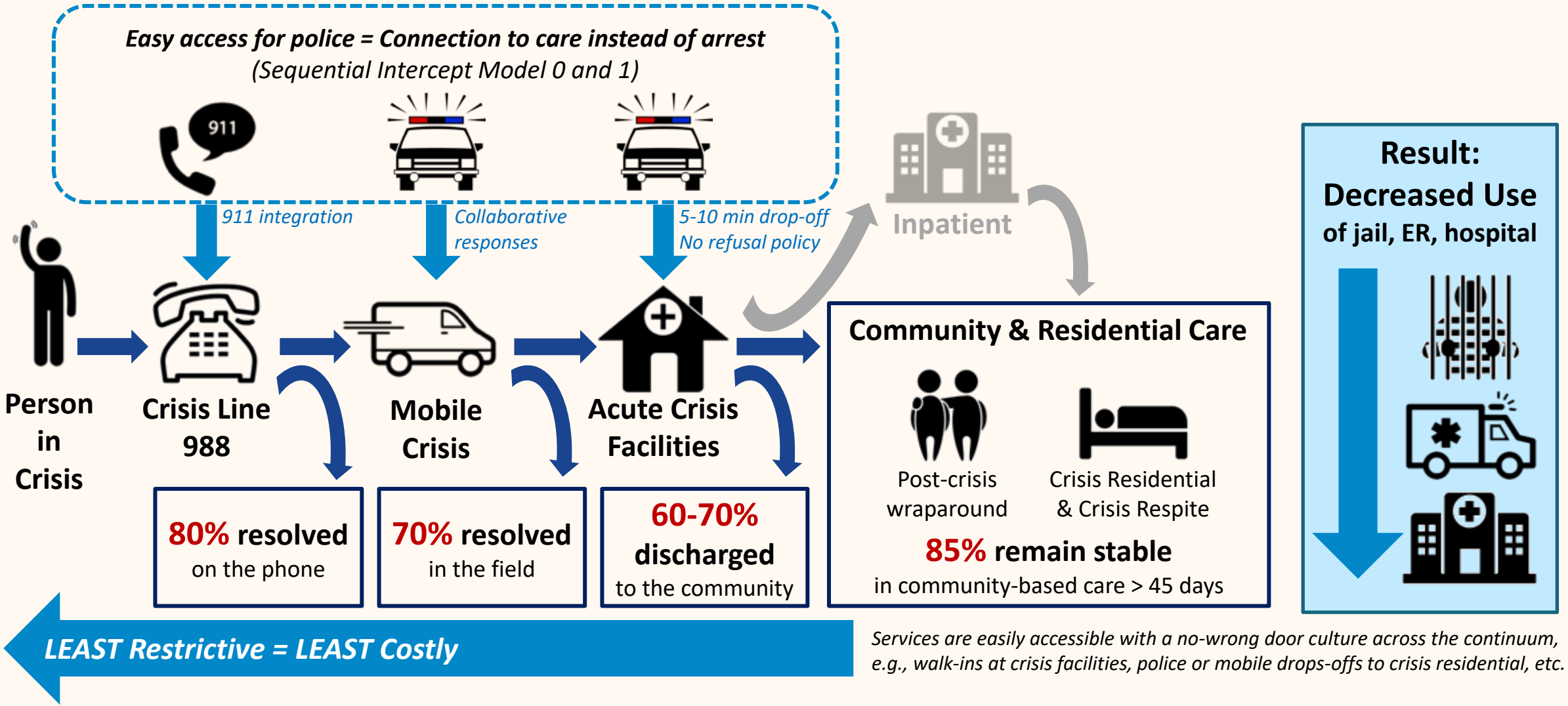
15 Counties
22 Tribal Nations
Population 7.2 million
AHCCCS enrolled 2.4 million





9

# Arizona Crisis System: Alignment towards common goal of care in the least-restrictive (and least-costly) setting




*Services are easily accessible with a no-wrong door culture across the continuum, e.g., walk-ins at crisis facilities, police or mobile drops-offs to crisis residential, etc.*




Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

# Virginia Crisis Initiatives

RIGHT HELP. RIGHT NOW.

Transforming Behavioral Health Care for Virginians

**Exhibit 9: Six Pillars of the Behavioral Health Plan**

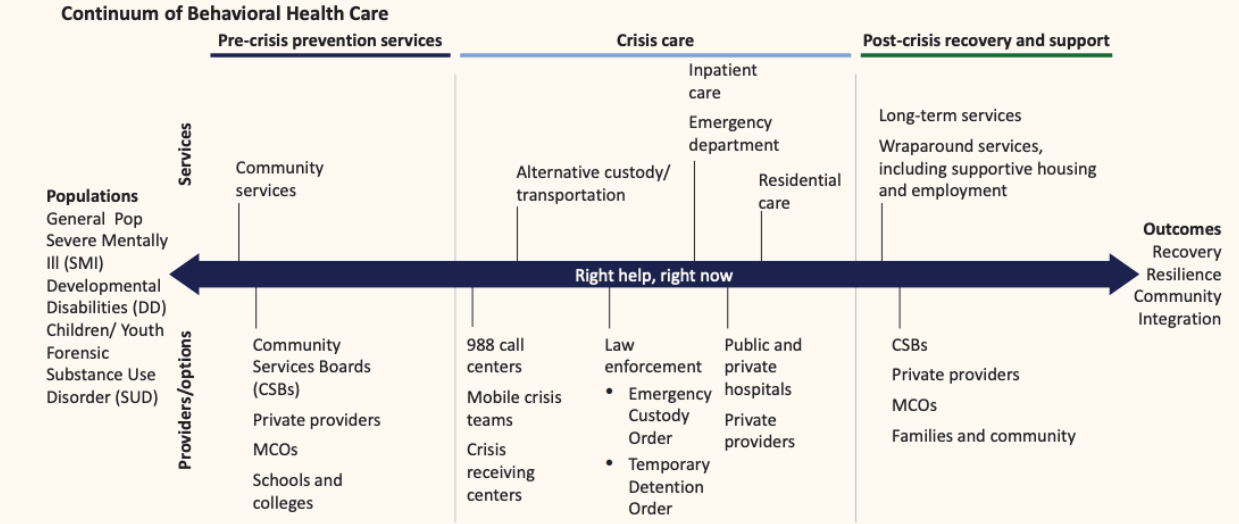
The Commonwealth's Behavioral Health Plan is founded on six pillars

**An aligned approach to BH** that provides access to **timely, effective, and community-based care** to reduce the burden of mental health needs, developmental disabilities, and substance use disorders on Virginians and their families

| | | | | | |
|---|---|---|---|---|---|
| **1:** We must strive to ensure **same-day care for individuals experiencing behavioral health crises** | **2:** We must **relieve the law enforcement communities' burden** while providing care and **reduce the criminalization of behavioral health** | **3:** We must **develop more capacity** throughout the system, going beyond hospitals, especially to enhance community-based services | **4:** We must **provide targeted support for substance use disorder (SUD)** and efforts to prevent overdose | **5:** We must **make the behavioral health workforce a priority**, particularly in underserved communities | **6:** We must **identify service innovations and best practices** in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps |

**Exhibit 4: Continuum of Behavioral Health Care in Virginia**

Solutions to the Commonwealth's Behavioral Health crisis benefit from a system-wide perspective




Source: VA HHR: DBHDS

# Someone to call

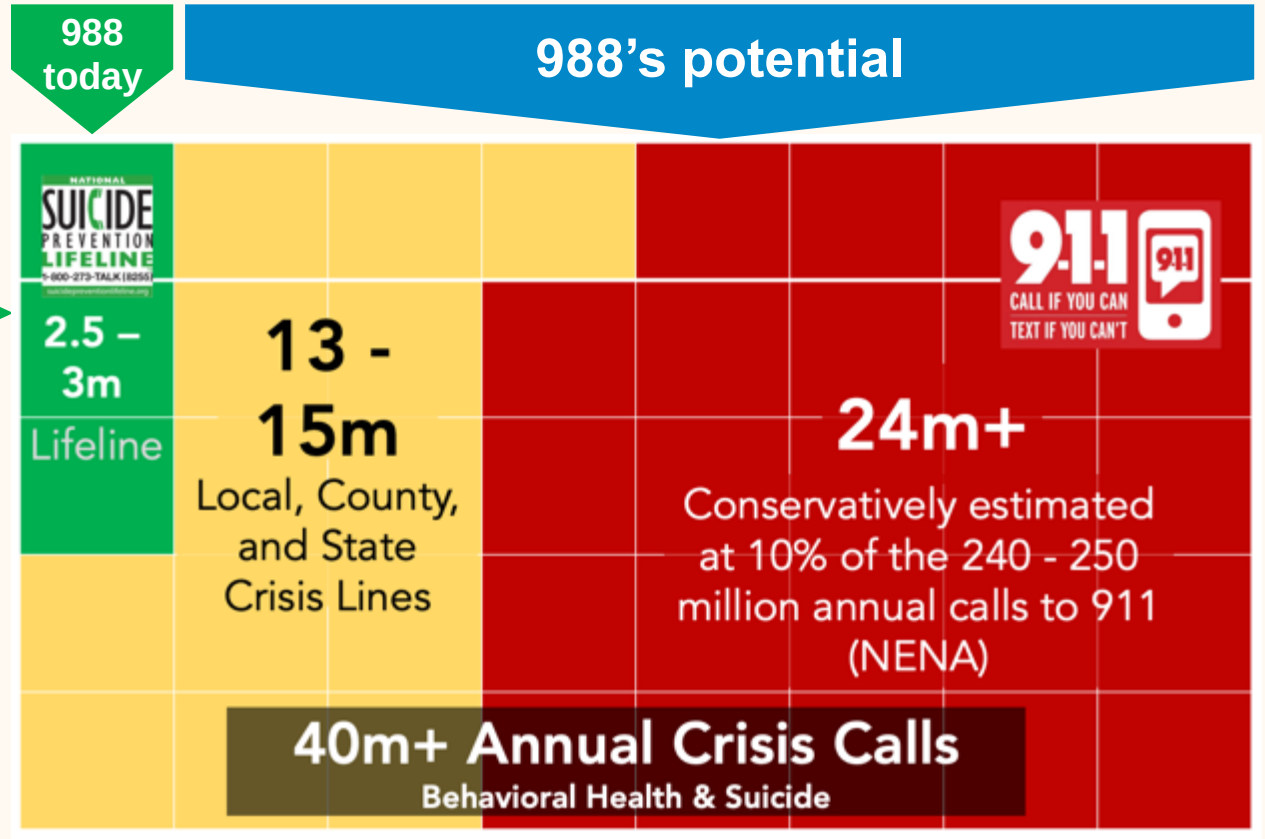
- Crisis Contact Centers
- 988
- Phone / text / chat

# 988 is the new nationwide 3-digit number for BH emergencies

- Launched July 2022!
- **Connects to the National Suicide Prevention Lifeline (formerly 1-800-273-TALK)**
- Network of nearly 200 call centers with call-takers trained in suicide/crisis intervention
- 24/7 call, text, or chat (988lifeline.org)
- National standards
  - SAMHSA oversight
  - single national administrator
    *Vibrant Emotional Health: www.vibrant.org*
- More info at samhsa.gov/988

Today, we can't imagine 911 without thinking of the response system that goes with it (EMS, fire, ERs, trauma centers, etc.)

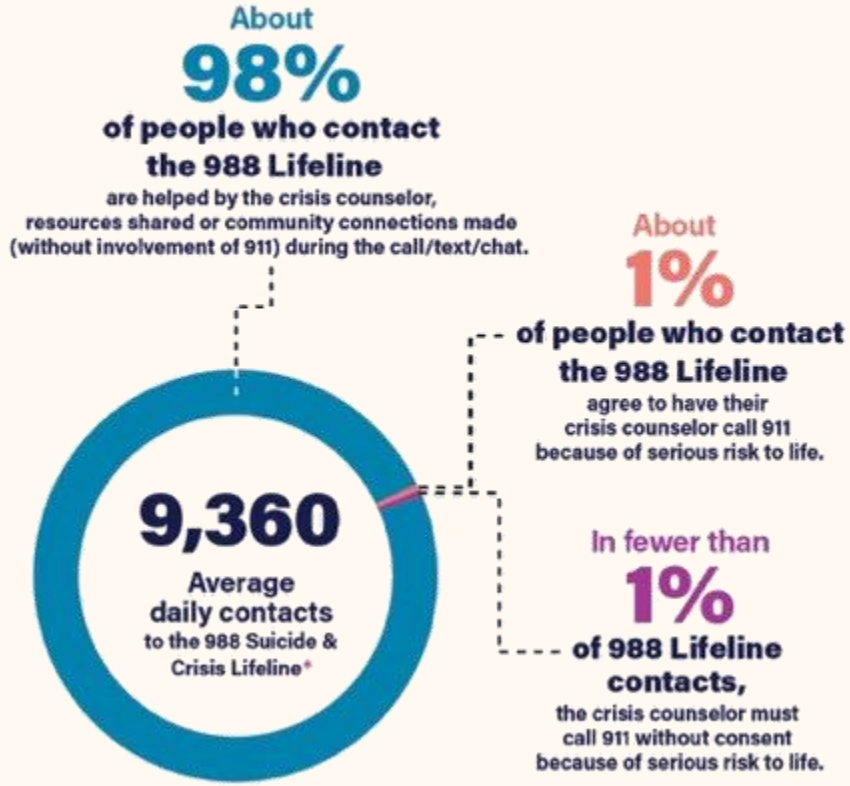
**988 is the first step towards a comparable emergency response system for people with MH/SUD emergencies.**




https://talk.crisisnow.com/wp-content/uploads/2021/04/01-Universe-of-potential-988-calls-2020-10-21.pdf

# What happens after the 988 call?


- *988 activates 911 in a small number of calls (about 2%) when there is an immediate threat to life.*
- ***The more alternatives a community has (like mobile crisis), the less need to involve law enforcement.***




*Source: [988lifeline.org](988lifeline.org)*

# What happens after the 988 call?
# It depends on where you live.

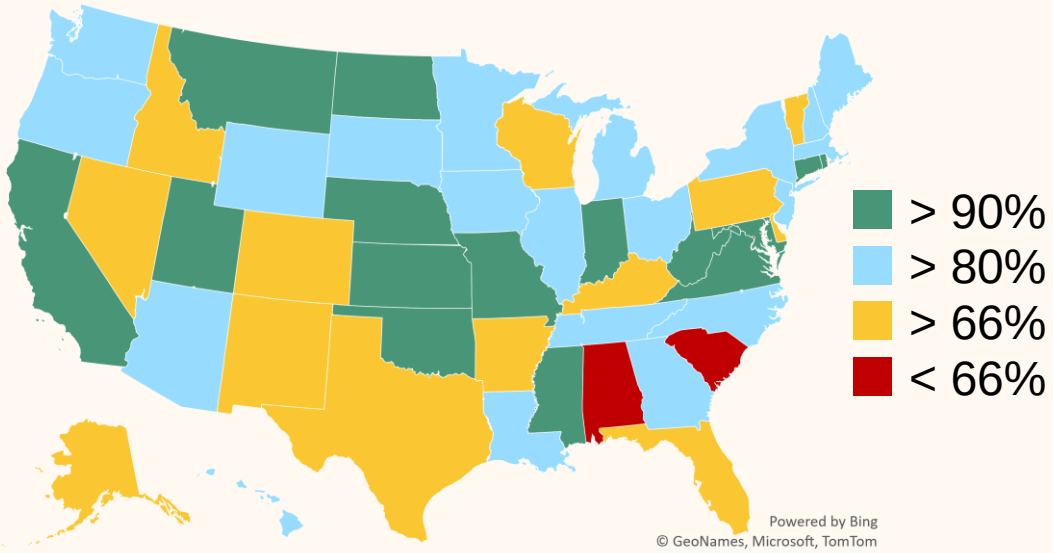
For the ideal outcome, 988 callers need to

- Be routed to a **local call center**
- Connect to **local crisis services** *(someone to respond, a safe place to go)*

## Challenges:

- ***Routing:*** Calls are routed based on the area code of the caller's phone, not their geolocation *(but hopefully a fix is coming soon)*
- ***In-state answer rates:*** Call center performance varies from state to state
- ***Availability of crisis services:*** varies from community-to community

988 In-State Answer Rate




April 2023. Source: https://988lifeline.org/our-network/

# 911 Integration:
# Routing BH calls to a “health-first” response

**No One-Size-Fits-All Approach**

- Over 9000 Public Safety Answering Points (PSAPs) across the US
- Local crisis lines & PSAPs are experimenting on ways to identify & re-route BH calls
- Different solutions for different situations (urban vs. rural, availability of services, etc.)
- Best practices are starting to emerge but no standards yet


**Coordinated**

Protocols for transferring appropriate BH calls to an off-site crisis contact-center

**Co-Located**

Crisis line staff are on-site to provide training and coaching to help 911 staff transfer calls to an off-site crisis contact center

**Integrated**

Crisis line staff are on-site and able to take and clear calls within the 911 system

**Health First Response**

988 SUICIDE & CRISIS LIFELINE

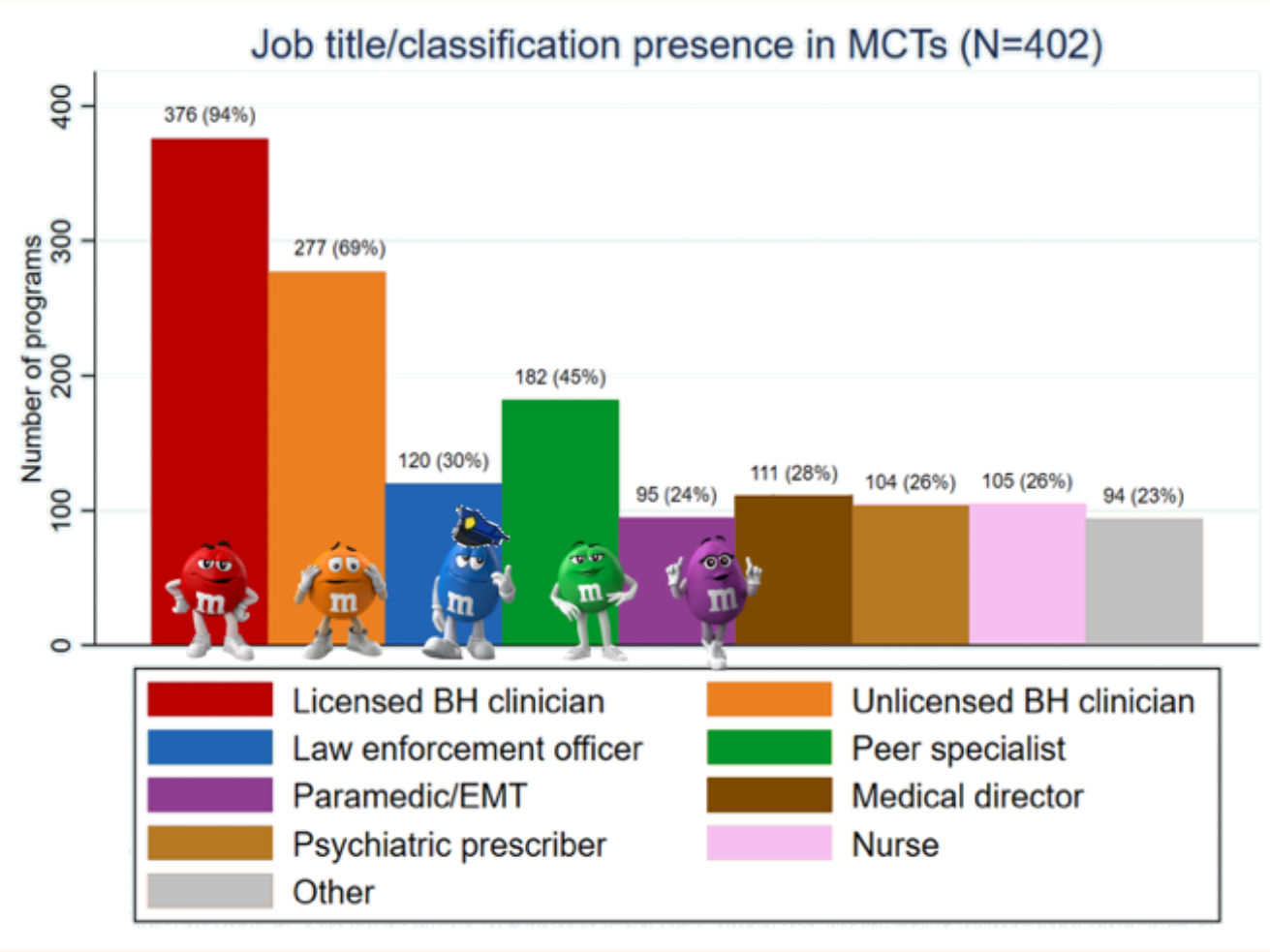
**Mobile Crisis**


17

# Someone to respond

- Mobile Crisis Teams
- Co-responders
- Multi-disciplinary Response Teams

# Mobile Crisis Teams (MCTs) come in many combinations




*Preliminary results from a survey of over 400 mobile crisis teams in the US.*
*Courtesy Preston Looper & Matt Goldman.* [http://doi.org/10.1176/appi.ps.20220449](http://doi.org/10.1176/appi.ps.20220449)

## Clinician-only MCTs (most common)

- Licensed BH clinician + unlicensed clinician or peer

*Rural areas: 1 person teams*
*+/- telemed backup*

## Co-Responder Teams

- Law enforcement + BH clinician or peer

- Civilian only: EMT + BH clinician
  *CAHOOTS (Eugene, OR); STAR (Denver)*

## Multi-Disciplinary Response Teams (MDRT)

- BH Clinician + Paramedic + Officer
  *RIGHT Care (Dallas)*

# Choosing a mobile crisis model

*More research is needed to determine best practices and if/when one model is preferable to another. In the meantime, communities need to adapt to local needs, capabilities, & preferences.*

## BIG QUESTION: Role of Police

Studies show that clinician-only MCTs:

- Decrease hospitalization
- Decrease ED utilization
- Are cost effective

Outcome studies of police co-responder teams are mixed.

*In qualitative studies:*
**Most people report they prefer clinician only or co-responder teams to police-only responses.** In particular, they value de-escalation and a compassionate and non-criminalizing approach.

**When designing crisis systems:**

- Acknowledge the distrust of 911, police and healthcare systems in BIPOC communities
- Law enforcement should not be the default or primary responders.
- ➢ **Employ a "Health First" approach**
  - **Civilian-led with clinicians and peers**
  - **Police involved only when necessary, with clearly defined roles**
- Central role for peers in service delivery and design
- Workforce that reflects the community they serve


https://www.fountainhouse.org/reports/from-harm-to-health


https://www.vera.org/civilian-crisis-response-toolkit





*For review see:* Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

# A safe place to go

- Urgent Care Clinics
- PES
- EmPATH Units
- 23-hour observation
- CPEP
- Crisis residential
- Living Rooms
- …and others

# “Crisis Stabilization Units” & Facility-Based Crisis Services – An Imperfect Guide

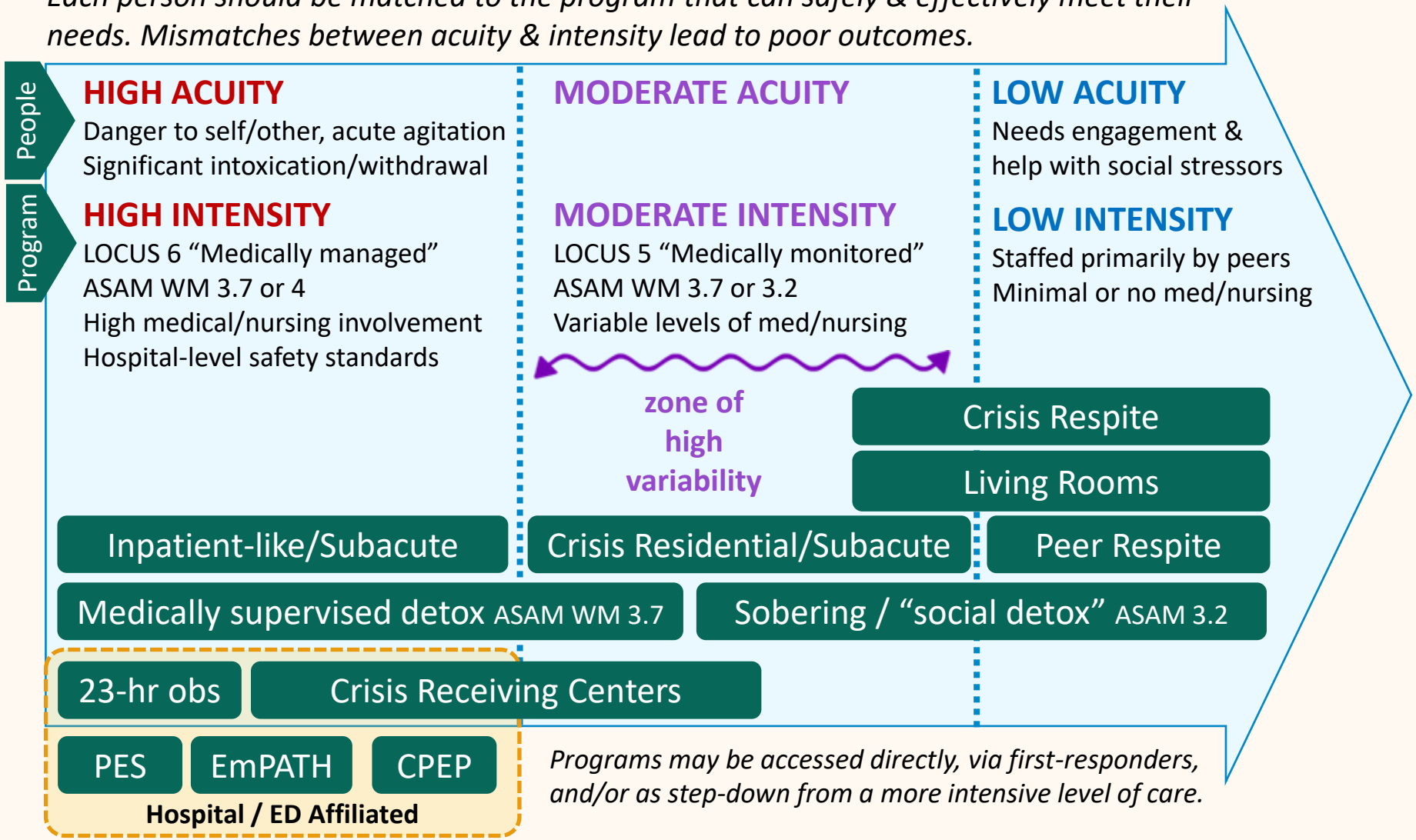
**Lots of local variation in:**

- Licensing
- Nomenclature
- Reimbursement
- Involuntary process
- Locked vs unlocked
- Police drop-offs
- Length of stay

**But ALL should provide**

- Crisis intervention/treatment *(vs holding to await transfer to another level of care)*
- Safe and therapeutic milieu
- Peer support & engagement
- Care coordination and help with social determinants of health
- Trauma-informed approaches
- Capability of addressing co-occurring MH and SUD needs

*Each person should be matched to the program that can safely & effectively meet their needs. Mismatches between acuity & intensity lead to poor outcomes.*





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# Example: The Crisis Response Center

- Built with Pima County bond funds in 2011
  - County owns the building, services funded by the RBHA
  - Alternative to jail, ED, hospitals
  - Serving 12,000 **adults** + 2,400 **youth** per year
- Services include
  - 24/7 walk-in **urgent care**
  - **23-hour observation**
  - Short-term adult **subacute inpatient**
- Police drop-offs with **NO WRONG DOOR that TAKES EVERYONE**
- Space for co-located community programs
- Unique Campus: CRC is adjacent to
  - Crisis Line Call Center
  - Banner University of Arizona Medical Center
    - Emergency Department
    - 66-bed inpatient psychiatric unit that performs most of Pima County's civil commitment evals
  - Mental health court

# A Solution to the “Divert to What?” Question


## CIT Recommendations for Mental Health Receiving Facilities[1]

1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Police Turnaround Time**
5. Wide Range of Disposition Options
6. Community Collaboration

Studies show this model:

- Critical for pre-arrest diversion[2]
- Reduces ED boarding[3,4]
- Reduces hospitalization[3,4]

These two are the hardest to do well.

It means

- **Be easier to use than jail.**
- Drop off time less than 10 min
- Never turn police away.
- Take everyone:
  - High acuity: No such thing as “too agitated” or violent
  - Can be highly intoxicated
  - Involuntary or voluntary
  - Without using security guards on clinical units



1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
2. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22
3. Little-Upah P et al. (2013). The Banner psychiatric center: a model for providing psychiatric crisis care to the community while easing NH holds in EDS. Perm J 17(1): 45-49.
4. Zeller S et al. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15(1): 1-6.

# Crisis Response Center: Quick & Easy Access for Law Enforcement

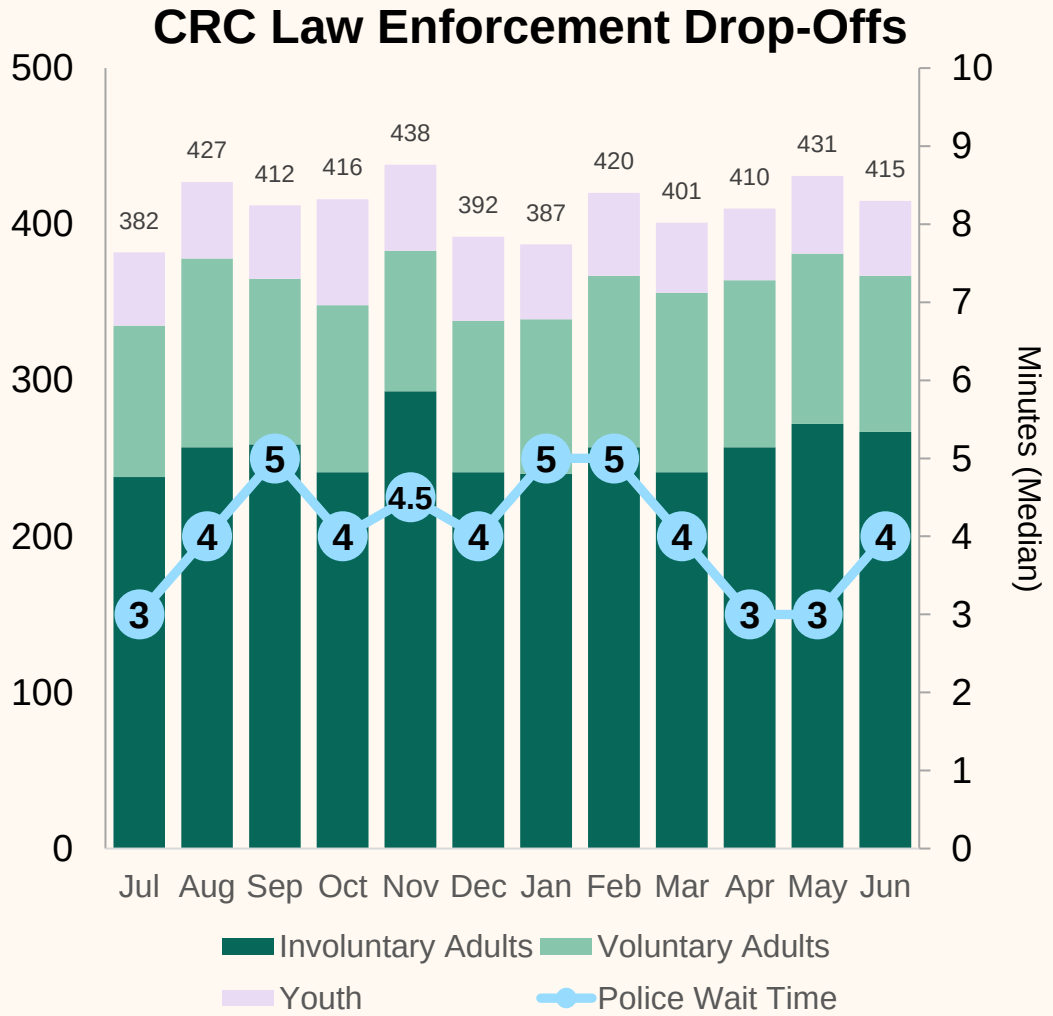
## so that we're the preferred alternative to jail or the emergency room


Officers don't like:

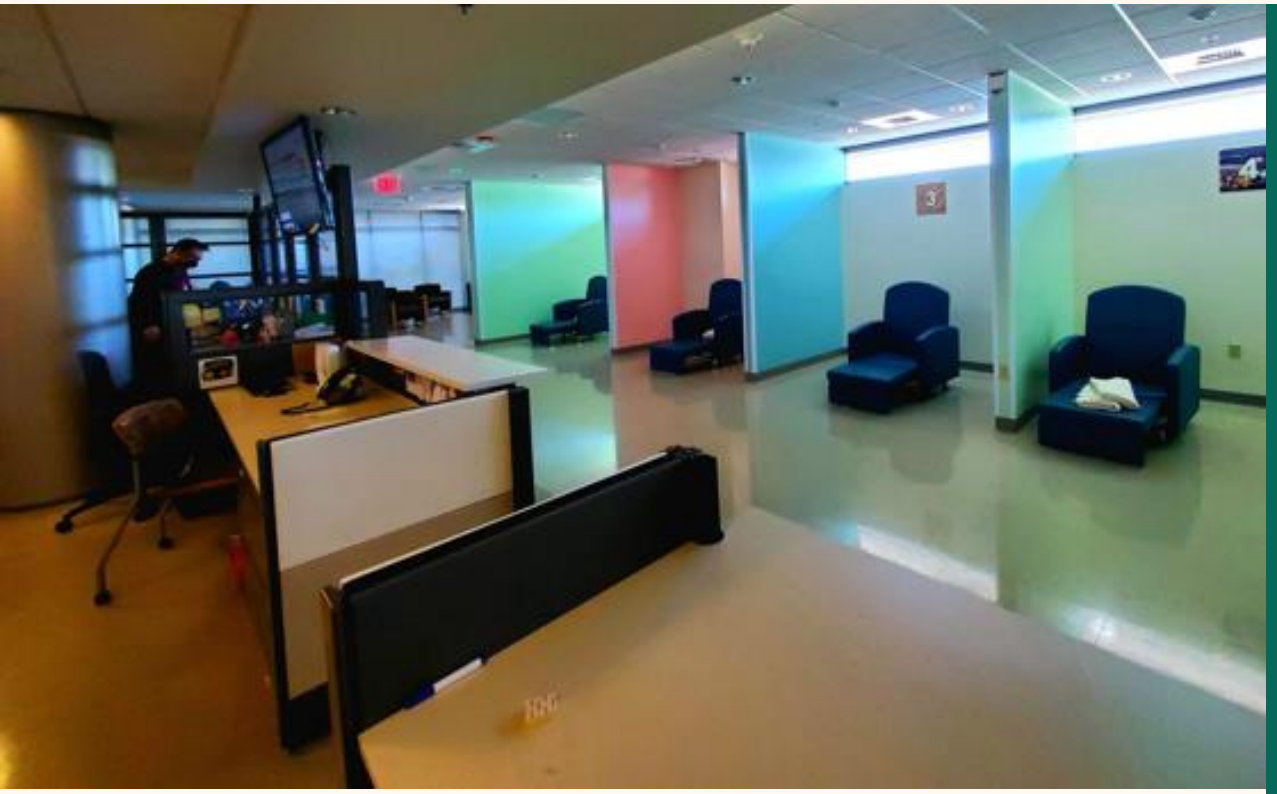
- Waiting
- Being turned away
- Taking their guns off
- Parading people through the front lobby

Dedicated police entrance with secure gated sally port & workspace

*Crisis Response Center - Tucson AZ*

# 23-Hour Observation: Interdisciplinary treatment starting with the assumption that the crisis CAN BE resolved



The open design facilitates:

- Safety: Continuous observation
- Therapeutic milieu: Open area for therapeutic interactions with others
- Flexibility: Ability to accommodate surges in volume

**Interdisciplinary Teamwork**

- 24/7 psychiatric provider coverage (MD, NP, PAs)
- Peers, nurses, techs, case managers

**Early Intervention**

- Door to doc time 90 min
- Meds, detox/MAT
- Peer support & groups

**Proactive discharge planning**

- Coordination with clinics, community & family supports

**Majority are**

- **discharged to community-based care**
- **converted to voluntary status**

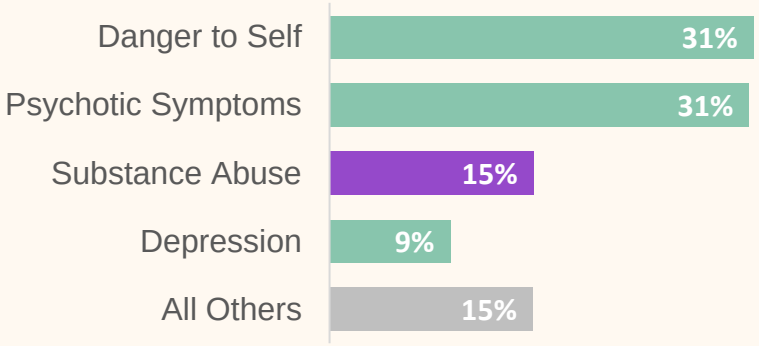
# Crisis facilities should address both MH & SUD needs

**15%** of CRC adults present with **SUD as the primary concern,**

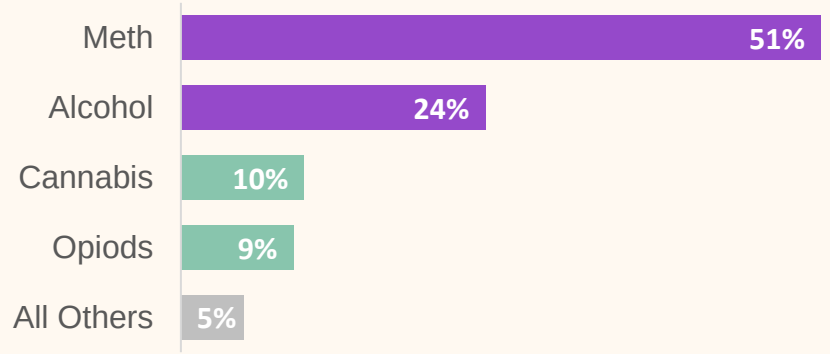
but...

**65%** have a **SUD diagnosis or positive toxicology results.**

**Meth & alcohol** account for **three quarters of SUD diagnoses.**








Crisis observation units provide

- Medically supervised detox
- Initiation of MAT
- SUD counseling & peer support
- Harm Reduction (e.g., Naloxone kits distributed at discharge)

## Youth and SUDs

- **28%** of CRC youth obs patients have a SUD diagnosis or positive toxicology result.
- The most common diagnoses are **Cannabis** (66%) followed by **Alcohol** (12%) and **Opiates** (11%).

# Law Enforcement Collaboration

- Training
- CIT
- Co-responders
- Dedicated vs Designated Teams
- Tucson MHST Model
  (Mental Health Support Team)

# Tucson Police Dept. Organizational Approach

Research shows that CIT is *most effective* when the training is VOLUNTARY. TPD mandates basic training for everyone, while more advanced training is voluntary. High rates of training are achieved through culture and by creating incentives to make the training desirable.

**LEADERSHIP enacts organization-wide policies, procedures, training, culture**

- Community Policing
- Guardian vs. Warrior
- Use of Force Continuum
- De-escalation Required
- Implicit Bias Training
- Officer Wellness

**ALL officers receive Basic Training (Mental Health First Aid – 8 hours)**

- Mental health basics and community resources
- De-escalation and crisis intervention tools

**SOME officers receive Intermediate Training (CIT – 40 hours)**

- ***Voluntary*** participation
- ***Aptitude*** for the population

**SPECIALIZED Units receive CIT + Advanced Training**

- ***Collaboration*** with behavioral health systems, social services, and other community partners
- Dedicated Specialty Teams:
  *Mental Health Support Team*
  *Substance Use Deflection Team*
  *Homeless Outreach Team*
  SWAT & Hostage Negotiators

**100%** of the dept is **MHFA trained**

**60%** of first responders & 911 call-takers are **CIT trained**

Specialty units are **100% CIT trained** & receive ongoing **Advanced CIT & other training**





Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

# Evolution of Co-Responder Model:
## Finding the right solution to fit community needs

### Co-Responder 1.0: LA Model

**MHST Team Officers**
*already employed by TPD*

**1 Mobile Crisis Team**
*already employed by mobile provider financed via RBHA/Medicaid*

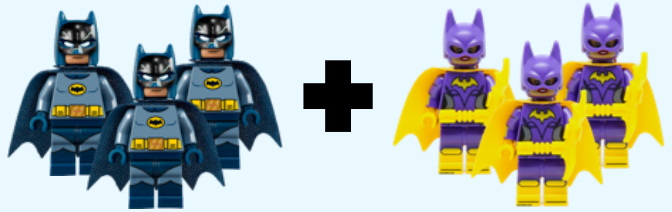
**2 Co-Responder Teams**
*Cost neutral*

Officer + clinician ride and respond to crisis calls together

### Co-Responder 2.0

Dedicated mobile team with officers and clinicians in their own vehicles

### Co-Responder 3.0



**TPD MHST Officers & Detectives**

**Peer Support Specialists**
*Employed by Connections billing case mgmt. codes*

Peer follow-up and wraparound for high-risk individuals

# Dedicated Specialty Teams: Prevention, outreach, & follow-up

## More ways for officers to do the right thing = more community stabilization

### Mental Health Support Team (MHST)

- Mobile crisis clinician assigned to MHST detectives
- Investigations & follow-up for high-risk individuals

*Percent of calls resulting in*

**involuntary hospitalization decreased from 60% to 20%**

### Substance Use Response Team (SURT) Deflection Program

- Peer co-responders focused on SUD and overdoses
- Option not to arrest for possession of small amounts

*In the first 2 years,*

**2,000 people connected to treatment instead of arrest**

### Homeless Outreach Team (HOT)

- Peer co-responders focused on homeless recovery
- Identify and engage with individuals instead of arrest

**500 people housed**

*in the first 2 years of the program*



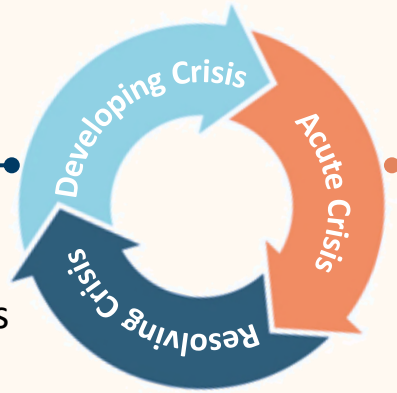


*Data courtesy Sgt. Jason Winsky at Tucson Police Department*

# Tucson's Police-MH Collaborative Response Model

## Prevention

- Outreach
- Follow-up
- Multiple touches
- Lower urgency




## Response

- De-escalation
- Intervention
- Discrete event
- Higher urgency

## *Breaking the Crisis Cycle*

**Outreach & follow-up can "break the cycle"** by ensuring that the person is connected to the care they need to stay well in the community. Community-based peers and/or clinicians work with LE to help with engagement and navigating the mental health system.

## *Health-First Response*

With 911/crisis line integration, calls are **triaged to a clinician-only response as early and often as possible**, with law enforcement involvement reserved for cases with higher safety risk or criminal nexus. Responding officers are CIT-trained and can request additional assistance if needed.

| Safety Risk | Outreach & Follow-up | Acute Response |
|---|---|---|
| | **Collaborative**<br>***Dedicated LE specialty teams working with peer co-responders***<br>- Follow-ups after OD or SUD deflection<br>- Public safety risks: investigations & f/u<br>- Homeless outreach | **Collaborative**<br>***CIT Trained Officer + assistance from the crisis system to fit the situation***<br>- CIT officer transport to CRC<br>- Mobile crisis assist at suicidal barricades |
| | **Clinician-Only**<br>***BH System is responsible***<br>- "Second responders"<br>- Case management<br>- Timely access to needed care | **Clinician-Only**<br>***BH System is responsible***<br>- Crisis Line/988<br>- Mobile Crisis Teams<br>- Transport to CRC/crisis facilities |

Urgency

# Arizona Model Return on Investment

A study of the crisis system in Phoenix estimated that a **$100 million investment in crisis care** resulted in savings of

- **$260 million** in psychiatric inpatient spending
- **$37 million** in emergency room costs
- **45 years** of psychiatric ER boarding hours
- **37 FTE** of police officer time and salary

In 2016, metro area Phoenix law enforcement engaged 22,000 and transferred them *directly* to crisis facilities and mobile crisis without visiting a hospital ED.

Aetna/Mercy Maricopa 2017 report

***What difference did it make?***

**Improved Crisis Clinical Fit to Need (CCFN) by 6x**

**Reduced potential state inpatient spend by $260m**



**Saved hospital EDs $37m in avoided costs/losses**

**Reduced total psychiatric boarding by 45 years**

Calculated from "Impact of psychiatric patient boarding in EDs" (2012) (Nicks and Manthey)

Calculated from Arizona data, 2017

**Saved the equivalent of 37 FTE Police Officers**

**Fire savings just starting.**

BJA presentation at ISMICC (2017), Madison, Wisconsin data





*Adapted from https://crisisnow.com/wp-content/uploads/2020/02/CrisisNow-BusinessCase.pdf*

# Quality Measurement in Crisis Services

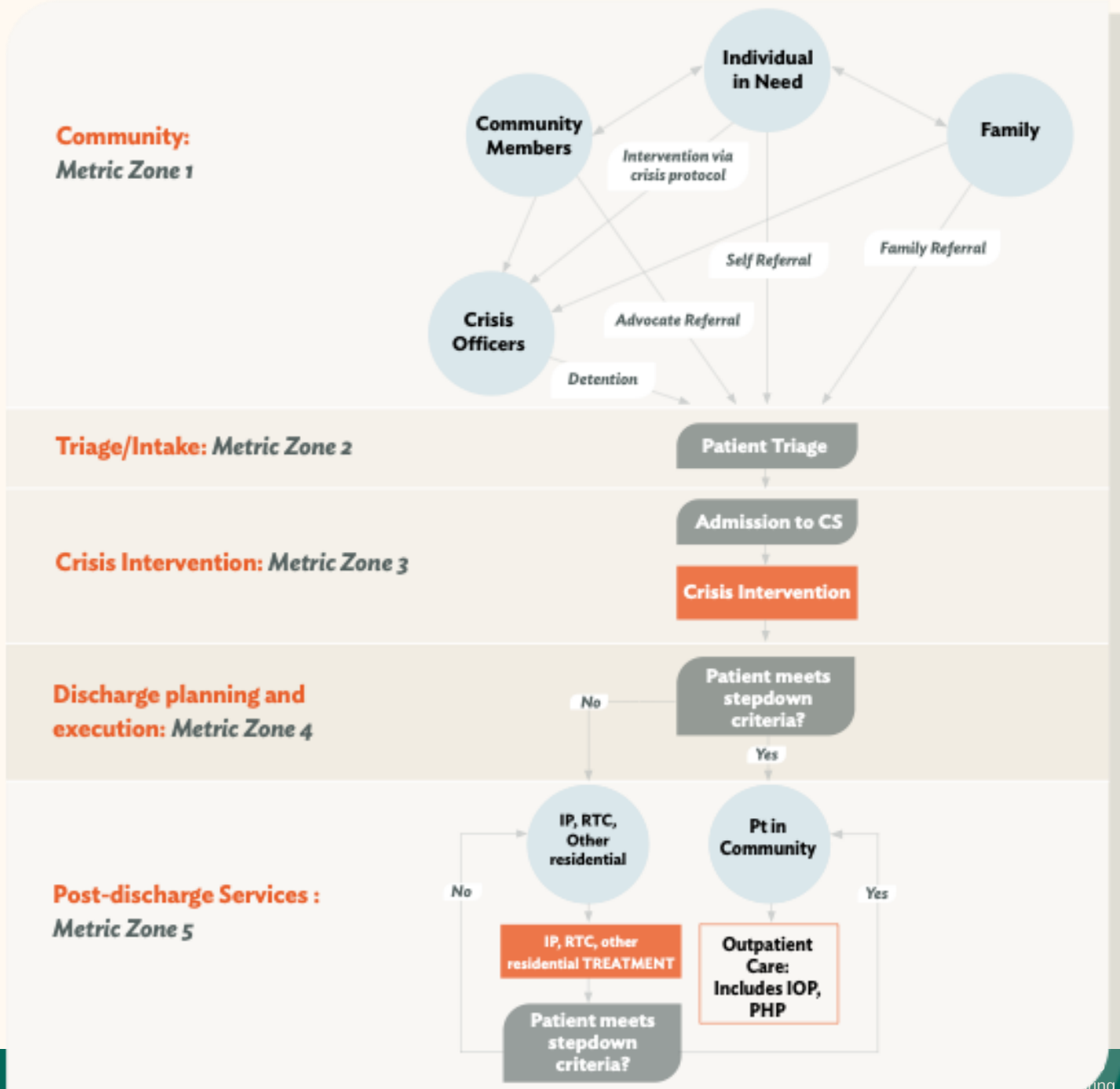
NATIONAL COUNCIL for Mental Wellbeing®

## Medical Director Institute Crisis Services Committee

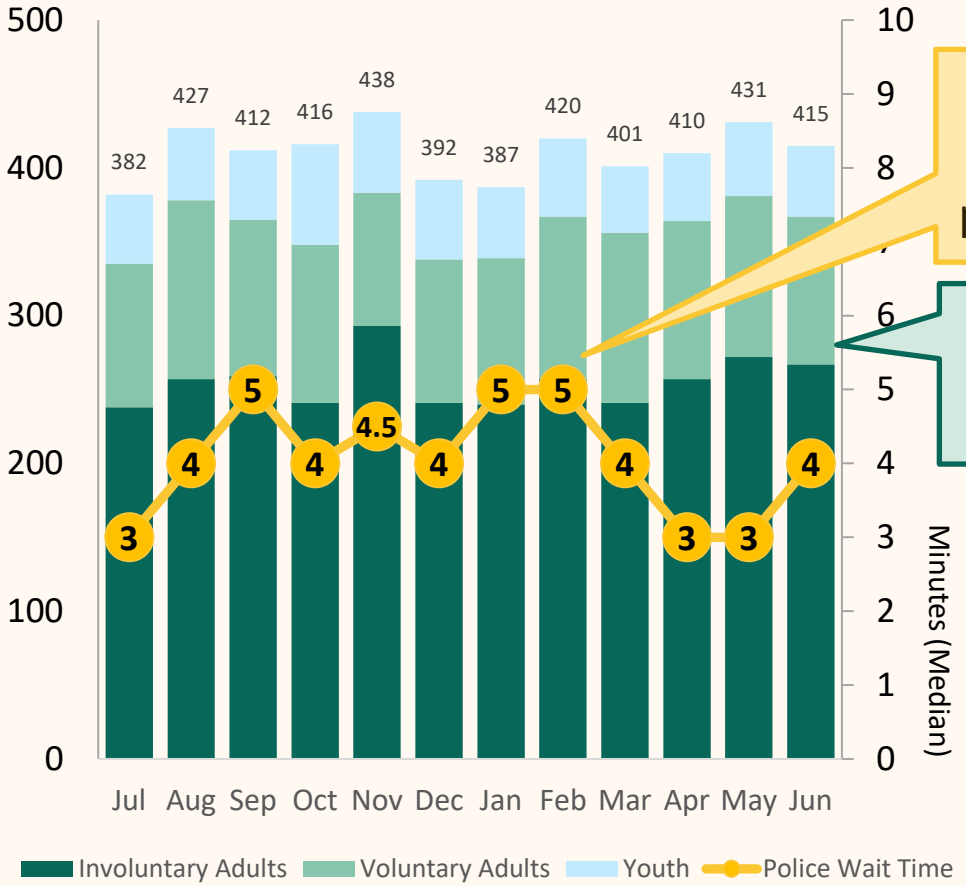
A companion to the
*Roadmap to the Ideal Crisis System* report

# Conventional Framework

- Based on process engineering methods.
- Map the flow of the person in crisis through the system.
- Consider the inputs, outputs, gaps, and best practices that should occur in each “zone.”

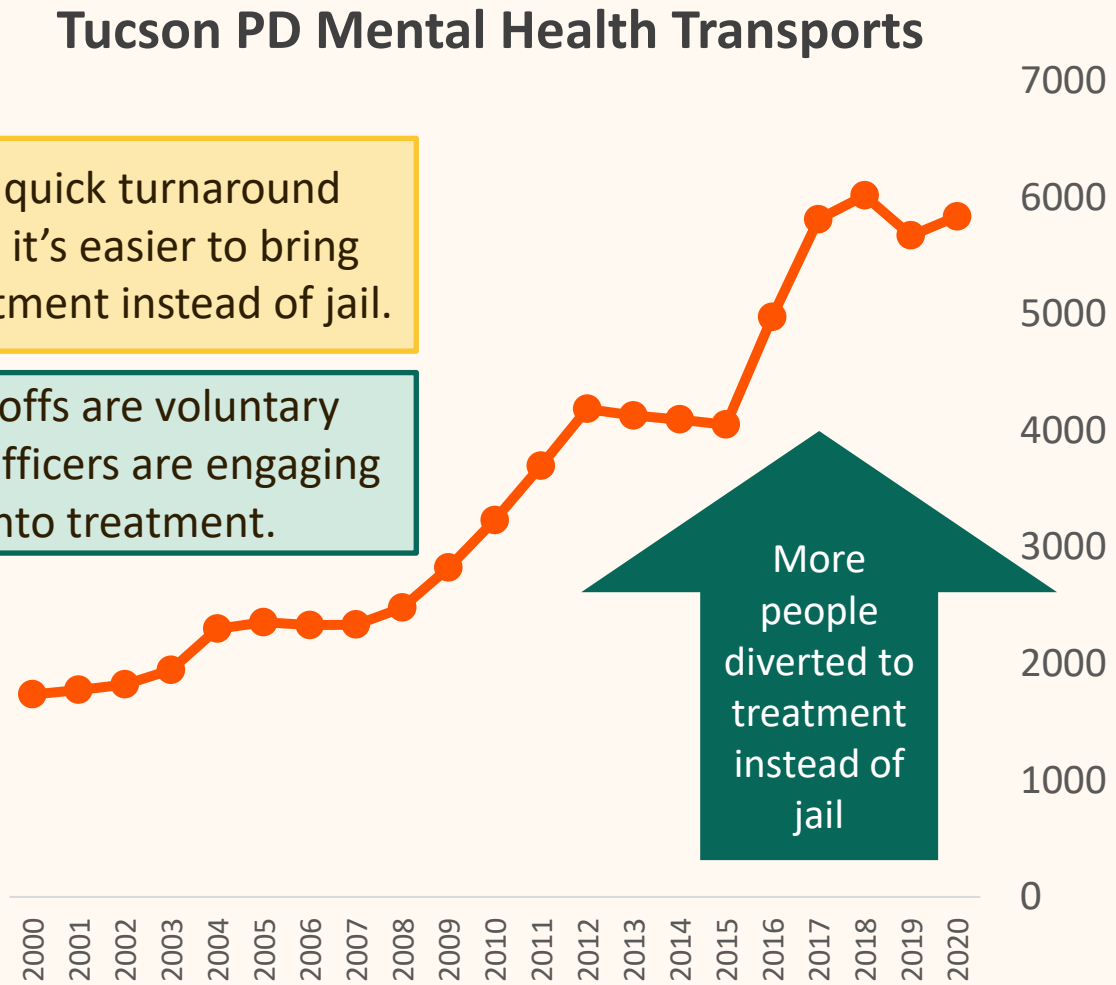


# MORE People Taken to Treatment…




Officers like quick turnaround times so that it's easier to bring people to treatment instead of jail.

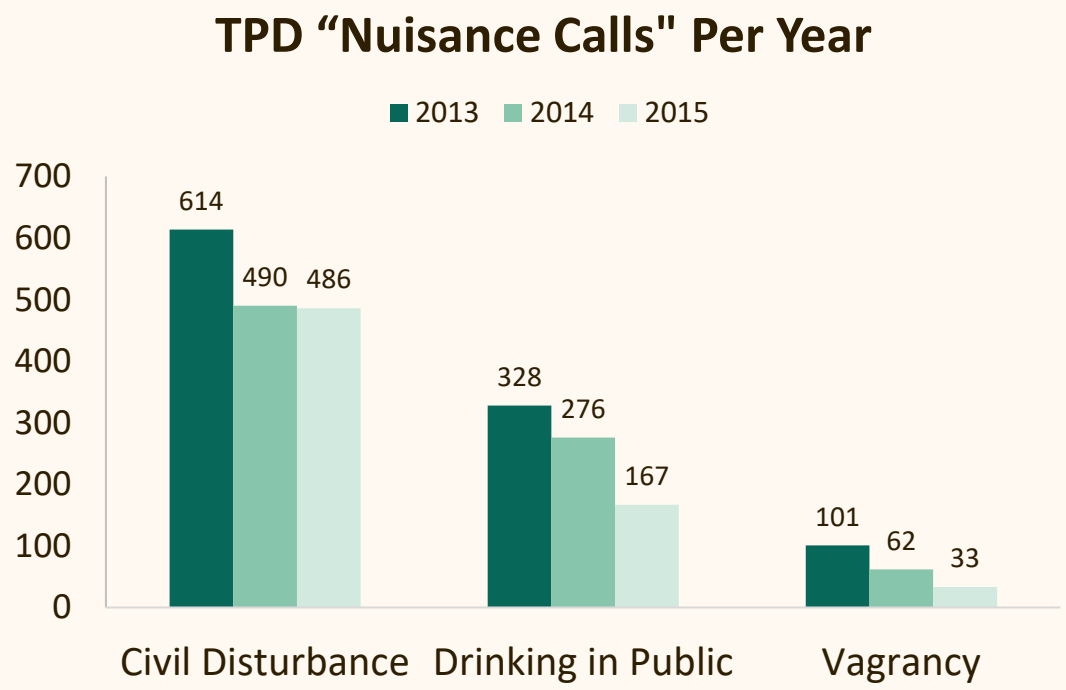
Many drop-offs are voluntary because the officers are engaging people into treatment.

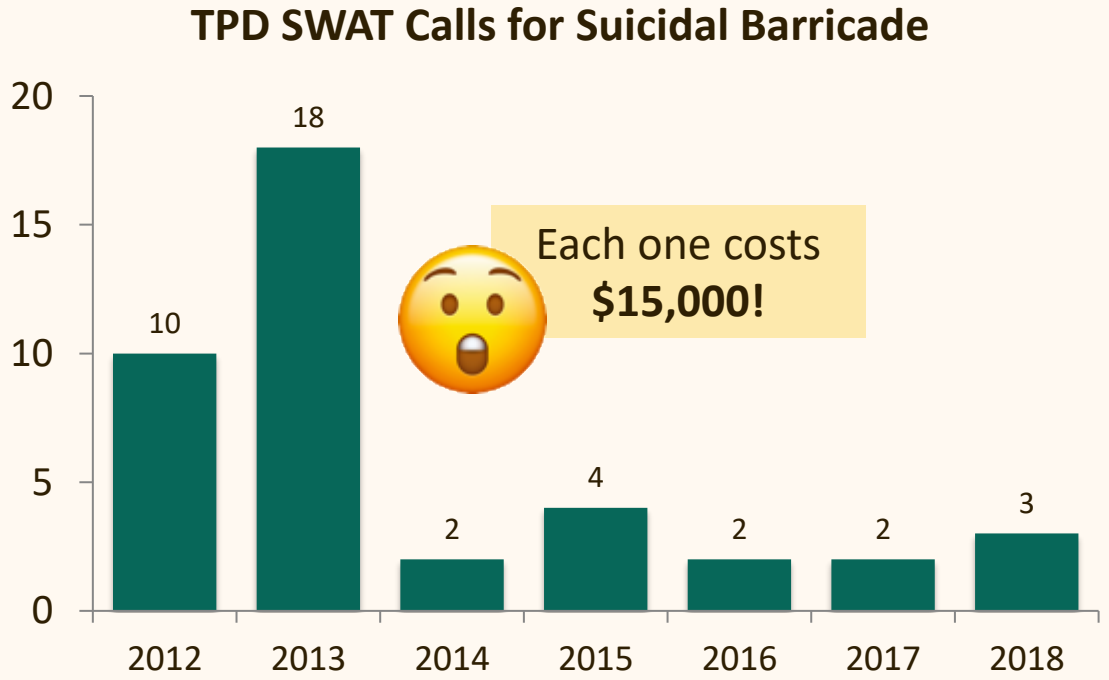


# … and LESS Justice Involvement

Fewer calls for low-level crimes that tend to land our people in jail.

Culture change in how law enforcement responds to mental health crisis.




Balfour ME, Winsky JM and Isely JM; The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety. Psychiatric Services. 2017;68(2):211-212; https://dx.doi.org/10.1176/appi.ps.68203

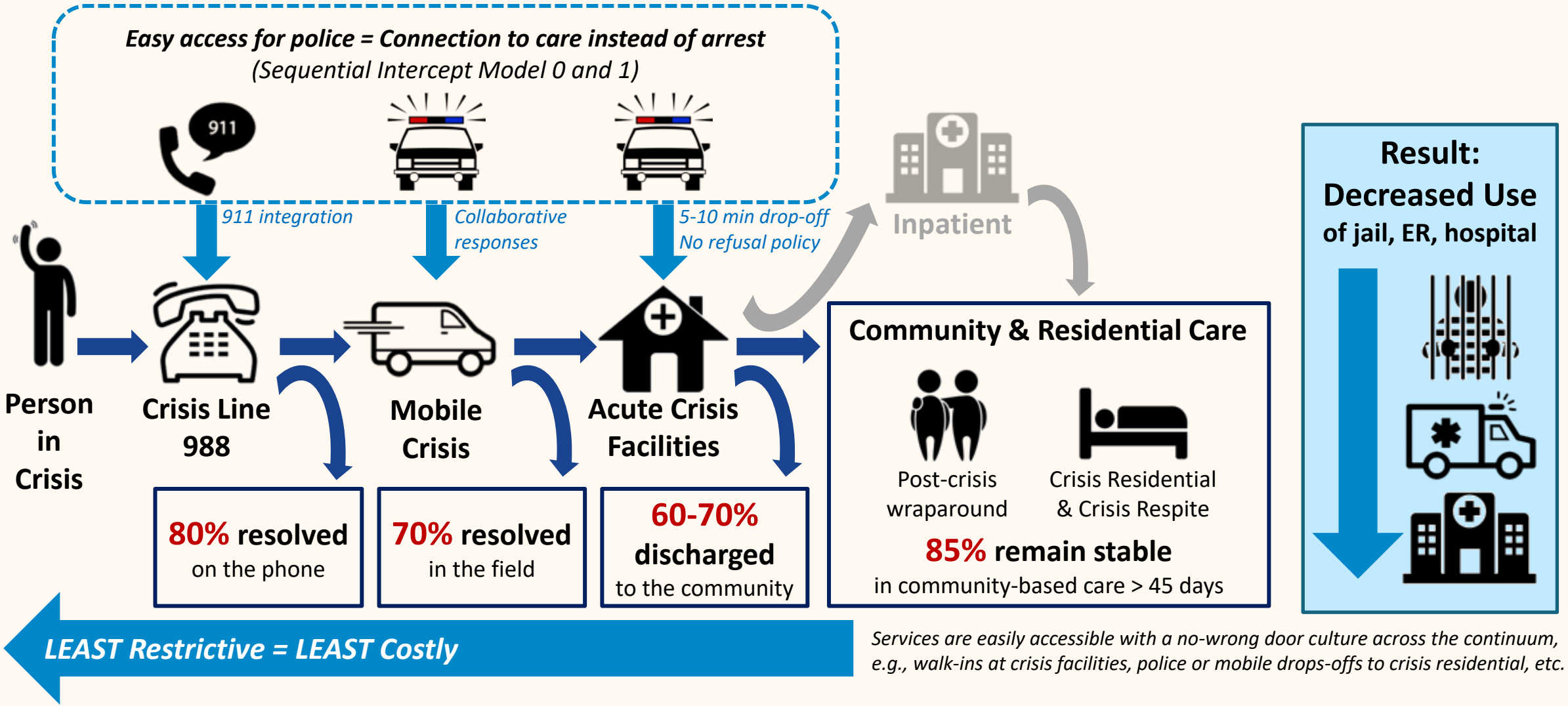
# Person-Centered Approach to Crisis Metrics

| | Value | Meaning | Examples |
|---|---|---|---|
| A | *Accessible/ Affordable* | I am welcomed wherever I go. I am not turned away. | • Percentage of help-seekers who receive appropriate care vs. all who have sought care.<br>• Percentage of persons seeking care who are turned away due to lack of coverage vs declined due to not being able to afford care. |
| C | *Collaborative* | Helpers work in partnership with me, my family, my caregivers, and other responders. | • The programs assess consumer/family satisfaction surveys and/or net promoter scores. |
| C | *Comprehensive* | I get help for all my issues that are part of the crisis. | • Access to medical screening.<br>• Able to treat co-occurring substance use disorder (SUD), intellectual/developmental disorder (I/DD), etc. |
| E | *Equitable* | The quality of services I receive are not affected by my race, ethnicity, gender, sexual orientation, etc. | • Stratify outcome metrics (e.g., return to crisis centers, access to care) by race/ethnicity and other key demographics (e.g., ZIP code). What percentage of poor outcomes are disproportionately influenced by performance in underrepresented populations? |
| S | *Safe* | My experience of help is safe and not harmful. I am never traumatized by asking for help. | • What percentage of individuals presenting in crisis end up injured, hurt or killed while doing so? |
| S | *Successful* | The care I receive meets my needs. | • Readmission rates.<br>• Symptom reduction. |

| | Value | Meaning | Examples |
|---|---|---|---|
| T | *Timely* | I get help quickly enough to meet my needs. | • Time to intervention (e.g., call answer times, mobile dispatch times, facility door-to-doctor times).<br>• Abandonment rate (e.g., call abandonment, left without being seen, etc.).<br>• Lag time between seeking care and receiving care. |
| O | *Ongoing* | I receive help to move from my crisis situation to ongoing support that wrap around me to help me thrive. | • Successful linkage to continuing care at adequate intensity: 3-, 7-, 30-, 60-, 90-day follow up. |

| | Value | Meaning | Examples |
|---|---|---|---|
| H | *Hopeful* | I am helped to feel more hopeful, and I make better decisions as a result. | • Decrease in suicide, violence, self-harm.<br>• Personal Outcome Measures (POMS). |
| E | *Engaging* | I am treated as a valuable customer, with respect and dignity. | • Complaints, adverse incidents, escalation. |
| L | *Least Intrusive* | I receive help in a place that is designed to meet my needs. | • Avoidance of inappropriate emergency department use or arrest diversion, voluntary conversion. |
| P | *Publicized* | I know who to call and/or where to go. | • Information about call lines and walk in centers, increased use of 988 vs. 911. |

# Arizona Crisis System: Aligning system components towards a common value (Least Intrusive) via a common outcome metric (community disposition rate)

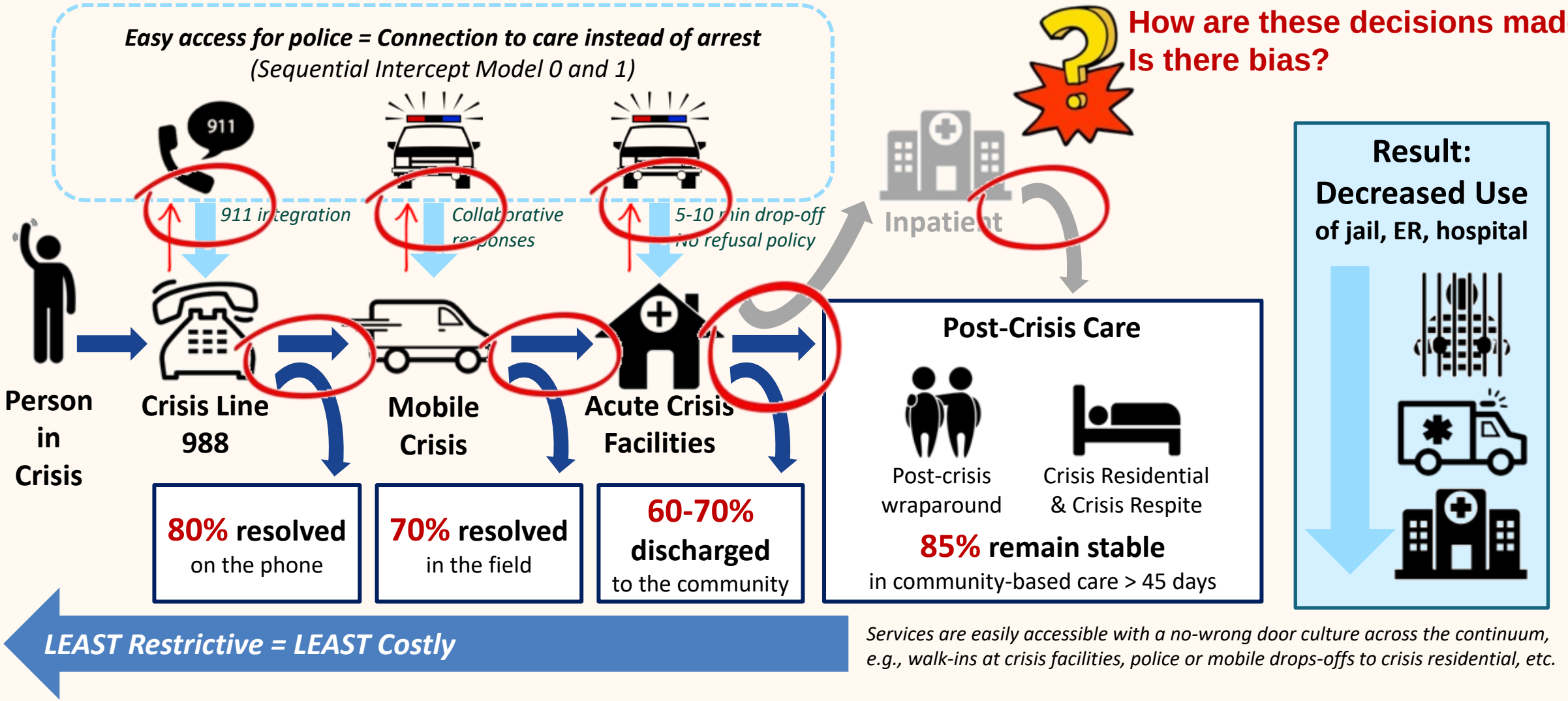



*Services are easily accessible with a no-wrong door culture across the continuum, e.g., walk-ins at crisis facilities, police or mobile drops-offs to crisis residential, etc.*




Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

# Looking for disparities

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# Systems Approach: How can crisis data help improve the whole behavioral health system?

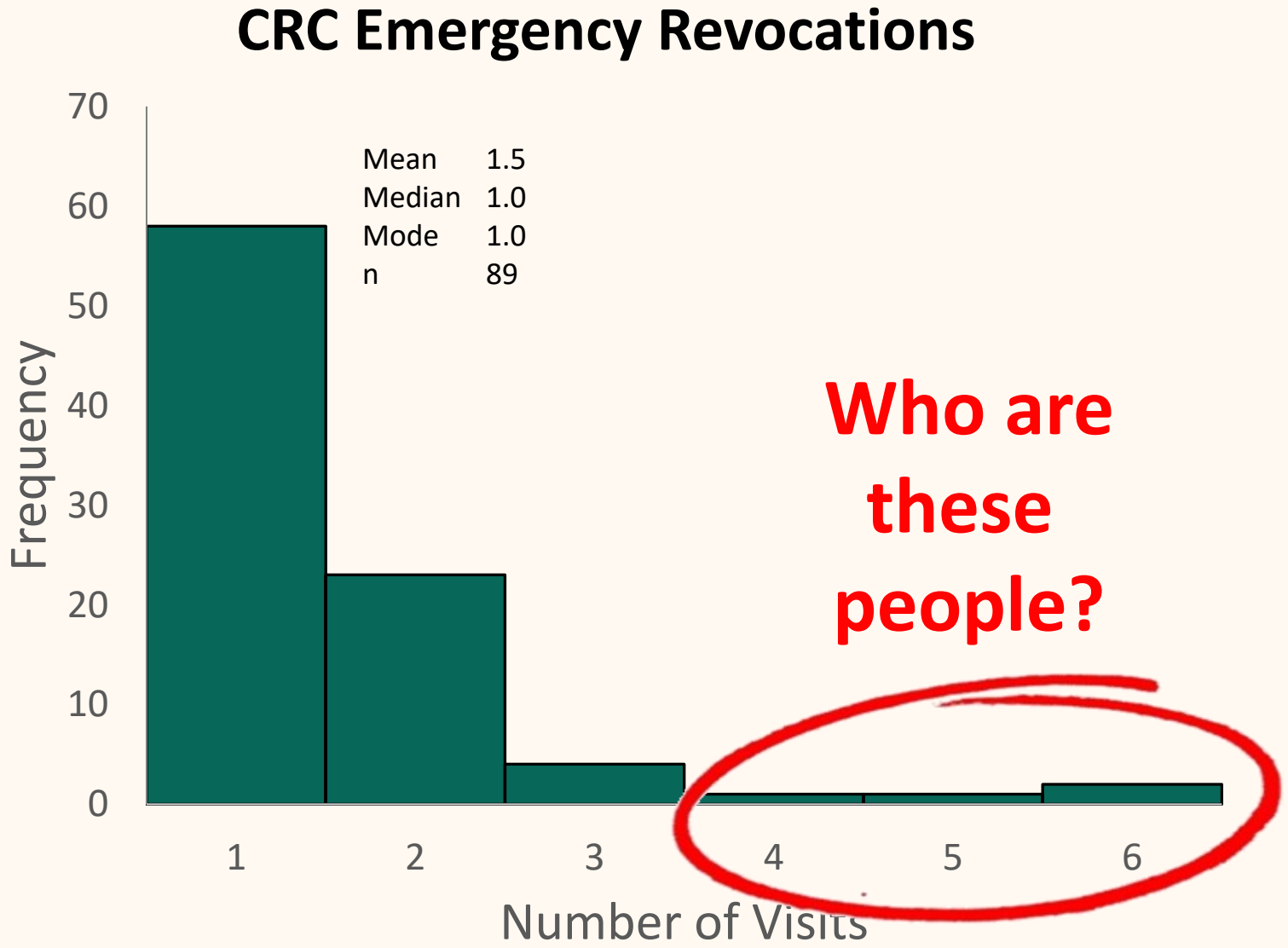
Every crisis visit is a **story** about how someone **couldn't get their needs met** in the community.

If we **turn the stories into data**, it can **reveal trends** about things that need improving in the overall behavioral health system.

# Using Data to Solve Complex Problems

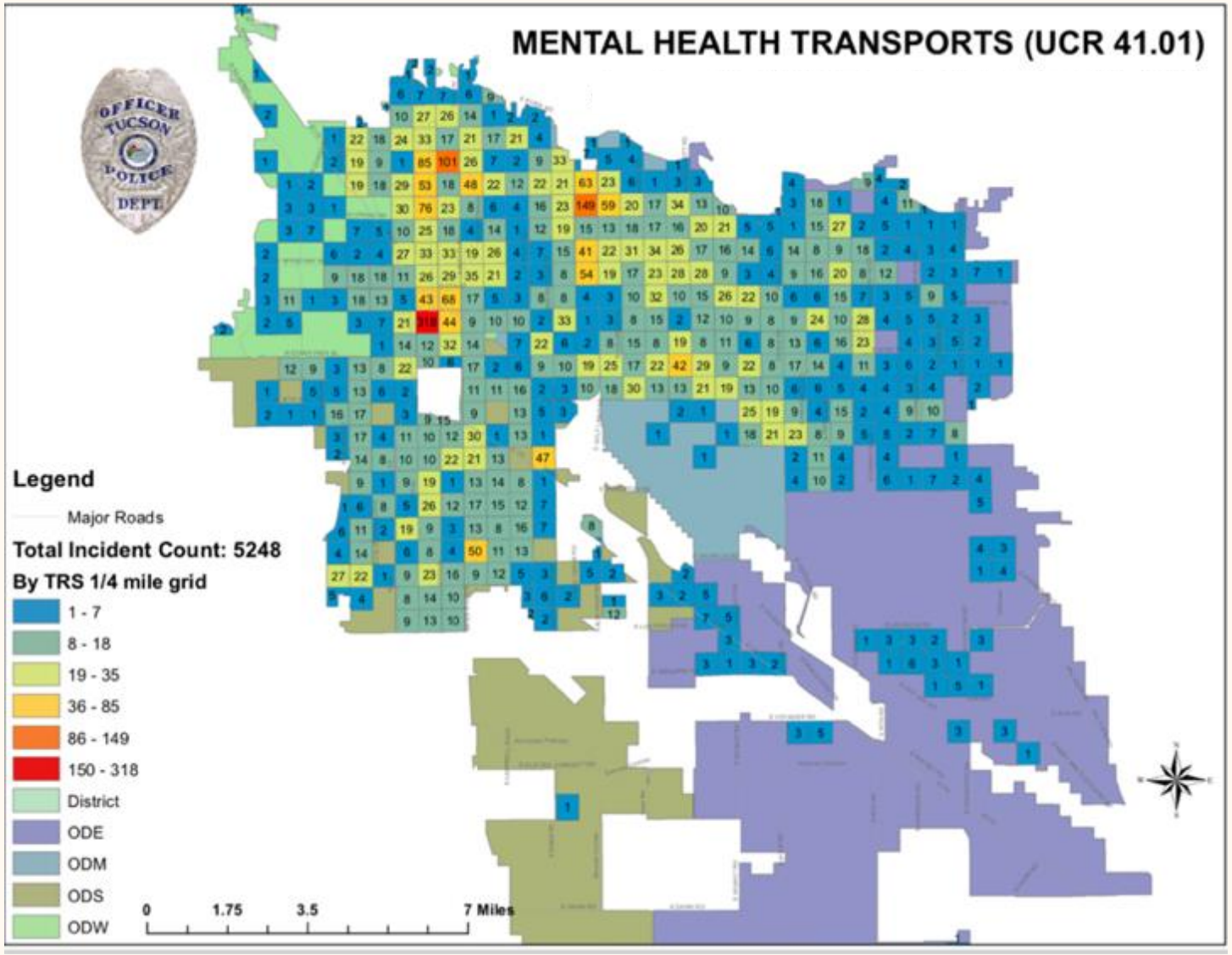
## Example: Repeat revocations to the CRC

**for individuals on COT (outpatient civil commitment)**



Where are these individuals coming from?

Can we target interventions to prevent the need for involuntary law enforcement transports?




*Courtesy Sgt. Jason Winsky, Tucson Police Dept.*



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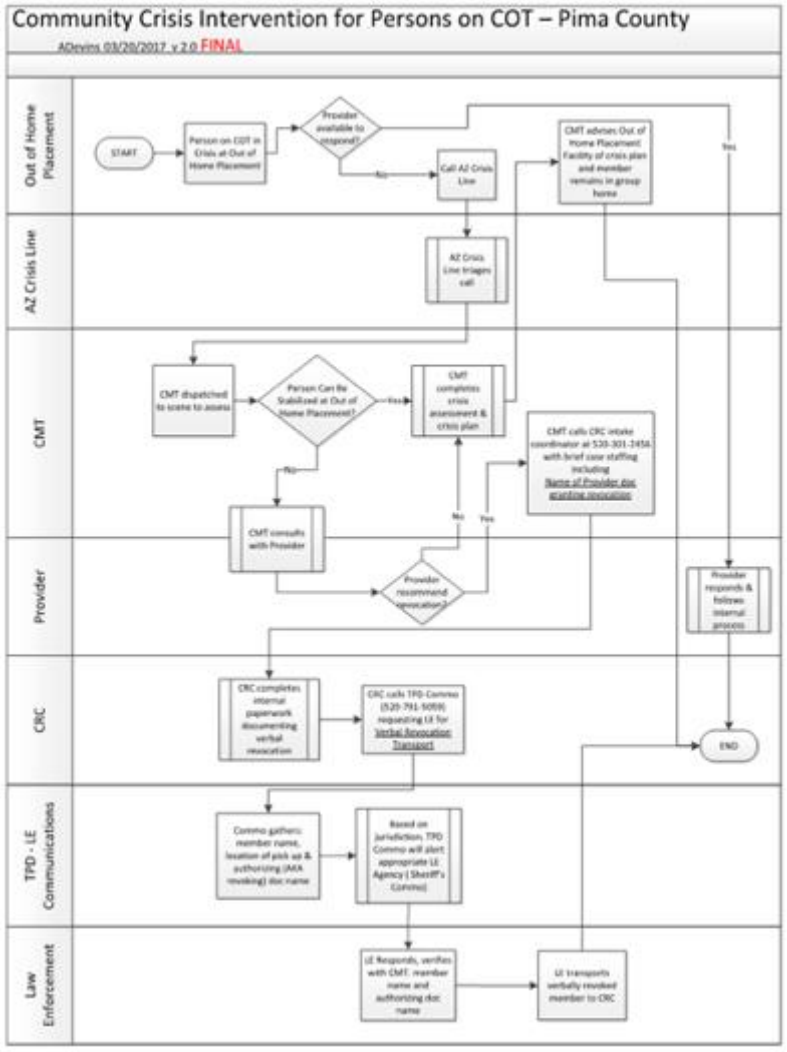
# “The Group Home Guy”

## Multiagency QI Process to reduce repeat civil commitment orders

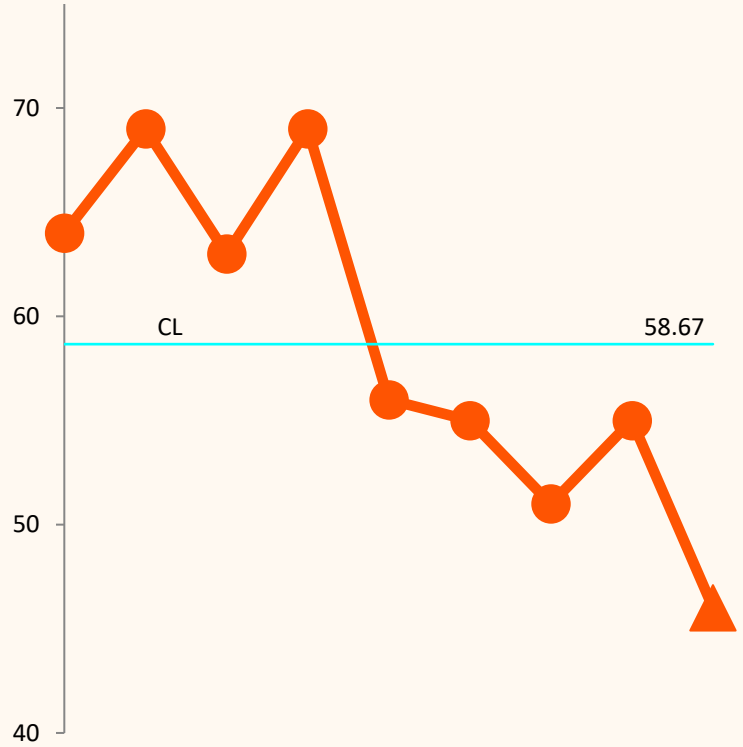
**A “Swim Lane” diagram** shows how each agency plays a role in making the new process work.

- Group Home
- Crisis Line
- Mobile Crisis Team
- Outpatient Clinic
- Crisis Response Center
- 911 Communications Center
- Law Enforcement




*Courtesy of Amy Devins, Arizona Complete Health*

**Decrease in CRC COT Revocations Per Month**





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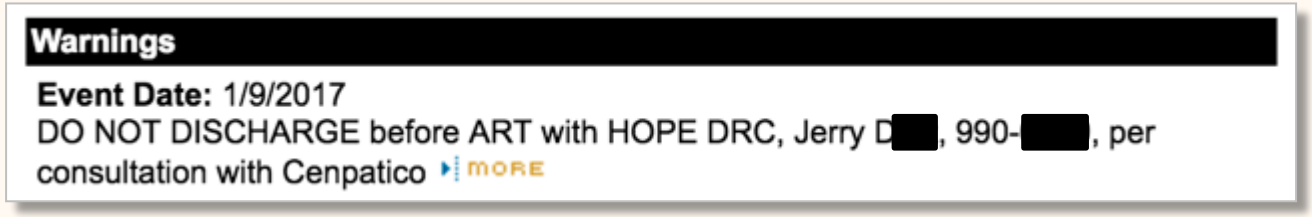
# "Familiar Faces" QI Plan

1 **DATA REPORTING:** The CRC sends a monthly rolling frequent utilizer report to the RBHA.

| Last name | First name | dob | ICC | T19 status | rbha | payer | Clinic Only | Obs | Total | Visit this month? |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | LA FRONTERA | SMI T19 | Cenpatico | AHCCCS only | 9 | 10 | 19 | Y |
| | | | LA FRONTERA | SMI T19 | Cenpatico | AHCCCS only | 0 | 4 | 4 | Y |
| | | | COPE | SMI T19 | Cenpatico | AHCCCS & Medicare | 0 | 4 | 4 | Y |
| | | | LA FRONTERA | SMI T19 | Cenpatico | AHCCCS only | 0 | 6 | 6 | Y |
| | | | COPE | SMI T19 | Cenpatico | AHCCCS only | 1 | 4 | 5 | Y |

2 **MULTI-AGENCY TEAM MEETINGS** with CRC, RBHA, clinic staff to discuss the patient's needs and develop improved crisis and service plans. The goal is at least 3 staffings per patient regardless of whether they are at the CRC that day.

3 **CHARTS FLAGGED** at the CRC with information about the new crisis plan and who to contact so that the new plan can be implemented.

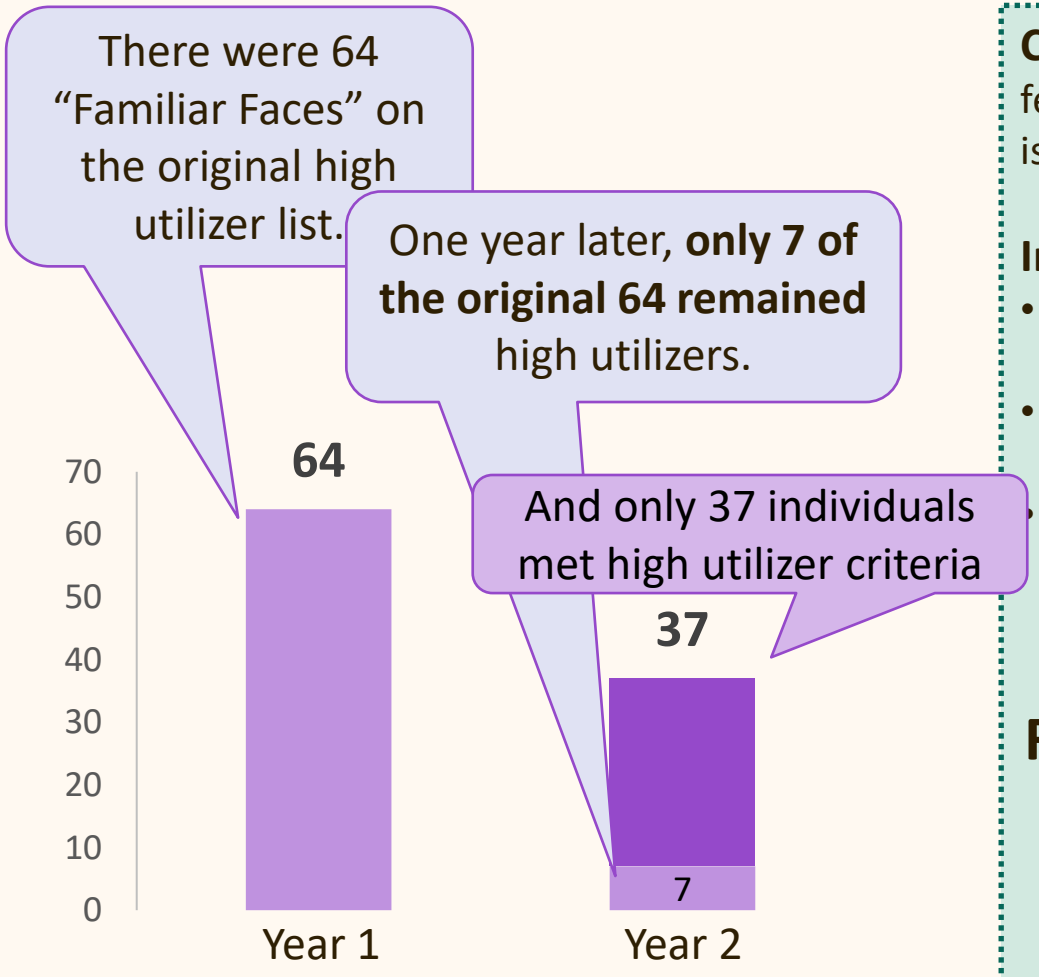







Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services*; 2018;69(6):623-625; https://doi.org/10.1176/appi.ps.201700533

# Results: Fewer "Familiar Faces"




**Case Example:** Ms. X becomes lonely during the weekend, which is a trigger for feeling overwhelmed and suicidal and coming to the CRC. She has a partner who is also enrolled in services.

**Individualized Plan:**

- The outpatient provider will proactively do **welfare checks on nights and weekends** to help plan for triggers that historically result in CRC visits.
- The team will explore **working with her partner's team** (with consent) in order to assist both in recovery together.
- **The CRC will call her clinic Peer Support Specialist immediately upon arrival to reinforce the relationship with her outpatient team** and help connect her more quickly with outpatient support.

**Results:** CRC visits decreased from

**14** in Q1 2016 to

**1** in Q1 2017.





Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services*; 2018;69(6):623-625; https://doi.org/10.1176/appi.ps.201700533

# Pima County Journey: A long time and lots of collaboration

**2000**

**< City** (Tucson) MH Court

**2001**

**2002**

**< Mobile Crisis Teams**

**2004**

**Felony >** MH Court

**Bond passes >** to build crisis facility

**2006**

**Jail Based >** Restoration to Competency

**2007**

**Jan 8 2011 shooting >** at *Congress On Your Corner*


**2010**

**2011**

**< Peers in the Jail**

**< Crisis Response Center** opens Aug 2011

**2012**

< Pima County **Office of BH Administrator**

**< DTAP Program** Drug Treatment Alternative to Prison

**< Rural** MH Courts

**Law Enforcement MH Support Teams**

< PCSO TPD >

**2013**

**2014**

Jail + MH **Data Exchange** < JHIDE Analytics >

**2015**

**< MH First Aid** Training for law enforcement begins

**2016**

**MacArthur Grant** awarded to Pima County

**2017**

**< Co-responders** (cop + clinician)

**< Repeat T36 Utilization** (civil commitment/AOT)

**Data Sharing Task Force**

**< 24/7 access to MAT**

**< 100% MHFA training** achieved TPD + PCSO

**2018**

**< Learning Site** designation by DOJ/BJA

**< MHFA Impact Award** National Council for BH

**< Repeat Jail Detainees** Task Force

**2019**

**< 911/crisis line** co-location

**< CoMPaSs Court** Consolidated misd. problem-solving court

**< Drug Deflection** UMATTER program

**2021**

**< Launch of STEPs Court** Pre-indictment diversion court

**< Creation of Justice Services** New Pima County Department

**2023**

**< Launch** Pima County Transition Center

# Questions?

**Margie Balfour, MD, PhD**
Connections Health Solutions
Chief of Quality & Clinical Innovation
Associate Professor of Psychiatry, University of Arizona
margie.balfour@connectionshs.com

Tucson is one of the DOJ's
**Law Enforcement - Mental Health Collaboration Learning Sites**
Funding for a visit may be available.
https://csgjusticecenter.org/law-enforcement/projects/mental-health-learning-sites/

***Further Reading:***

- ***Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.***
  Paper: https://bit.ly/CopsCliniciansBothPaper
  Podcast: https://bit.ly/CopsCliniciansBothPodcast
- ***Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards, and Best Practices for Behavioral Health Crisis Response*.**
  http://www.CrisisRoadmap.com
- ***Psych News overview of Tucson model:***
  https://doi.org/10.1176/appi.pn.2022.1.7
- ***Psych Times overview of facility-based models:***
  *https://www.psychiatrictimes.com/view/an-imperfect-guide-to-crisis-stabilization-units-matching-the-right-level-of-care-to-individual-needs*

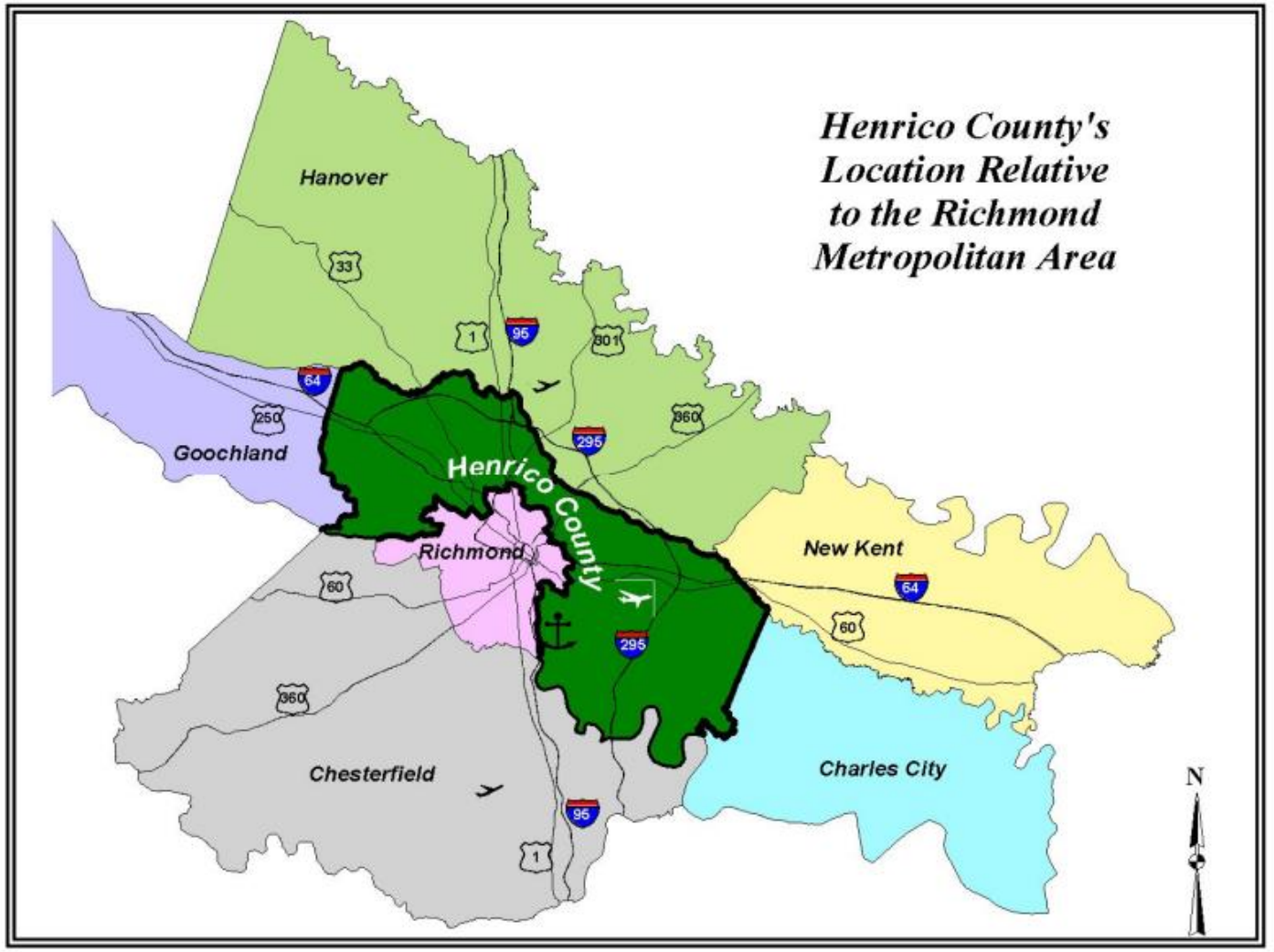

# Prevention Services Unit

# Henrico County, Virginia

- Approximately 245 square miles in size
- As of 2022, estimated population 333,962
- 5 Magisterial Districts (Brookland, Fairfield, Three Chopt, Tuckahoe and Varina)

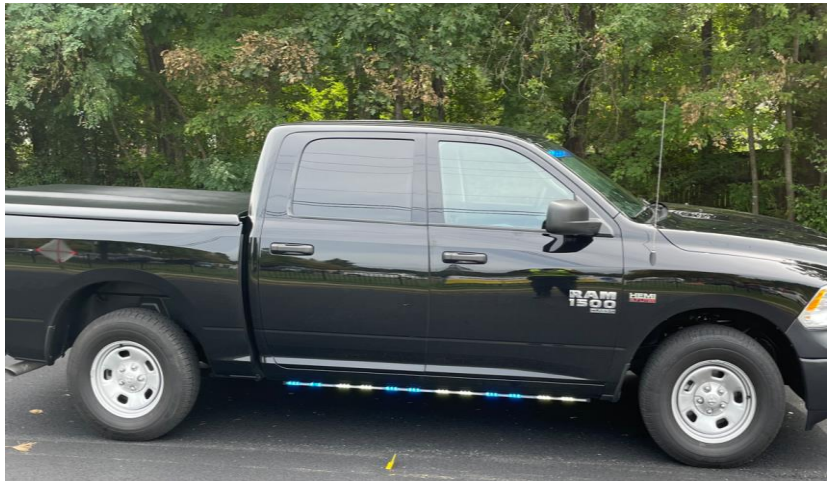
**Henrico County Police**

- Three police stations
- Over 694 sworn police officers that serve the County





# Prevention Services Unit Officers




# STAR – Services To Aid Recovery

- Team of Henrico county agencies (Police, Fire, Sheriff's Office, HCPS, Henrico Mental Health, APS, CPS, Building Inspections) who meet WEEKLY (every Monday)
- Referrals via various avenues
- Preventative visits

# Active Call Response

Mobile Response Team (MRT) (Marcus Alert) – Mental Health worker rides with Henrico County Police CIT Officer and respond to active mental health calls for service ‘in-progress’

MRT also makes planned prevention visits

Prevention Services Unit Officers also respond to active calls for service when not doing preventative visits (have always done this)

HENRICO POLICE
COUNTY OF HENRICO, VIRGINIA

HENRICO AREA
MENTAL HEALTH &
DEVELOPMENTAL SERVICES
SERVING THE COUNTIES
OF HENRICO, CHARLES CITY AND NEW KENT

# Education and Training

Prevention Service Unit instructs all the Henrico Police sworn personnel as well as various other jurisdictions

- 40-hour basic CIT course
- Mental Health block for De-Escalation Training
- CITT (CIT train the trainer) to develop future CIT instructors
- Mental Health First Aid Course
- JSRO (Juvenile Services Resource Officer School) to instruct SROs on Mental Health

# Community Outreach

- Prevention Services Unit organizes and leads the Homeless Point in Time Count.
- Homeless Count is conducted biannually to connect homeless individuals living within Henrico County with services that they may be eligible for.
- Henrico Police collaborates with various organizations to include Henrico Fire, Henrico Mental Health, Homeward and Moments of Hope Outreach.


# Henrico County Courts and Mental Health

Mental Health Diversion Program (MHDP)

- Prevention Service Officers attends weekly docket and assists with analyzing potential candidates for safety risks to the community

Behavioral Health Docket

- Specialized Docket is pending
- Prevention Service Officers will be participating on the docket multidisciplinary team.

# Threat Assessments

Prevention Service Unit (PSU) reviews and follows up on threat assessment investigations

- Mental health nexus to Threat Assessment investigations
- Provide mental health resources and support

**PSU/CIT**
**C**risis **I**ntervention **T**eam:
8 Sworn Henrico Police Officers

STAR: **S**ervices **T**o **A**id **R**ecovery

CIT participates in the STAR multidisciplinary program.

Henrico County Departments included in STAR:

- HPD (CIT, Schools), HMH, HCPS, HFD/CARE, Social Services (APS, CPS), Sheriff's Dept, Building Inspections
- Meets weekly; every Monday

Follow up response:

- CIT officers coordinate with various agencies to follow up visits for consumers
- Approx. 50 cases weekly & 1000 scheduled visits a year

Active Call Response:

- CIT will respond to active mental health calls for service to assist.
- CIT is always on call with 24/7 availability

**M**obile **R**esponse **T**eam (MRT): CIT responds to active calls and/or follow up calls with MRT HMH Clinician.

Education and Training within Henrico Police- CIT instructs all sworn personnel:

- CIT 40-hour course
- Mental health block of De-Escalation
- CITT (CIT train the trainer) to develop future CIT instructors.
- Mental Health First Aid course
- JSRO (Juvenile Services Resource Officer School) to instruct SROs on Mental Health

Training outside Henrico Police: CIT instructs various jurisdictions in CIT 40-hour basic course.

Threat Assessment: CIT reviews and follows up on threat assessment investigations.

**ESRO**: **E**mergency **S**ubstantial **R**isk **O**rder.

Community Outreach: CIT organizes and leads the Homeless Count, Hotel Initiative and Refugee Education

Mental Health Diversion Program (MHDP): CIT attends weekly docket and assist with analyzing potential candidates for safety risks to the community

Behavioral Health Docket is in progress and CIT will be a part of the new docket.

# Prevention Services Unit Moving Forward….

- Expanding co-responder community response
  - Adding more Henrico Mental Health Mobile Response Team (MRT) Clinicians to the team
  - Henrico Fire's role
  - Adding Peers to the MRT
- Continuing education for the PSU officers as well as the Henrico Police Division
- Utilizing the Marcus Alert Database to assist with call response


Questions?

NATIONAL COUNCIL for Mental Wellbeing

# The Certified Community Behavioral Health Clinic (CCBHC) Model

***A Conversation with Virginia***

October 2023

CCBHC SUCCESS CENTER


Agenda:

Overview of the CCBHC Model in a Justice Context

- Defining the model
- Clinic-level impacts
- State-level impacts
- Connections to Justice Systems
- CCBHC Model updates
- CCBHC payment

Growth and Outcomes Nationally

Next Steps and Action Items

# The CCBHC Model



NATIONAL COUNCIL for Mental Wellbeing

# The Vision for the CCBHC Model


The CCBHC model is established in every state and its providers will work to ensure:

- **Integrated Services:** Each CCBHC will provide affordable, community-based mental health and substance use services, including but not limited to evidence-based prevention, treatment and recovery supports
- **Cost-related Reimbursement:** Each CCBHC will have a site-specific bundled-payment rate such as a prospective payment system (PPS) and adhere to the CCBHC federal criteria established by SAMHSA for the CCBHC Medicaid Demonstration
- **High Quality Care:** Each CCBHC – and the state leaders in which they reside – will maintain quality measures and reporting structures required of the CCBHC model

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# The CCBHC Model


Staffing


Availability & Accessibility of Services


Care Coordination


Scope of Services


Quality & Other Reporting


Organizational Authority, Accreditation & Governance

A CCBHC is a specially-designated clinic that receives flexible funding to expand the scope of mental health and substance use services available in their community to ensure health equity and high-quality care for underserved populations.

- CCBHCs are **required to serve everyone** regardless of insurance status or diagnosis
- CCBHCs must meet **timeliness of access standards**, including **immediate response for crisis needs** and access within 10 days or less for routine needs
- CCBHCs must **directly provide** or **ensure access to an array of crisis response services and supports,** including 24/7 mobile crisis response and crisis stabilization
- CCBHCs must **partner and coordinate with other entities involved in crisis response** (e.g., law enforcement, emergency departments)

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# CCBHC Policy Perspective Nationally



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# History: Federal Funds Led to State Actions

| 2017 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| 8 states | 21 states | 33 states | 42 states | 46 states |
| 66 clinics | 113 clinics | 229 clinics | 430 clinics | 500+ clinics |

**2014:** Congress passed PAMA
**2016:** 23 states received planning grants
**2017**: 8 state demo launched!
**2019:** SAMHSA CCBHC-E grants launched
**2020:** 2 new demo states! Data published!
**2021:** State legislative options emerged.
**2022:** Congress passed BSCA
**2023:** 15 states received planning grants

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# CCBHC Options via Medicaid

| Medicaid Waiver (e.g., 1115) | State Plan Amendment | CCBHC Demonstration |
|---|---|---|
| Enables states to experiment with delivery system reforms | Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc. | Enables states to experiment with delivery system reforms |
| Requires budget neutrality | Does not require budget neutrality | Does not require budget neutrality and provides an enhanced FMAP for states |
| Must be renewed every 5 years | With CMS approval, can continue PPS | For only 10 states every 2 years in 2024 |
| State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan) | Cannot waive "state-wideness," may have to certify additional CCBHCs (future CCBHCs may be phased in) | State may limit the number of clinics selected to receive the PPS rate |
| With CMS approval, offers opportunity to continue or establish PPS | | State must be sure to follow all CCBHC criteria with ability to build onto them |

**E-FMAP Mobile Crisis Response Rate**: 85% (3 years – CMS approval)
**Virginia FY2023 Medicaid Match Rate:** 51.22%

**Virginia CHIP Rate:** 65.85%

**1115 waivers:** Texas
**SPAs:** Missouri, Nevada, Oklahoma, Minnesota – and Kansas (outside of the demo)!
**Demonstration states include** SPA states and Kentucky, Michigan, New Jersey, New York, & Oregon

# CCBHC Grants

| CCBHC Grants (SAMHSA funds) |
|---|
| $4 million available for a 4-year period; Previously for a 2-year term |
| Grants are given directly to clinics with self-attestation that they meet CCBHC criteria. |
| Clinics provide all CCBHC services and activities of a CCBHC as required by SAMHSA, including basic reporting requirements. |
| Grant funds supplement but do not supplant other coverage sources |

**400+** CCBHC grantees
**500+** in total this year

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# CCBHC Clinic-level Data



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**77%**

**CCBHCs & GRANTEES**

say their caseload has increased since becoming a CCBHC

*Nearly*

**180,000**

total new clients served by these clinics

This represents a 23% increase since becoming a CCBHC

**30%** average increase for state-certified sites vs. **18%** for grantee-only sites*

**6,220**

**STAFF HIRED**

Across the 249 responding CCBHCs and grantees as a result of becoming a CCBHC

*Estimated*

**11,240**

**STAFF HIRED**

across all 450 active CCBHCs as of August 2022

**27**

**NEW POSITIONS PER CLINIC**

on average since becoming a CCBHC

*(82% of organizations have created at least 10 new staff positions)*

**These workforce expansions represent a 13% increase** compared to prior to becoming a CCBHC.

Grantee sites had a **10%** increase in staff; state-certified sites had a **16%** increase in staff.*

*Difference is statistically significant

www.TheNationalCouncil.org

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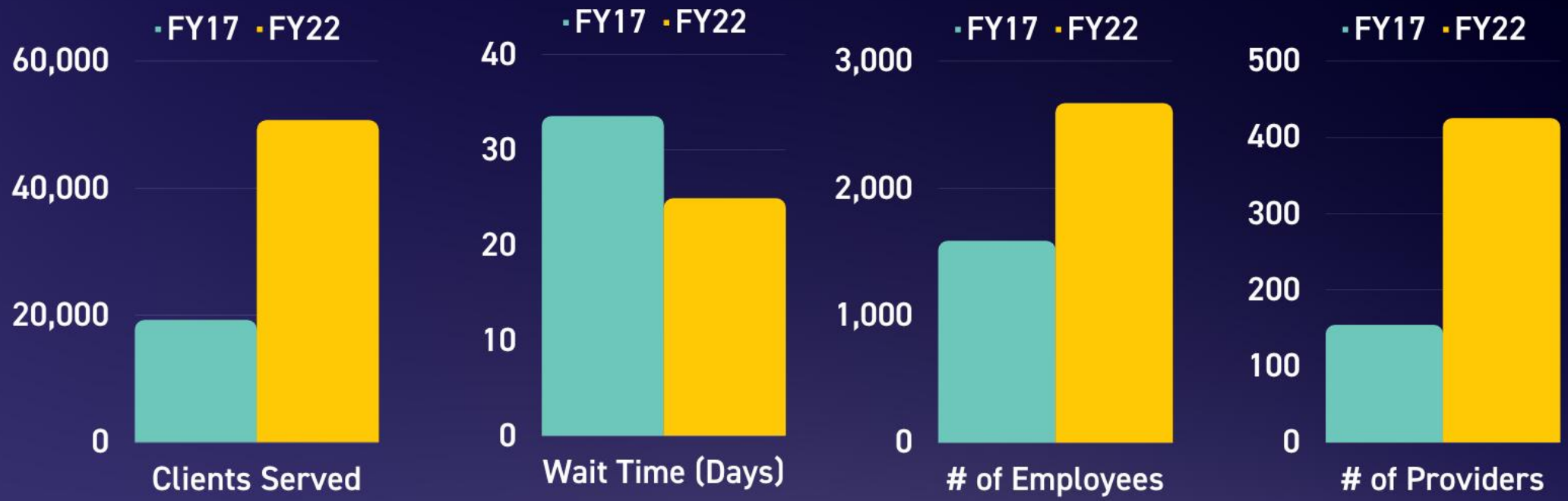
# HIGH-LEVEL ADVANTAGES





BRIGHTLI
livebrightli.org

# Comparative Data

## Before CCBHC

- 2,500 clients served
- 100 employees
  - Avg MHP $55,000
  - Avg Rehab $42,000
  - Avg Peer $15.00
- Access
  - To Comp Eval 19 days
  - To Ongoing Svc 15 days
- Revenue
  - $6 million

## Current

- 4,200 clients served (2021)
- 150 employees
  - Avg MHP $65,000
  - Avg Rehab $51,000
  - Avg Peer $18.25
- Access
  - To Comp Eval 7 days
  - To Ongoing Svc 12 days (Covid)
- Revenue
  - $13.5 million

# CCBHC State-level Data



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# Oklahoma Outcomes

Reduced the average time for initial assessment to **3.2 days**

**78.4%** change in adults receiving a body mass index and follow-up counseling

**82.4%** increase in children's weight assessments

**70%** change in suicide risk assessment

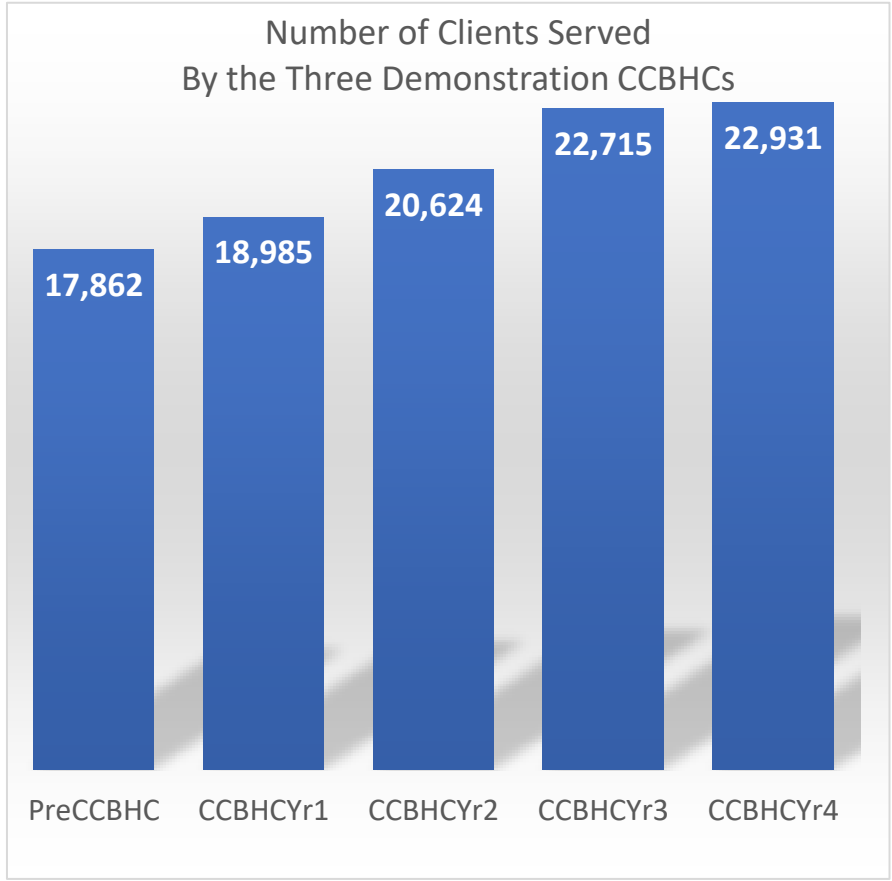
**76.4%** change in adult suicide risk assessment

**75%** percent of adults are seen within seven days following a hospitalization and **93%** are seen within 30 days.

**70.1%** of children are seen within seven days and **92.3%** are seen within 30 days.

**Expanded services to increase availability and access, while adding recovery supports to enhance scope of services**.

- **Added** Care Coordination, Vocational, Housing, Nutrition, and Occupational Therapy
- Numbered served grown **102%**
- Increased number of **Urgent Recovery Centers**
- Established infrastructure for **Mobile Crisis Teams**



# Workforce Expansion and Consumer Impact

Added **981** new jobs to the healthcare workforce sector -an estimated economic impact of **$34,953,525.41** annually.

Reduction of unemployment for persons receiving treatment services resulting in **$31.6M** new wages earned.

# CCBHC

Certified Community Behavioral Health Clinics

Missouri's Impact Report | Year 5

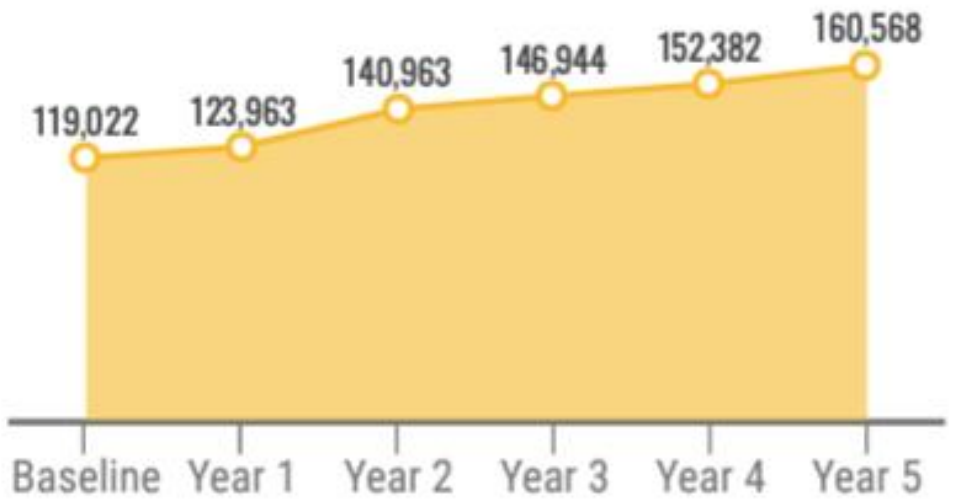
# Improving Outcomes & Access to Care

## 35%

### Increase in patient access to care

Overall increase in patients served from baseline (2017) to Year 5 (2022)

### Missourians Served by CCBHCs




## 3,185

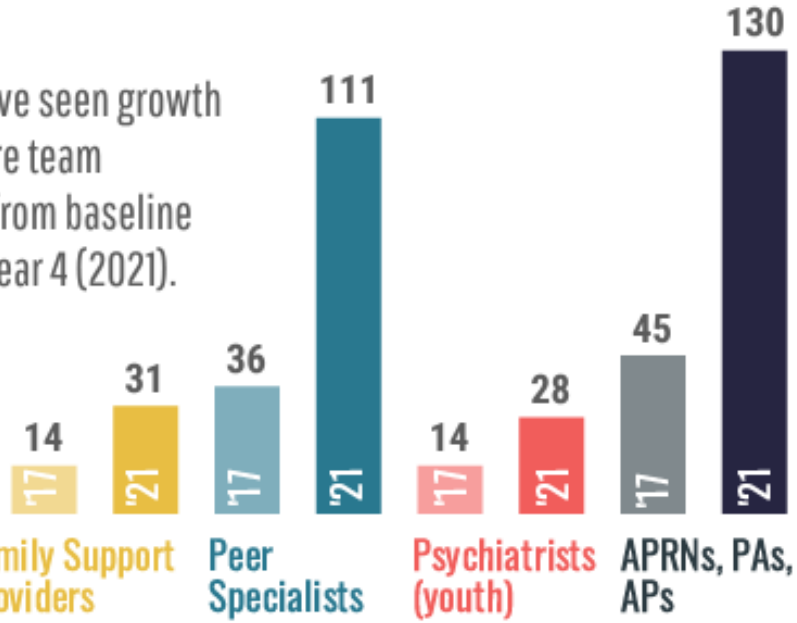
### Veterans & active military served by CCBHCs

**26%** Overall increase in veterans and active military served from baseline to Year 5

# Certified Community Behavioral Health Clinics > Missouri's Impact Report | Year 5

## Workforce Recruitment

CCBHCs have seen growth in their care team positions from baseline (2017) to Year 4 (2021).




## Cost Savings

CCBHC pre and post period hospital costs


Costs per person pre and post


**14%**

Decrease from pre to post period hospital costs totaling

**$15.4 million in savings**

**$483.67** savings per person

# CCBHC Connection to the Justice Sectors



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# Sequential Intercept Model

The federal CCBHC guidelines establish criteria clinics must meet across six domains.

These requirements are the floor upon which states may build the model to meet the state's unique public health needs, including with justice-involved individuals.

| Components of the SIM as outlined by PRA | | The CCBHC Care Delivery Model |
|---|---|---|
| 0 | **Mobile crisis outreach teams and co-responders** | CCBHCs are required to provide crisis response services, including 24-hour mobile crisis response and crisis stabilization services. EDs and local justice agencies are required care coordination partners for CCBHCs. The CCBHC model has supported clinics in engaging in co-responder initiatives (38%), dispatching MH/SU response teams in lieu of law enforcement (19%), establishing crisis drop-off facilities to allow officers to transition an individual more quickly to clinical treatment rather than hospitalization or jail (33%) and working with EDs to divert individuals in crisis to outpatient services where clinically appropriate (79%).[43] |
| | **Emergency department (ED) diversion** | |
| | **Police-friendly crisis services, including deflection services** | |
| 1 | **Dispatcher training** | The CCBHC funding model supports clinics in working with 911 and law enforcement when MH/SU-related calls are made with 72% of CCBHCs provide training to law enforcement or corrections officers in MHFA, CIT or related trainings that support officers in responding to individuals with MH/SU needs. Many CCBHCs (20%) provide officers with tablets to deliver telehealth support when interacting with an individual with a MH/SU need, and 13% partner with 911 to have relevant calls rerouted to a behavioral health response team. CCBHCs are required to develop a crisis plan with each consumer and to have an established protocol specifying their role with law enforcement in the provision of crisis services. |
| | **Specialized police responses** | |
| | **Intervening with high-need persons and providing follow-up post-crisis** | |
| 2 | **Screening, assessments and diagnoses for MH/SU conditions** | Screening, assessment and diagnosis are required core services for CCBHCs. Two-thirds (63%) of CCBHCs increased their efforts to engage with individuals who have justice system involvement or are at risk of being involved with the justice systems,[44] and 83% have targeted outreach to consumers who were previously incarcerated in order to bring them into treatment.[45] Many CCBHCs (34%) have initiated data-sharing activities with law enforcement and/or local jails to support improved collaboration.[46] |
| | **Data initiatives between the justice systems and MH/SU providers** | |
| | **Pretrial diversion to reduce episodes of incarceration with local treatment** | |
| 3 | **Court diversion programs for persons with MH/SU needs, including but not limited to specialty courts** | CCBHCs are required to establish care coordination partnerships with juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts). While 33% of CCBHCs deliver direct services in courts, police offices and other justice-related facilities,[47] 98% of CCBHCs accept referrals from courts,[48] with 76% actively participating in specialty courts.[49] And although Medicaid funding cannot be used to deliver direct services in jails, many CCBHCs are providing jail-based services through grants or other sources of funding. CCBHCs are also required to partner with local Veterans' Affairs facilities to support military members as their care is a component of CCBHCs' required scope of service. |
| | **Jail-based programming and health care services** | |
| | **Collaboration with specialist from the Veterans Health Administration** | |
| 4 | **Transition planning by the jail or in-reach providers** | More than two-thirds (70%) of CCBHCs coordinate with local jails to provide pre-release screening, referrals or other activities to ensure continuity of care upon individuals' reentry to the community from jail. Through their partnerships with jails and prisons, CCBHCs support warm hand-off supports from correctional settings to community-based settings to reduce risks of harms, including overdose, suicide or other adverse events. CCBHCs have staff that can also work to enroll or re-enroll individuals into benefits like Medicaid to ensure their services are covered. |
| | **Medication and prescription access upon release from jail or prison** | |
| | **Warm hand-offs from corrections to providers increases engagement** | |
| 5 | **Specialized community supervision caseloads of people with MH needs** | The extent of CCBHCs' relationships with community supervision has not been fully documented, but at least 5% of CCBHCs include corrections staff such as external probation and parole offers on treatment teams to create a plan to support successful outcomes for individuals with MH/SU needs.[50] CCBHCs must ensure MAT and MH medications are part of individuals' treatment plans where necessary. The majority (89%) of CCBHCs offer direct access to MAT (with the remainder partnering with other organizations to deliver this service), compared with only 56% of SU treatment facilities nationwide.[51] CCBHCs create community partnerships with organizations that provide job training, housing and other needed supports within their communities. |
| | **MAT for people with SUDs** | |
| | **Access to recovery supports, benefits, housing and competitive employment** | |

# Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014

The CCBHC statutory requirements outline specifically which partnerships, through formal contracts or otherwise, are required, including but not limited to "**schools, child welfare agencies, and juvenile and criminal justice agencies and facilities**."


https://aspe.hhs.gov/system/files/pdf/263986/CCBHCImpFind.pdf



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# Justice Partners Defined by SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines “juvenile and criminal justice agencies” to include drug, mental health, veterans, and other specialty courts.

| Proportion of CCBHCs with Justice System Partnerships, as of 2019 | | |
|---|---|---|
| **Care Coordination Partner** | Proportion of CCBHCs with a **Formal** Relationship | Proportion of CCBHCs with an **Informal** Relationship |
| Juvenile justice agencies | 52% | 44% |
| Adult criminal justice agencies/courts | 68% | 29% |
| Mental health/drug courts | 76% | 24% |
| Law enforcement | 53% | 47% |



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# Staffing and Service Expansions with Justice-involved Populations

83% of CCBHCs targeted outreach and engagement efforts to individuals who were previously incarcerated by end of year 2

45% of CCBHCs offered telehealth services in courts, police offices, other criminal justice-related facilities

Proportion of CCBHCs offering:

- Supported employment: 82%
- Supported housing: 79%
- Supported education: 68%

| CCBHC REQUIRED SCOPE OF SERVICES |
| --- |
| **Must be delivered directly by a CCBHC** |
| • Screening, Assessment, Diagnosis |
| • Patient-centered Treatment Planning |
| • Outpatient Mental Health/Substance use Disorder (MH/SUD) |
| • Crisis Services: 24-Hour Mobile Crisis; Crisis Stabilization |
| **Delivered by a CCBHC or a Designated Collaborating Organization (DCO)** |
| • Peer Support |
| • Psychiatric Rehab |
| • Targeted Case Management |
| • Primary Health Screening & Monitoring |
| • Armed Forces & Veteran's Services |

# Partnering with Law Enforcement & Other Criminal Justice Agencies

| Research-based Practices in Justice Collaborations | Percent of CCBHCs |
|---|---|
| Participate in mental health court, drug court, or veterans' court | **76%** |
| Train law enforcement or corrections officers in Mental Health First Aid, CIT, or other mental health/SUD awareness training | **72%** |
| Provide pre-release screening, referrals, or other activities to ensure continuity of care upon re-entry to community from jail | **70%** |
| Increased outreach and/or access to individuals with or at risk of criminal legal system involvement | **63%** |
| Initiated data or information sharing with law enforcement or local jails to support improved collaboration | **34%** |
| Embed a clinician or peer specialist with law enforcement officers responding to mental health/SUD calls | **32%** |
| Provide telehealth support to law enforcement officers responding to mental health/SUD calls | **20%** |

# Making Crisis Services & Supports Available to All

CCBHCs can be **988 Call Centers** in your community

**100%** of CCBHCs offer crisis response services, including hosting (75%) or referring to a behavioral health hotline.

Required crisis activities: 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization

**91%** are engaging in one or more research-based practices in crisis response, including but not limited to:

- Coordinates with hospitals/emergency departments to support diversion from EDs and inpatient
- Behavioral health provider co-responds with police/EMS (e.g., clinician or peer embedded with first responders)
- Operates a crisis drop-in center or similar non-hospital facility for crisis stabilization (e.g., 23-hour observation)
- Mobile behavioral health team responds to relevant 911 calls instead of police/EMS (e.g., CAHOOTS or similar model)
- Partners with 911 to have relevant calls routed to CCBHC



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# The CCBHC Criteria



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# Updated Criteria Areas of Focus

## Crisis Care

- Required coordination with 988 crisis center serving the CCBHC service area
- Updated crisis service requirements to align with SAMHSA's National Guidelines, including coordination with area air traffic control and urgent care/crisis walk-in capacity, aligned mobile crisis response with guidelines

## Responding to Overdose Epidemic

- Must have addiction medicine staffing or consultation
- Placed stronger emphasis on the ability to prescribe buprenorphine and coordinate with OTPs (if not an OTP)
- Added provisions to strengthen ability to address overdose risk
- Included requirement to provide intensive outpatient services for SUD
- Added focus on harm reduction and motivational techniques
- Requires quality improvement plans to address fatal and non-fatal overdoses

## Addressing Health Equity

- Updated training requirements to align with National Cultural and Linguistically Appropriate Services (CLAS) standards
- Included stronger focus on outreach to underserved populations as required activity
- Added including stronger focus on SDOH and community and social supports in comprehensive diagnostic and treatment planning evaluation
- Required that quality improvement plans have an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and that CCBHCs disaggregate data to track and improve outcomes for populations facing health disparities

# What is a DCO? "Designated Collaborating Organization"

| Activities & requirements | Relationship with CCBHC | Advantages to the DCO |
|---|---|---|
| • Augment or fill gaps in CCBHCs' service array<br>• Coordinate care with CCBHC<br>• Provide access to all CCBHC clients (regardless of ability to pay) | • Formal contract = "purchase of services"<br>• DCO reports patient visits to CCBHC; CCBHC bills for visits and pays DCO the agreed-upon rate | • Negotiate favorable (i.e., cost-related) payment with CCBHC<br>• Improved access to full continuum of care for clients and/or families through CCBHC/DCO network |

The cost of contracted (DCO) services is included in the CCBHC prospective payment rate, and DCO encounters are treated as CCBHC encounters for purposes of the prospective payment.



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# Key Changes to General Provisions

- Changes requirement for CCBHCs to directly provide four of the nine CCBHC required services to requirement that *CCBHCs directly deliver the majority (51% or more) of encounters* across the required services (excluding Crisis Services) rather than through Designated Collaborating Organizations (DCOs) (Criteria 4.a).
- *Enhances definition of Designated Collaborating Organization (Appendix A – Terms and Definitions)*. Additional clarity provided on the mechanisms for formal relationships and payment mechanisms with DCOs. Addresses expectations that DCO relationships require more regular, intensive collaboration across organizations than would take place with other types of care coordination partners.
- *Detailed expectations of Needs Assessments (Appendix A – Terms and Definitions).* The CCBHC needs assessment is critical to development of staffing, services and implementation plan. The revised criteria include a detailed list of required elements, inputs and engagements within the needs assessment.



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# Updated Quality Measures

Proposing 5 clinic collected measures and 13 state collected measures - a change from 9 clinic reported measures and 12 state reported measures.

Strengthened the focus on time to services, crisis response, social determinants of health (SDOH), and Medications for Opioid Use Disorder (MOUD).

Will be using updated technical specifications that are now out-of-date for existing CCBHC measures that are retained.

Removing or making optional some of the existing quality measures that have been problematic. This will balance the burden created by new measures.

| **Clinic-Collected Measures (Required)** |
|---|
| Time to Services (I-SERV)* |
| Depression Remission at Six Months (DEP-REM-6) |
| Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) |
| Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD) |
| Screening for Social Drivers of Health (SDOH)* |
| **State-Collected Measures (Required)** |
| Patient Experience of Care Survey |
| Youth/Family Experience of Care Survey |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) |
| Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD) |
| Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH) |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD) |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD) |
| Plan All-Cause Readmissions Rate (PCR-AD) |
| Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH) |
| Antidepressant Medication Management (AMM-BH) |
| Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)* |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)* |

*new or significantly expanded measure

# CCBHC PPS



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# Prospective Payment System (PPS)

Rate is clinic-specific; accounts for varying costs in varying regions; CCBHCs will be required to develop annual cost reports

Payment is the same regardless of intensity or quantity of services received during encounter period (month or day)

Does not prioritize higher-margin services over services that may better fit patient need

No financial incentive to provide lots of units of service when fewer services would be as effective

Does not require that all services be translated into units
(i.e., supports nonbillable activities)

States currently have two options to choose from: PPS-1 vs. PPS-2

# CCBHC Payment Methodology (PPS)

Sustainable, cost-related Medicaid payment rate supports direct services, indirect costs, and non-billable activities critical to client care

CCBHCs continue to receive funding from outside sources (e.g., state general funds, grants, etc.)

Opportunity to leverage federal match for CCBHC services/activities previously funded through general funds

States can customize the payment model for their unique needs and goals



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# PPS Structure and Options (Current)

**Daily rate (PPS-1):** One payment per client for any day in which the client receives at least one service

**Monthly rate (PPS-2):** One payment per client for any month in which the client receives at least 1 service

- Rate may be stratified by population complexity, with higher rates for higher-complexity clients and lower rates for the general population

**Quality Bonus Payments** are optional in PPS-1 and required in PPS-2.

CCBHCs are required to develop annual cost reports.

The cost of DCO services is included in the CCBHC prospective payment rate, and DCO encounters are treated as CCBHC encounters for purposes of the prospective payment.

# FFS and PPS

| FFS | PPS |
|---|---|
| Psychiatrist typically loss leader; difficult to give patients as much access to MDs as needed | Cost-related reimbursement covers full cost of psychiatric services |
| Case management & community support services have better margin; clinics often rely more heavily on these services | Case management & community support may not be billable; costs are included in rate but clinics don't get a payment |
| Service mix often driven by financial constraints | Does not incentivize one service over another; costs for all are covered in rate |
| Billed in units of service | Does not require that services be translated into units |
| Incentive for higher volume of service units | No financial incentive to provide lots of units of service |

# Implication of All-Inclusive Rate Payment

- Operating Expenses:
  - The following variables impact the all-inclusive cost per visit:

    - Salary levels, benefit packages and staffing mix
    - Support staff ratios (direct care versus patient support)
    - Amount of enabling and ancillary services
    - Administrative/overhead infrastructure
    - Provider productivity/clinician capacity

$$\frac{\textbf{\$ 1,600,000}}{\textbf{16,000 visits}} = \textbf{\$ 100.00 per visit}$$

*CCBHCs have flexibility to design their care delivery model as long as it is managed within the PPS rate system!*



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# CCBHC-PPS Proposed Updates

The Centers for Medicare & Medicaid Services is seeking public comment on proposed updates to the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Technical Guidance published as part of the Substance Abuse and Mental Health Services (SAMSHA) CCBHC 2015 Notice of Funding Opportunity.
A summary of the proposed updates include:

- Simplifying the PPS-2 methodology to make special population rates optional,
- Addition of two new PPS rate options (PPS-3, daily; PPS-4, monthly) which includes a Special Crisis Service rate component,
- Updating the quality bonus payment measure-set and providing clarification and examples regarding flexibilities for quality bonus payments,
- Updating specific sections of the existing CCBHC PPS Guidance to bring it up-to-date, and provide additional flexibilities as allowable under the Demonstration, and
- Establishing a standard 3-year cadence for states to rebase clinic-specific PPS rates.



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# CCBHC Efforts in States



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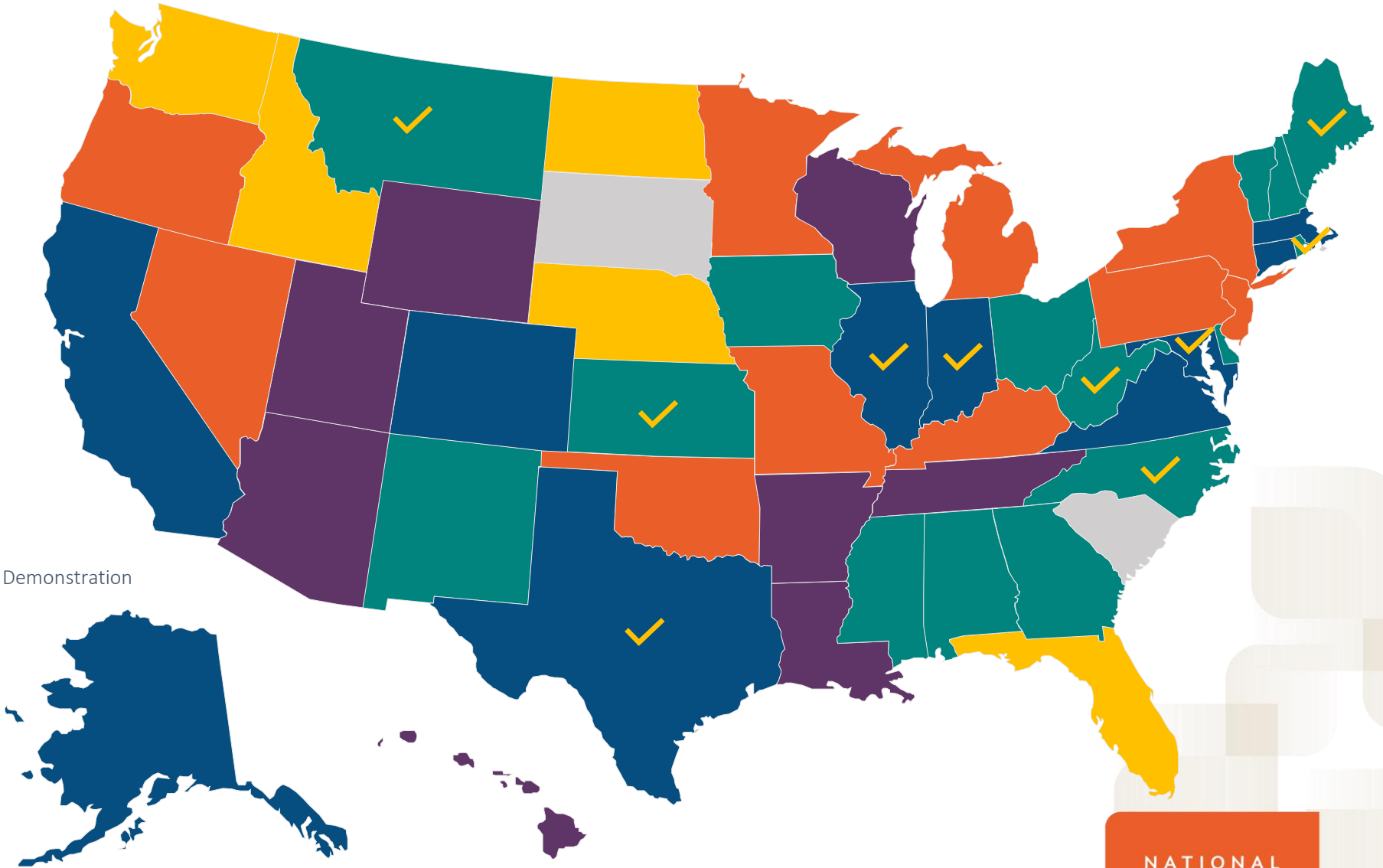
# Federal & State Actions Across the Country



- Established the CCBHC Model through Medicaid Demonstration
- CCBHC Planning Grant (2016)
- CCBHC Planning Grant (2023)
- No CCBHC Actions
- State Legislation to Pursue the CCBHC Model
- CCBHC Clinic-level SAMHSA Grant
- ✓ CCBHC State Legislation or Appropriations

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# Questions?

CCBHC SUCCESS CENTER

# MOUNT ROGERS COMMUNITY SERVICES
# NEW RIVER VALLEY COMMUNITY SERVICES
# RICHMOND BEHAVIORAL HEALTH AUTHORITY

## Certified Community Behavioral Health Centers

Mount Rogers COMMUNITY SERVICES

NRVCS NEW RIVER VALLEY COMMUNITY SERVICES

RBHA RICHMOND BEHAVIORAL HEALTH AUTHORITY

## Aggregate NOMS Data Summary


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**September 2023**

SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS
VIRGINIA TECH

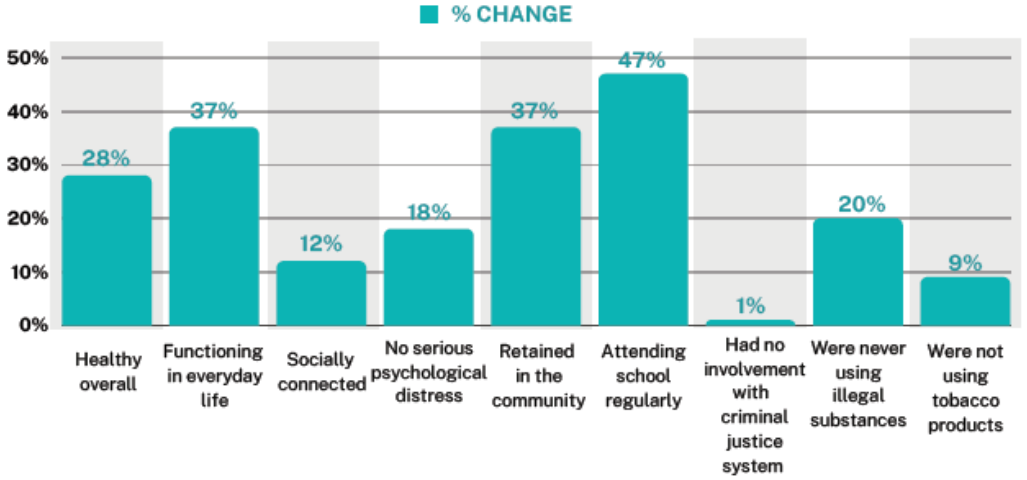
INSTITUTE FOR POLICY AND GOVERNANCE

# MRCS, NRVCS & RBHA CCBHC NATIONAL OUTCOME MEASURES (NOM) AGGREGATE DATA SUMMARY

## WHAT'S HAPPENED IN THE WORLD OF NOMS?

**3** CCBHC SITES COLLECTED **10,201** NOMS FORMS FROM **4,174** INDIVIDUALS

## OUTCOME IMPROVEMENT FOR ADULTS




*The percent increase or decrease in the number of consumers who were positive at the 6 month reassessment interview compared to baseline.

**TOTAL N= 535**

### REPORTING BY SITE (N=)

| 150 | 180 | 205 |
|---|---|---|
| NRVCS | MRCS | RBHA |
| FFY2019-FFY2022 | FFY2021-FFY2022 | FFY2020-FFY2022 |

# Improving the Court and Community Response to those with Mental Illness:
# Sequential Intercept Model Intercepts 2-3

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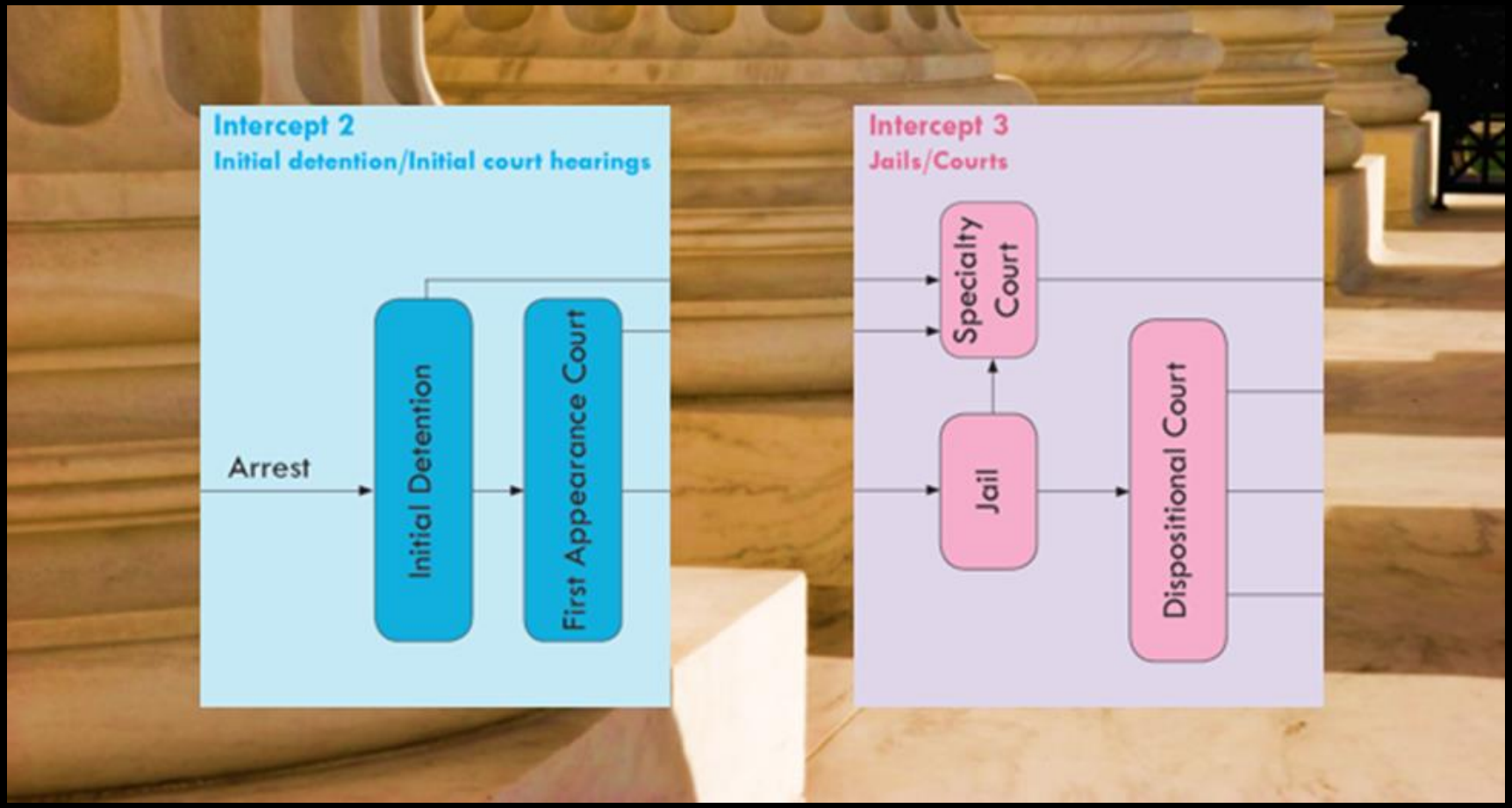
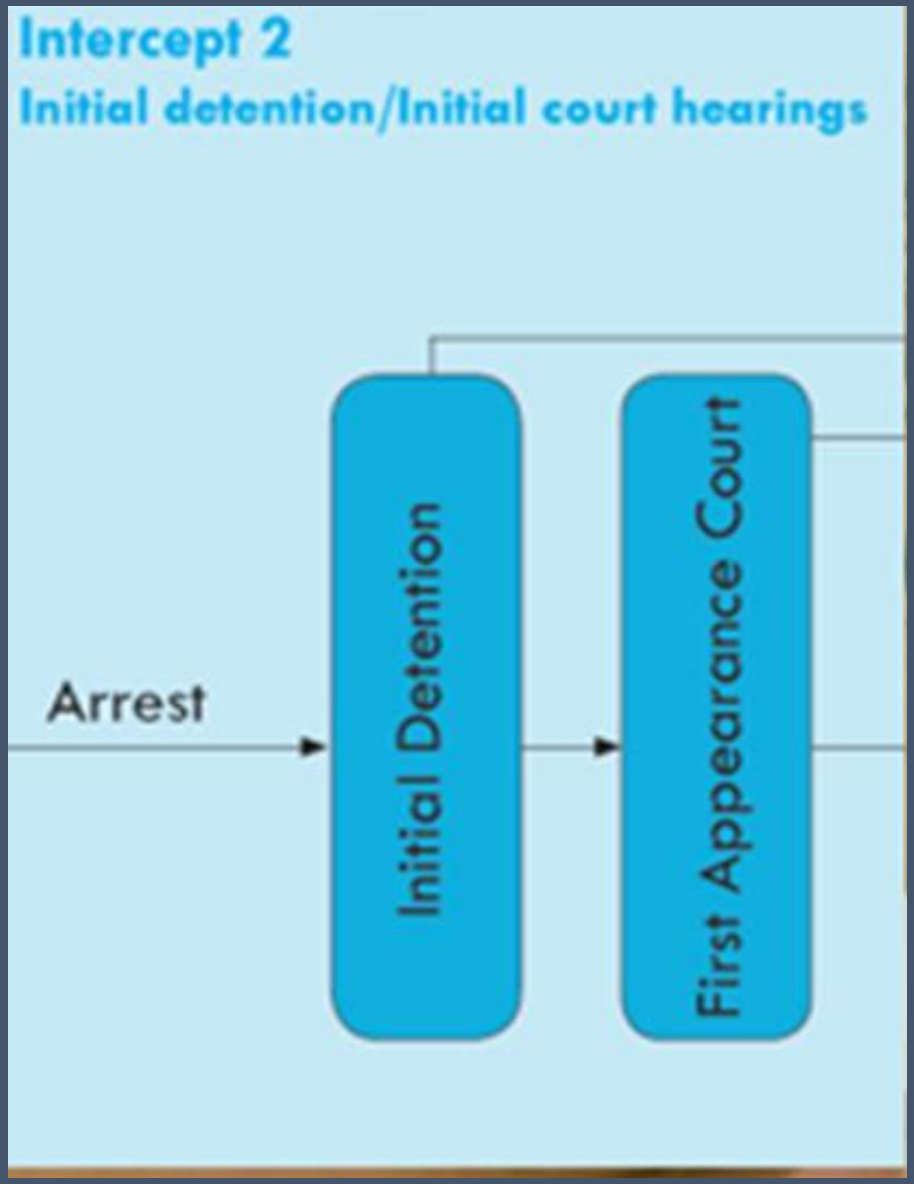
UNIVERSITY OF MICHIGAN

# Intercepts 2 and 3




Intercept 2
Initial detention/Initial court hearings
Arrest
Initial Detention
First Appearance Court

# Intercept 2

# Intercept 3

## Jails/Courts

Specialty Courts?

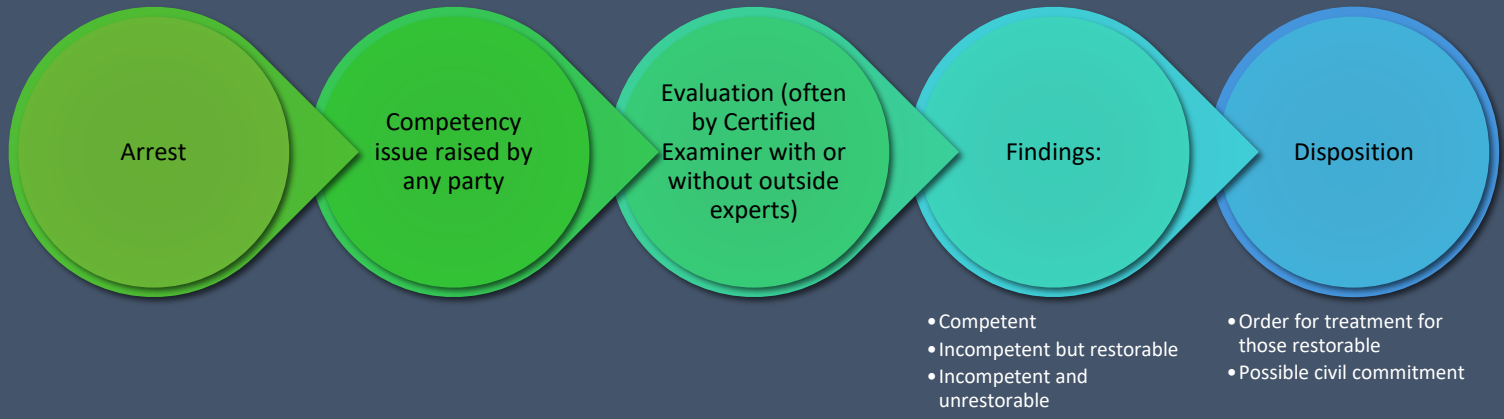
Other Court Programs?

Jail-Based:

**Diversion?**

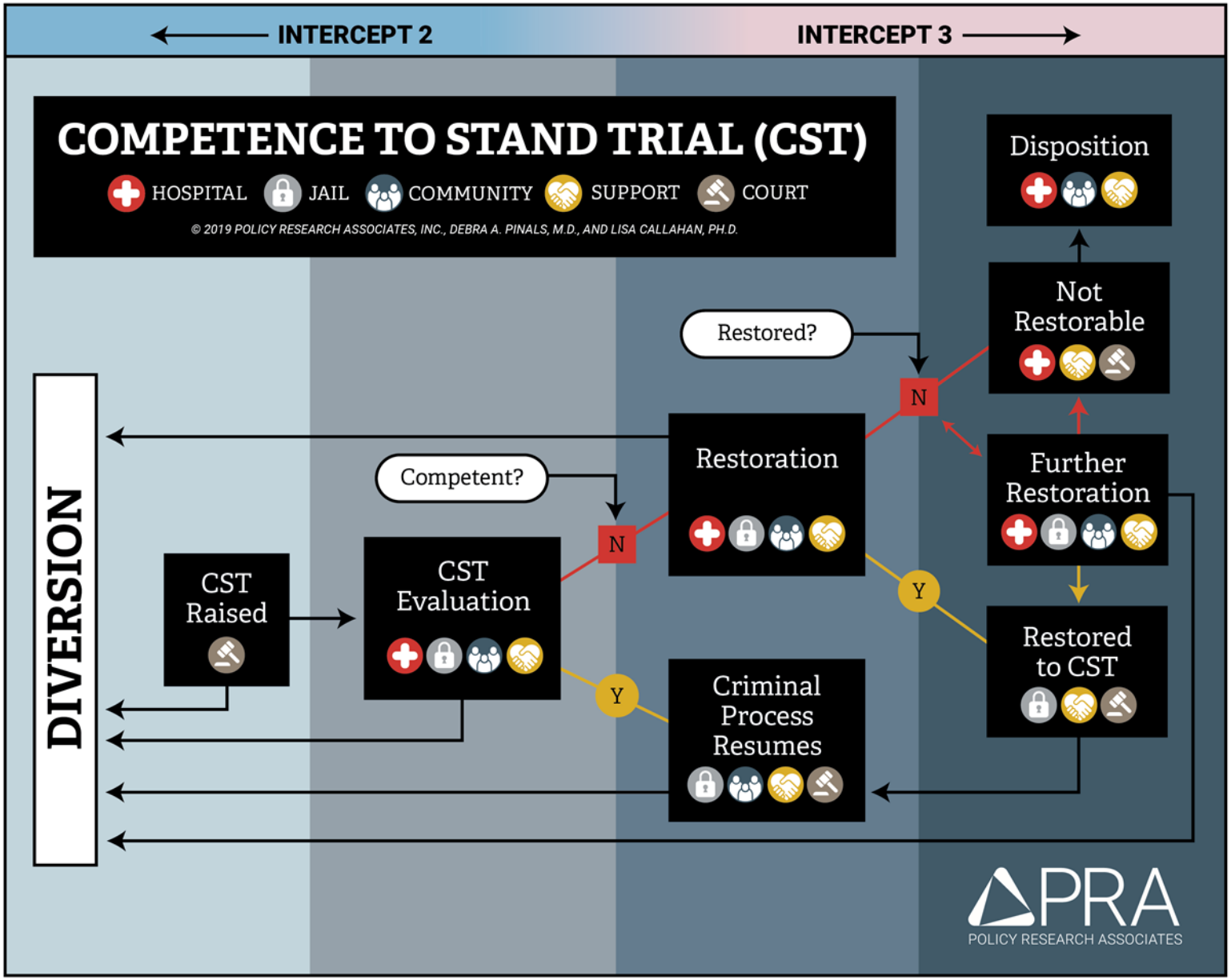
**Mental Health & Substance Use Services?**

# Competency Process



# Clinical Issues Among Forensic Patients

- Mental Health
- Substance Use Disorders
- Intellectual and Developmental Disabilities
- Medical Conditions
- Often have trauma histories
- May have complex personality issues- but not all do


INTERCEPT 2
INTERCEPT 3
COMPETENCE TO STAND TRIAL (CST)
HOSPITAL
JAIL
COMMUNITY
SUPPORT
COURT
© 2019 POLICY RESEARCH ASSOCIATES, INC., DEBRA A. PINALS, M.D., AND LISA CALLAHAN, PH.D.
DIVERSION
CST Raised
Competent?
CST Evaluation
N
Y
Restoration
Restored?
N
Y
Criminal Process Resumes
Not Restorable
Further Restoration
Restored to CST
Disposition
PRA
POLICY RESEARCH ASSOCIATES

# Specialty Court Services: Goals and National Outcomes

Reduced arrest rates

Reduced days incarcerated

Improvements in recovery from illness and substance use conditions

Improved linkages to services

# Historical Perspective

| Type | Year Started | Current Estimated # |
|---|---|---|
| Drug Courts | 1989 | 2700 |
| Mental Health Courts | 1997 | 350 |
| Veterans Treatment Courts | 2008 | 200 |


Sources: NADCP 2014; Steadman et al. 2014

# Conclusions: Examining the Intercepts

Duration of Intercept may be brief but offers significant opportunities

Intercept interventions can take many shapes and sizes

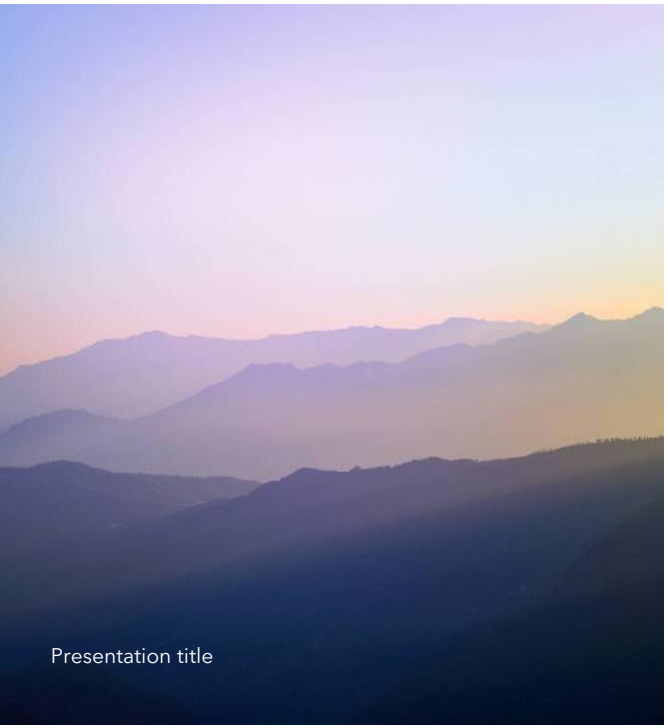
# Thank you!

# Pre Trial Diversion

Jacqueline F. Ward Talevi


The way to get started is to quit talking and begin doing.
Walt Disney

# Pre Trial Release

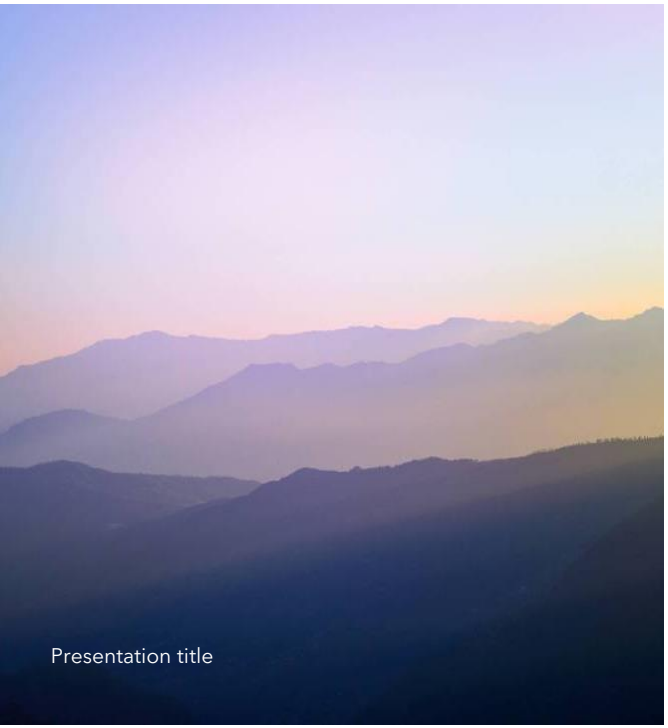



Virginia Code Section 19.2-120 provides the accused shall be admitted to bail unless probable cause to believe accused will not appear for trial/hearing or is a danger to self/others or the public

Specific factors the judicial officer should consider enumerated in Code

Release on an unsecured or secured bond or promise to appear

# Pre Trial Diversion

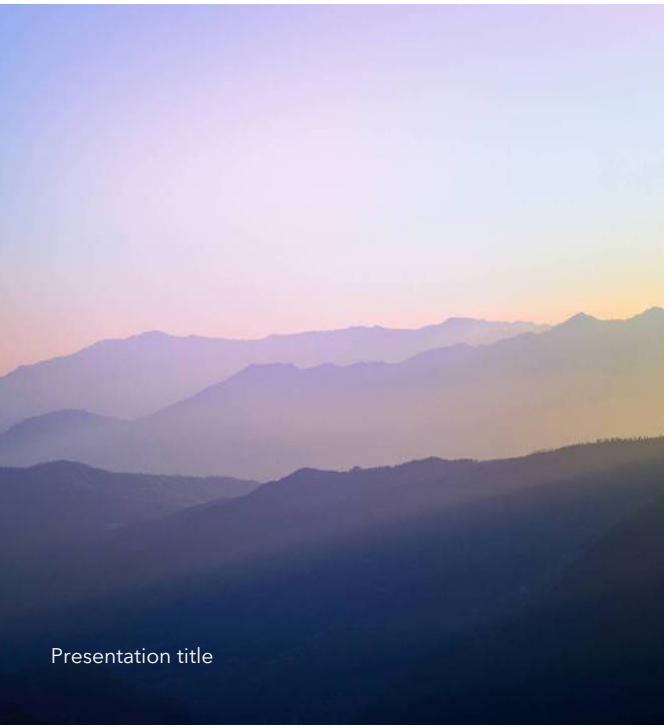



Diversion is different

No express statutory authority; however, may be implied from 19.2-120- terms of bail: "will be reasonably fixed to ensure the appearance of the accused and to ensure his good behavior pending trial. "

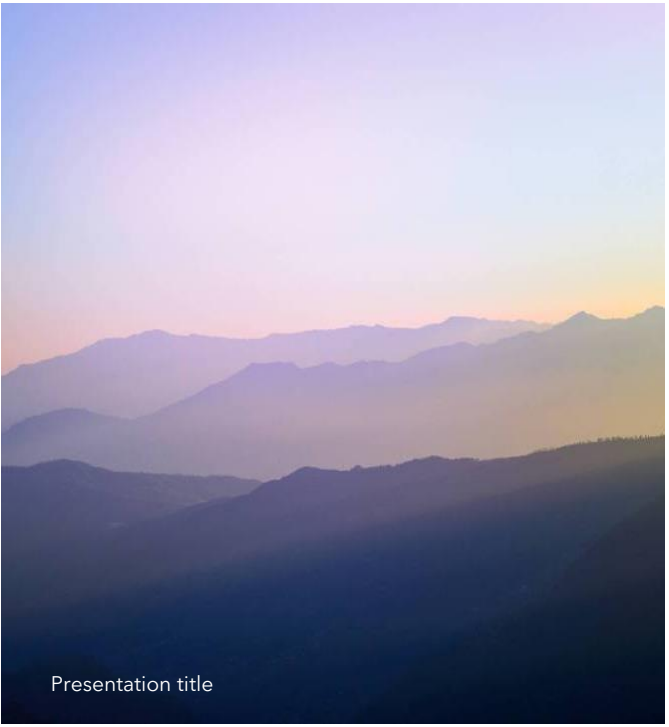
Authority may be implied from 19.2-123: "Impose any other condition deemed reasonably necessary to assure appearance as required, and to assure his good behavior pending trial"

# Pre Trial Diversion-Intercept II




- Grant from DBHD
- Program began in May 2023-"Intercept II"
- Blue Ridge Behavioral Health-CSB
- Goal-divert SMI identified defendants immediately after arraignment to community based mental health treatment
- Offenses-low level misdemeanor
- Immediate accountability through pretrial probation supervision

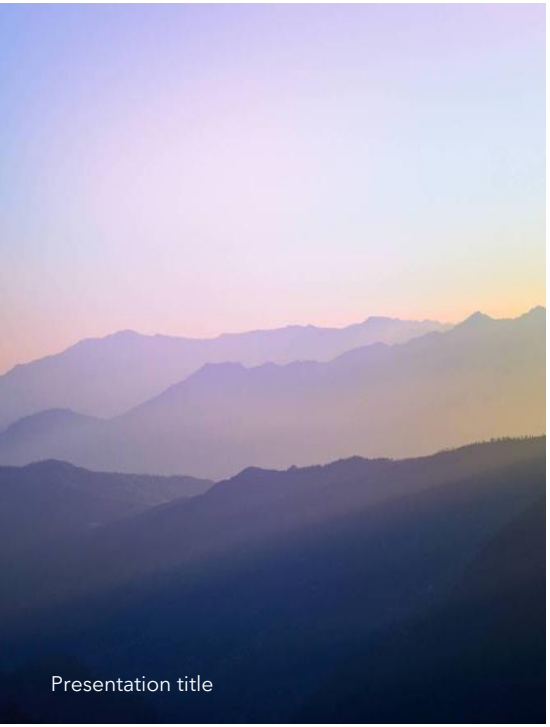
# Pre Trial Diversion-Roanoke City




Target population:

1. Adults
2. Charged with low level misdemeanor offenses
3. Identified by jail personnel using the BJMH screen as mentally ill
4. Limited to Roanoke City jail
5. Limited to Roanoke City General District Court initially; expanded to include Roanoke City J&DR in July 2023

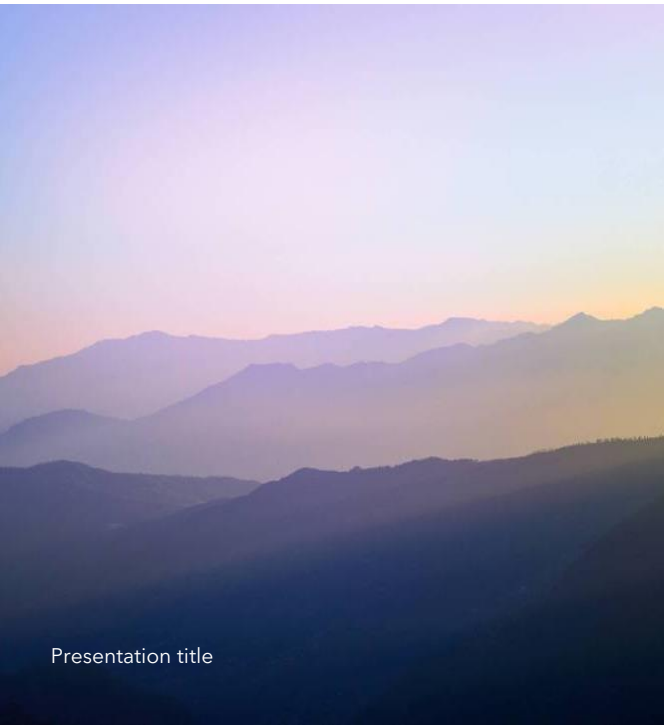
# Pre Trial Diversion-Roanoke City




How the process works:

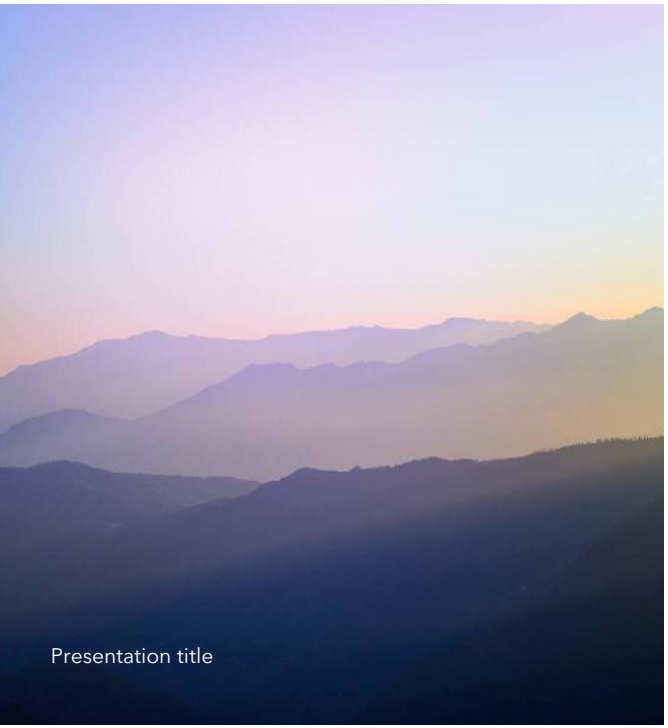
1. Jail notifies clinician by email of potential referral
2. Clinician interviews accused as soon as possible typically within 12 hours of notification
3. Clinician confirms accused past mental health treatment
4. Voluntary participation
5. Clinician prepares a report for the judge before the accused is arraigned

# Pre Trial Diversion-Roanoke City




6. Court shall appoint counsel if appropriate
7. Court shall set case for trial
8. Court may release accused on pretrial supervision per 19.2-123 with Intercept II mental health discharge plan as a condition of pre trial probation
9. Accused released from jail on an unsecured bond

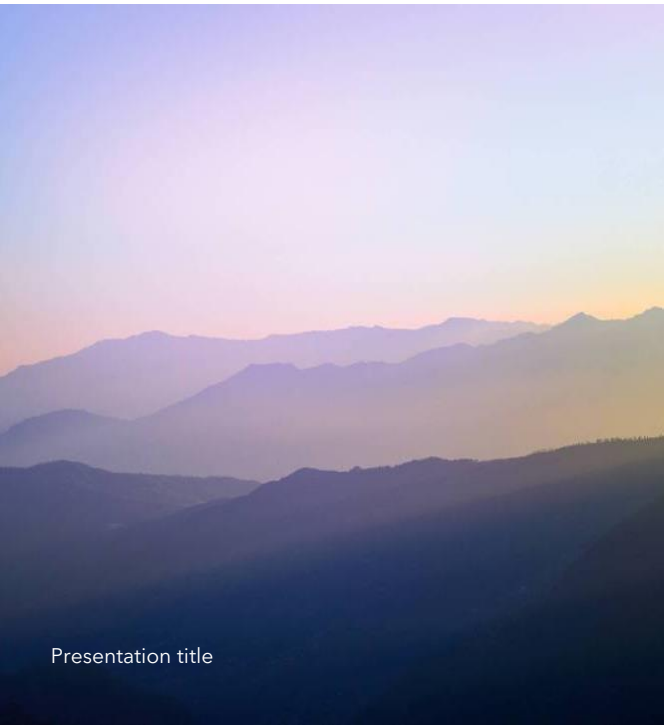
# Pre Trial Diversion-Roanoke City The Clinician's Report




1. The report contains the name, address, sex, etc. of the accused
2. Mental illness diagnosis and treatment, last hospitalization, treatment providers, last medication prescribed, etc.
3. Substance use disorder, if applicable, and treatment recommendations
4. Discharge plan: home address, family in the area, employment, etc

Clinician should try to confirm all information contained in the report prior to the arraignment

# Pre Trial Diversion-Roanoke City  Non compliance




Accused fails to follow through with diversion/discharge plan:

1.  The mental health clinician notifies pretrial officer of the noncompliance

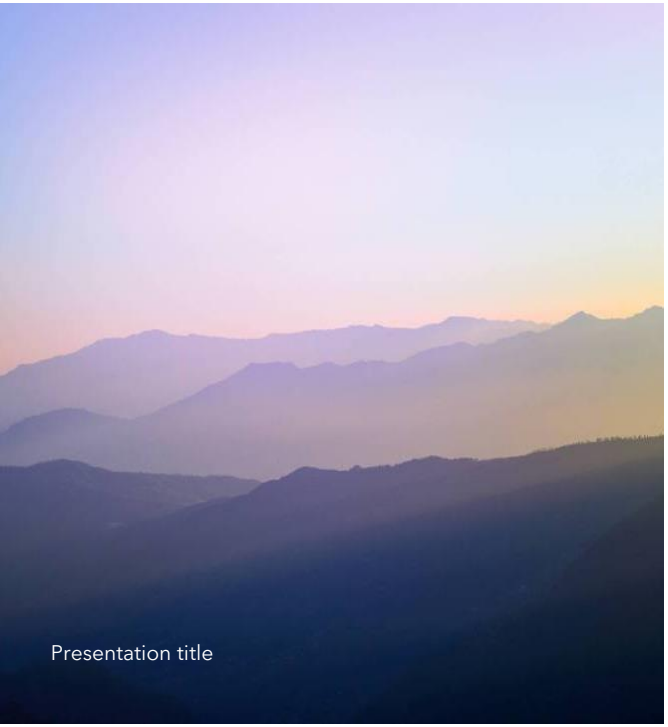
2. Pretrial officer notifies court by letter

3. Court issues a rule to show cause or a capias under Va. Code Section 18.2-456 (5) or violation of conditions of pretrial release/bond under Va. Code Section 19.2-123

4. Court conducts an arraignment on the capias

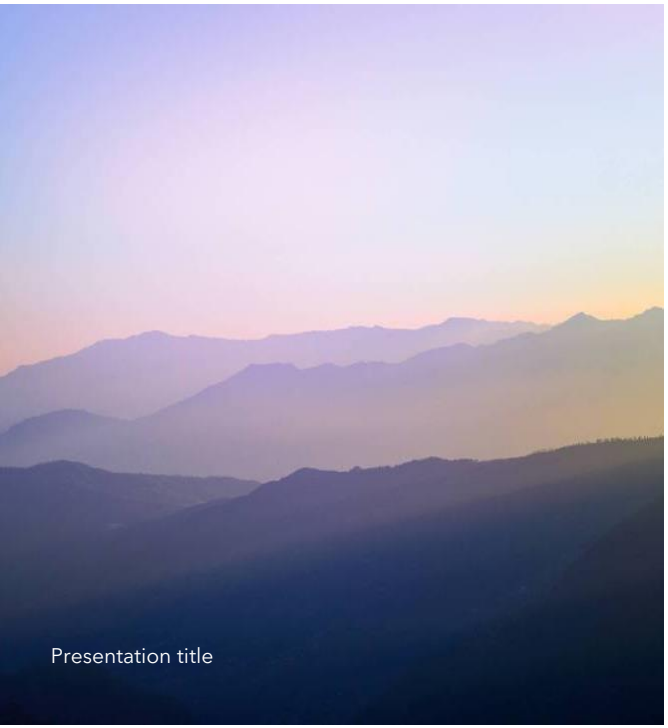
5. Accused may be remanded to custody and removed from the program or permitted to remain in the program with different conditions

# Pre Trial Diversion-Roanoke City Program Strengths



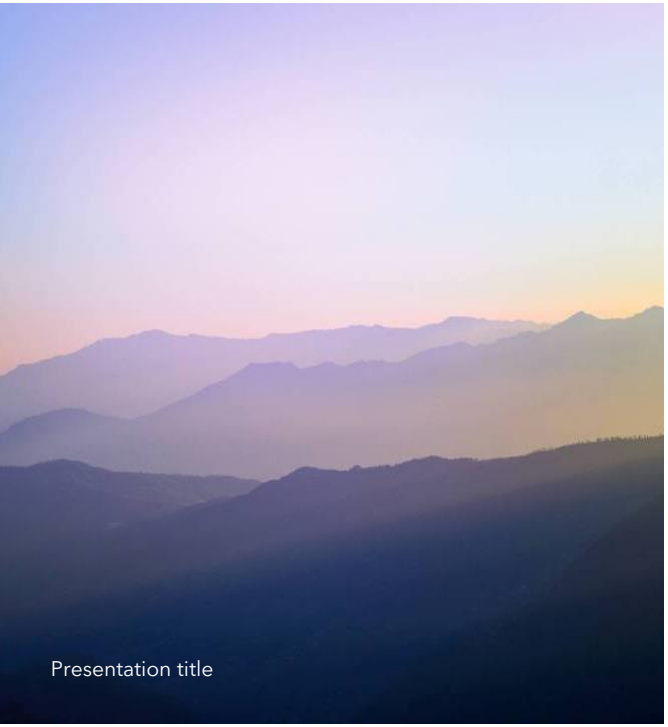

1. Early identification of SMI individuals
2. Improved communication between jail and BRBH
3. Clinician accesses BRBH database to obtain information regarding previous diagnosis and treatment, previous hospitalizations, etc. prior to interviewing the accused
4. Clinician can confirm availability of housing and family support prior arraignment

# Pre Trial Diversion-Roanoke City Program Strengths



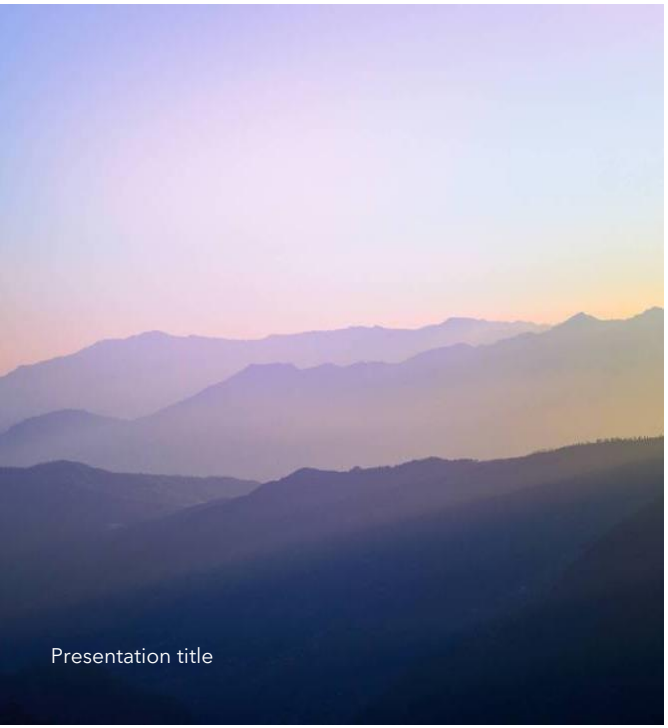

5. Clinician provides written report containing **confirmed** information regarding prior mental health diagnosis and treatment to judge prior to arraignment
6. Clinician provides the court with a confirmed mental health treatment discharge plan
7. Clinician may remain in the courtroom during arraignment to answer judge's questions
8. CA present in the courtroom and may participate

# Pre Trial Diversion-Roanoke City Strengths and Benefits



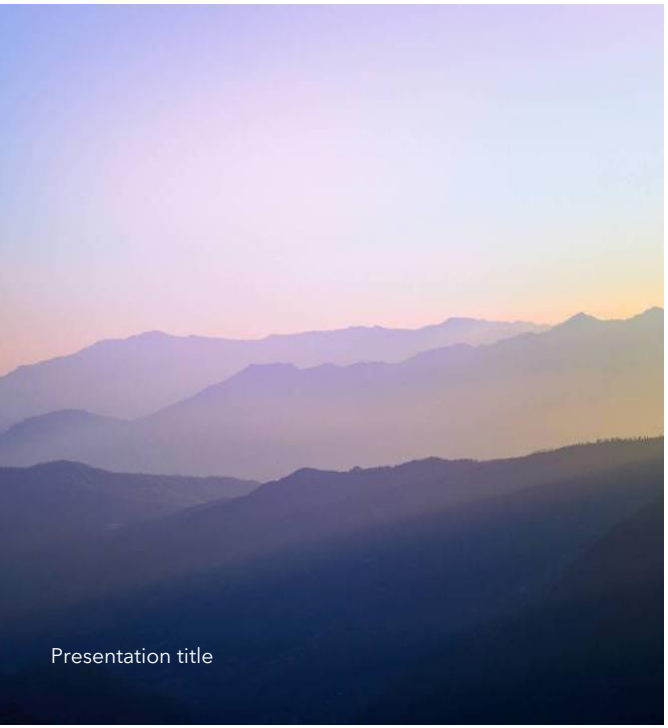

9. Accused connected to treatment early
10. Accused released from jail early
11. At trial, accused's compliance with diversion/discharge plan may influence CA's decision to prosecute the underlying charge
12. If prosecuted, accused may be referred to behavioral health docket for continued treatment and supervision in lieu of active jail sentence to serve

# Pre Trial Diversion-Roanoke City Barriers




1. Jail staff issues:  Education; Investment; Unfamiliarity with program; Unmotivated
2. Uncooperative accused due to intoxication or mental health symptoms
3. Judges hesitation to set unsecured bond prior to the attorney scheduling a bond motion

# Pre Trial Diversion-Roanoke City Program Numbers




**General District Court** May-August 2023

Identified by jail: 45

Agreed to participate: 28

Released to Intercept II Discharge plan: 28

Compliance with Intercept II Discharge Plan: 4

Non compliance with Intercept II Discharge Plan: 24

**J & DR Court** July-August 2023

7 participants identified

# Thank you

Presentation title

# City of Richmond GDC Behavioral Health Docket

# Roadmap

1. Meet the Team
2. Mission Statement
3. Eligibility
4. Docket Phases
5. Graduation & Alumni Recognitio

30

# OUT OF OFFICE: Virginia Specialty Docket Conf. 2023

# 1 Meet the Team

1. Judge
2. Prosecution Attorney
3. Defense Attorney
4. Assessment Clinician
5. Treatment Clinician /Case Worker
6. Probation Officer
7. Peer Recovery Support Specialist
8. Docket Coordinator

# MISSION STATEMENT

The General District Court Behavioral Health Docket is a specialized criminal court docket that calls on collaboration between the City of Richmond Department of Justice Services (DJS), Richmond Behavioral Health Authority (RBHA), Office of the Commonwealth's Attorney (CA), Office of the Public Defender (PD) and other defense counsel, and Substance Abuse Advocacy and Addiction Recovery Alliance of Virginia (SAARA). The mission of the BHD is to serve its participants through an interdisciplinary team collaboration to (1) increase connections to mental health and substance use disorder treatment; (2) empower self-management of mental health recovery; and (3) reduce recidivism while enhancing and personal and public safety.

# 3 Referrals & Eligibility

- **Referrals. You want them. From whom?**
  - **jail deputies, lawyers, police officers, pre-trial, mental health providers, and other judges.**
- **How do you get the referral sources to send referrals?**
  - **Relationships**
  - **Educate your bar and peer judges**
  - **Make the referral process clear and easy to understand.**
  - **Invite your referral sources to graduations and alumni receptions.**

# 3 Eligibility

- **Initial Referrals go to BHD Prosecutor for a review of charge & conduct and criminal history**
- **CST not an issue**
- **Mental Health Assessment – must yield medium / high needs**
- **Criminogenic Assessment – must yield medium/high needs**
- **Candidate wants to do it (voluntary)**

# 4 Docket Phases

- Length: 6-8 months
- Intake
- Phase 1: Orientation
- Phase 2: Stabilization
- Phase 3: Community Re-integration
- Phase 4: Maintenance
- Graduation

# 5 Graduation & Alumni Reception

“Theater of Graduation”

# 5 BHD Graduation

**To the Judges – how to prepare for the big day:**

- **Read the warrant(s) and what observations were made by the arresting LEO and magistrate at time of arrest**
- **Read the clinical assessment**
- **Read the staff meeting notes**
- **In court, create proximity!**

**To the Team:**

- **Celebrate!**
- **Remember the audience members!**

# 5 Alumni Celebration

https://richmond.com/news/state-regional/government-politics/hugs-roses-and-smiles-as-behavioral-health-docket-grads-celebrate/article_c3d46af6-5efd-11ee-8a0b-ef8b9b62aec7.html

**GOALS**

- **Community**
- **Network**
- **Exposure**

# Thank you ☺

**Judge Mansi Shah**

**mshah@vacourts.gov**

# ARLINGTON COUNTY GENERAL DISTRICT COURT BEHAVIORAL HEALTH DOCKET

# MISSION STATEMENT

- The mission of the Arlington County Behavioral Health Docket ("BHD") is to apply evidence-based tools through a multidisciplinary approach in order to successfully reintegrate justice-involved seriously mentally ill ("SMI")/Dual diagnosis ("DD") and developmentally disabled ("DD") individuals back into the community and in so doing, to enhance public safety.

# ELIGIBILITY

- Individuals 18 years of age or older
- Diagnosed with a SMI/DD/DD
- Misdemeanor charges
- Felony offense with concurrence of the Commonwealth's Attorney
- Assessed at medium to high risk of recidivism per the Risk Needs Responsivity (RNR) Simulator Tool or MOST/OST. Individuals who do not meet medium to high risk of recidivism and dosage level will be considered for participation in the docket on a case-by-case basis dependent upon the severity of the charges, recent onset of symptoms and any historical information available.
- Arlington resident or Arlington homeless (those who are considered Arlington residents and/or on the path to becoming an Arlington resident, i.e., street homeless in Arlington for 90 days)

# REFERRAL SOURCES

- General District Court judges
- Defense Attorney
- Commonwealth’s Attorney
- Magistrate
- Pretrial Officer
- Jail Mental Health Team
- Law Enforcement
- Forensic Jail Diversion Team
- Mental Health Case Manager
- Community Members

# Referral process

- If an individual through counsel or upon inquiry of the court is interested in participating in the BHD, the court will order the individual to be screened to determine eligibility to participate in the BHD
- The potential BHD participant will be screened for eligibility by the BHD Mental Health Clinician or the BHD Case Manager. The Office of the Commonwealth's Attorney will be alerted to the new referral and provide a summary of the facts of the pending charges, information regarding any pending charges in other jurisdictions and outstanding warrants. The appropriate risk assessment will be conducted by the Pretrial Officer or the Community Corrections Unit (CCU) Probation Officer.
- If the individual is eligible to participate in the BHD and consents to participate, then the individual and counsel review the applicable Agreement to Participate form

# TWO TRACKS

- PRE-PLEA
- An individual enters the Pre-Plea track without entering a plea. Participants entering the BHD pre-plea will sign the Agreement to Participate setting forth the rights being waived. The intended purpose of the Agreement to Participate is to permit the participant to petition for an expungement if otherwise eligible. These participants are supervised by the Sheriff's Pre-release BHD officer, who is part of the docket team
- POST-PLEA
- Participants enter the Post-Plea track after a plea of guilty or nolo contendere, upon a stipulation of facts sufficient for a finding of guilt, upon a plea of not guilty and a proffer of facts by the Commonwealth's Attorney, a trial and a finding of guilt, or upon a finding that the individual is in violation of the terms of probation. Participants entering the BHD post-plea/post-disposition will sign the Agreement to Participate which sets forth the rights being waived. These participants are supervised by the Community Corrections unit who are part of the docket team

# BHD TEAM MEMBERS

- Docket coordinator
- Mental health clinician
- Pretrial/CCU representatives
- Commonwealth’s Attorney
- Public Defender
- Case managers
- Housing
- Certified peer support
- Co-occurring Specialist
- Recreation therapist

# PHASES

- Phase I Orientation: the participant learns about the supervision and requirements of the docket including the role of the BHD team. The participant begins participation in structured activities, in his/her treatment plan, meets with the BHD Mental Health Clinician and BHD Case Manager, begins attending meetings with the Pretrial or CCU Probation Officer, and attends court weekly. (Minimum 90 days)
- Phase II Stability: meetings with treatment team generally every 2 weeks and continues to comply with the requirements of the individualized treatment plan. The participant continues to attend specialized programming, meets with the appropriate Pretrial Officer or CCU Probation Officer, attends all structured activities, provides urine screens, attends scheduled court hearings, attends all mental health treatment appointments, remains medication compliant and remains law abiding. Court appearances every 2 weeks. (Approximately 90 days)
- Phase III Maintenance and Community Reintegration: the participant demonstrates continued stability and progress towards treatment goals. The participant attends court every 3 weeks, attends treatment, Pretrial or CCU Probation meetings, remains medication compliant, attends all structured activities, remains compliant with all aspects of the treatment plan and remains law abiding. (Approximately 90 days)
- Phase IV Transition, Successful Completion and Graduation: the participant is demonstrating sufficient personal and clinical improvement since entry into the BHD and is preparing for transition and graduation. (Approximately 90 days)
- Post-graduation follow-up

# THE “ARLINGTON WAY”

- The path to create docket
  - Began approximately 11 years before its launch
  - Mental Health Criminal Justice Advisory Committee
    - DHS CSB CA PD Judges Police Sheriff Probation Community
    - Years working through SIM to address needs of SMI-justice involved
    - Next step was creation of a BHD
- Collaborative effort
  - Stakeholder engagement in creating framework
  - CA and PD at the table along with DHS Court and CCU
- Launch derailed
  - Community input
  - Pre-plea vs. post-plea

# SUCCESSES

- TOTAL PARTICIPANTS-36
- GRADUATES-8
- VOLUNTARY WITHDRAWALS-5
- TERMINATION-8
- RECIDIVISM
  - REARRESTED WITH IN 1 YEAR-1
  - REARRESTED WHILE IN THE PROGRAM-6






# Adult Correctional Services

Dr. Kevin Cuffee

CITY OF VIRGINIA BEACH
Human Services

# Philosophy

The philosophy of the Adult Correctional Services program includes the belief that individuals who have behavioral health needs and enter the legal system should have access to services that improve their wellbeing and prepare them for recovery. The goal is to improve the quality of life for individuals with forensic involvement by enhancing access to services, increasing life skills, fostering community stability and preventing recidivism.

# Specialized Forensic Services

| Not Guilty by Reason of Insanity (NGRI) | Restoration to Competency | Jail Diversion |
|---|---|---|
| ACS staff collaborate with court and state hospital staff to develop a conditional release plan that provides treatment and support services to promote a successful transition back into the community. | ACS clinicians provide restoration to competency services on an outpatient basis for individuals who have been charged with a crime and found by a court to be Incompetent to Stand Trial (IST) due to a mental illness or intellectual disability. | Collaboration between ACS, ES, and PD to ensure individuals with a serious mental illness are not charged, incarcerated and later admitted to a state facility under an Emergency Treatment Order (ETO), when local mental health treatment would have been appropriate. |

# Specialized Jail Programs

| Jail Educational Services | Re-Entry Program | Forensic Discharge Planning | Jail & Re-Entry Services Coordination Pathway |
|---|---|---|---|
| Curriculum-based education designed to reduce the incidence and prevalence of substance abuse, and co-occurring related problems for offenders. | A specialized block in the jail for inmates who are serving a sentence of six months or less.<br><br>This program prepares individuals for release into the community by working on life skills, vocational abilities, budgeting and money management, and housing opportunities. | Discharge planning to include linking, coordinating and monitoring services for inmates diagnosed with a serious mental illness or co-occurring disorder. | Provides services for diversion, screening, education, and discharge planning to individuals diagnosed with behavioral health conditions incarcerated at the Virginia Beach Correctional Center (VBCC). |

# Jail Educational Services

Overview

- The program consists of four phases:  Phase I Awareness, Phase II Change of Mind, Phase III Restitution, and Phase IV Reintegration.
- Utilizes curriculum-based education designed to reduce the incidence and prevalence of substance abuse and co-occurring related problems.
- Revive Training
- Reentry planning
- Referral/linkage to community resources

Goals

- To improve the quality of life for offenders who experience substance use and co-occurring problems through the provision of education services
- To contribute to the reduction of recidivism
- To foster commitment to drug free, violence free and crime free lifestyle

# Re-Entry Program

Overview

- This Re-entry program is a specialized block in the jail for inmates who are serving a sentence of 6 months or less in the Virginia Beach Correctional Center.
- Aids with training and education to include outside providers such as the Step-up program, Opportunity INC, Wells Fargo, Probation & Parole, and Recovery for Life.
- Reentry planning
- Referral/linkage to community resources

Goals

- To prepare individuals for release into the community by working on life skills, vocational abilities, budgeting and money management, and housing opportunities.
- To contribute to the reduction of recidivism

# Not Guilty By Reason of Insanity

Overview

- The NGRI program provides services to individuals with a mental illness, substance use disorder, or co-occurring disorder who have been adjudicated NGRI in a Court of Law. ACS staff collaborates with court and state hospital staff to develop a conditional release plan that provides treatment and support services to promote a successful transition back into the community.

Goals

- To link, coordinate and monitor services for individuals who have been found Not Guilty by Reason of Insanity
- To assist adult clients to live independently in the community
- To minimize hospitalization/institutionalization
- To provide quality services to meet the needs of the community and Court

# Restoration To Competency

Overview

- ACS clinicians provide restoration to competency services on an outpatient basis for individuals who have been charged with a crime and found by a court to be Incompetent to Stand Trial (IST) due to a mental illness or intellectual disability.

Goals

- To provide education and training services to Virginia Beach residents and individuals who are homeless in Virginia Beach with the goal of assisting the individual with attaining adjudicative competence.

# Forensic & Discharge Planning Services

Overview

- The service provides hospital discharge planning and forensic discharge planning to inmates diagnosed with a serious mental illness or co-occurring disorder.

Goals

- To monitor the inmates with serious mental illness incarcerated in Virginia Beach Correctional Center and those who have been transferred to state hospitals
- To link, coordinate and monitor services
- Promote adherence to treatment
- To reduce recidivism
- To effectively liaison with family members, Correctional Medical Services, Attorneys and community resources

# United States Correctional Services Dilemma

Overrepresentation of Individuals with Mental Health Disorders

- There is a disproportionately high number of individuals with mental health disorders within the U.S. correctional system. Many individuals with mental illnesses end up in jails and prisons due to a lack of adequate mental health services in the community, leading to criminalization of their conditions.

Inadequate Mental Health Services

- Many correctional facilities lack the resources, staff, and expertise to provide adequate mental health care to inmates. This results in untreated or under-treated mental illnesses, which can exacerbate the challenges of managing incarcerated individuals and may lead to deteriorating mental health.

Recidivism

- The lack of effective mental health treatment in correctional facilities can contribute to a cycle of recidivism. Individuals with untreated mental illnesses may struggle to reintegrate into society upon release, increasing their likelihood of reoffending and returning to incarceration.

# United States Correctional Services Dilemma

- The United States, local jails, and correctional facilities admits individuals with a serious mental illness an average of 2 million times per year.

- Virginia Beach experienced similar circumstances with an average of 1,630 inmates incarcerated, of which 26.5% are prescribed medications for mental health conditions.

# Timeline

- 2014: Joint meetings with DHS and VBSO were initiated to evaluate behavioral health service needs and brainstorm solutions.
- 2015 – 2018: Adult Correctional Services tripled the number of individuals served in the jail without additional resources.
- Feb. 2018: A White Paper was completed that addressed the Virginia Beach Forensic Response.
- Nov. 2018: A Criminal Justice Service Expansion Executive Summary was completed as a tool to communicate with legislators.
- 2019: The Virginia State Budget Bill, HB1700, appropriated $916,066 in FY20 for the new Jail and Re-entry Services Coordination Pathway.
- Nov. 1, 2019: The program went live

# Virginia Beach DHS and VBSO Partnership

- A Collaboration to serve individuals with mental illness for arrest and/or incarceration in the City of Virginia Beach.
- Utilizes a comprehensive approach that addresses prevention, diversion and support across the entirety of an individual's incarceration.
- Increases linkage between DHS, VBCC and VBCC Medical Staff in an effort to reduce recidivism and increase access of appropriate care.


# Jail &Re-Entry Services Coordination Pathway

Overview

- The Jail & Re-Entry Services Coordination Program aims to sustain behavioral health and wellness, as well as to nurture the skills and abilities needed for successful return to the community. The Program does this by providing services for diversion, screening, education, and discharge planning to all individuals diagnosed with behavioral health conditions incarcerated at the Virginia Beach Correctional Center (VBCC).

Goals

- To use a collaborative, comprehensive approach that will focus on prevention and continuity of care for individuals with behavioral health conditions.
- Prevent incarceration
- Reduce recidivism
- Promote healthy, crime-free lifestyles

# Jail and Re-Entry Services Coordination
## Initial Screening

- Clinicians complete mental health screenings on all inmates upon entry unless they decline.

- Clinicians  advocate for diversionary psychiatric intervention (i.e., recommend local inpatient treatment at arraignment when possible).

- Clinicians notify Jail Medical Provider, Watch Commander and Classifications of high risk individuals who have urgent psychiatric treatment needs.

# Jail and Re-Entry Services Coordination
# Treatment

- Clinicians conduct face to face sessions to monitor mental status and changing needs.
- Clinicians complete Risk/Needs Assessment for housing recommendations.
- Clinicians assist with obtaining personal identification documents.
- Forensic Peer Specialists will initiate MH/SU Peer Service.
- Collaboration with DHS, VBCC and VBCC Medical Provider leads to discuss new admissions, emergent needs, and upcoming re-entry plan.

# Jail and Re-Entry Services Coordination Community Transition

- Clinicians will provide direct linkage from the jail to community providers and services.
- Clinicians will facilitate referrals to meet essential needs (e.g. housing, food, medication, etc.).
- Clinicians will connect to a same day access intake appointment.
- Peers will conduct peer face-to-face contact within 5 business days of release.

# Outcomes

- In FY2022 the Jail and Re-Entry Services Coordination Pathway program conducted 1,680 screenings. Of those screened:
  - 1,060 inmates met criteria for behavioral health services
    - 253 inmates actively enrolled in services
    - 166 inmates were on the waitlist for services
    - 143 inmates successfully discharged from services post release
    - 186 inmates were released prior to completing the behavioral health admission intake
    - 312 inmates met criteria, but refused behavioral health services

- **Total Enrolled in FY2022**: 332 inmates (79 were screened in the prior FY)

# New Initiatives

Jail MAT

- Reducing Recidivism: MAT programs in jails provide individuals struggling with substance use disorders (SUDs) access to evidence-based treatments, such as methadone, buprenorphine, or naltrexone. These medications can help stabilize cravings and withdrawal symptoms, making it less likely that individuals will return to substance abuse upon release. Consequently, this can reduce the likelihood of reoffending and re-incarceration.

- Improving Public Safety: By addressing SUDs through MAT, individuals are more likely to engage in rehabilitation and recovery efforts. This reduces the risk of engaging in criminal activities to support their substance dependencies, thus enhancing public safety.

- Healthcare Continuity: Many individuals with SUDs enter jail with existing opioid dependencies. MAT programs ensure that they continue to receive appropriate medical care, minimizing disruptions in their treatment. Consistency in healthcare can be crucial for recovery.

Opioid Abatement

Integrate two additional two Licensed/Licensed eligible clinicians in the jail to enhance addiction services and equip inmates for successful re-entry into the community. The specialized clinicians will enhance jail treatment options by providing:

- Evidence-based addiction groups
- Individual clinical counseling sessions
- Adjunct MAT clinical counseling (enhance the existing MAT medication offering)

# Questions?

CITY OF VIRGINIA BEACH
Human Services

**Judge Fiore's Memorandum**

***A Process Governing Sentencings and Alleged Violations of Suspended Sentence Conditions to Address Behavioral Health Conditions for Appropriate Cases "Mental Health Action Process - MHAP"***

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***Effective August 1, 2022***

To address certain needs in the criminal justice system, Arlington previously established a diversion process to reduce unnecessary court involvement in cases of those experiencing a mental health crisis, to support those who need behavioral health services, and to promote fairness throughout the criminal justice system by identifying a collaborative court-community response to behavioral health needs. This effort includes sharing identified data and information spanning local SIM intercepts to examine community services and crisis response, law enforcement training and deflection, court diversion programs, and improved access to health care and needed services during a probationer's reentry to the community. In association with charges of criminal behavior, someone experiencing a mental health crisis may thereby be able to avoid a criminal conviction. The foregoing encompasses Arlington County's current diversion process.

For matters not appropriate for diversion and which result in a conviction, it is important to consider the implementation of procedures to identify the extent to which behavioral health impacted a current criminal conviction or probation violation, not necessarily in relation to intent, but to address an underlying impact on behavior. The process described in this memorandum is intended to improve the judge's decisional process for imposition of sentences and terms of probation for non-violent criminal offenders who, with proper counseling or mental health treatment and a concrete plan, will reasonably be expected to avoid future criminal behavior, successfully complete probation, and achieve rehabilitation while paying their debt to society for the crime committed. An underlying behavioral health issue may at times drive behavior that could result in a probation violation.

MHAP is intended, at the time of sentencing or a probation violation hearing, to provide a process for mental health assessments, identification of community-based services and development of special conditions of probation to address behavioral health issues that may reasonably be expected to interfere with probation compliance.

The purpose of MHAP is to determine whether the Court should consider special conditions of probation to foster a greater probability of success by addressing an underlying mental health condition.

1. Case Identification. Initially, the following processes will apply to certain case types, with future consideration for readjustment. The Court may order the implementation of these procedures to apply to each defendant who is before the Court with at least one drug possession charge, or such case as Probation may bring to the Court's attention or the court may otherwise determine ("identified defendant"). Probation may implement these procedures where appropriate. The Court may also consider entering an order prior to any

recommendation by Probation to implement these procedures in particular cases. In any given case, the Court may enter an order requiring an identified defendant's compliance with the procedures contained herein.

2. Application of Resources to Identify Behavioral Health Needs Based on Voluntary Collaboration. For each case where there was determination that these procedures should be implemented, the following shall occur:
    a. A Probation officer will review the case indictment, statement of material facts submitted by the Commonwealth's Attorney, the presentence investigation report in the underlying criminal case, and such other information applicable to the identified defendant necessary to meet the intended purpose of this procedure.
    b. Probation will contact the Behavioral Health Division of the Arlington Department of Human Services (BHD) to refer the identified defendant for assessment as part of the presentence investigation or under the Probation Officer's authority pursuant to the Court's ordered terms of probation. If identified defendant does not cooperate with the assessment, the matter shall be reported to the Court.
    c. BHD will apply an appropriate psycho-social assessment to the cooperating identified defendant to determine any underlying mental health condition for treatment, notwithstanding any denial of such condition by the identified defendant. The plan at this stage will expressly include the behavioral health diagnosis and the treatment appropriate to that diagnosis.
    d. If an underlying mental health condition is not identified, Probation will be informed, and Probation will report that result to the Court.
    e. If an underlying mental health condition is identified, Probation and BHD will meet to consider needed treatment and whether obstacles exist that could impair community-based mental health treatment.
    f. After such meeting, BHD will then complete the ASAM assessment of the identified defendant to determine whether substance abuse treatment is also needed and the necessary level of care.
    g. Probation and BHD will again confer regarding the ASAM assessment results.
    h. If, during the collaboration between Probation and BHD, unresolvable obstacles to community-based mental health treatment are identified, a mental health plan will not be developed for the Court at that time. Instead, Probation will address the obstacles and issues at the next court hearing, including proceeding with such other referrals as the Court may order.
    i. If any obstacles can be resolved prior to the next court hearing or obstacles do not exist, a plan will be developed for community-based services for mental health treatment and for substance abuse treatment, if needed, based on the ASAM results.
    j. Separately, if BHD determines the identified defendant suffers from impaired capacity, this circumstance will be addressed by Probation and BHD.

3. Identification of Community-Based Services. Following ascertainment of the identified defendant's mental health needs, Probation should recommend resources and opportunities in the identified defendant's jurisdiction to meet the needs. The compilation of community-based resources created by chambers staff should be considered.

    In the event an identified defendant is actively abusing a substance at a level sufficient to impair the mental health treatment plan (before or after the Court orders a recommended

plan as a special condition of probation), a substance abuse treatment plan should be developed on a parallel track. At this stage of plan development, an identified defendant may still be required by Probation or otherwise ordered by the Court to comply with substance abuse treatment that was not incorporated by Probation and BHD. If the substance abuse is at a severe level, Probation and BHD may decide that the substance abuse plan could take priority, and a mental health treatment plan could be adapted by the clinician, and later reimplemented in its original or revised state as the primary plan after the severe substance use has been addressed. In either of the foregoing events, Probation shall provide updates to the Court.

4. Preparation of Formalized Plan. Probation and BHD will prepare for submission to the Court a written mental health treatment plan to include all findings and detailed recommendations, with a copy to all counsel of record. Probation will also request a meeting with the identified defendant and his/her counsel to occur prior to submission of the plan to the Court. After the meeting, Probation and BHD may consider revisions to the plan prior to submission to the Court.

5. Submission to the Court for Consideration. No sooner than the Monday prior to the next court hearing when the Court considers the plan, Probation will submit the plan to the Court by filing it under seal (to provide such privacy protection as required by law) with the Clerk of the Court and by providing a courtesy copy to the judges' chambers. A copy will also be provided to the Commonwealth's Attorney (to be held confidentially, unless otherwise ordered by the Court) and identified defendant's counsel.

6. Court Proceeding. In addition to the customary and permissible issues the Court may be asked to address, the Court will determine whether the plan, either as presented or a revised version thereof, should be ordered as a special condition of probation, and whether and by when a review hearing should be set.

   At the hearing, in addition to the foregoing, the Court may inquire to the effect:

   Would punishment weigh more heavily on the offender than on others subject to the applicable sentencing guidelines who were not suffering from the same mental health diagnosis?

   Could it be reasonably concluded that incarceration would exacerbate an existing mental health condition, thus leading to a greater chance of recidivism than if community-based treatment were ordered?

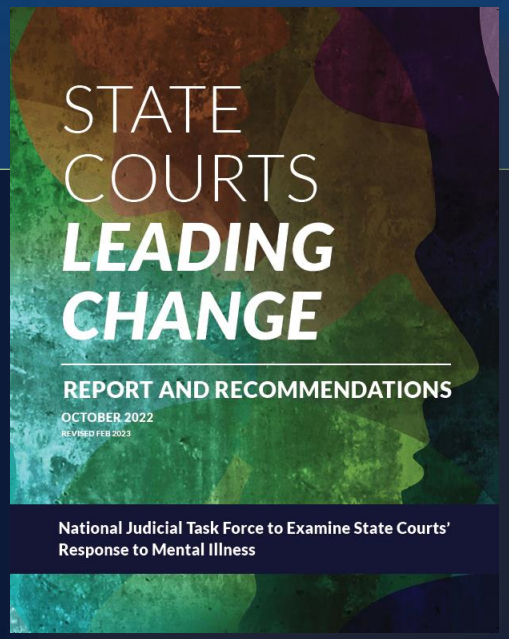
7. Review Hearings. The Court will consider setting a review hearing 2 months later (more or less) when ordering the mental health plan special conditions of probation to review the probationer's compliance. Positive reinforcement for compliance has beneficial impact. If, at any time after the Court may have ordered a health treatment plan as a special condition of probation, Probation learns that the plan should be revised, a request for a hearing should be submitted to the Court with a copy to the Commonwealth and defense counsel of record. Consistent with long established jurisprudence, either party may petition the Court to address any of the foregoing.

# State Courts Leading Change: National Judicial Task Force to Examine State Courts' Response to Mental Illness

## Report and Recommendations

October 2022

(Revised February 2023)




**Paul DeLosh**

Director of Judicial Services | Office of the Executive Secretary, Supreme Court of Virginia

**Michelle O'Brien**

Principal Court Management Consultant | National Center for State Courts

# Task Force Members

**Task Force Co-Chairs**

Chief Justice Paul L. Reiber (VT) and Chief Administrative Judge Lawrence K. Marks (NY)

## Criminal Justice Work Group

**Co-Chairs:**

Chief Justice
Richard Robinson (CT)

Nancy Cozine (OR)

**Members:**

Hon. Paula Carey (MA)
Terrance Cheung (DC)
Jerry Clayton (MI)
Hon. Matthew D'Emic (NY)
Tim DeWeese (KS)
Travis Finck (ND)
Sim Gill (UT)
Dr. Debra Pinals (MI)
Dr. Kenneth Rogers (SC)
Hon. John Stegner (ID)
Walter Thompson (FL)
Hon. Nan Waller (OR)

## Civil, Probate and Family Work Group

**Co-Chairs:**

Chief Justice
Robert Brutinel (AZ)

Tonnya K. Kohn (SC)

**Members:**

Kent Batty (AZ)
Rachel Bingham (KY)
Hon. Theresa Dellick (OH)
Judith Harris (MD)
Joseph Homlar (CO)
Hon. Milton Mack (MI)
Hon. Kathleen Quigley (AZ)
Neira Siaperas (UT)
Hon. Sheldon Spotted Elk (CO)
Dr. Linda Teplin (IL)
Dr. Sarah Vinson (GA)

## Education and Partnerships Work Group

**Co-Chairs:**

Chief Justice
Loretta H. Rush (IN)

Marcia M. Meis (IL)

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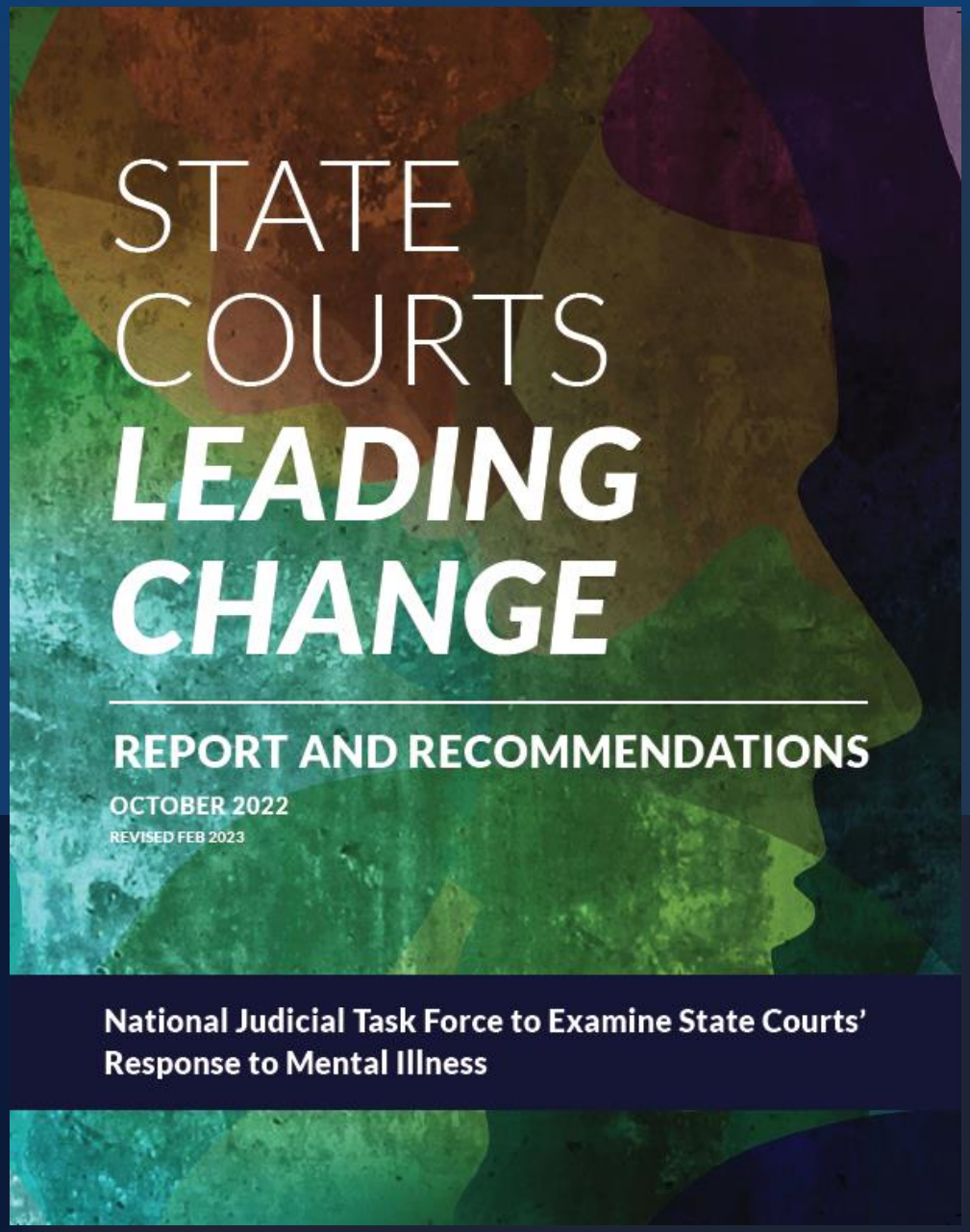
Hon. James Bianco (CA)
Janice Calvi-Ruimerman (CT)
Dr. Michael Champion (HI)
Paul DeLosh (VA)
Russell Deyo (NJ)
Sonja Gaines (TX)
Hon. Christopher Goff (IN)
Hon. Steve Leifman (FL)
Dr. Kenneth Minkoff (AZ)
Gary Raney (ID)
Hon. Kathryn Zenoff (IL)

# State Courts Leading Change: National Judicial Task Force to Examine State Courts' Response to Mental Illness

**Report and Recommendations**
October 2022
(Revised February 2023)



# Leadership Support

## Conference of Chief Justices

"The Conferences of Chief Justices and State Court Administrators are deeply indebted to the Task Force members for their tireless effort, extraordinary contributions, and commitment to improving the responses of state courts and communities to individuals with serious mental illnesses. The members have each contributed their own special expertise and experience to the examination of our collective systems, the development of recommendations and resources, and provided leadership and guidance for the important work that is now underway."

Chief Justice Loretta A. Rush, President
Conference of Chief Justices

## Conference of State Court Administrators

"The Task Force has been one of the most significant national efforts I've seen undertaken by the Conferences, recommending the systemic changes needed in our courts and communities. Mental illness touches all of our families; oftentimes with tragic consequences."

Karl Hade, President, Conference of State Court Administrators and Executive Secretary, Supreme Court of Virginia

# Resolution 1:

# In Support of the Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness

**CONFERENCE OF CHIEF JUSTICES**
**CONFERENCE OF STATE COURT ADMINISTRATORS**

**RESOLUTION 1**

**In Support of the Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness**

WHEREAS, the Conference of Chief Justices (CCJ) and the Conference of State Court Administrators (COSCA) established the National Judicial Task Force to Examine State Courts' Response to Mental Illness (Task Force) to "assist state courts in their efforts to more effectively respond to the needs of court-involved individuals with serious mental illness"; and

WHEREAS, multiple Resolutions adopted by CCJ and COSCA over the last twenty years have recognized that mental illness is a far-reaching problem and have identified the enormous impacts that it has on all aspects of the judicial system; and

WHEREAS, many courts have implemented successful programs, improved court practices and procedures, and initiated significant reform, but there is still a need and responsibility for all state and local courts to lead and promote systemic change in the ways that courts and communities respond to individuals with serious mental illness; and

WHEREAS, the Task Force has benefitted greatly in its work from a strong collaboration with Substance Abuse and Mental Health Services Administration (SAMHSA) leadership and Regional Administrators and building upon this collaboration with SAMHSA and with other federal agencies will be critical in addressing the needs of justice-involved individuals with serious mental illness or substance use disorder; and

WHEREAS, members of CCJ and COSCA are uniquely positioned to assume a leadership role to address the impacts of serious mental illness on the court system in every state and territory; and

WHEREAS, the Task Force has comprehensively examined all aspects of the impacts of serious mental illness on state courts and now offers its findings and recommendations; and

NOW, THEREFORE, BE IT RESOLVED, that CCJ and COSCA support the Findings and Recommendations of the Task Force and urge each member of the Conferences to take the following action in his or her state or territory to improve the state courts' response to mental illness:

- LEAD. Create and support a state-level, inter-branch mental health task force and encourage and support local judges and courts in the creation of local or regional mental health task forces. Consider the appointment of a behavioral health director/administrator and a team within the Administrative Office of the Courts to develop and implement improved court responses for court-involved individuals with serious mental illness;

- EXAMINE. Utilizing the recommended models and best practice and policy recommendations of the Task Force undertake an assessment of the court system including state laws, court rules, policies, practices, and procedures across all case types involving individuals with serious mental illness. Recommend and encourage judges to exercise their "power to convene" and support courts and communities in the use of the Leading Change Guides and Sequential Intercept Model to map resources, opportunities, and gaps, and develop plans to improve court and community responses to serious mental illness;

- EDUCATE. Provide and support opportunities for the education and training of judges and court professionals on all aspects of serious mental illness and effective court responses. Distribute and make available the tools, resources, and recommendations developed by the Task Force to all state and local judges and court professionals; and

- ADVOCATE. Support state efforts to utilize a public health model rather than a criminal justice approach to guide behavioral health policies, practices, and funding, including efforts to, when appropriate, deflect or divert cases involving individuals with mental illness from the court system and into treatment. Advocate for funding and resources needed to implement a continuum of diversion programs, treatment, and related services to improve public safety as a more humane and cost-effective approach.

BE IT FURTHER RESOLVED, that CCJ and COSCA renew their commitment to work closely with SAMHSA and other federal agencies to increase the capacity of state courts to respond to the needs of justice-involved individuals with serious mental illness or substance use disorder; and

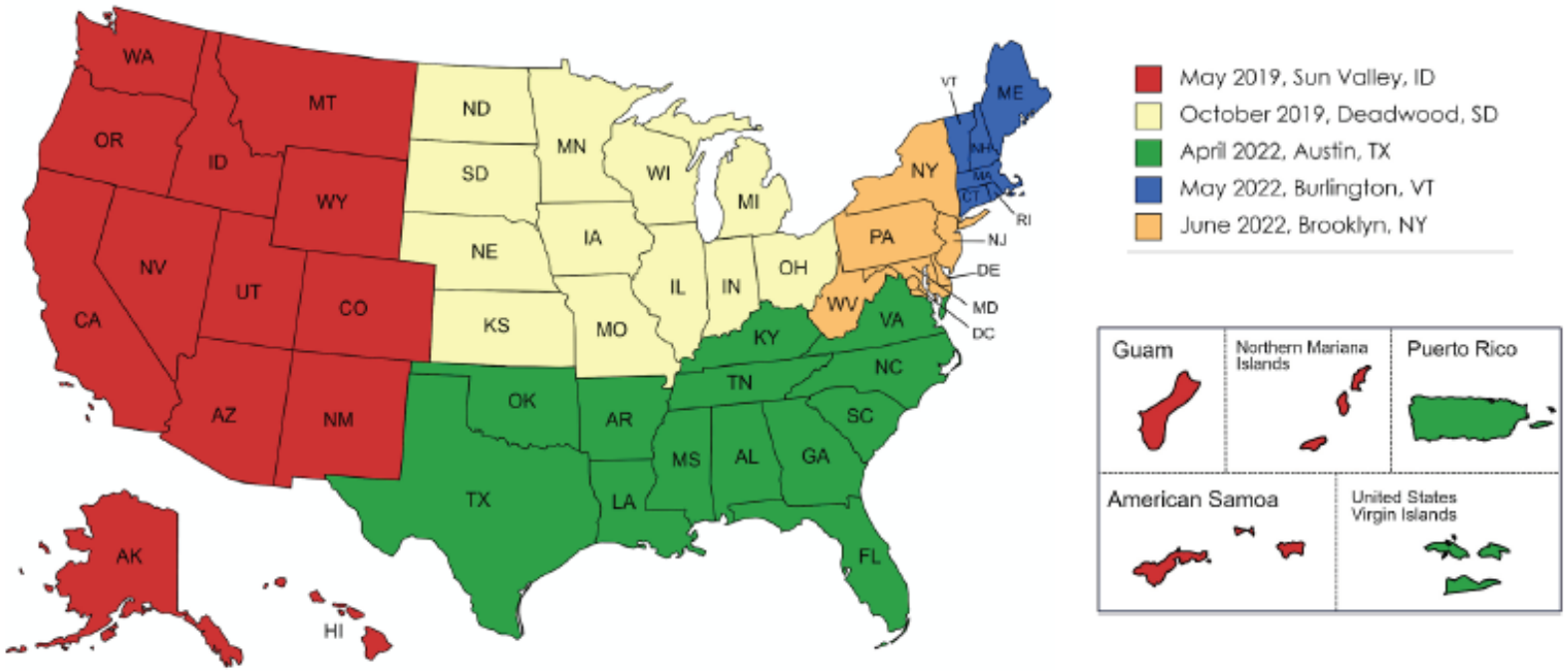
BE IT FURTHER RESOLVED, that following the termination of the Task Force, CCJ and COSCA support future efforts, with the leadership of the CCJ/COSCA Behavioral Health Committee and supported by the National Center for State Courts, to implement the recommendations of the Task Force, develop performance measures for state courts and communities, and monitor and report progress and success.

Adopted as proposed by the CCJ/COSCA Behavioral Health Committee at the CCJ/COSCA 2022 Annual Meeting on July 27, 2022.

Conference of CHIEF JUSTICES

COSCA
Conference of State Court Administrators

# Regional Mental Health Summits




**45 states and territories attended one of the Summits, and 36 state courts received SJI funding to accomplish their state team priorities.**

RECOMMENDATION

**State-Level Commissions, Task Forces, and Work Groups provide a solid foundation for systemic change and improving responses to individuals with behavioral health needs.**

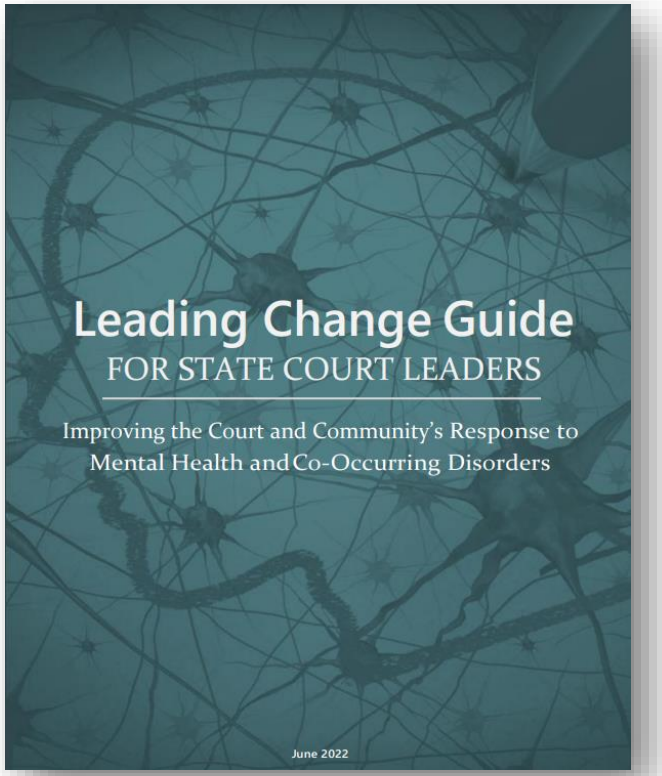
Lead change through establishment of state-level, three-branch multidisciplinary

# Commissions, Task Forces and Workgroups

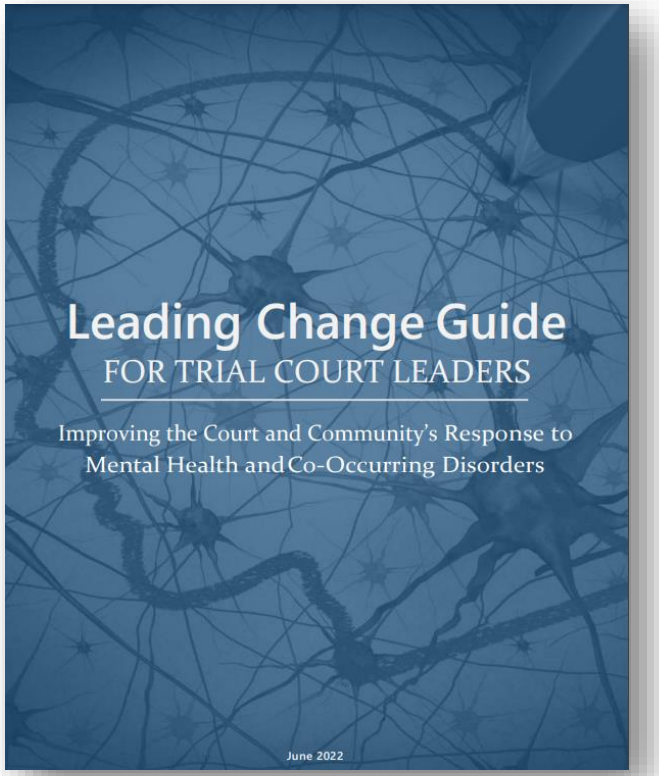
to promote systemic changes necessary to improve court and community responses to mental illness.

# Leading Change Guides

## State Court Leaders




## Trial Court Leaders




**Visit:** https://www.ncsc.org/__data/assets/pdf_file/0025/78073/Leading-Change-Guide-for-State-Court-Leaders.pdf
https://www.ncsc.org/__data/assets/pdf_file/0024/78072/Leading-Change-Guide-for-Trial-Court-Leaders.pdf

**A continuum of behavioral health programs, services, and alternatives must be available in the community to prevent individuals with mental illness from entering the criminal justice system, and when appropriate, if criminal justice involvement occurs, deflect and divert to treatment and care as soon as possible.**

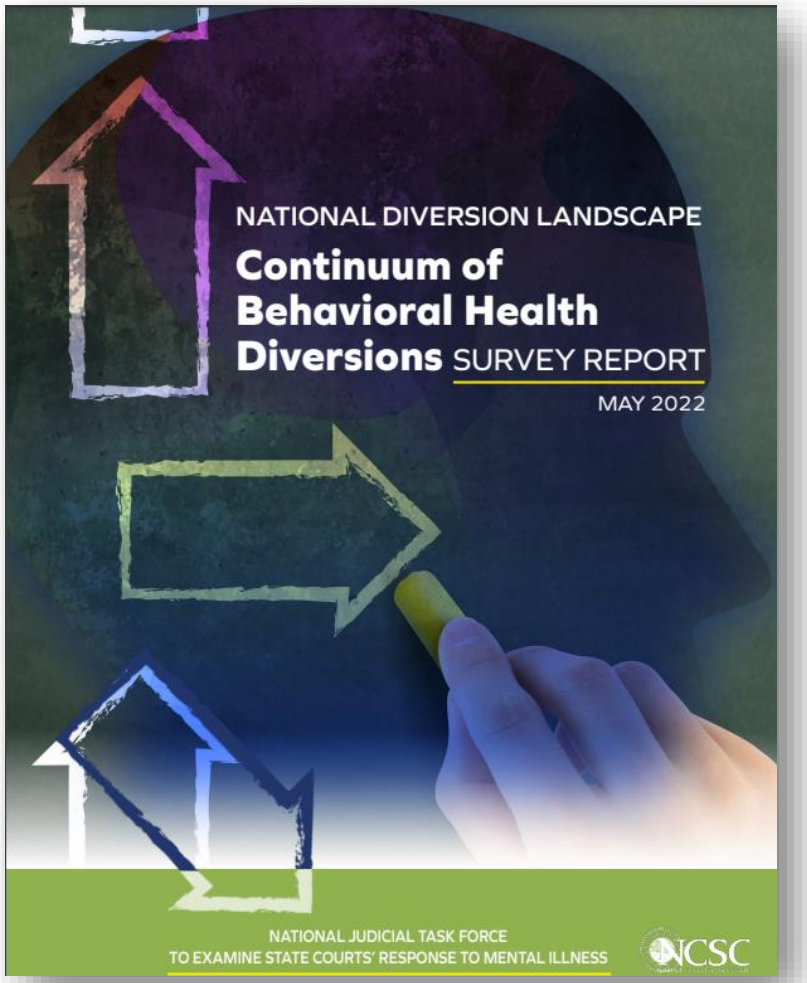
RECOMMENDATION

Where appropriate, promote

# Deflection and Diversion Treatment Options

at the earliest point possible.

# Deflection and Diversion to Treatment




Visit: https://www.ncsc.org/__data/assets/pdf_file/0022/77143/National-Diversion-Landscape.pdf

PMHC
Police-Mental Health Collaboration

Police-Mental Health Collaboration Self-Assessment Tool

Visit: https://csgjusticecenter.org/projects/police-mental-health-collaboration-pmhc/self-assessment-tool/

RECOMMENDATION

**Large numbers of defendants, including many who are charged with misdemeanors or non-violent felonies, spend excessive time in jail awaiting mental health evaluations and competency restoration.**

Reform the

# Competency to Stand Trial System

to actively manage the progress of a competency case to avoid an individual languishing in jail and decompensating.

# Rethinking Competency to Stand Trial

NATIONAL JUDICIAL TASK FORCE TO EXAMINE STATE COURTS' RESPONSE TO MENTAL ILLNESS

## Leading Reform: Competence to Stand Trial Systems

A Resource for State Courts[1]

August 2021 v2

### THE ISSUE

The majority of state hospitals maintain bed-wait lists of defendants who have been court-ordered for competency to stand trial evaluation or restoration services. A 2017 report found that in some states these waits are around 30 days, but three states reported forensic bed waiting lists of six months to a year. At any given time, there were at least 2,000 defendants waiting in jail for these beds.[2] During the pandemic these waits have skyrocketed, and in just three states combined, over 3,000 people were reported waiting in jail for a restoration bed. These are pre-trial defendants, sometimes charged only with misdemeanor offenses, all of whom are presumed innocent. And yet, many of them will spend far longer in jail or otherwise confined than they ever would have had they pled to or been convicted of the underlying offense.

### BACKGROUND

Of the countless ways in which mental illness and the justice system intersect, one of the most direct is when courts and judges are involved in an order for evaluation and ultimate determination of a defendant's competency to stand trial.[3] Any defendant, their counsel, the prosecutor, or the court can raise a concern that the defendant may be incompetent to stand trial in any criminal proceeding, from misdemeanors to capital murder. The United States Supreme Court in *Dusky v. U.S.* (1960) held that in order for a defendant to be found competent to stand trial, a defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" *and* a "rational as well as factual understanding of the proceedings against him."

If incompetence is raised, the defendant is evaluated by a mental health professional, and based on that evaluation (or evaluations) and other information, the court makes a determination of legal competency. If an individual is found incompetent, a process of restoration to competency generally commences.

Visit: https://www.ncsc.org/__data/assets/pdf_file/0019/66304/Leading_Reform-Competence_to_Stand_Trial.pdf

**Current state court caseflow management practices are not designed to address the behavioral health needs of individuals. Individuals with serious mental illnesses are languishing in jails as a result of case backlogs and a lack of community-based alternatives and supports.**

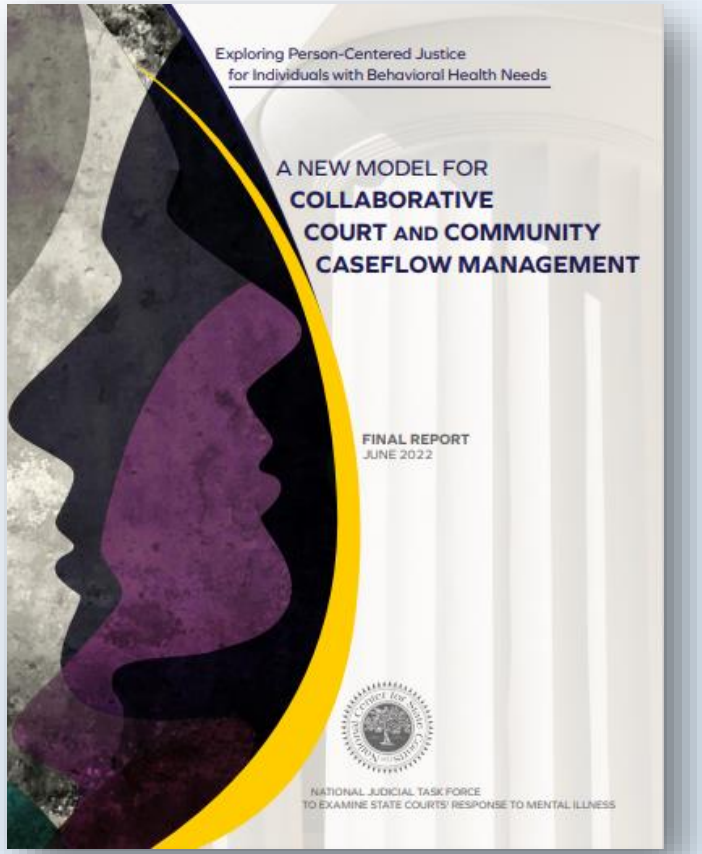
RECOMMENDATION

Establish

# Case Management Best Practices

through collaborative court and community caseflow management which explores **person-centered** justice for individuals with behavioral health needs.

# Framework for Redefining Collaborative Court and Community Responses





**Visit:** https://www.ncsc.org/__data/assets/pdf_file/0018/66303/CCC-Caseflow-Mgmt.pdf

**Most state laws for the involuntary commitment of persons with mental illnesses in existence today were adopted in the 1970s. As a result, in many states today, individuals with mental illnesses who do not clearly present an imminent risk of harm may not be subject to involuntary treatment.**

RECOMMENDATION

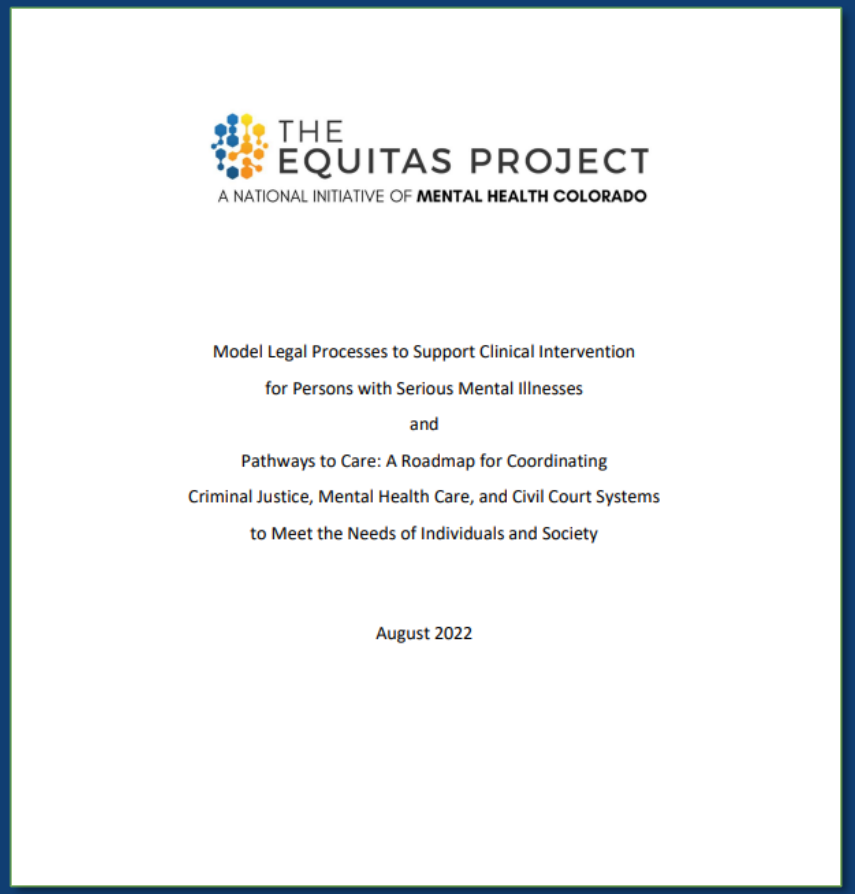
Develop and provide multiple

# Laws and Processes for Civil Commitment

that are easily accessible by individuals, families, and behavioral health systems.

INVOLUNTARY COMMITMENT

# Model Civil and Criminal Mental Health Law




*Blue Ribbon Workgroup*: Goal to create a model law that provides for least restrictive involuntary commitment (inpatient and outpatient), and for civil and criminal approaches to optimizing individual health outcomes, defending civil liberties, and preserving public safety, has been endorsed by the Task Force.

RECOMMENDATION

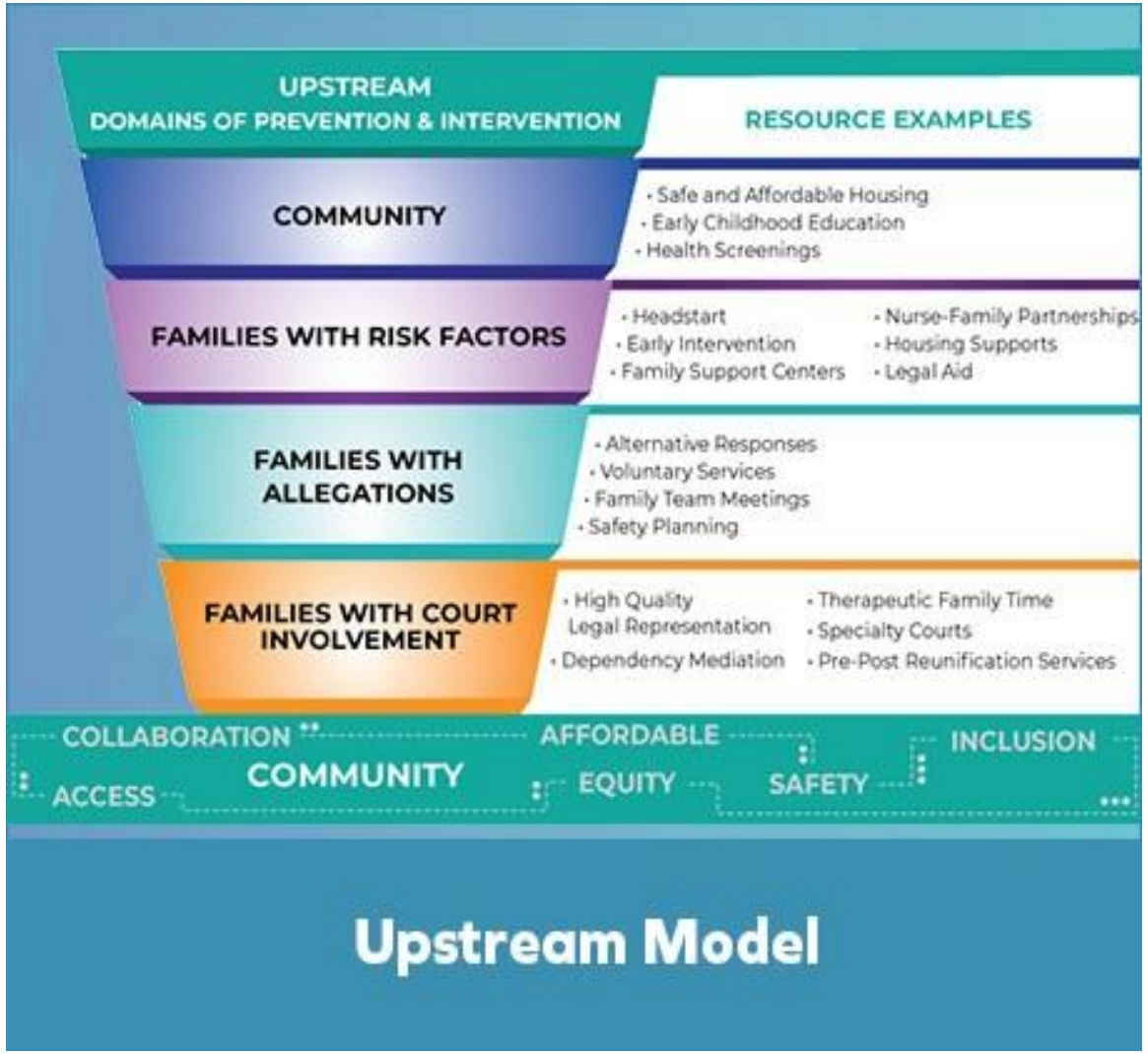
**It is not just a criminal justice issue. The needs of adults, children, and families impacted by serious mental illness touch every aspect of the court system, including child welfare, juvenile, and domestic relations cases.**

Courts should examine

# Upstream and Other Resources

to ensure a continuum of behavioral health practices and improve outcomes for children and families with behavioral health needs.

# Upstream
# (Framework for Community Collaboration)




Community-based approach that leverages judicial leadership, child welfare agency partnership, and state, local, and community stakeholder engagement to collaboratively develop a plan of action that aims to strengthen communities, prevent child maltreatment and out-of-home placement, reduce court involvement, and support safe and healthy families

**Education and training is needed for state court judges and court professionals necessary to equip them with the knowledge, data, research, and resources they need to improve the state courts' response to court-involved individuals with mental illness.**

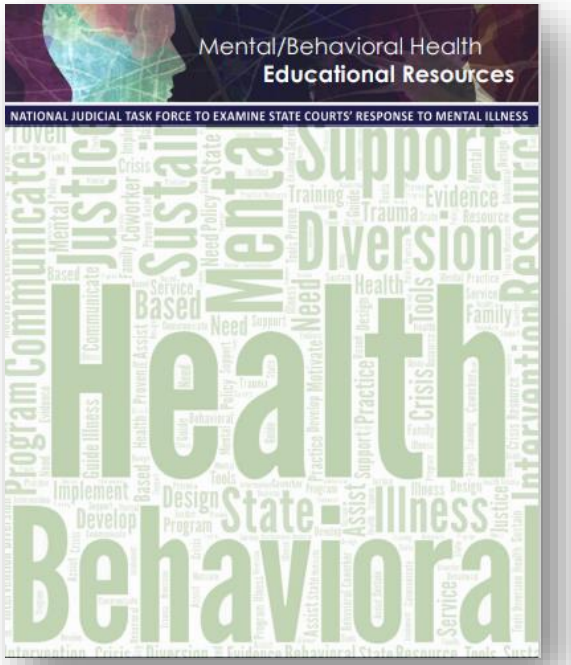
RECOMMENDATION

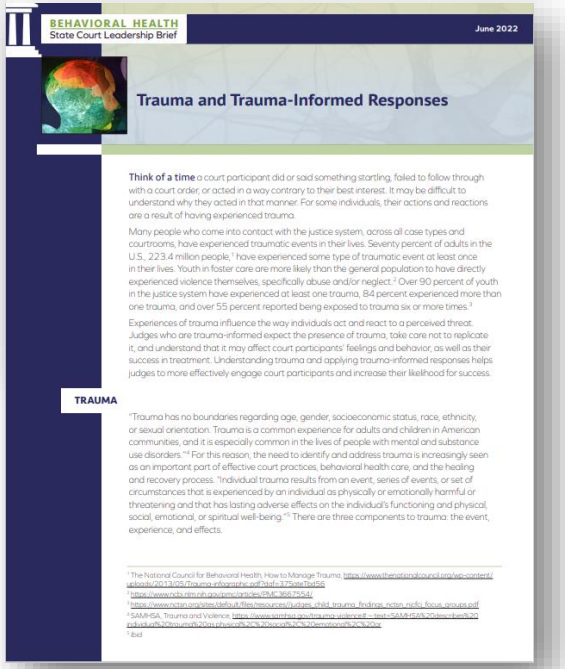
All should be

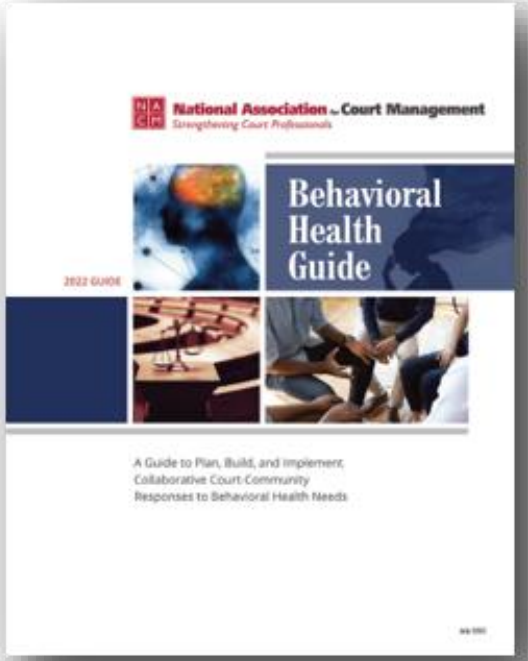
# Trained, Educated and Trauma-Informed

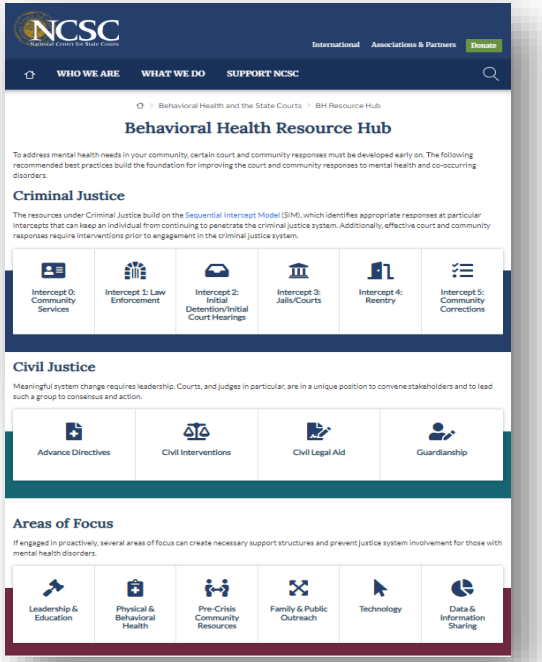
across all case types utilizing Task Force Education resources, including Trauma and Trauma-Informed Responses, and the Behavioral Health Resource Hub.

# Educational Resources




**Visit: https://www.ncsc.org/behavioralhealth/resourcehub**

RECOMMENDATION

**Ample evidence points to the inequities that exist in access to treatment, misdiagnoses for marginalized populations, an over-representation of minority communities in the justice system, and a lack of behavioral health providers of color.**

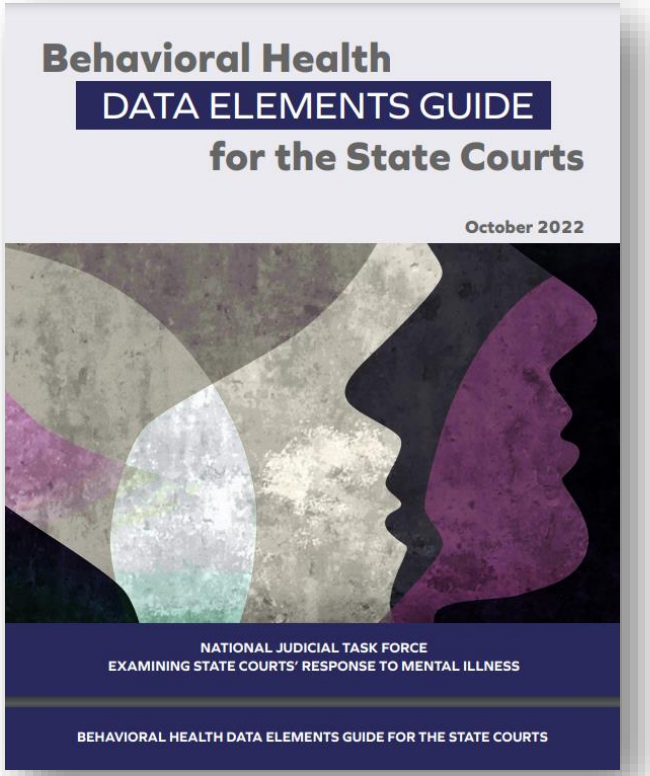
Examine the

# Disproportionate Impact

of behavioral health conditions and associated conditions and demographics such as race on the over-representation of individuals who enter the justice system.

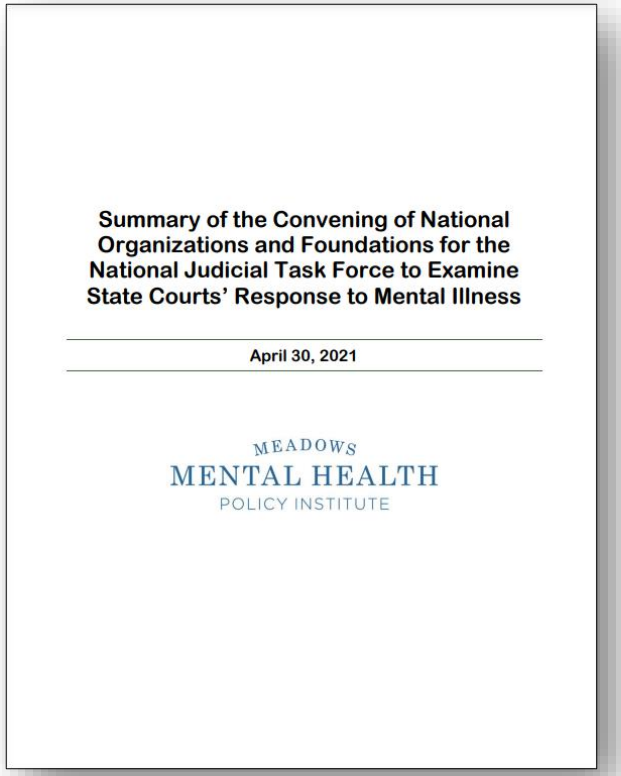
# Behavioral Health and Equity

## Data Elements Guide




Visit: https://www.ncsc.org/__data/assets/pdf_file/0023/84254/Behavioral-Health-Data-Elements-Guide.pdf

## Meadows Mental Health Policy Institute




Visit: https://www.ncsc.org/__data/assets/pdf_file/0025/65860/Judical-Task-Force-Convening-Summary-30April2021.pdf

RECOMMENDATION

**Too often the voices of families and individuals with lived experience are left out of implementation and improvement efforts, and our responses suffer as a result.**

Examine the

# Peers in Court

to learn about strategies for the use of peers in court settings and other SAMHSA resources available to support these efforts.

# Peers, Individuals with lived experience

Lived experience refers to having firsthand experience with the subject such as mental health, trauma, justice system involvement or substance use.

## Peers in Courts

All courts should consider hiring peers into their programs, services, and operations. This Court Leadership Brief describes different types of peers in court settings, the roles peers can play in court, lessons from the field with examples of peers in the courts and links to additional resources.

### TYPES OF PEERS IN COURTS

Many types of peer specialists work throughout court systems nationwide. For some, it is the same court system where they became justice-involved themselves. This "lived" experience with the justice system is preferred, but not required. In the most general sense, peer specialists in court settings provide peer support services to justice-involved individuals using a person-centered, strength-based support system (GAINS Center, 2017; PMHCA, n.d.).

Lived experience refers to having firsthand experience with the subject such as mental health, trauma, justice system involvement or substance use. The word "lived" is used to differentiate from others who may have experience working with these conditions but not have personally lived with those challenges. Typically, those with lived experience who work in the healthcare and justice systems have been successful in their recovery process. Their shared understanding provides a unique perspective to their peers and their clients (SMIadviser.org).

Forensic Peer Specialist (FPS) is a term often used to describe peers working in the court system. In fact, there are many FPS programs and certifications throughout the country. Peers who are certified and employed are in professional positions like others in the courts, requiring supervision and management. However, there is growing discussion about the stigma associated with the term "forensic" related to persons with mental health issues who are also justice-involved (Baron, 2011). In this brief, we choose to use "peers in courts" as a less stigmatizing term describing all peer specialists working in court settings.

### ROLES OF PEERS IN COURTS

Generally, the goal of peers in courts is to support people in court-based programs by:

- Providing person-centered, strength-based support to build recovery and resilience
- Providing relationship-focused support and role-modeling based on lived experience
- Advocating for the individual in stressful and urgent situations and in respect for their rights
- Assisting individuals with understanding and navigating the Justice System
- Supporting individuals to achieve their goals, live a self-directed life, and strive to reach their full potential (Abdenour & Sepulveda, 2022)

Visit: https://www.ncsc.org/__data/assets/pdf_file/0029/77690/Peers-in-Courts.pdf

RECOMMENDATION

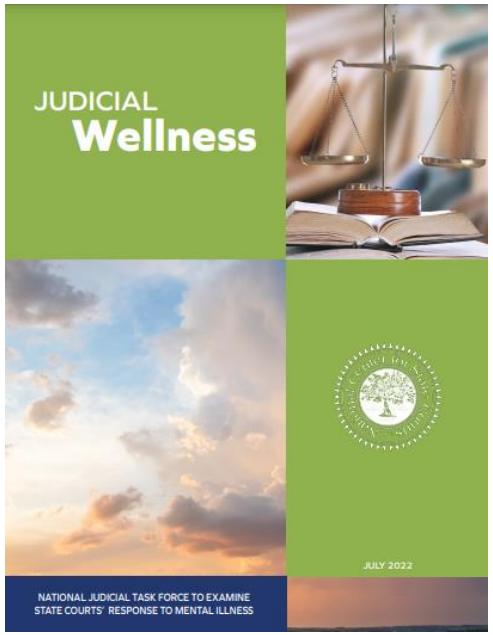
**Daily interactions with individuals, children, and families who are reliving trauma takes an emotional toll on justice system practitioners and places them at high risk for experiencing secondary trauma.**

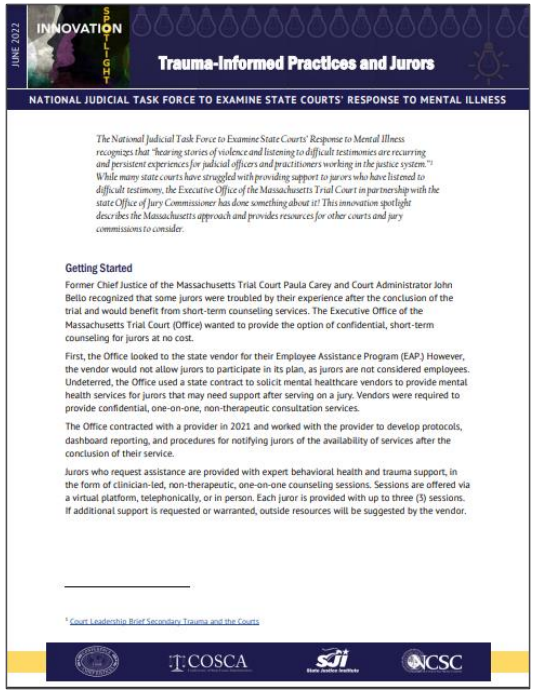
Consider the well-being of personnel through

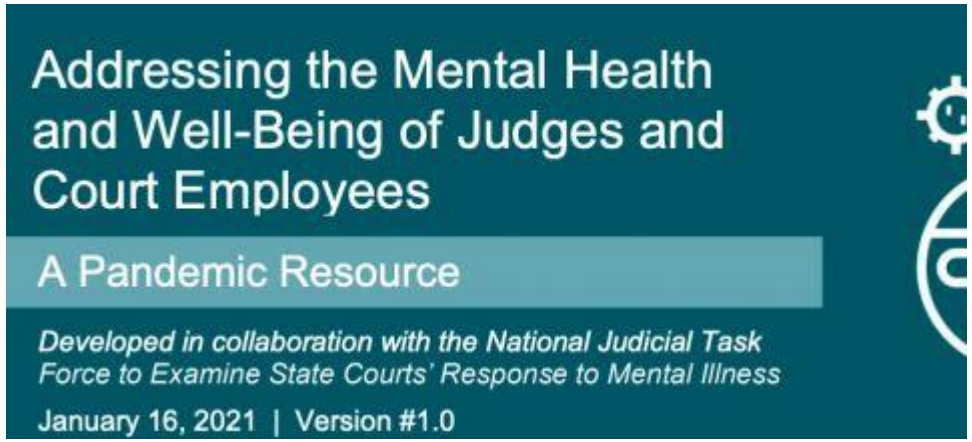
# Secondary Trauma Prevention and Intervention Strategies

that promote self-care, safe work environment, secondary trauma education, peer-mentoring programs, supportive services, and manageable work and caseload expectations.

# Mental Health & Well-Being





**Visit: https://www.ncsc.org/behavioralhealth/webinars-and-podcasts**

**Information sharing within and across systems utilized by courts and behavioral health agencies is inadequate, undermining opportunities to identify issues, target resources, and improve system responses.**

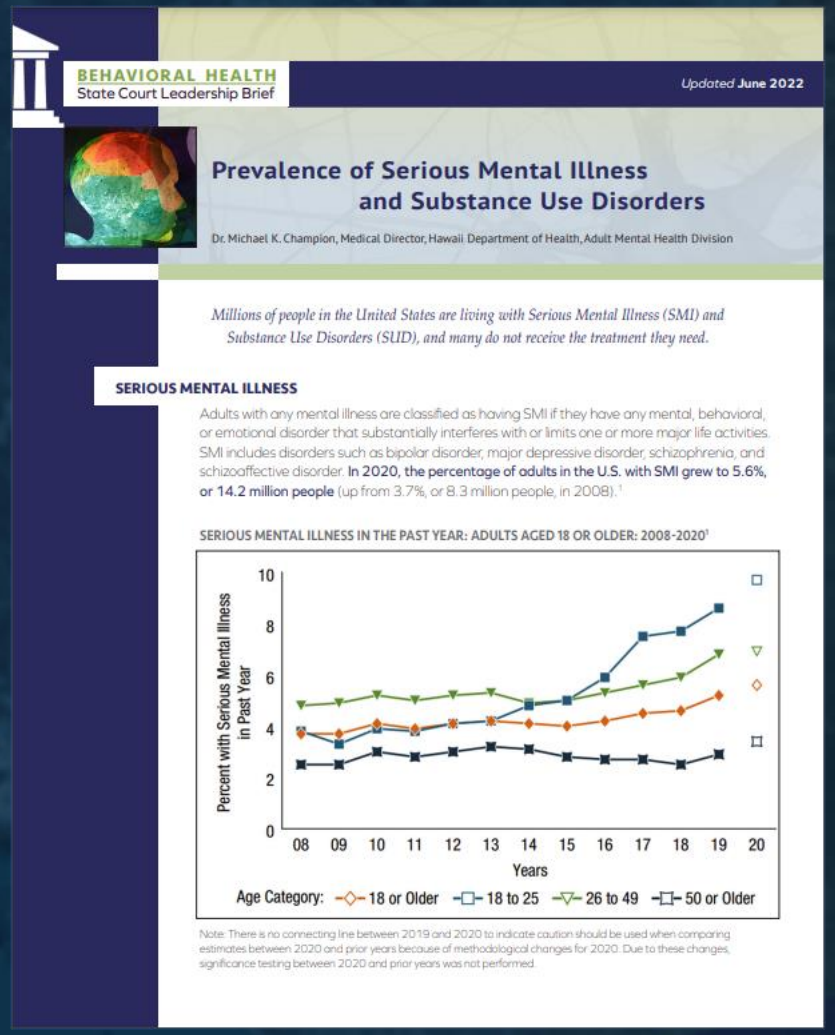
RECOMMENDATION

Support identification of

# Appropriate Data, Data Collection and Information-sharing

opportunities across the community, behavioral health, and justice systems as a critical part of developing a comprehensive and collaborative continuum of behavioral health services.

# Prevalence of people in the United States living with serious mental illness (SMI) and substance use disorders (SUD)



BEHAVIORAL HEALTH
State Court Leadership Brief

Updated June 2022

## Prevalence of Serious Mental Illness and Substance Use Disorders

Dr. Michael K. Champion, Medical Director, Hawaii Department of Health, Adult Mental Health Division

*Millions of people in the United States are living with Serious Mental Illness (SMI) and Substance Use Disorders (SUD), and many do not receive the treatment they need.*

### SERIOUS MENTAL ILLNESS

Adults with any mental illness are classified as having SMI if they have any mental, behavioral, or emotional disorder that substantially interferes with or limits one or more major life activities. SMI includes disorders such as bipolar disorder, major depressive disorder, schizophrenia, and schizoaffective disorder. **In 2020, the percentage of adults in the U.S. with SMI grew to 5.6%, or 14.2 million people** (up from 3.7%, or 8.3 million people, in 2008).[1]

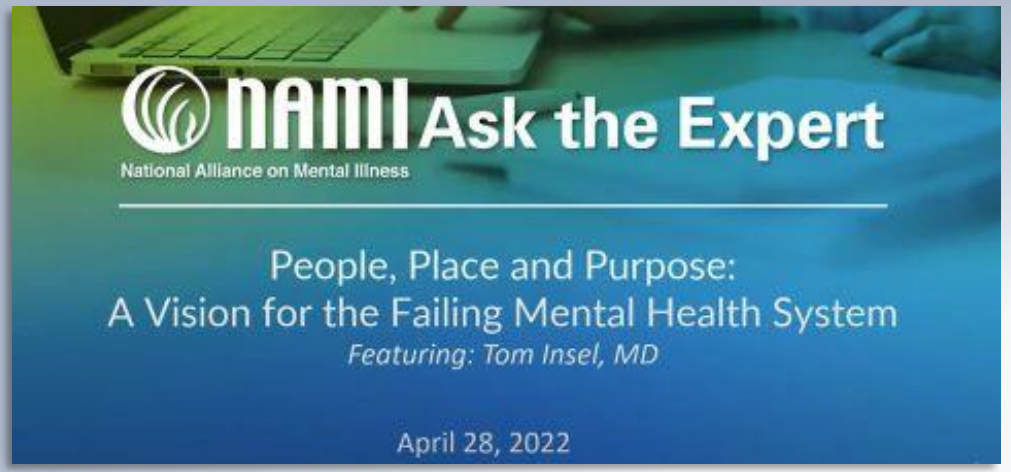
SERIOUS MENTAL ILLNESS IN THE PAST YEAR: ADULTS AGED 18 OR OLDER: 2008-2020[1]



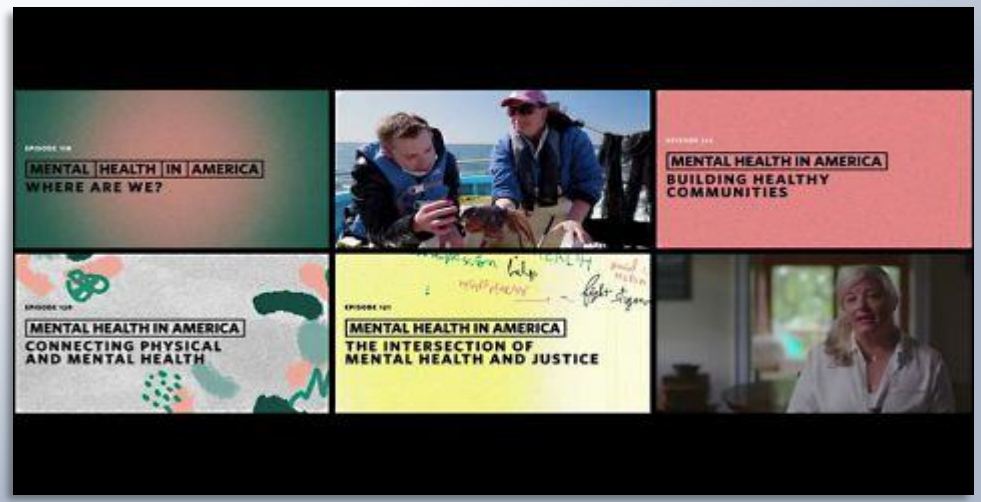
Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

Visit: https://www.ncsc.org/__data/assets/pdf_file/0031/78736/BH_in_State_Courts-Prevalence_of_SMI_and_SUD.pdf

# Podcasts & Webinars






Visit: https://www.ncsc.org/behavioralhealth/webinars-and-podcasts

# TASK FORCE
## Publications and Resources

November 2022

TASK FORCE
Publications and Resources

NATIONAL JUDICIAL TASK FORCE TO EXAMINE STATE COURTS' RESPONSE TO MENTAL ILLNESS

**ONLINE RESOURCES**

- Behavioral Health and the Courts Website
- Behavioral Health Resource Hub
- Behavioral Health Alerts Newsletter (published 2x/month, Jan 2020 – present)
- State Innovations and Resources
- Webinars and Podcasts
- Behavioral Health eLearning Series & Resources

**PUBLICATIONS**

**TASK FORCE BACKGROUND AND REPORTS**

- State Courts Leading Change: Final Report and Recommendations (Oct 2022)
- Conference of Chief Justices Conference of State Court Administrators Final Resolution 1 (Aug 2022)
- Findings and Recommendations of the Task Force (Aug 2022)
- Conference of Chief Justices Conference of State Court Administrators 2021 Annual Conference Report (Jul 2021)
- National Judicial Task Force to Examine State Courts' Response to Mental Illness Overview (Jul 2021)
- 2020-2021 National Convenings Summary (Jun 2021)
- State Courts' Responsibility to Convene, Collaborate, and Identify Individuals Across Systems (Jun 2020)
- The Future Is Now: Decriminalization of Mental Illness (May 2020)

**STATE AND TRIAL COURTS LEADING CHANGE**

- Violence and Mental Illness Myths and Reality (Nov 2022)
- Implementation of the 988 Suicide and Crisis Line Lifeline: What Court Leaders Need to Know (July 2022)
- Leading Change Guide for Trial Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders (Jun 2022)
- Leading Change Guide for State Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders (Jun 2022)
- Fostering a State Court Informed Behavioral Health Continuum of Care (May 2022)
- External Funding Support to Lead Change (May 2022)
- Measuring Your Progress (Feb 2022)
- Building Relationships to Lead Change (Feb 2022)
- Strategic Planning Through Sequential Intercept Mapping (Feb 2022)
- State Court Commission or Task Force Composition (Feb 2022)

COSCA

Visit: https://www.ncsc.org/__data/assets/pdf_file/0028/79309/TF-Publications-and-Resources.pdf

# Task Force Next Steps

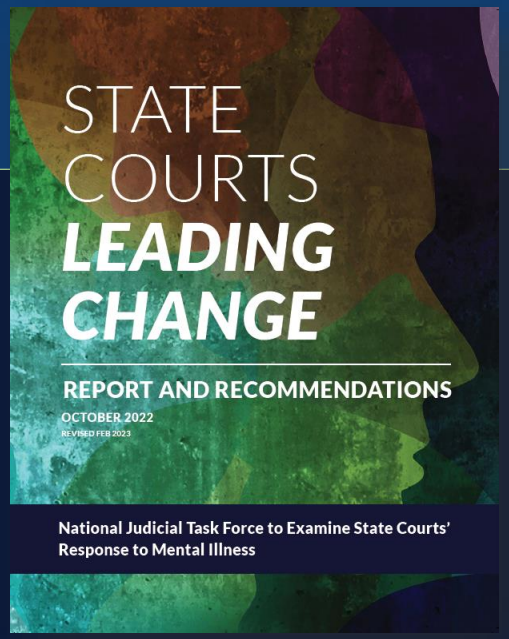
- Conference of Chief Justices/Conference of State Court Behavioral Health Committee
- Mission to assist state courts to implement the recommendations of the task force
- Workgroups within the Committee with outside experts
- Initial workgroups
  - Deflection and Diversion
  - Competency
  - Data
  - Funding
  - Education and Training

# PATHWAY FORWARD

Team discussion of Task Force Recommendations

# State Courts Leading Change: National Judicial Task Force to Examine State Courts' Response to Mental Illness

**Report and Recommendations**
October 2022
(Revised February 2023)

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