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DBHDS Forensic Conference Topics: Cross Systems Collaboration between Legal and Mental Health Partners

- Use of Diversion Alternatives to Enhance Public Safety
- Forensic Mental Health Issues
- Improving the Utility of Mental Health Products

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Lessons Learned in Virginia

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National Jail Perspective
Scope of the Problem

- GAINS Center estimates approximately 1,100,000 persons with serious mental illness are admitted annually to U.S. jails.
  - ➢ Among these admissions, 72% also meet criteria for co-occurring SU disorder.
- 14.5% of male and 31.0% of female inmates recently admitted to jail have a serious mental illness.
- The vast majority will be released into the community.

GAINS Center 2007

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Virginia Jail Perspective
Inmates with Mental Illness

2012 Compensation Board Jail/Mental Health Survey of 64 Local and Regional Jails

- **23.71%** of the local and regional jail inmate population known or suspected to be mentally ill.
- **48.13%** of the mentally ill population had been diagnosed as having a ***serious mental illness***.

ADP for July 2012:

6, 982 State Responsible
19, 241 Local Responsible
446 Ordinance Violators
26, 669 Total (31.83% Pretrial)

Compensation Board 2012

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Sequential Intercept Model
The Basis for Cross-Systems Mapping

Cross-Systems Mapping is an activity which depicts contact/flow within the criminal justice system.

A tool to:

- ✓ Help transform fragmented systems,
- ✓ Identify local resources, gaps and
- ✓ Help identify where to begin interventions.

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Sequential Intercept Model
Patty Griffin, PhD & Mark Munetz, MD

People move through criminal justice system in predictable ways.

Illustrates key points to "intercept" individuals to ensure:

- ✓ Prompt access to treatment.
- ✓ Opportunities for diversion.
- ✓ Timely movement through criminal justice system.
- ✓ Linkage to community resources.

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Five Key Points of Interception

1. Law enforcement / Emergency services.
2. Booking / Initial court hearings.
3. Jails / Courts.
4. Re-entry from jails/prisons.
5. Community corrections / Community support.

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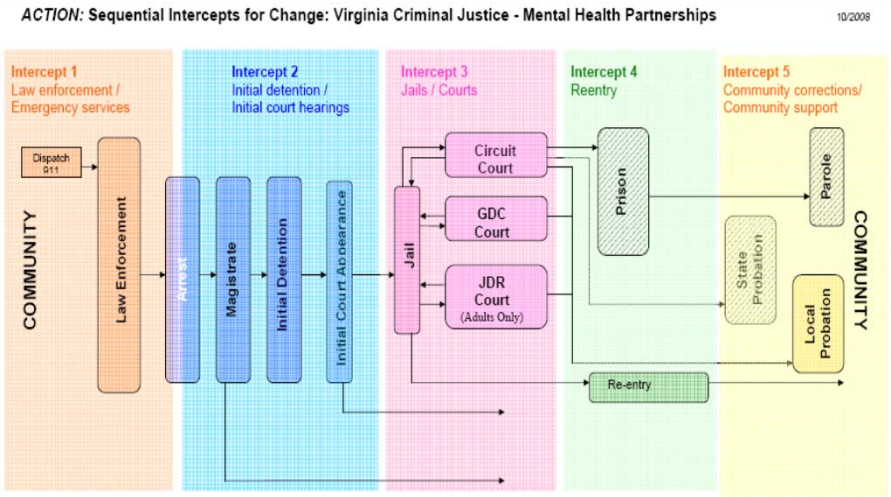
Sequential Intercept Model: Virginia



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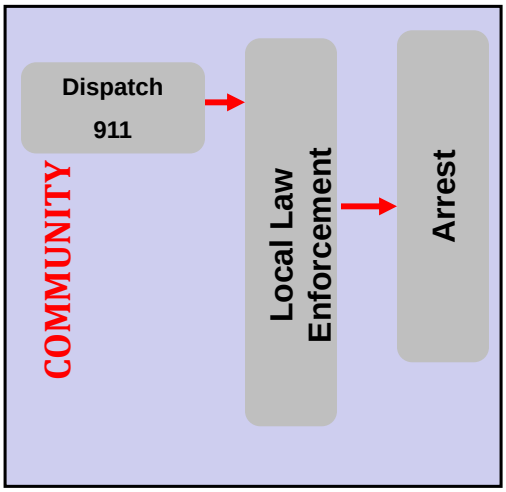
Pre-booking Jail Diversion

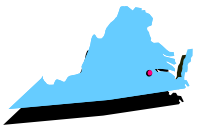
Intercept 1

Law enforcement / Emergency services



Model Programs: *Intercept 1*

Virginia examples:



33 Crisis Intervention Team initiatives (CIT):

- Statutory oversight by DBHDS and DCJS (Section 9.1- 187, et. seq.)
- Utilizes best practice Memphis Model adapted to address Virginia systems needs (Essential Elements of CIT in Virginia, policy)

Collaboration, Infrastructure, Training make a CIT Program

- Local task force to oversee multi-system policies, procedures
- Improved access to services utilizing CIT Drop Off (Assessment)sites
- 40 hour training to ID mental illness, de-escalate and determine best course of action

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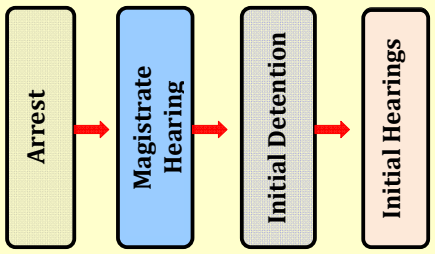
Post–Booking Diversion Options

After arrest has been made.

Intercept 2

Initial detention/Initial court hearings



Model Programs: *Intercept 2*

Virginia examples:

New River Valley Bridge Program:

Post –booking, pre-trial release to wrap around forensic informed services program

Arlington Magistrates Post-Booking Release Program:

Identification and linkage to services from jail/accelerated access to psychiatric care

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Specialty Courts?

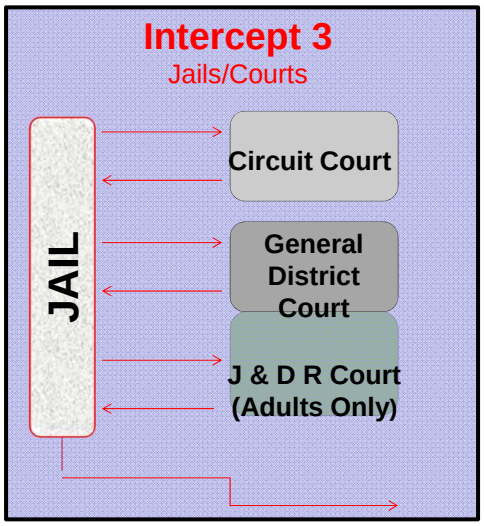
Other Court Programs

Jail-Based Diversion Programs

&

Jail Mental Health Services

State Hospital Treatment



Model Programs: *Intercept 3*

- Virginia examples:
  - Norfolk MH Court and Norfolk MH Docket:
    - CSB and CC staff develop post-plea community MH treatment and supervision plan
  - Petersburg MH Docket:
    - Therapeutic justice programs for MH consumers currently involved in the justice system which offer sentencing options designed to reduce recidivism

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Model Programs: *Intercept 3*

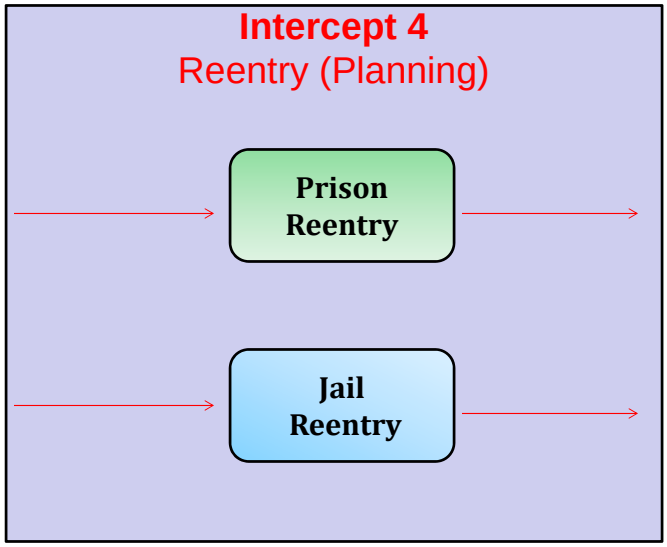
Virginia examples (cont.)

Richmond MH Docket:

A multipurpose GDC docket with the primary goal of early identification of MI misdemeanant offenders and diversion to community services. Offenders are assessed for MHASP eligibility and monitored by specially trained probation officers

HPR IV Jail Team:

Provides in-jail competency restoration, post-booking diversion and in-jail services for inmates with mental illness in the greater Richmond area



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Model Programs: *Intercept 4*

- Virginia examples:

  Northern Virginia CSBs (HPR II):
  - 5 localities have Forensic Discharge Planners; promote continuity of care from jail and state hospitals to community

  Alexandria CORE Program:
  - Funds a full time mental health trained PO with MH/SA caseload
  - Referrals directly from Circuit Court or DOC inmates upon release
  - Strong collaboration and coordination of services b/n PO and CSB

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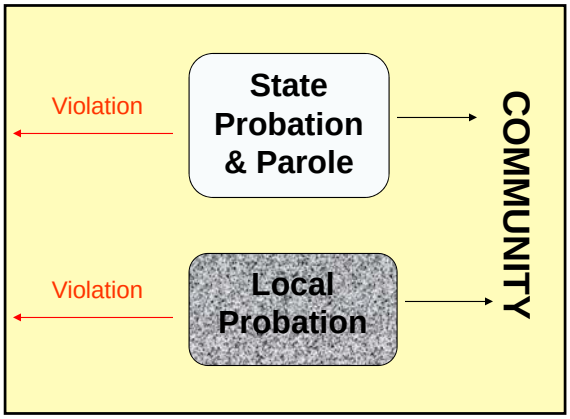
Intercept 5

Community corrections/Community support



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Model Programs: *Intercept 5*

- Virginia examples:

  Daily Planet, Richmond:

  Offers reentry shelter access, including Safe Haven Home, MH and SA treatment and general medical care

  Local Reentry Councils:

  Provides interagency collaborative approach to reentry from jail or prison, including MH and SA treatment in 5 Virginia localities

Summary of Presentation: An Analysis of the Code of Virginia from the Office of the Attorney General's Perspective

Mental Health Law in Virginia

- For criminal court involved defendants, found in Title 19.2, Chapter 11 §§ 19.2-167 through 19.2-182.16
- Also found in §37.2-814 et seq (Civil Commitment)
- §37.2-900 (Commitment of Sexually Violent Predators

Competency to Stand Trial & Restoration to Competency Code sections §§19.2-169.1, 19.2-169.2 and 19.2-169.3

- By Code, a competency evaluation be performed by at least one psychiatrist or clinical psychologist who is qualified by training and experience in forensic evaluation.
  - Ultimately Court decides who is qualified
  - At a minimum must be psychiatrist (MD or DO) or clinical psychologist (Ph.D. or Psy.D.)
  - Under practice standards for professions, individual should be licensed to practice in Virginia
  - Intent of law is that only those professionals with specialized training are deemed qualified. Not enough simply to be psychiatrist/psychologist, but also must demonstrate training/experience in area of competency assessment
  - To ensure expert is qualified, it is prudent to refer to UVA ILPPP website to find experts who have completed Virginia specific forensic training

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Issues with Evaluators

- National studies have found that some level of disagreement between evaluators in normal.
- Evaluators have their own standard to which they compare defendant's performance
- To minimize bias and to balance findings, it is prudent to not rely on just one evaluator for all evaluations
- Not all evaluators created equal – look for specialized knowledge/skills necessary for current case – i.e. ID issues, chronic mental illness, etc.

Location of Evaluation

- The evaluation shall be performed on an outpatient basis at a mental health facility or in jail unless the court specifically finds that outpatient evaluation services are unavailable or unless the results of outpatient evaluation indicate that hospitalization of the defendant for evaluation on competency is necessary.
  - Least Restrictive
  - More Cost Effective ($400 for outpatient evaluation vs. approx $600 per day for inpatient evaluation)
  - Speedy Trial – in general it takes longer to complete inpatient evaluation

What *Should* Happen if Defendant Found Incompetent to Stand Trial?

Per §19.2-169.2 the court *shall* order that the defendant receive treatment to restore his competency on an outpatient basis or, if the court specifically finds that the defendant requires inpatient hospital treatment, at a hospital designated by the DBHDS Commissioner as appropriate for treatment of persons under criminal charge.

- Look to competency evaluation for guidance as to whether inpatient or outpatient treatment is needed
- In general, inpatient is indicated when defendant needs *intensive,* likely involuntary psychiatric treatment

Length of Restoration

- Can order for up to six months and can continue to re-order in six month increments
- Exceptions
  - Misdemeanor Trespassing – limited to 45 days
  - Misdemeanor Disorderly Conduct – Limited to 45 days
  - Misdemeanor Larceny – Limited to 45 days
  - Capital Murder – unlimited

What Happens if Defendant Opined Unrestorable?

- If provider of restoration services feels defendant remains incompetent and is likely to remain so for the foreseeable future then (per § 19.2-169.3), provider must opine to one of four options:
  - Defendant should be released
  - Defendant should be committed under 37.2-814 et seq
  - Defendant should be referred for possible commitment under 37.2-900 (this often takes 6-12 months)
  - Defendant should be certified to training center under 37.2-814 (rarely, if ever happens).

What Happens if Defendant Committed under § 37.2-814?

- Generally, criminal court orders provider (usually state hospital) to seek commitment through local special justice
  - Civil commitments generally done through special justices through General District Courts
  - To be subjected to civil commitment, certain rights/ procedures need to be guaranteed (i.e. pre-screening, independent evaluation, representation by attorney) which are hard to coordinate within code specified time lines.

What Happens if Defendant Committed under § 37.2-814?

- If defendant is committed, then the defendant's continued stay in hospital is dictated by his/her continuing to meet civil commitment criteria.
- When defendant no longer meets criteria then hospital can discharge and/or special justice may not renew commitment order
- To remain committed, individual must be at risk: cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (b) less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and are determined to not be appropriate

What Happens if Defendant Committed under § 37.2-814?

- While criminal court may still have retained charges, presence of charges are not sufficient for defendant to remain hospitalized
- If charges remain (not dismissed or nolle processed) then hospital will make courtesy notification of criminal court of intention to discharge.
- While criminal court can raise concerns, they cannot order continued hospitalization
- Court can order that hospital return defendant to jail, but as defendant likely remains incompetent there is little likelihood case will proceed to trial.

- Existence of pending legal charges often becomes barrier to discharge planning.
- May render patient ineligible for certain services/programs.
- Having such programs/services in place diminishes risk to community.

Sanity at the Time of the Offense (§19.2-169.5)

- Such mental health expert shall be (i) a psychiatrist, a clinical psychologist, or an individual with a doctorate degree in clinical psychology who has successfully completed forensic evaluation training as approved by the Commissioner of Behavioral Health and Developmental Services and (ii) qualified by specialized training and experience to perform forensic evaluations.

Sanity at the Time of the Offense (§19.2-169.5)

- Consult UVA-ILPPP website for list of trained evaluators who are accepting referrals
- http://www.ilppp.virginia.edu/ExpertDirectory/Search
- Vast majority of sanity evaluations are conducted on outpatient basis (in community or in jail).
- Burden is on defendant to prove he/she was insane at time of offense.

Second Opinion Sanity Evaluation (§19.2-168.1)

- If defense indicates intention to pursue insanity defense, then Commonwealth entitled to own evaluation
- Qualifications of evaluator same as §19.2-169.5
- As there is more subjectivity with sanity evaluations, it is often prudent to get second evaluation and then let trier of fact weigh out evidence (if opinions conflict)

What Happens Post NGRI Adjudication (§19.2-182.2)

- Defendant placed in custody of Commissioner
- Custody = inpatient in state hospital
- Temporary Custody lasts 45 days from date of admission, not date of NGRI finding
- 1 psychiatrist & 1 psychologist will perform independent evaluation
- Possible recommendations: commit to DBHDS custody; conditional release; or unconditional release

What Happens Post NGRI Adjudication (§19.2-182.2)

- If either evaluator recommends Conditional/Unconditional Release then DBHDS will request 45 day extension in order to develop conditional release plan/ discharge plan
- Approximately 25% of NGRI acquittees are released out of temporary custody
- For those committed to DBHDS custody, average length of stay is 7 years.

Conditional Release

- While acquittee is on conditional release, CSB will file reports with Court every six months
- CSB will provide updates and make recommendations for whether acquittee should remain on conditional release and/or whether certain conditions should be removed
- Acquittee can request unconditional release/ modification of Conditional Release yearly (starting 6 months after release)

Summary of Presentation: Feedback from a Lawyer's Perspective

Readability of Reports

- Remember that all notes/reports will/may be reviewed by others. Facts should be objective and to the extent possible verifiable
- Avoid using mental health jargon. If you are going to use a technical term, make sure you explain it (e.g. delusions, hallucinations, etc)
- Avoid describing services by program name (i.e. Harmony House) but instead describe by function (Peer run clubhouse where individuals engage in peer run support groups).

Reports (cont.)

- If offering a diagnosis, explain the basis of the diagnosis and how it pertains to this particular defendant.
- Balance need to inform parties versus confidentiality (probative value vs. prejudicial value)
- If providing treatment recommendations, explain how treatment might affect the underlying issues.

Competency Reports

- If offering opinion that defendant is incompetent:
  - Provide specific examples of observed deficits
  - Provide hypotheses about etiology of deficits
  - Describe treatment needs to ameliorate incompetency
  - Best to guide parties regarding need for inpatient vs. outpatient treatment.

Post Competency Restoration Reports

- Include description of type of treatment defendant received
- Describe frequency of services
- It's not sufficient to simply say defendant is now competent; rather must describe how defendant moved from being incompetent to now competent
- If defendant still has residual symptoms describe them and explain why they don't impact on competency.
- If defendant requires any special accommodations (i.e. they are unable to read) explain those.

Sanity Reports

- If offering opinion that defendant was insane at time of offense, it is best to base your opinion on more than just defendant's self-report
- If there are competing hypotheses to explain illegal behavior explain why the data does/ does not support alternate hypotheses
- It is not sufficient to simply cite the required elements for insanity; rather the evaluator must explain how elements apply to this particular defendant charged with this particular offense

Boundary Issues

- If Court appointed, remember you are the neutral, independent party. Except when mandated by Code, communication should be copied to all parties
- Avoid sharing results prior to submission of formal report
- Avoid engaging in behavior which could be perceived as biased.

Issues Working in Legal System

- While you may be a mental health expert, legal system by design is adversarial – don't be surprised when your opinions are questioned.
- Be prepared to explain the basis of your opinion
- Don't expect the system to simply accept your opinions because they are offered by you
- Understand your role – are you there as a fact witness or expert witness. You need to appreciate the difference

Final Thoughts

- Remember all cases have the potential of becoming forensic cases. Clients are best served when services, opinions, and recommendations are well documented
- Keep in mind the reason for your involvement in the case. While as a clinician your goal may be to get the patient the best treatment, your appointed role may be more circumscribed. It is important to adhere to the boundaries of your prescribed role.