Office of Forensic Services

CIT Assessment Sites and CIT Programs: A Report on Status

FY2016

Collaborate

Innovate

Transform

Virginia Department of Behavioral Health & Developmental Services

VIRGINIA CIT COALITION

CIT Assessment Site Annual Report FY2016

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Volume 2

Inside this issue:

Executive Summary

The Commonwealth of Virginia, through the Department of Behavioral Health and Developmental Services (DBHDS), currently provides funding and support to 28 Community Services Boards (CSB) for the establishment of, or expansion of, Crisis Intervention Team (CIT) Assessment Sites. Within those programs a total of 32 individual locations functioned to provide immediate therapeutic assessment to Virginia's behavioral health consumers.

The Assessment Sites, which have also in the past been known as "Drop Off Centers" or in some locales as "Receiving Center" provided a safe location away from criminal justice settings for 9,245 therapeutic assessments during FY'16. These assessments keep those experiencing crises related to a mental illness and who become or are very likely to become justice involved, from inappropriately ending up in jails when therapeutic intervention best serves the needs of the individual and the public.

Over 6,300 of the events in FY2016 involved law enforcement officers recognizing a need for immediate mental health intervention with a member of the public and using their lawful discretion to choose a safer and more productive path for those in crisis. Officers chose to transport those subjects to a CIT Assessment Site instead of making an arrest which allowed for a pre-screen assessment to occur.

The CIT Assessment Site program in Virginia is quickly becoming recognized on the national stage for its varied models, ability to adapt to local needs, and strong support from our state legislature and local governments alike.

This report is a summation of the growth and activity within the CIT Assessment Site program during FY2016, including expenditures, utilization, and changes that have occurred relative to past operations and status.

A Brief History of CIT in Virginia

The catalyst for the development of the Crisis Intervention Teams (CIT) in the U.S. is now a fairly well known account. A group of mental health practitioners and police in Memphis, TN realized after a police shooting involving a man with mental illness that a better way had to exist for law enforcement to intervene in behavioral health crises. The training curriculum and foundations of CIT were developed in 1988 as a result of law enforcement and mental health professionals working together to find that way and create a solid foundation upon which to build. Law enforcement and mental health practitioners around the county soon took notice of this innovative new approach to law enforcement intervention in mental health emergencies.

In the early 2000's, several localities in Virginia travelled to Memphis to learn from those who had crafted the CIT curriculum and returned with their own plan to implement in the Commonwealth. In 2007 the Virginia General Assembly realized the importance of Crisis Intervention Teams and allocated funding for its expansion. In 2009 additional funding was provided to support established programs sharing their knowledge and skills to assist other localities in building their own CIT programs around Virginia through shared training programs and staff.

The New River Valley as well as other emerging CIT programs worked to create training curriculum and in a relatively short time were assisting efforts around Virginia to establish programs in many more localities.

CIT is more than just training as described by the "three legged stool" model. The legs represent the importance of training, community collaboration, and infrastructure as equally important parts of the foundation of a successful CIT program. Even with the support of these three components, each program still requires some variation and is organized and managed dependent on the needs of programs. Virginia's CIT programs are reliant on local partners to provide personnel, funding, and time in order to successfully sustain their programs. In what has become the spirit of CIT in Virginia, programs have worked hard to assist other localities by providing training to personnel from other areas without means, sharing qualified trainers to conduct remote classes, and by committing program members to the Virginia CIT leadership. The collaboration of programs has supported the growth in Virginia such that 35 programs currently exist around the majority of the Commonwealth. Virginia is also currently planning its Fifth annual CIT conference, to occur in May 2017 in Blacksburg.

Continued Growth for CIT Throughout Virginia

Henrico County CIT Program

CIT Programs and CIT Assessment Sites are currently active in the majority of Virginia's localities. There are still areas in the Commonwealth that do not have enough support to make CIT a reality. The difficulty is often because of the cost and personnel demands on attending the intensive five day training.

Beginning with the first programs in the 2000's, Virginia programs and state government agencies have supported localities in their efforts to establish and grow CIT with whatever resources have been available.

Based on feedback from the FY2016 annual CIT survey, Virginia currently has over 7,700 first responders spread throughout active CIT programs. In total over 11,000 staff from law enforcement, mental health, the court system, hospitals, and peer support specialists have taken part in CIT core training in Virginia.

The continued growth of CIT programs in Virginia is evident when the current personnel numbers are compared with those of previous years. As we continue to grow the number is expected to continue trending upward.

Current Status of Virginia CIT Programs

Virginia's CIT programs are offered the opportunity to submit updates about their local programs through the annual Virginia CIT Survey. It is important to remember that the data submitted for this survey is voluntary, and submission by almost all programs shows the willingness of Virginia programs to collaborate to support the continued growth of CIT.

Localities shoulder the financial and managerial responsibilities of establishing and sustaining CIT programs. This includes the employment and/or designation of CIT Coordinators, an essential part of a strong and growing program. In any region the CIT coordinator may be a full time employee of the CSB or a law enforcement agency or may be an employee with other full time duties as each program feels is necessary.

The chart on the next page includes the total number of personnel who have been trained by each CIT program that has its own training staff, as well as the current number of trained first responders (when available). Some CIT programs may support and practice CIT ideals, however have had to rely on neighboring programs to train their personnel for part or all of the existence of their CIT program. In these instances the chart on page 5 will show lower numbers in the total trained category.

CIT Program	Total Members Trained	Current Law Enf. First Responders
Alexandria CIT	323	200
Alleghany-Highlands CIT	0	17
Arlington CIT	417	434
Blue Ridge CIT	442	435
Chesapeake CIT	334	166
Chesterfield CIT	316	293
Colonial CIT	263	75
Crossroad's Heartland CIT	60	12
Danville-Pittsylvania CIT	265	230
Eastern Shore CIT	40	18
Fairfax-Falls Church CIT	195	195
Goochland-Powhatan CIT	11	0
Hampton-Newport News CIT	799	Not available
Hanover CIT	259	257
Harrisonburg-Rockingham CIT	201	Not available
Henrico CIT	1,484	1,344
Loudoun CIT	300	312
Lynchburg-Central Virginia CIT (Horizon)	287	270
Middle Peninsula-Northern Neck CIT	239	180
Mount Rogers CIT	192	
New River Valley CIT	590	275
Norfolk CIT	451	230
Northwestern CIT	181	140
Piedmont CIT	202	125
Portsmouth CIT	36	15
Prince William CIT	179	175
Rappahannock Area CIT	488	317
Rappahannock-Rapidan CIT	44	192
Richmond CIT	632	575
Roanoke Valley CIT	561	499
Rockbridge-Bath CIT	140	100
South Central CIT (District 19)	No submission	No submission
Southside CIT	0	52
Thomas Jefferson CIT (Region Ten)	1,000	500
Virginia Beach CIT	591	325
Western Tidewater CIT	129	150

Appropriate Intervention is a Key Component to Recovery

Crisis Intervention Team (CIT) programs, and the accompanying training have become a mainstay of policing in the past twenty years.

The vast majority of CSB catchment areas in the Commonwealth are home to CIT programs that instill knowledge and skills in first responders for recognizing and de-escalating situations involving behavioral health crises. Programs also foster close relationships between behavioral health, medical providers, with various components of the criminal justice system.

Recognizing and learning to communicate better with someone in crisis is a great first step. While protecting lives is the first priority, the needs to preserve dignity and being able to provide fast and appropriate care for individuals in need cannot be overstated.

Understanding the needs of someone in crisis is the first step. Providing them access to proper care outside of the criminal justice system is the next logical step on the path to successful recovery. CIT Assessment Sites provide the needed link to proper care in a location away from criminal justice facilities in Virginia.

In FY'16 28 CSBs were funded by DBHDS, allowing for the operation of 32 individual Assessment Site locations. These locations provide a physical embodiment of a process that offers Consumers a vital link to therapeutic intervention and assessment while also allowing law enforcement officers to quickly return to crime prevention and response duties within their localities

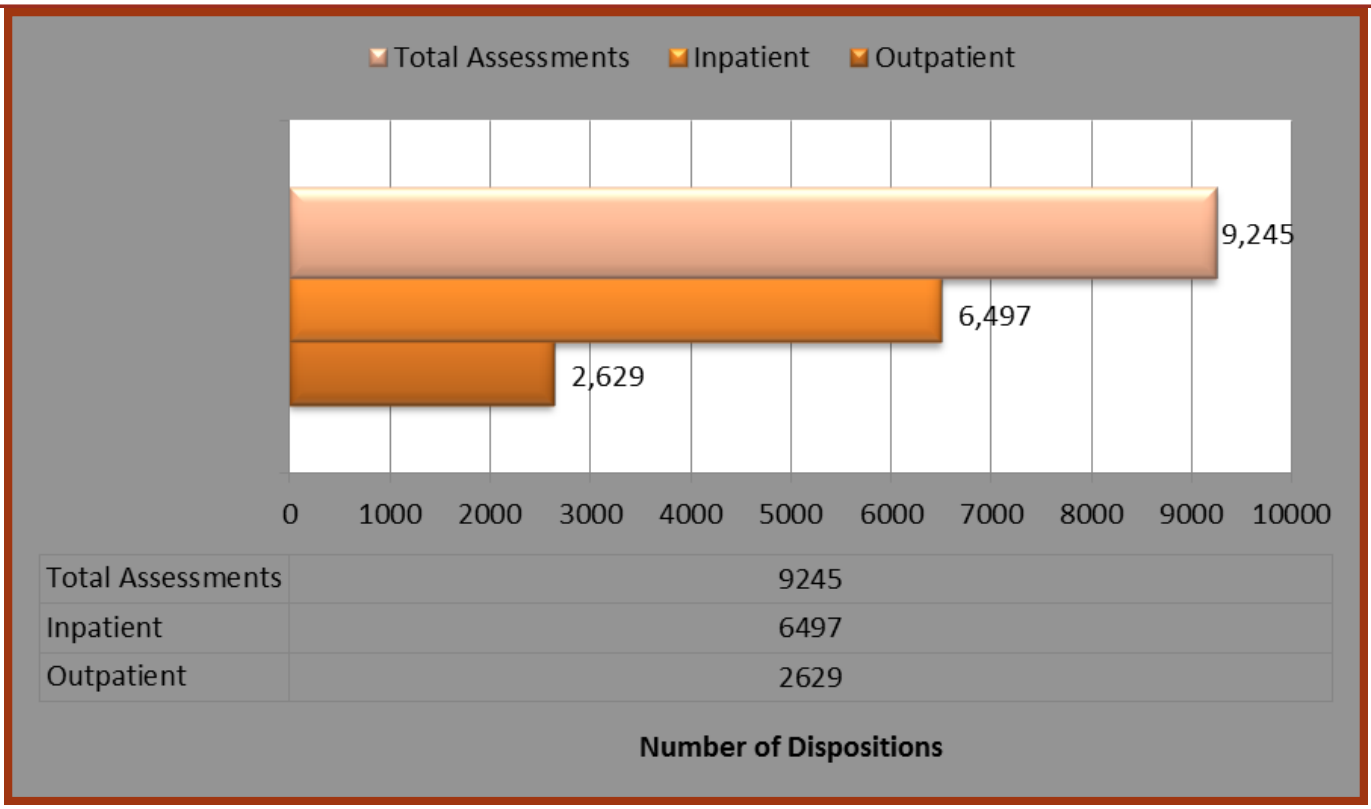
INPATIENT VS. OUTPATIENT SERVICE REFERRALS

The information contained throughout the remainder of this report details many aspects of CIT Assessment Sites and the services provided. One decision that must be made at the conclusion of the pre-screen assessments occurring at an Assessment Site is the referral to appropriate services. Although there are many different solutions to offer consumers, they can easily be separated into inpatient and outpatient services.

Inpatient dispositions are simply those situations when consumers have been either placed into inpatient hospitalization under a Temporary Detention Order, or those who have agreed to accept inpatient treatment voluntarily after the pre-screen assessment.

Outpatient dispositions include those consumers who either require no further service, or are candidates for less restrictive intervention including crisis stabilization or other scheduled outpatient services.

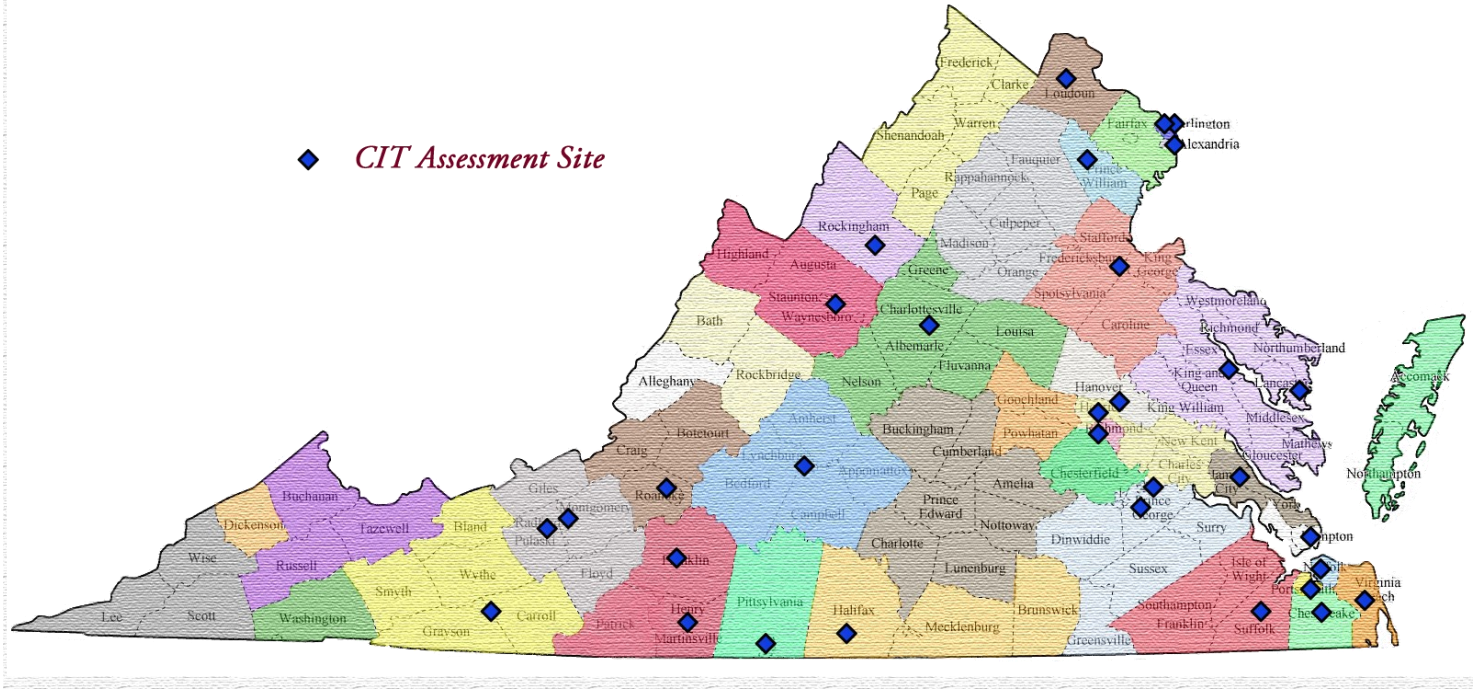
The chart below shows the inpatient and outpatient disposition numbers for all Assessment Sites during FY'16. The chart shows that the inpatient referrals account for about 70% of overall clinical dispositions while outpatient referrals account for about 28%. The total assessments do not add to 100% because of errors in data reporting from several programs.



Through fiscal year 2016, DBHDS funded CIT Assessment Sites provided approximately 126,480 hours of operational service to the local communities. With 9,245 assessments completed during that time, there were an average of 1.7 assessments per service hour in the Commonwealth.

It is important to note that the available service hours as well as the length of time that each program has existed in its community varies as well. These differences, along with population density and the familiarity of each locality with available service help to understand why the average usage is very different between different programs in Virginia.

Increases in funded Assessment Sites and Service Hours



Virginia's Assessment Site funding program began with three locations in FY2013, followed by an additional three in FY2014.

Another six Assessment Site locations were added in FY2015 for a total of 12.

The rapid growth of the Assessment Site program continued in FY'16 when the total number of funding awards was increased, resulting in 32 assessment site locations operated by 28 CSBs.

PROGRAM PARTICIPANTS

Assessment Site Program	Stakeholder Groups and Agencies
Alexandria	Alexandria CSB, Alexandria Police, Alexandria Sheriff, Alexandria INOVA
Arlington	Arlington CSB, Arlington Police Virginia Hospital Center
Blue Ridge	Blue Ridge BH, Roanoke County Police, Roanoke County Sheriff, Roanoke Police, Roanoke Sheriff, LewisGale Hospital
Chesapeake	Chesapeake IBH, Chesapeake Police, Chesapeake Regional Medical Center
Colonial	Colonial CSB, James City County Police, York-Poquoson Sheriff, William and Mary Police, Williamsburg Police, Poquoson Police, Riverside Doctor's Hospital
Danville-Pittsylvania	Danville-Pittsylvania CSB, Danville Police, Pittsylvania Sheriff, Danville Sheriff. Danville Regional Medical Center
District 19	District 19 CSB, Hopewell Police, Petersburg Police, John Randolph MC, Southside Regional MC
Hampton-Newport News	Hampton-Newport News CSB, Hampton Police, Newport News Police
Hanover	Hanover CSB, Hanover Sheriff, Ashland Police, Bon Secours Medical Center
Harrisonburg-Rockingham	Harrisonburg-Rockingham CSB, Harrisonburg Police, Rockingham Sheriff, Sentara RMH Hospital, James Madison University Police,
Henrico	Henrico CSB, Henrico Police, Henrico Sheriff, Parham Doctor's Hospital
Horizon	Horizon CSB, Lynchburg Police, Lynchburg Fire,, Lynchburg Sheriff, Amherst Sheriff, Campbell Sheriff, Bedford Sheriff, Centra Health
Loudoun	Loudoun CSB, Loudoun Sheriff, Leesburg Police, Purcellville Police, Metropolitan Washington Airports Authority
Middle Peninsula-Northern Neck	Middle Peninsula-Northern Neck CSB, Northumberland Sheriff, Mathews Sheriff, Middlesex Sheriff, Richmond County Sheriff, King and Queen Sheriff, King William Sheriff, Gloucester Sheriff, Tappahannock Police, Westmoreland Sheriff, Kilmarnock Police, Lancaster Sheriff, West Point Police, Warsaw Police, Essex Sheriff, Colonial Beach Police, Whitestone Police

PROGRAM PARTICIPANTS

Assessment Site Program	Stakeholder Groups and Agencies
Mount Rogers	Mount Rogers CSB, Galax Police, Chilhowie Police, Saltville Police, Marion Police, Wytheville Police, Independence Police, Hillsville Police, Smyth Sheriff, Wythe Sheriff, Grayson Sheriff, Carroll Sheriff, Bland Sheriff
New River Valley	New River Valley CSB, Blacksburg Police, Montgomery Sheriff, Giles Sheriff, Radford Sheriff, Radford Police, Pulaski Sheriff, Floyd Sheriff, Christiansburg Police, Virginia Tech Police, Pulaski Police, Pearisburg Police, Narrows Police, Lewis Gale Hospital
Norfolk	Norfolk CSB, Norfolk Police
Piedmont	Piedmont CSB, Martinsville Police, Franklin Sheriff, Ferrum College Police, Henry Sheriff, Patrick Sheriff, Martinsville Sheriff, Carilion Franklin Memorial Hospital
Portsmouth	Portsmouth CSB, Portsmouth Police, Safe Harbor at Maryview Hospital
Prince William	Prince William CSB, Prince William Police, Prince William Sheriff Manassas Police, Manassas Park Police, Prince William ADC
Rappahannock Area	Rappahannock CSB, Fredericksburg Police, Spotsylvania Sheriff, Stafford Sheriff, King George Sheriff, Mary Washington U. Police, Germanna CC Police, Caroline Sheriff
Richmond/Chesterfield	Richmond Behavioral Health Authority, Chesterfield CSB, Richmond Police, Chesterfield Police, Virginia Commonwealth University Police, Chippenham MC
Region Ten	Region Ten CSB, Charlottesville Police, Albemarle Police, Louisa Sheriff, University of Virginia Police, University of Virginia Medical Center
Southside	Southside CSB, South Boston Police, Halifax Police, Halifax Sheriff Sentara Halifax Medical Center
Valley	Valley CSB, Augusta Sheriff, Staunton Police, Augusta Health Middle River Regional Jail
Virginia Beach	Virginia Beach CSB, Virginia Beach Police, Virginia Beach Psychiatric
Western Tidewater	Western Tidewater CSB, Suffolk Police, Franklin Police, Windsor Police, Suffolk Sheriff, Southhampton Sheriff, Isle of Wight Sheriff

The varied models of successful CIT Assessment Sites reflect the diversity of the communities in which they are located. These differences are especially evident when examining the list of Assessment Site addresses around the Commonwealth.

DBHDS is proud to report that CIT Assessment Sites served approximately 78% of the Virginia population by the end of FY2016.

Below and on the next page are locations of the funded sites separated into rural and urban population groupings.

Programs with population over 200,000

Program Name	Site Addresses
Arlington	1701 N. George Mason Dr., Arlington 2100 Washington Blvd., Arlington
Chesapeake	736 Battlefield Blvd., Chesapeake
RBHA/Chesterfield	7101 Jahnke Rd. Richmond
Hampton-Newport News	2244 Executive Dr., Hampton
Henrico	7700 E. Parham Rd., Richmond
Horizon	1901 Tate Springs Rd., Lynchburg
Loudoun	102 Heritage Way NE, Leesburg
Norfolk	7460 Tidewater Dr., Norfolk
Prince William	7969 Ashton Ave., Manassas
Rappahannock Area	1001 Sam Perry Blvd., Fredericksburg
Region Ten	1215 Lee St., Charlottesville
Virginia Beach	1100 First Colonial Rd., Virginia Beach

Programs with population over 100,000

Program Name	Site Addresses
Alexandria	4320 Seminary Rd., Alexandria
Blue Ridge	1902 Braeburn Dr., Salem
Colonial	1500 Commonwealth Ave., Williamsburg
Danville-Pittsylvania	142 South Main St.. Danville
District 19	411 W. Randolph Rd., Hopewell 3335 S. Crater Rd., Petersburg
Hanover	8260 Atlee Rd., Mechanicsville
Harrisonburg-Rockingham	2010 Health Campus Dr., H'burg
Middle Peninsula-Northern Neck	26 Office Park Dr., Kilmarnock 1922 Tappahannock Blvd., Tappahannock
New River Valley	3700 S. Main St., Blacksburg 1201 W. Main St., Radford
Piedmont	320 Hospital Dr., Martinsville 180 Floyd Ave., Rocky Mount
Valley	78 Medical Center Dr., Fishersville
Western Tidewater	2800 Godwin Blvd., Suffolk

Programs with population under 100,000

Program Name	Site Addresses
Mount Rogers	200 Hospital Dr., Galax
Portsmouth	3636 High St., Portsmouth
Southside	2204 Wilborn Ave., South Boston

What Does an Assessment Site Look Like?

CIT Assessment Sites exist in many forms, much as the CSBs that host them.

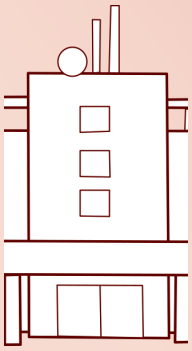
A key point to remember is that Assessment Site locations are merely a vehicle, so to speak, to support the process of diversion for mental health Consumers in crisis, in order to keep them from inappropriately entering the criminal justice system. Whether the Assessment Site is located within an emergency department, a CSB, or a private office space, there are similarities in what they offer for Consumers, law enforcement, and clinicians.

Sites typically offer a dedicated space where Consumers are safe while they have the ability to calm and receive an appropriate therapeutic assessment, usually with comfortable furniture and snacks. The clinicians and law enforcement officers typically have space to work and to maintain assessment related paperwork. Because the partners for each program are different, and many of those are hospitals, there are different factors that must be considered depending on which location is involved.

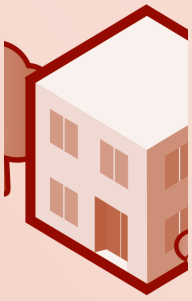
For these reasons, DBHDS works closely with applicant programs to allow for establishment of an Assessment Site in the manner that best suits the needs of each locality and the partners within each program.

FY16 SITES

20 Sites were co-located within or adjacent to hospital emergency departments



3 Sites were hosted in other hospital or psychiatric facility campus locations

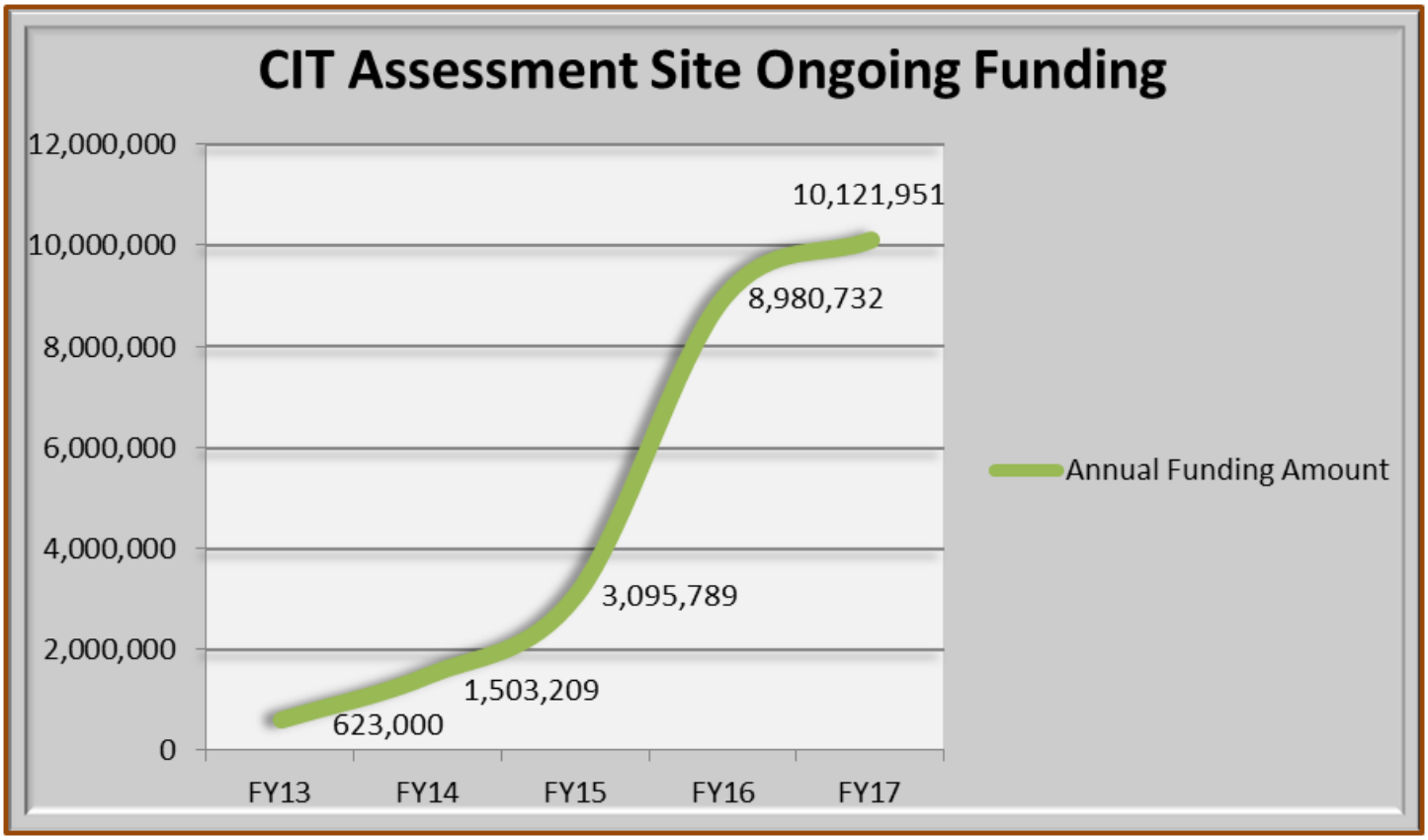


9 Sites were located in office environments including CSBs

Growth in Funding to Support Treatment

Since inception of the CIT Assessment Site funding program through DBHDS, the amount of funding available to provide crucial intervention for justice involved behavioral health service Consumers has grown significantly. The chart below shows the total ongoing funding amount provided each fiscal year since the first awards were distributed in FY2013. Ongoing awards pay for needs including pre-screen evaluator time, law enforcement and security wages to support transfers of custody at the site, transportation wages for off-duty personnel to complete TDO transports to receiving hospitals, ongoing costs for location upkeep, and funding for Peer Support specialists.

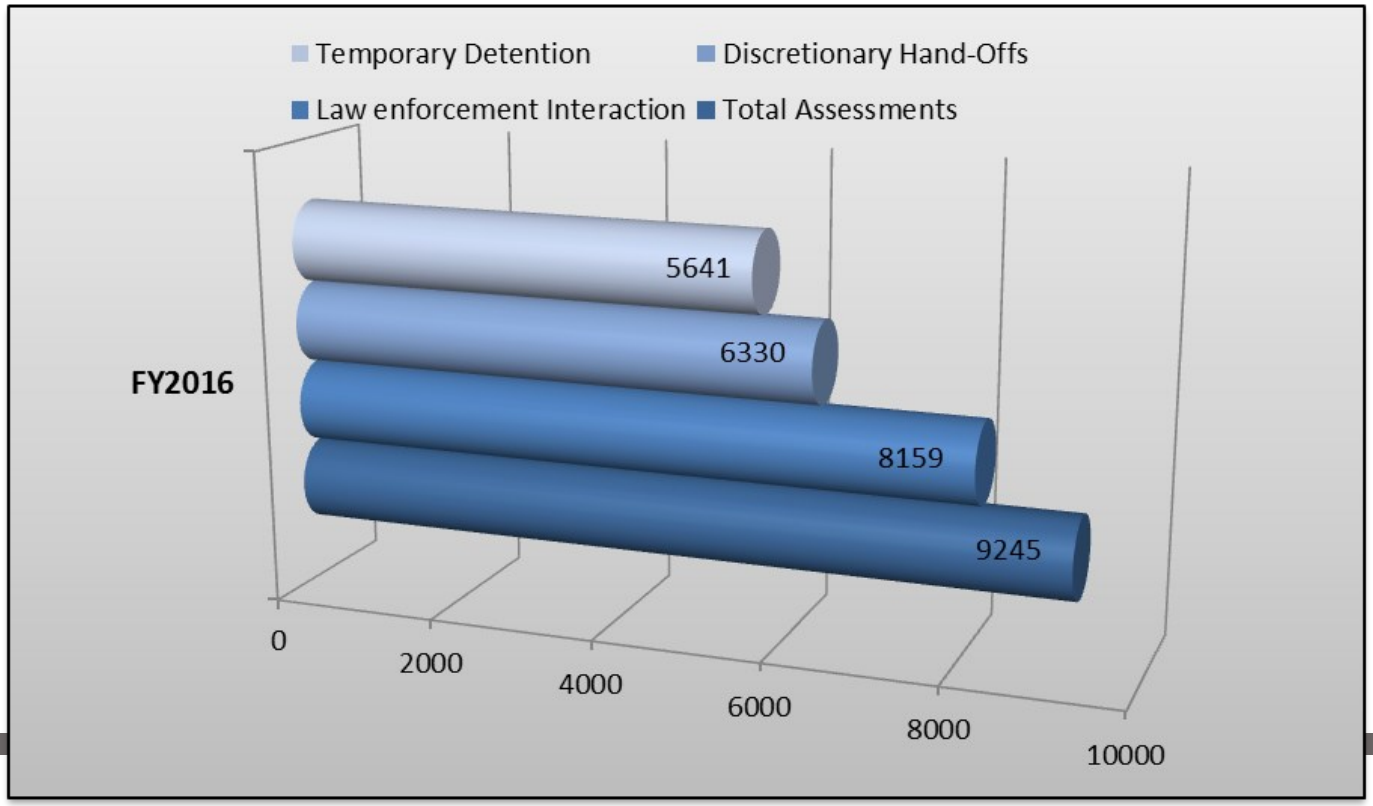
Although a total of $10.5 million is allocated for Assessment Sites, the chart below specifically shows the funding that is disbursed for ongoing award costs. These ongoing costs are used for direct Consumer services including clinicians for pre-screen assessments, staff for security to complete custody transfers, and Peer Support Specialists. Smaller one-time awards have been provided to support programs in the Commonwealth that have not yet been able to establish a fully self-sustainable CIT program. These funds are intended to support self sustained program growth in hopes of supporting the future establishment of additional Assessment Sites, with the goal of having a CIT Assessment Site available to all the citizens of the Commonwealth.

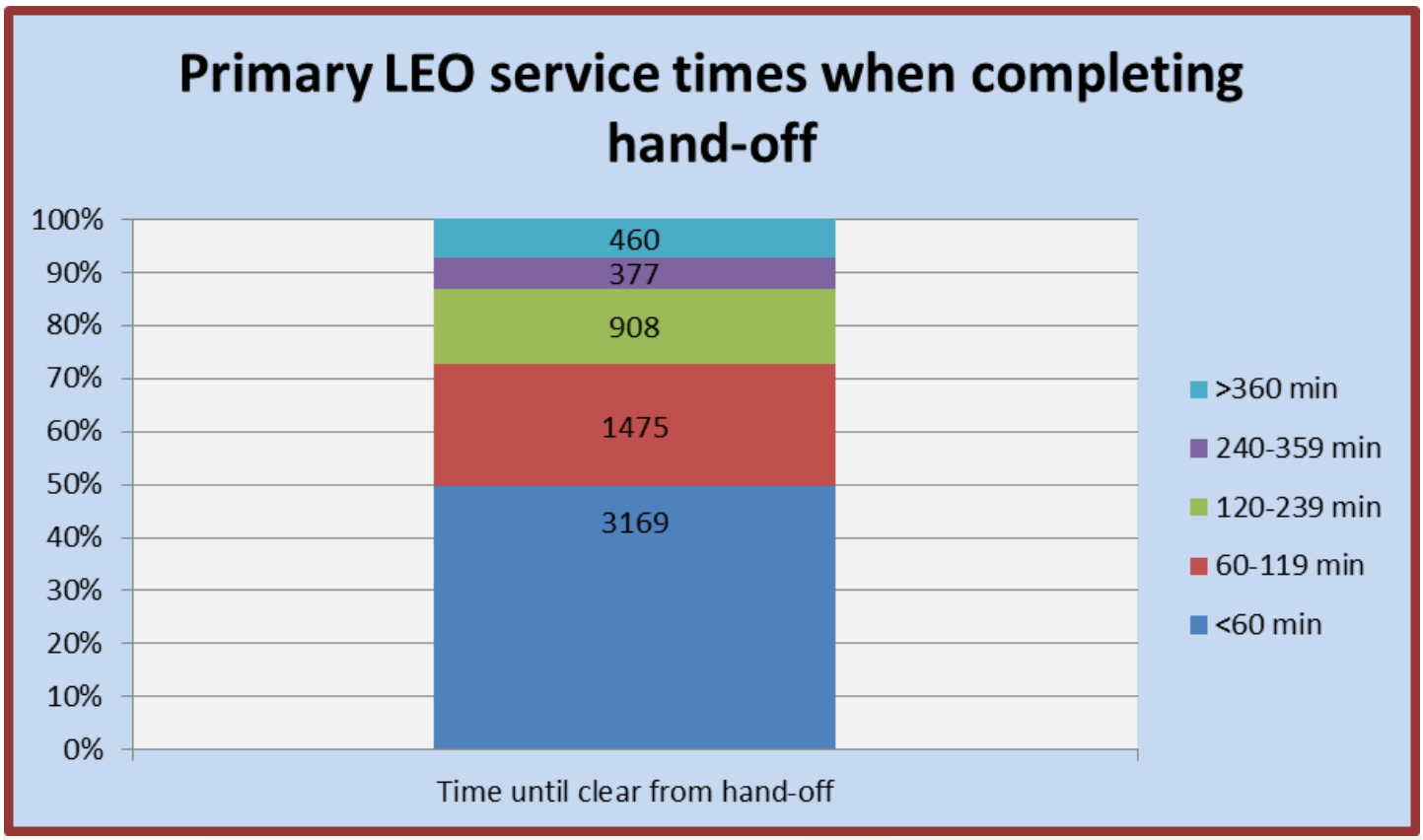


Opportunities for Discretionary Hand off to the Behavioral Health System

Law enforcement officers must face difficult choices every time they become involved with the public. Sometimes those decisions occur in tense, rapidly unfolding situations. Others occur with more time to plan. What remains consistent is that these situations are very important to the future of the person with whom the officer or deputy is interacting. This is especially true when someone is experiencing a behavioral health crisis. When these cases arise it is imperative that law enforcement officers recognize the importance of diverting people from unnecessary involvement with the criminal justice system and choose instead to deliver them to immediate and appropriate mental health services.

Virginia's law enforcement has clearly shown they understand these needs by choosing to connect individuals with CSB therapists in over 6,300 encounters during FY'16 (chart below). This translates to about 68% of the time that law enforcement came into contact with someone in crisis and chose to take them into custody and deliver them to treatment outside of the criminal justice system. The below chart shows a total assessment number exceeding the number of hand-offs because of differences in the local policies regarding Consumers accepted during Assessment Site hours. Aside from those in law enforcement custody, some programs also choose to accept Consumers experiencing acute or subacute crises when referred by family, friends, or hospital staff.





Discretionary Hand Off by Law Enforcement

Total Assessments FY'16: 9,245

88% of the assessments that occurred at funded Assessment Sites in FY'16 involved law enforcement interaction prior to arrival. The remaining 12% arrived through a referral source other than law enforcement including family, friend, or hospital staff in those localities where policies allow.

The chart above is based on the 78% of encounters when law enforcement made the choice to take a Consumer in crisis into custody and hand them over to the custody of personnel at the assessment site. In these instances a secondary goal of the transfer of custody is to ensure offices can return to their primary duties as soon as possible. The breakdown above shows the number of times officers were able to return to service from the Assessment Site by each time increment. About 50% of the time officers were clear in less than two hours. A total of about 73% of the time, officers are able to return to normal duty in less than four hours.

Transportation for Hospitalization is Resource Intensive

Whether a Consumer arrives on their own or in the custody of a law enforcement officer for a pre-screen assessment, a temporary detention order (TDO) creates several challenges that must be addressed. After the primary concern of finding an inpatient hospital bed has been addressed, the question becomes how best to transport the Consumer from the location of the assessment to the receiving hospital to begin the path to recovery.

Virginia code (§37.2-810) delineates the responsibilities and options for transportation of Consumers who are under the authority of a TDO. Transportation has historically been ordered to the law enforcement agency where the Consumer resides. When this occurs, agencies have utilized on-duty patrol officers to transport consumers under temporary detention to the destination hospital for inpatient treatment.

Finding an inpatient bed that provides the appropriate level of care based on the acuity of the Consumer can be very time consuming, even with the assistance of the bed registry. In many instances, especially in more rural localities, the bed that is located ends up being in a hospital that is a significant distance from the jurisdiction where the Consumer is located at the time of their crisis. Because of the code mandate, law enforcement agencies have had no choice in the past and have been required to transport the Consumer to the receiving hospital by using patrol personnel they must remove from current front line duty. This causes a significant strain on law enforcement resources, especially when considering that some agencies have policies that requires two personnel accompany a Consumer under TDO, which then takes two personnel off of patrol duties for a number of hours.

Mental health advocates have noted that the “old way” of transporting those in crisis, which has been in a marked police vehicle, is also not conducive to the welfare of those persons in crisis. Law enforcement agency policies often require handcuffs, even for those who are compliant, in the interest of safety. Being in a compartment designed for prisoners, not those who are experiencing illness is also not supportive of trauma informed care and reduction of stigma, a concern in the forefront of America’s mental health world. Besides environment, the physical comfort of the rear of police vehicles is not designed for comfort; the design is intended to reduce escapes, prevent the spread of infection, and allow for the easy cleanup of bodily fluids. These features do not combine for an enjoyable long distance trip.

Alternative Transportation

DBHDS engaged in a pilot program in 2015 with the Mount Rogers CSB to explore the feasibility of alternative transportation through a contract provider, for reasons as described above. Results in the experimental project received positive feedback, however fiscal concerns remain. In the meantime, several Assessment Site programs have begun working with an alternative method of their own involving officers and deputies.

Law enforcement agencies have historically completed transports for those in custody to the receiving hospital with on-duty personnel. This is a considerable burden on the front line staff by taking personnel off of the street sometimes for hours.

CIT Assessment Site stakeholder groups are now exploring the use of Assessment Site funds in several locations in order to facilitate the use of off-duty officers, deputies, and jail staff to conduct transports. These transports can take from 2 to 10 hours round trip depending on where the available bed space is located. Preliminary feedback from programs has been very positive as it allows assigned patrol staff to remain on duty in their jurisdiction while the Consumer is also safely transported to an appropriate hospital.

We continue to explore the possibilities in alternative transportation, including the use of Assessment Site funds when conditions are appropriate to support off-duty law enforcement to conduct transports. This enables on-duty officers and deputies to return quickly to their communities to perform primary law enforcement functions.

DBHDS will continue to assess the needs for transportation funds as state and local budgets are strained, and continue to work with partner agencies to develop solutions that benefit Consumers while providing relief for local law enforcement.

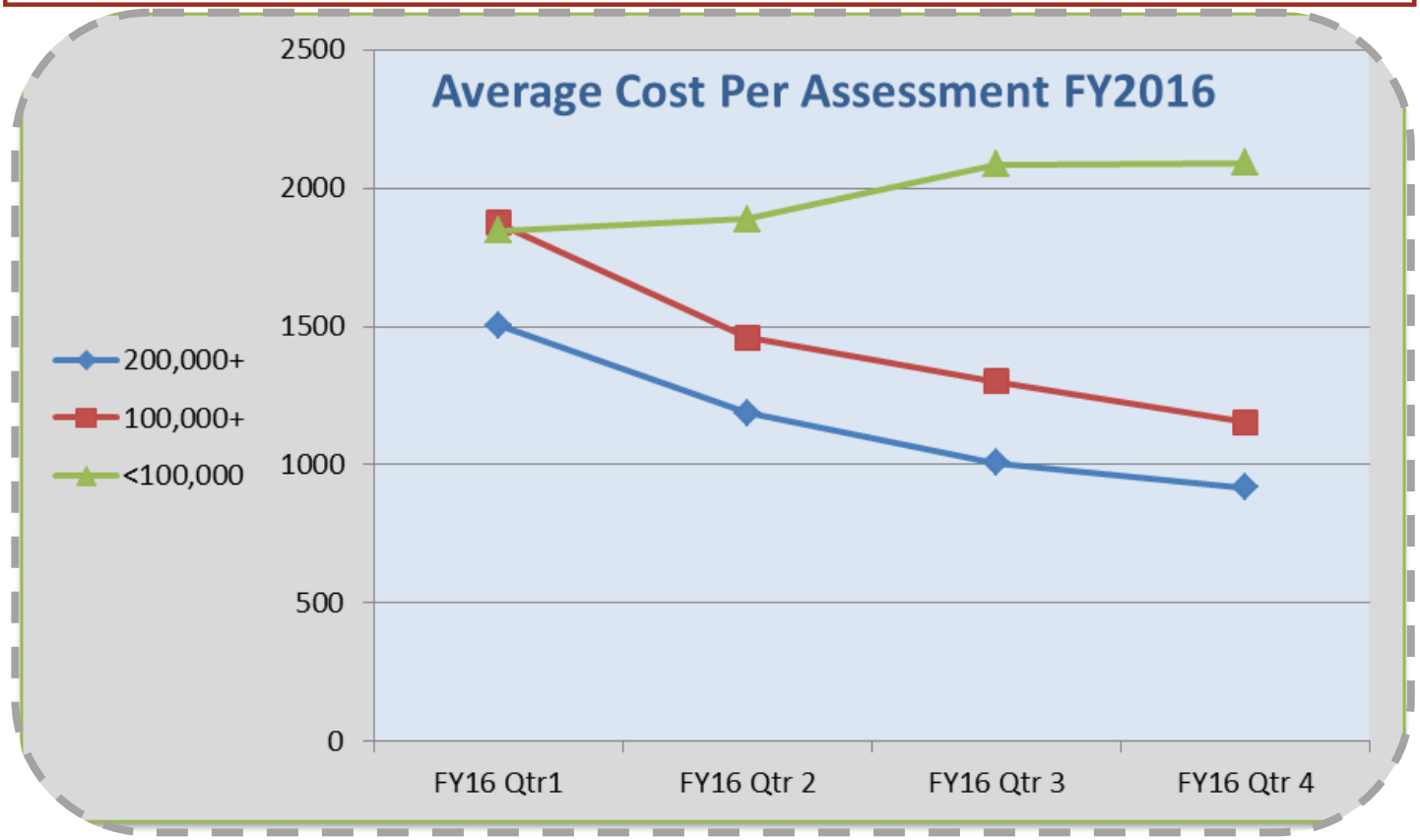
Cost Per Assessment

The average cost per assessment is calculated based on ongoing award funds disbursed to an Assessment Site program divided by the number of Consumer visits at the Assessment Site during operational hours in a fiscal quarter. Quarterly numbers are shown in line form on the chart below.

The average cost per assessment at the conclusion of FY2016 for programs in localities over 200,000 residents is $919. One program in this group (Virginia Beach) does not use award funds for direct consumer care, having established most components prior to receiving a DBHDS award. The result of this is an artificially low cost and therefore the costs per assessment for this program were not used in overall totals.

The average cost per assessment at the conclusion of FY2016 for programs in localities over 100,000 residents is $1,154

The average cost per assessment at the conclusion of FY2016 for programs in localities under 100,000 residents is $2,091. It is important to point out that some programs in this group have experienced additional challenges regarding local policies with regard to healthcare and mental health treatment. Because of these difficulties, these programs did not have consistent service for two full quarters of service. Therefore their numbers were not used in the cost comparison. Based on historical performance of Assessment Sites within the first 12-18 months, program staff believe the average cost in this subgroup will trend downward as well during FY2017.



FY2016 Ongoing Assessment Site Fund Amounts

Assessment Site Host CSB	FY2016 Ongoing Funding
Alexandria	$224,966
Arlington	$503,225
Blue Ridge	$241,401
Chesapeake	$566,972*
Colonial	$360,336
Danville-Pittsylvania	$294,240
District 19	$430,647
Hampton-Newport News	$133,053
Hanover	$220,379
Harrisonburg-Rockingham	$185,094
Henrico	$459,814
Horizon	$608,355
Loudoun	$266,160
Middle Peninsula-Northern Neck	$673,765
Mount Rogers	$335,989
New River Valley	$613,853
Norfolk	$305,295
Piedmont	$490,829
Portsmouth	$86,949
Prince William	$309,040
Rappahannock Area	$290,056
Richmond/Chesterfield	$408,182
Region Ten	$315,580
Southside	$293,014
Valley	$217,260
Virginia Beach	$150,857
Western Tidewater	$252,148

* denotes agencies as fiscal agents for other programs

Program Funding Allocation

CIT Assessment Sites all present a different slate of needs to be addressed by the funding award offered by the Commonwealth in order to support successful operations. Programs must choose funding requests carefully and provide justification for funding categories, as only those items requested and supported will receive award allocation.

Funding allocations are requested during the application process and approved based on demonstrated needs of each individual program. The Office of Forensic Services does not dictate, we advise programs on what type of funding to request. In rare circumstances DBHDS program staff may recommend funding for a purpose other than that requested based on successes and challenges observed through the operation of established Assessment Site programs. Programs may request changes for the allocation of funds as operations reveal better options to serve Consumers in their locality.

The categories shown on the chart on the next page (Clinicians, Security, Peer Services, and Transportation) are those categories for which awarded funds are most commonly requested. Clinicians to conduct assessments and security to accept transfer of custody are essential for Assessment Site operations, and are among the most difficult costs for localities to bear. Beyond those key needs, some programs have additional challenges including the ability to transport long distances or the desire to have Peer Support staff which is currently unfunded in most places.

Program	Clinicians	Security	Peer Services	Transportation	Other	Total
Alexandria	0.00%	58.83%	0.00%	0.00%	41.17%	100%
Arlington	17.81%	65.45%	16.74%	0.00%	0.00%	100%
Blue Ridge	48.24%	37.30%	0.00%	0.00%	14.46%	100%
Chesapeake	35.71%	62.94%	0.00%	0.00%	1.36%	100%
Colonial	43.71%	34.09%	10.63%	0.00%	11.57%	100%
Danville-Pitt.	41.72%	44.06%	14.22%	0.00%	0.00%	100%
District 19	44.35%	39.02%	0.00%	0.00%	16.80%	100%
HNN	0.00%	100.00%	0.00%	0.00%	0.00%	100%
Hanover	0.00%	90.13%	8.78%	0.00%	1.09%	100%
Harrisonburg/R'ham	40.56%	47.27%	0.00%	0.00%	12.18%	100%
Henrico	44.89%	42.41%	10.19%	0.00%	2.51%	100%
Horizon	22.60%	50.40%	8.09%	0.00%	18.91%	100%
Loudoun	0.00%	91.43%	8.57%	0.00%	0.00%	100%
Middle Penn/N.Neck	25.9%	15.9%	14.4%	4.7%	39.1%	100%
Mount Rogers	49.89%	47.97%	0.00%	1.79%	0.36%	100%
New River Valley	32.24%	62.34%	0.00%	1.64%	3.78%	100%
Norfolk	30.71%	23.85%	23.89%	0.00%	21.56%	100%
Piedmont	41%	32%	15%	1%	11%	100%
Portsmouth	0.00%	71.5%	16.3%	0.00%	12.2%	100%
Prince William	29.92%	56.54%	10.85%	0.14%	2.56%	100%
Rappahannock Area	0.00%	62.92%	15.65%	0.00%	21.43%	100%
RBHA/Chesterfield	50.62%	36.26%	11.79%	0.00%	1.33%	100%
Region 10	28.24%	31.01%	21.86%	0.00%	18.89%	100%
Southside	63.24%	31.94%	0.00%	4.61%	0.20%	100%
Valley	0.00%	100.00%	0.00%	0.00%	0.00%	100%
Virginia Beach	0.00%	0.00%	0.00%	0.00%	100.00%	100%
Western Tidewater	59.51%	40.49%	0.00%	0.00%	0.00%	100%

Cumulative Program Assessments by Quarter-FY'16

With the continued rapid growth of the Assessment Site program, there have been significant increases in the activity reported each quarter since FY'13. FY'16 is no different as the program expanded by 20 site locations as well as expanded service capabilities in almost all of the existing sites. The trend of increasing numbers is difficult to attribute to any one factor. Instead, it appears that community and law enforcement familiarizing with the Assessment Site and its capabilities as well as a continued increase in the number of CIT trained personnel both support the increased utilization.

Along with higher reported assessments, this annual report is also tracking the discretionary hand-offs by law enforcement as explained on page 17.

Chart 1 below shows the total assessments for all programs in each quarter of FY'16. The averages shown for each quarter correspond to the programs who had begun accepting Consumers during that quarter at any time.

Chart 2 also below shows the number of times in each quarter that law enforcement officers chose to and were able to successfully transfer the care of a Consumer in custody to security or law enforcement at the Assessment site and return to regular uniformed operations duties.

The chart on the next page shows the number of discretionary hand-offs that occurred within each program for each quarter of FY'16. Many programs were new this year, meaning they were not fully prepared for operations on July 1. The numbers in this chart show that, as programs became operational, and as existing programs continue to grow in comfort with the assessment process, the number of transfers continues to rise, showing more effective utilization.

Chart 1

2016 Fiscal Quarter	Q1	Q2	Q3	Q4
Total Assessments	1700	2207	2505	2833
Average per active program*	106	96	100	109

- programs which were funded and fully operational. Those that had not reached the ability to accept consumers for service were not considered active for this chart

Chart 2

FY'16	Total Assessments	Discretionary Handoffs	DHO %
Q1	1700	1280	75
Q2	2207	1552	70
Q3	2505	1657	66
Q4	2833	1841	65

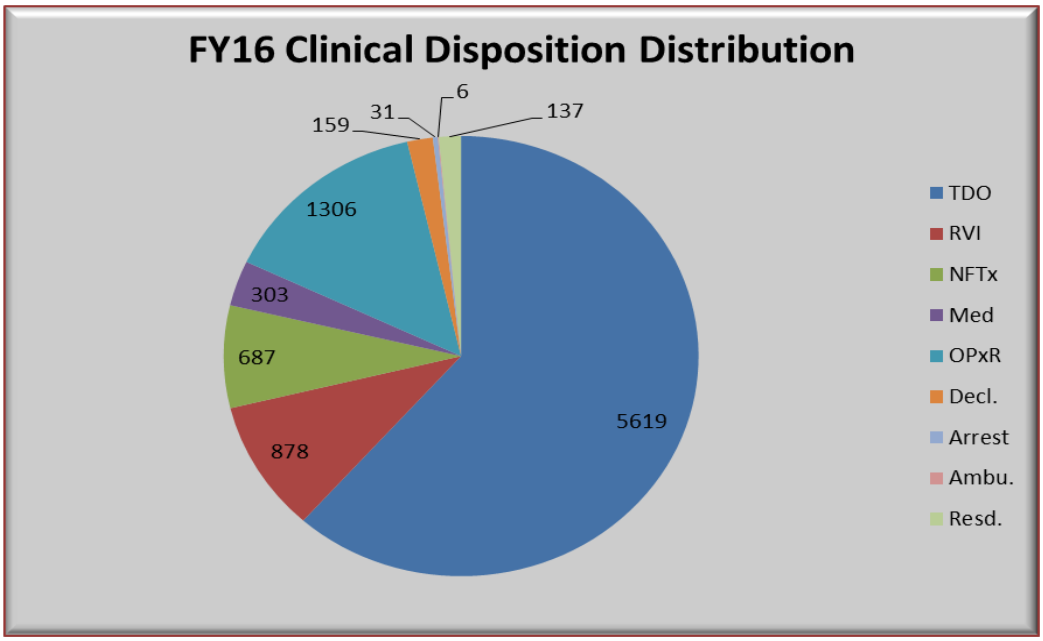
Discretionary Hand-Offs by Program by Quarter FY'16

Program	DHO Quarter 1	DHO Quarter 2	DHO Quarter 3	DHO Quarter 4
Alexandria	0	0	27	76
Arlington	104	99	111	127
Blue Ridge	0	0	0*	27
Chesapeake	*	73	92	61
Colonial	83	79	66	93
Danville-Pittsylvania	0	53	77	83
District 19	24	20	13	36
Hampton-Newport News	2	10	7	5
Hanover	44	45	35	37
Harrisonburg-Rockingham	0	10	28	49
Henrico	188	140	176	141
Horizon	110	166	55	185
Loudoun	0	1	1*	15
Middle Pen-Northern Neck	18	17	18	28
Mount Rogers	0	0	0	13
New River Valley	89	99	92	106
Norfolk	6	10	28	17
Piedmont	98	80	54	98
Portsmouth	44	61	52	54
Prince William	0	11	34	45
Rappahannock Area	21	92	105	116
RBHA/Chesterfield	106	135	139	143
Region Ten	104	93	88	98
Southside	0	0	0	0
Valley	0	0	115	*
Virginia Beach	239	172	159	123
Western Tidewater	0	87	86	65
Totals	1,280			

* indicates an error in submitted documentation. The figures shown may not represent Complete service totals

The Chart on the next page shows the breakdown of the clinical dispositions for assessments occurring at Assessment Sites during FY16. The key on this page explains the disposition options for prescreen assessment that occur at a Site.

The variation in total assessments reveals the differences in utilization between programs. A program with a lower assessment total often indicates that a program has been operating for a shorter period of time. The challenges to establish a smoothly operating program are numerous and do not accurately reflect the amount of collaborative work that goes into creating an Assessment Site program in Virginia, therefore the numbers in the chart should not be interpreted on their own as a measure of success without further understanding of program challenges.



Clinical Dispositions Key	
TDO	Involuntary inpatient treatment under temporary detention
RVI	Referred to voluntary inpatient treatment
NFTx	No further treatment was required after assessment
Med	Consumer was medically admitted following assessment
OPxR	Referral to outpatient services, no involuntary action necessary
Decl.	Consumer declined services and no involuntary action taken
Arrest	Involuntary psychiatric treatment inappropriate, criminally charged
Ambu.	Consumer was referred to ambulatory crisis stabilization
Resd.	Consumer was referred to residential crisis stabilization

Clinical Outcomes

Program	TDO	RVI	NFTx	Med	OPxR	Decline	Arrest	Ambu.	Resd.	Total
Alexandria	92	8	3	9	3	0	0	0	1	116*
Arlington	344	47	31	32	69	10	1	0	0	534
Blue Ridge	49	21	0	0	17	0	0	0	0	87
Chesapeake	225	37	41	10	27	3	1	0	0	344
Colonial	333	45	51	25	158	7	0	0	4	623
Danville-Pitt.	160	4	45	10	13	3	0	0	0	235
District 19	87	52	1	1	202	11	0	0	29	383
Hampton/N. News	21	1	0	1	1	0	1	0	2	27
Hanover	129	13	10	4	16	15	0	0	4	191
Harr./Rockingham	75	35	5	9	15	1	0	1	2	143
Henrico	487	75	80	19	10	0	12	0	8	691
Horizon	314	103	31	51	129	3	5	0	6	642
Loudoun	84	78	60	4	229	18	0	0	33	506
Mount Rogers	0	0	0	0	0	0	0	0	0	0
Middle Pen/N.Neck	41	2	38	0	3	0	0	0	1	85
New River Valley	394	20	17	22	89	1	0	0	18	561
Norfolk	53	19	14	6	33	13	0	0	14	152
Piedmont	240	47	90	20	45	4	1	0	8	455
Portsmouth	202	31	28	8	6	5	1	0	0	281
Prince William	54	15	9	0	16	1	0	0	2	97
Rappahannock Area	217	44	41	21	12	0	1	0	1	337
RBHA/Chesterfield	348	64	17	9	59	24	1	0	3	525
Region Ten	248	36	15	9	54	19	2	0	0	383
Southside	0	0	0	0	0	0	0	0	0	0
Valley	350	33	7	11	28	4	3	5	1	442
Virginia Beach	882	46	52	17	11	0	2	0	0	1010
W. Tidewater	190	2	1	5	61	17	1	0	0	277
Total	5619	878	687	303	1306	159	31	6	137	9,127*

* Individual data items occasionally do not calculate based on errors in spreadsheets, therefore totals vary slightly between charts

DBHDS CIT Initiatives

Program Staff

Michael Schaefer, Ph.D. ABPP
Asst. Commissioner of Forensic Services

Steven Dixon, Psy.D.
Forensic Operations Manager

Stephen Craver
CIT Assessment Site Coordinator and Virginia CIT program liaison

Sarah Shrum
Forensic Admissions and Jail Diversion Coordinator

Jefferson Building
1220 Bank St.
Richmond, VA 23219

Collaborate. Innovate. Transform.

The CIT Assessment Site program is funded through budget allocation by the Virginia General Assembly. Without the continued support of our legislators, thousands of behavioral health service Consumers would lack access to immediate and proper therapeutic care.

Virginia's therapeutic assessment and diversion programs are recognized around the United States and provide more comprehensive coverage than any others.

But there is work yet to be done.

Www.dbhds.virginia.gov

Looking to the Future of Consumer Service Availability

Treatment and services available for those with mental illnesses continue to be in the spotlight in the U.S. on a daily basis. Continuing to learn and improve solutions and including emergency services and other avenues to quicker recovery are in the best interest of Consumers, law enforcement, behavioral health professionals, and the public. DBHDS is committed to creating opportunities and solutions.

Legislative committees and work groups within the Virginia government continue to leverage the expertise of those working in the field. As a leader in many aspects of diversion programs DBHDS needs the ongoing support of our General Assembly to continue finding and implementing best practices in Virginia.

Few programs around the country have progressed more than Virginia in such a short time. We are in a solid position to gain valuable information from those programs that have been able to move ahead even further. With our level of experience and shared knowledge from other successful localities our programs will continue to grow and be models for others across the U.S.

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APPENDIX

The appendix contains individualized graphs and charts of information corresponding to those within the main body of this report. The programs are arranged alphabetically by CSB name instead of CIT program, as the data contained in these charts is specific to CIT Assessment Sites.

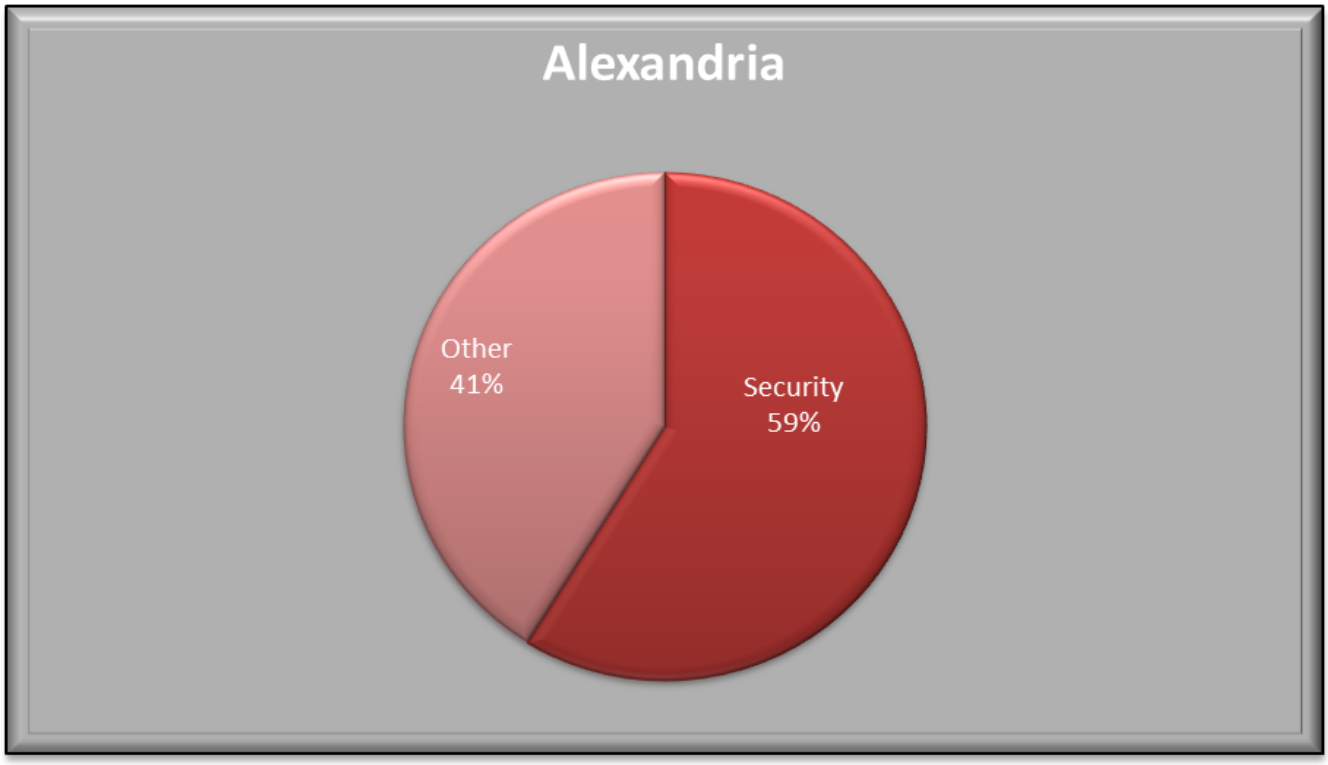
The first chart for each program displays the fund allocation percentage for each program. When CSBs apply for Assessment Site funds, they are able to specific the purpose of requested funds, which will differ based on the resources and needs of each program and locality partners' ability to contribute.

The second chart (bottom p.1 for each program) shows the cost per assessment for the program. This cost is calculated using only ongoing award funds since the ongoing funds are primarily for direct Consumer care related expenditures. The funds are distributed in equal installments from DBHDS to the CSB, and the assessments are reported quarterly on standardized data collection forms. The raw assessments are compared with the amount disbursed by the end of each quarter to achieve the cost represented.

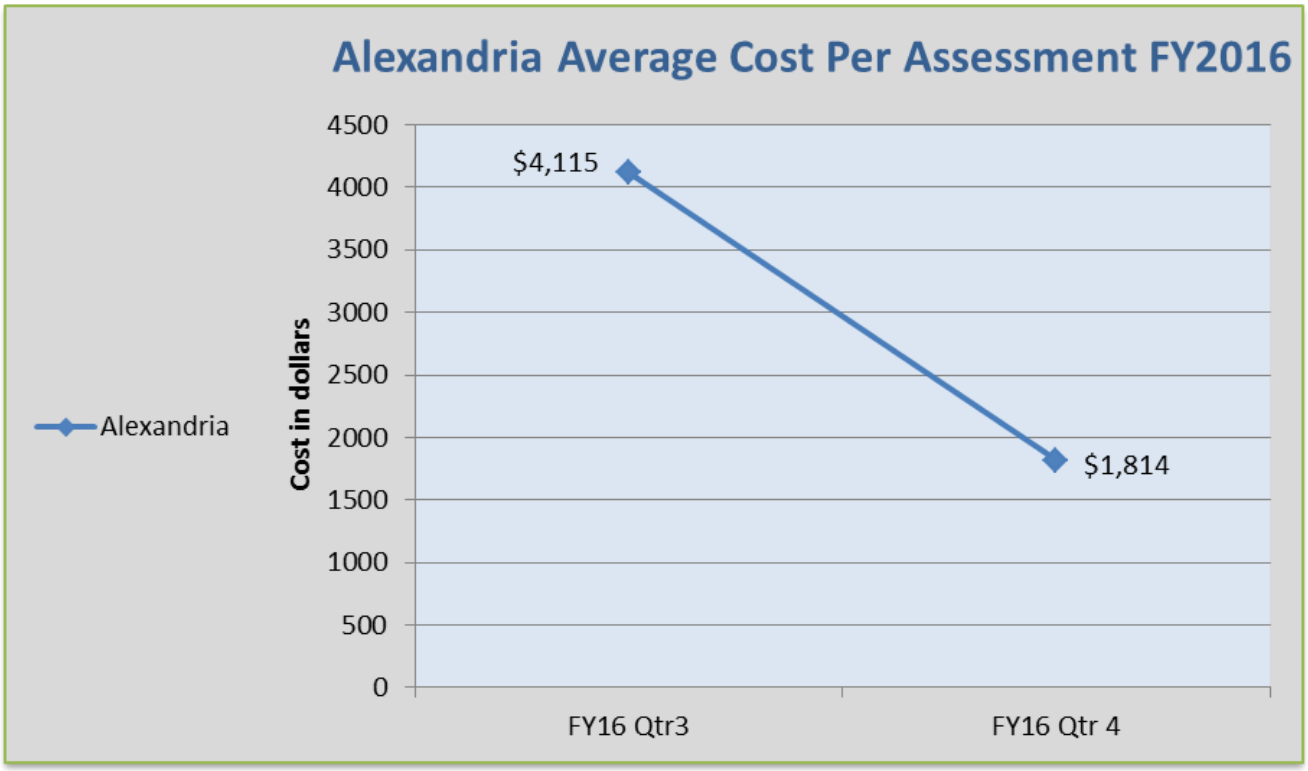
The third chart shows the raw numbers of how many officers were released prior to the specific time increments in those cases when law enforcement completed the transfer of custody of a Consumer to a security professional on duty at the assessment site.

The last chart (bottom of second program page) displays the raw number of each type of disposition for the clinical assessments which occurred at that program's Assessment Site during operational hours.

Allocation of Assessment Site Funds



Quarterly Cost Per Assessment



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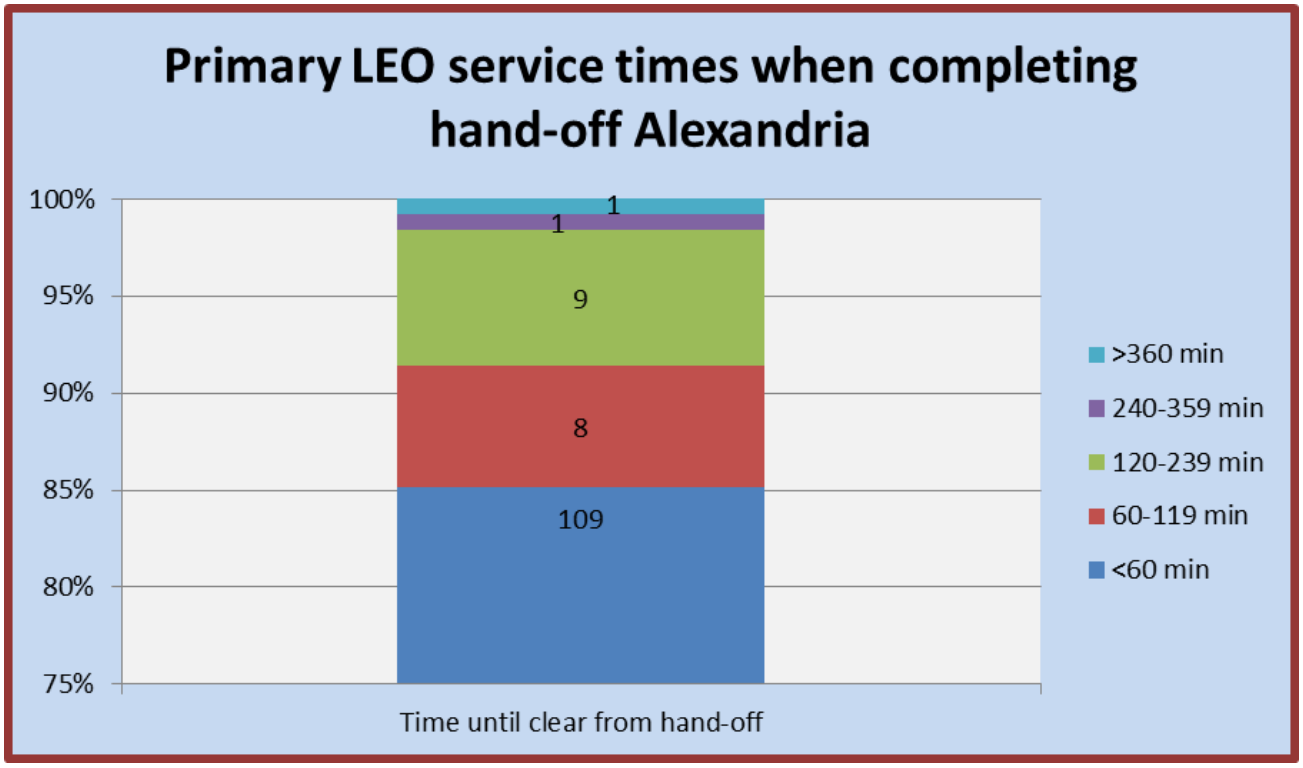
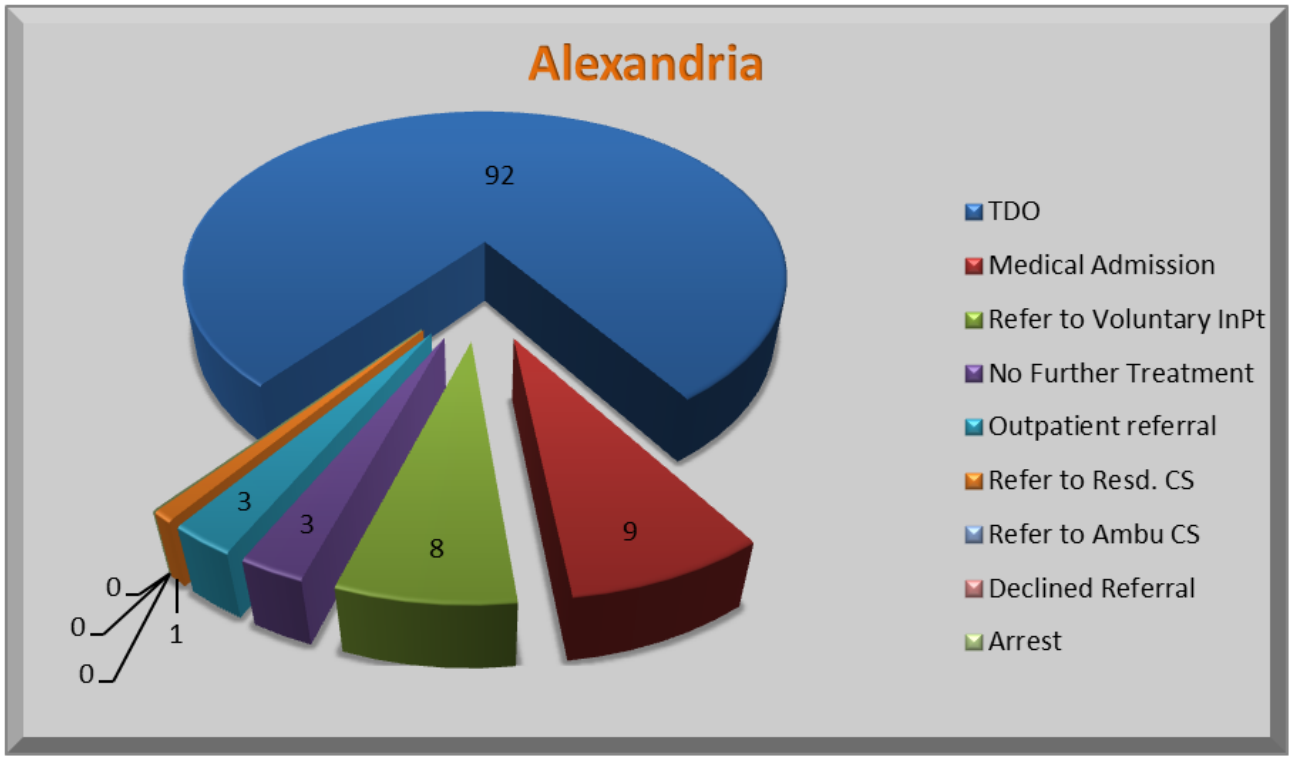
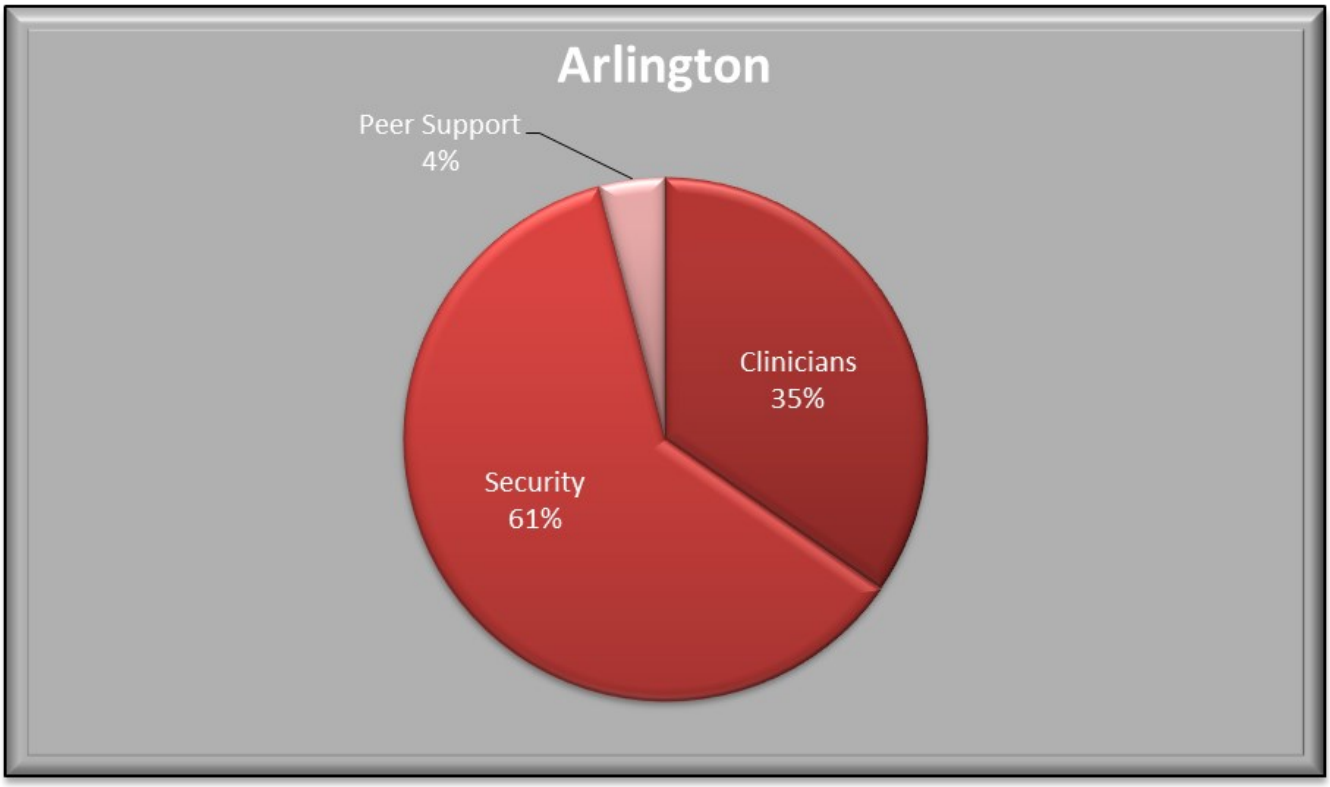


Clinical Dispositions



Allocation of Assessment Site Funds



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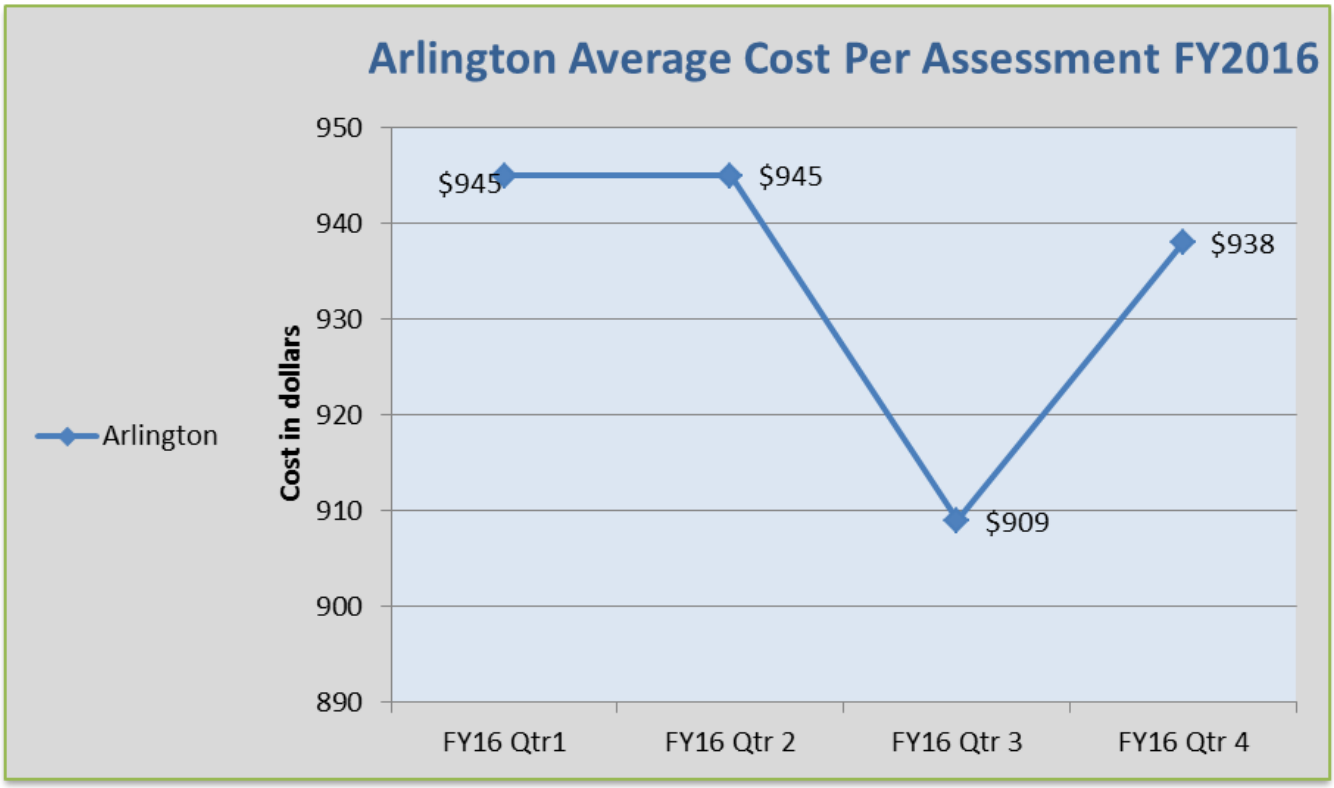

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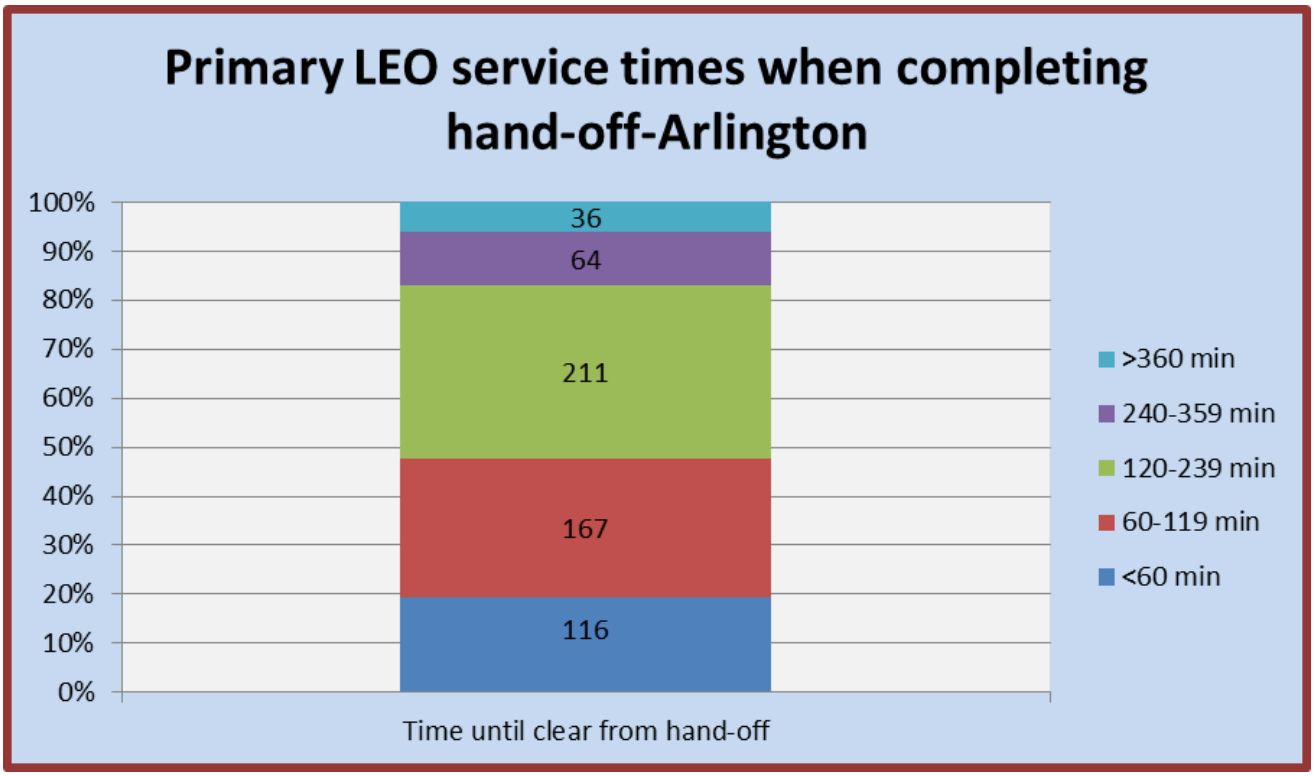
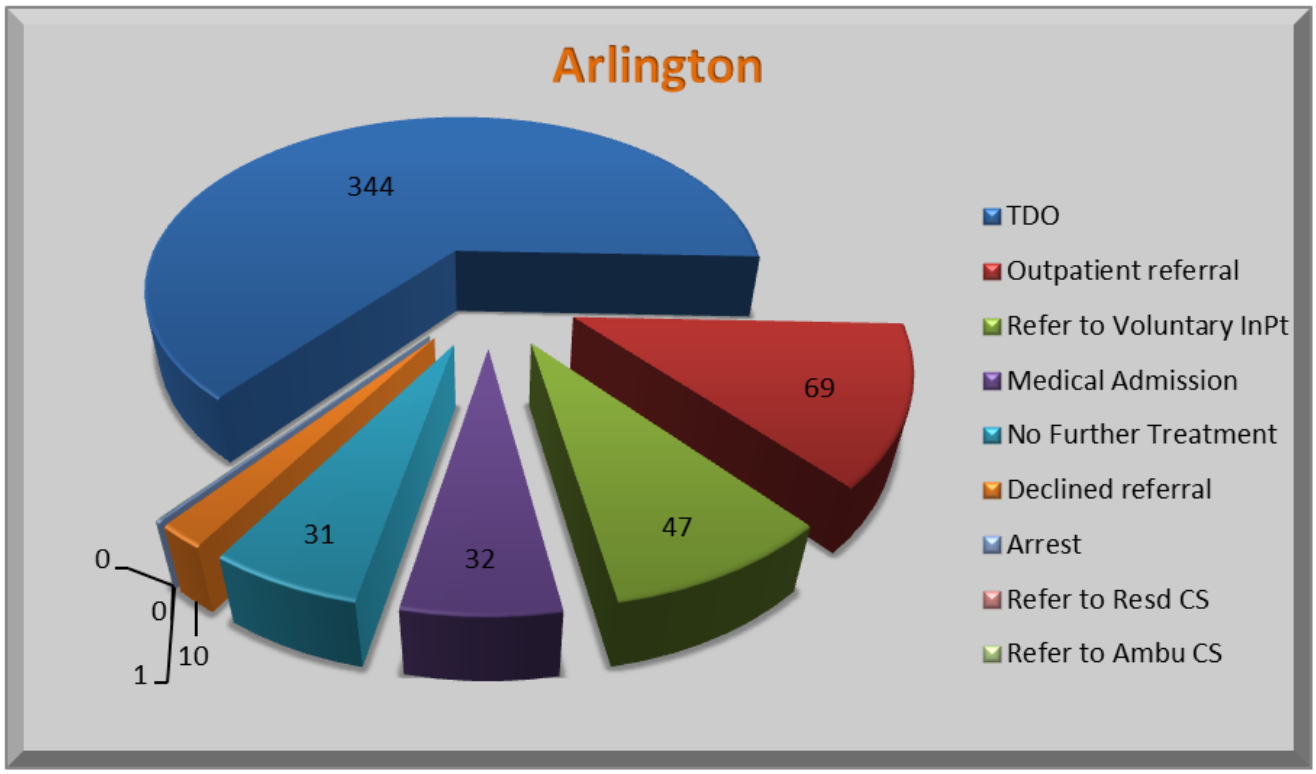


Clinical Dispositions



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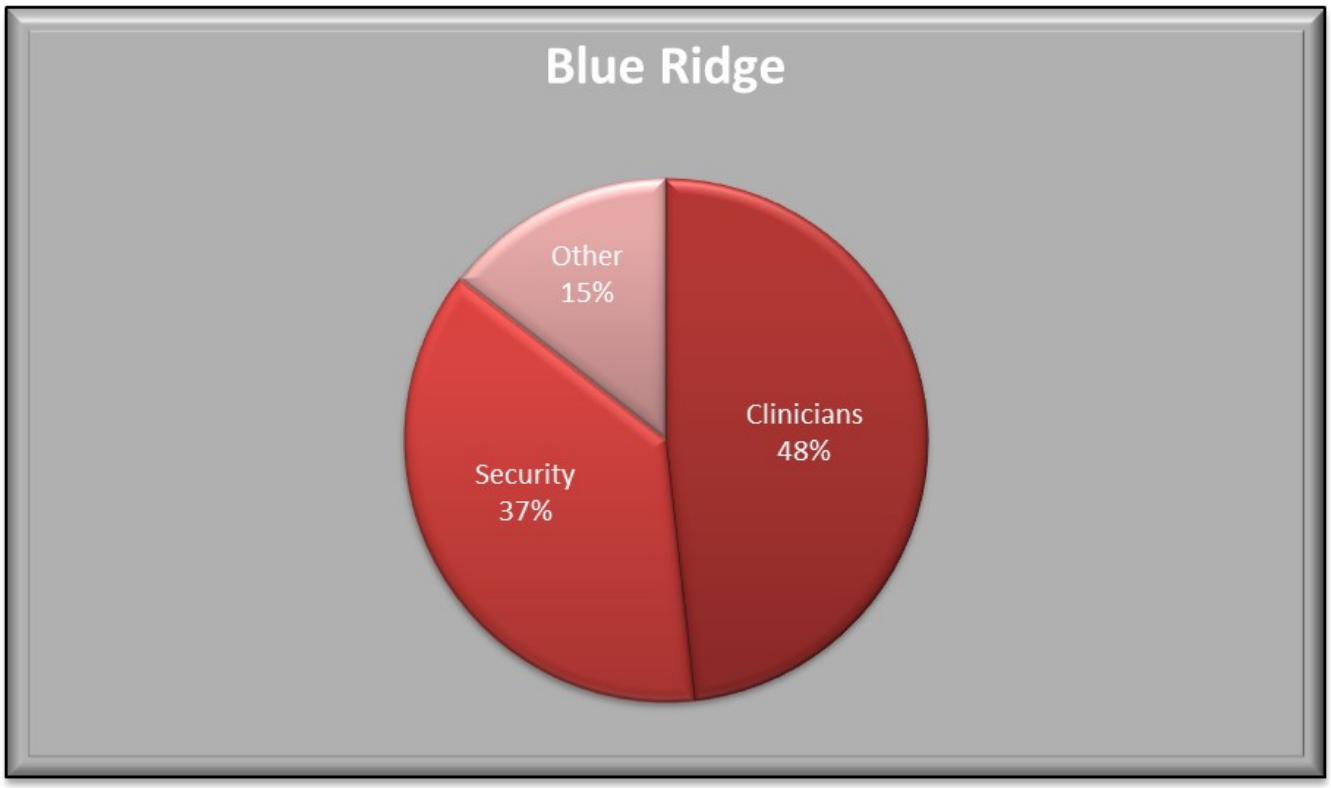

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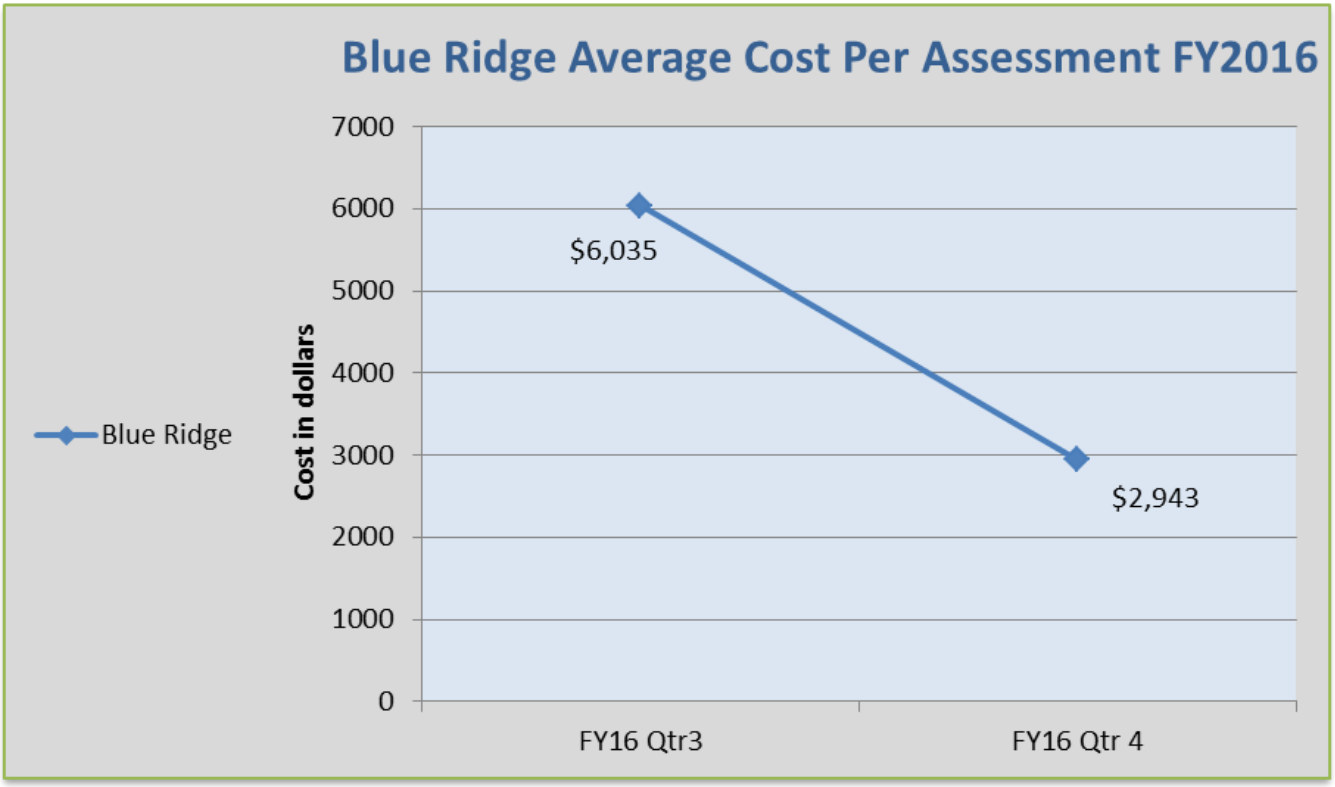

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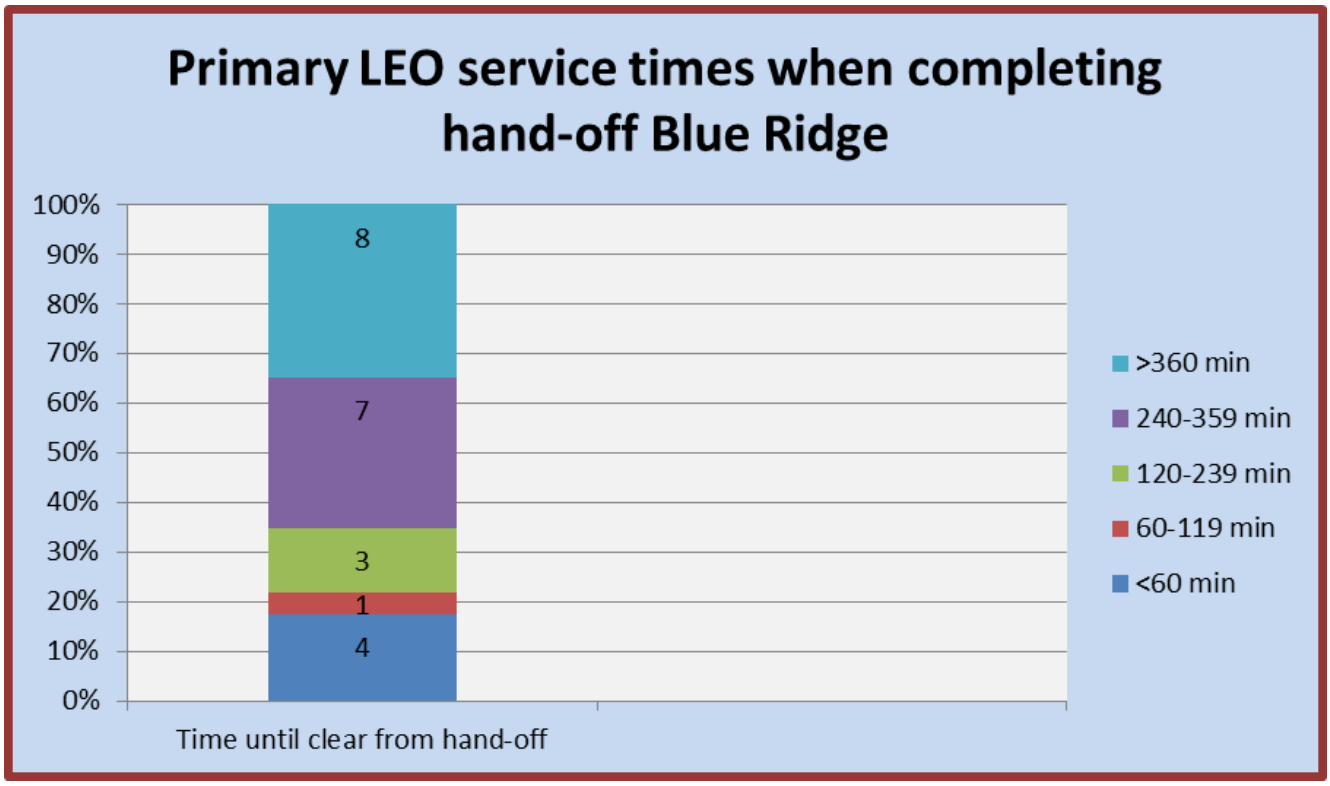

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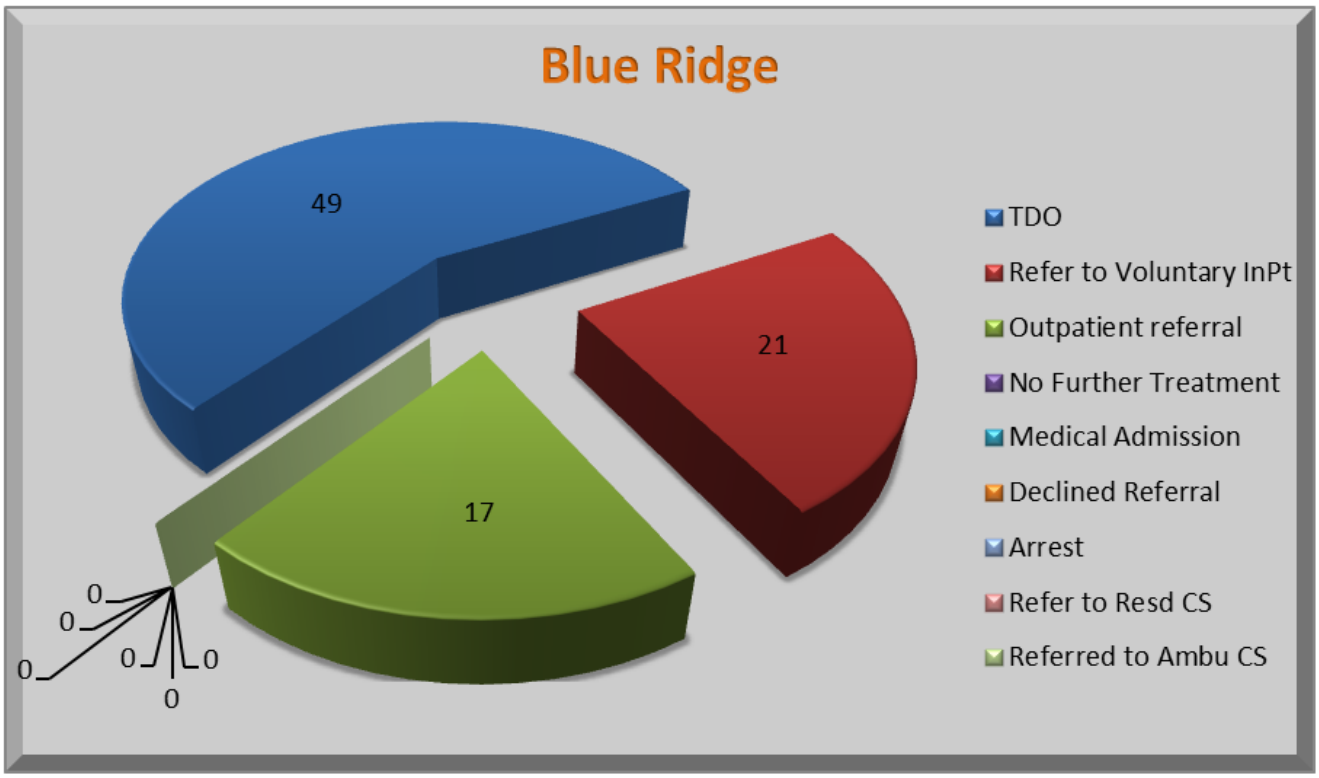
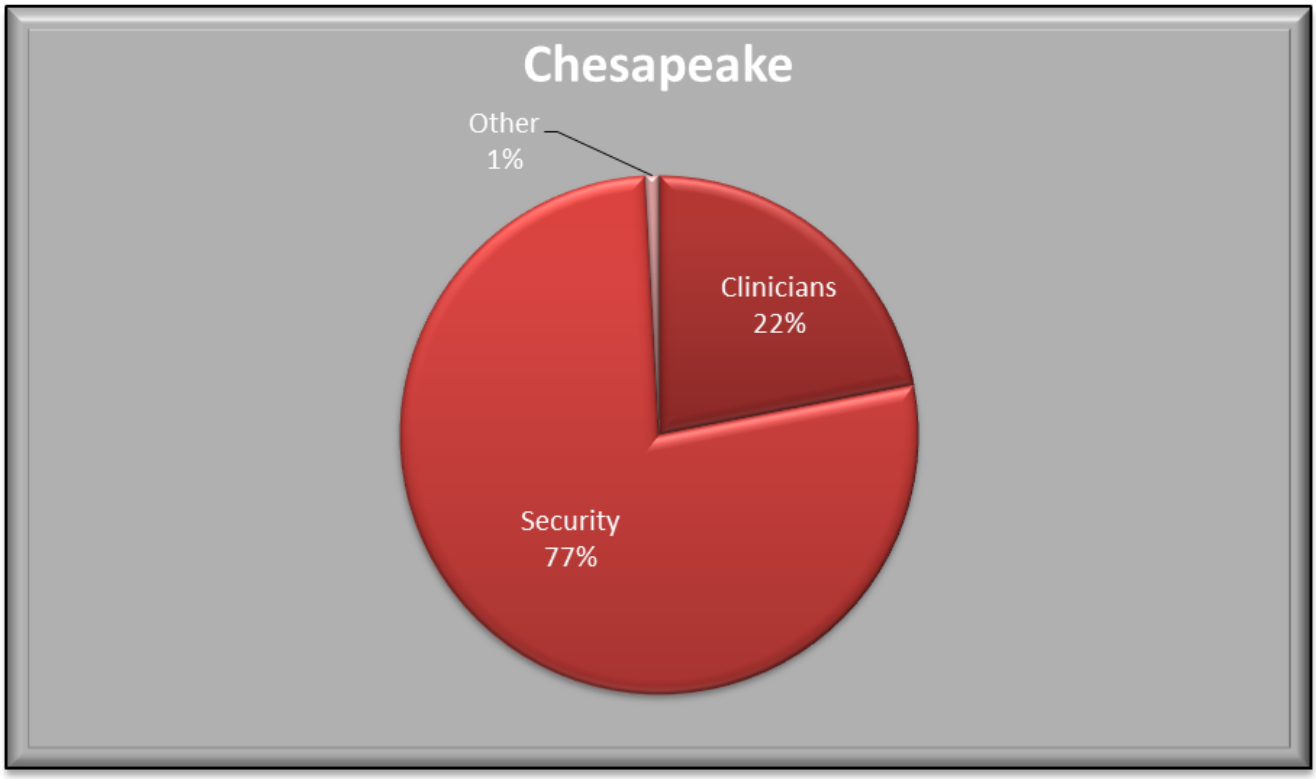


Allocation of Assessment Site Funds



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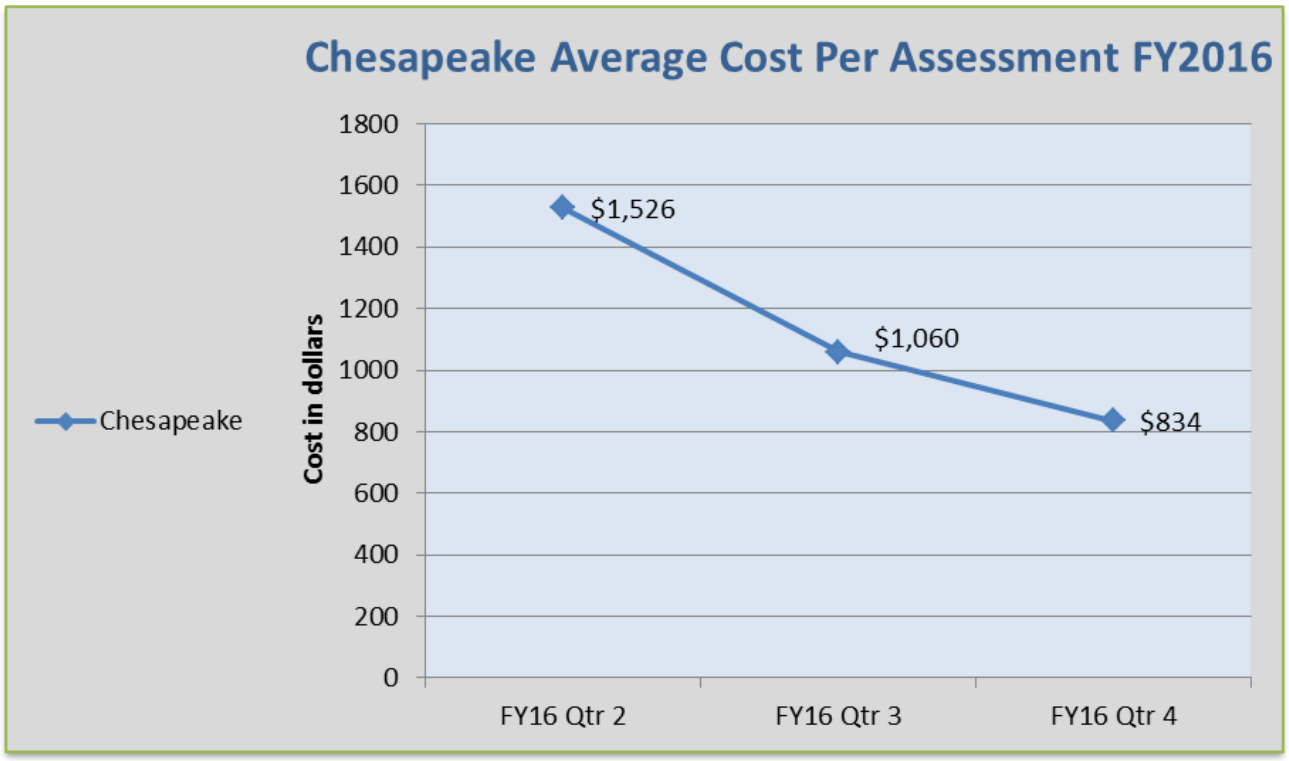

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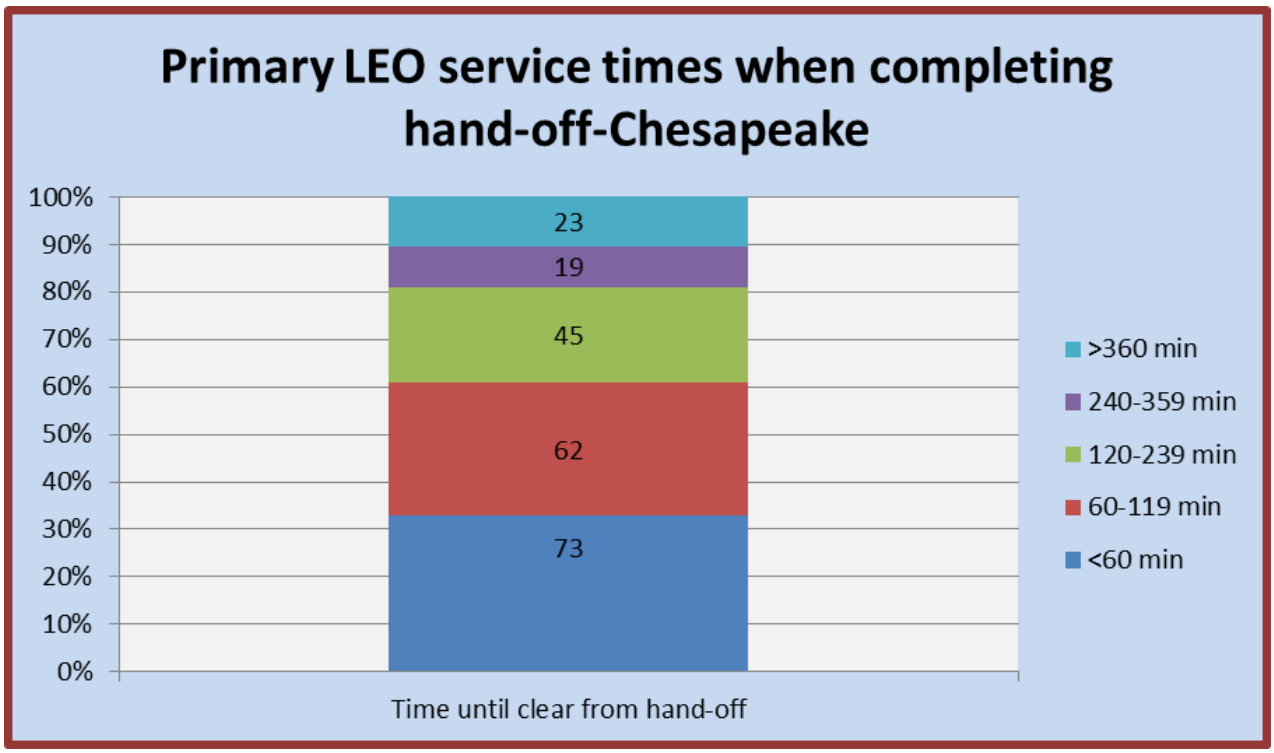
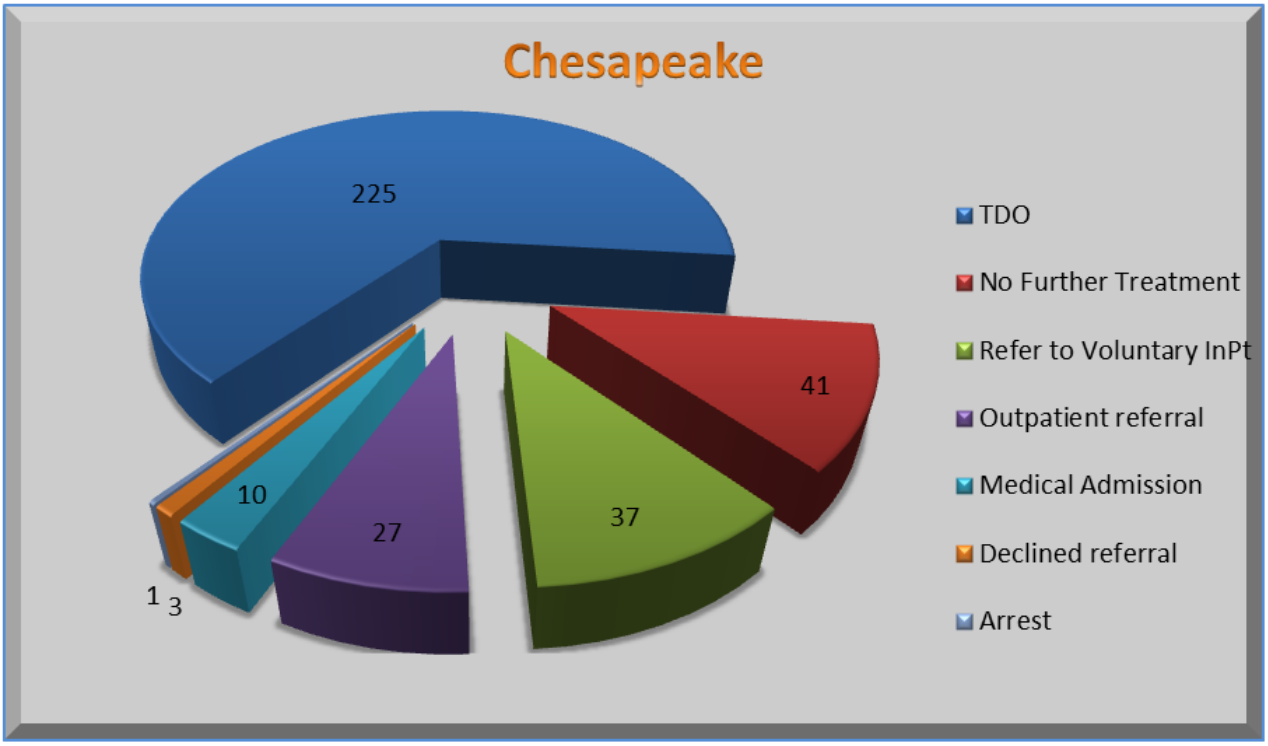


** 57 records incomplete, not included*

Clinical Dispositions



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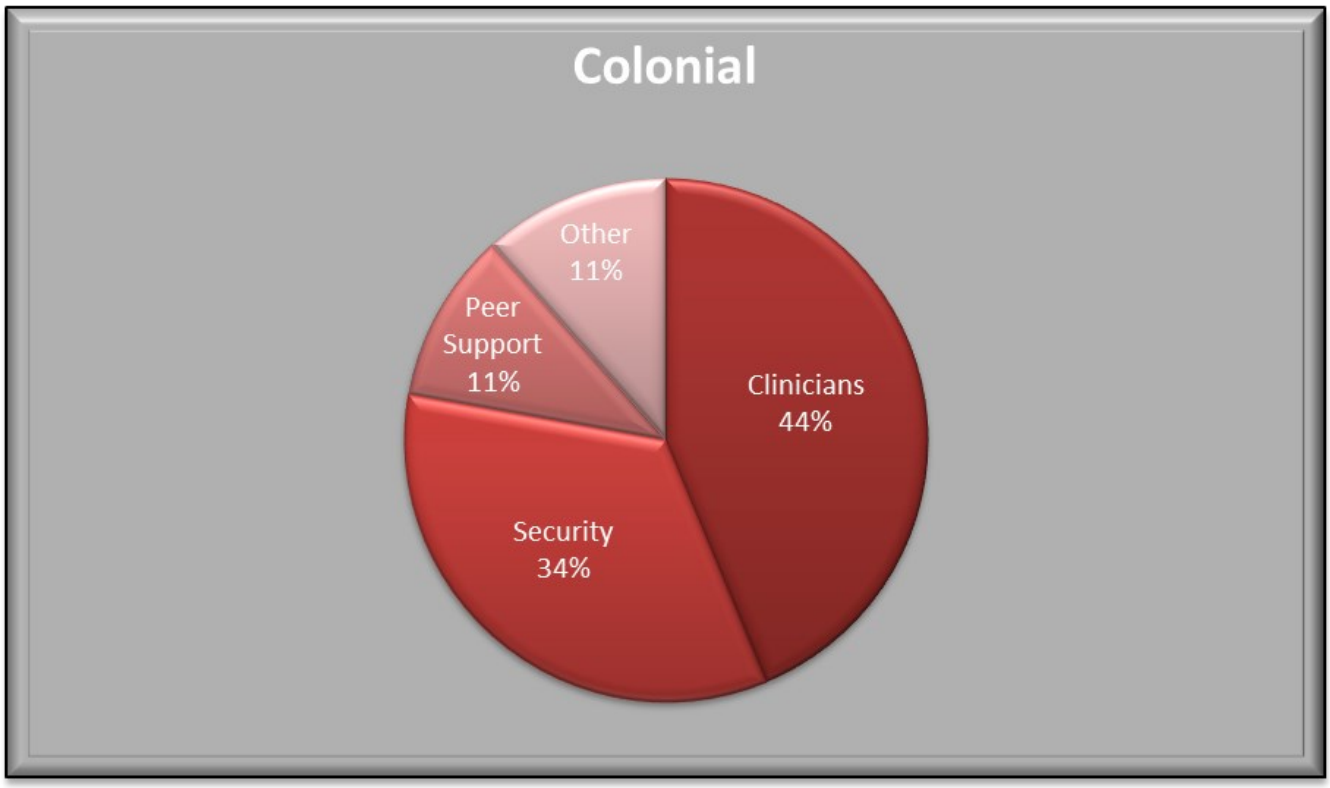

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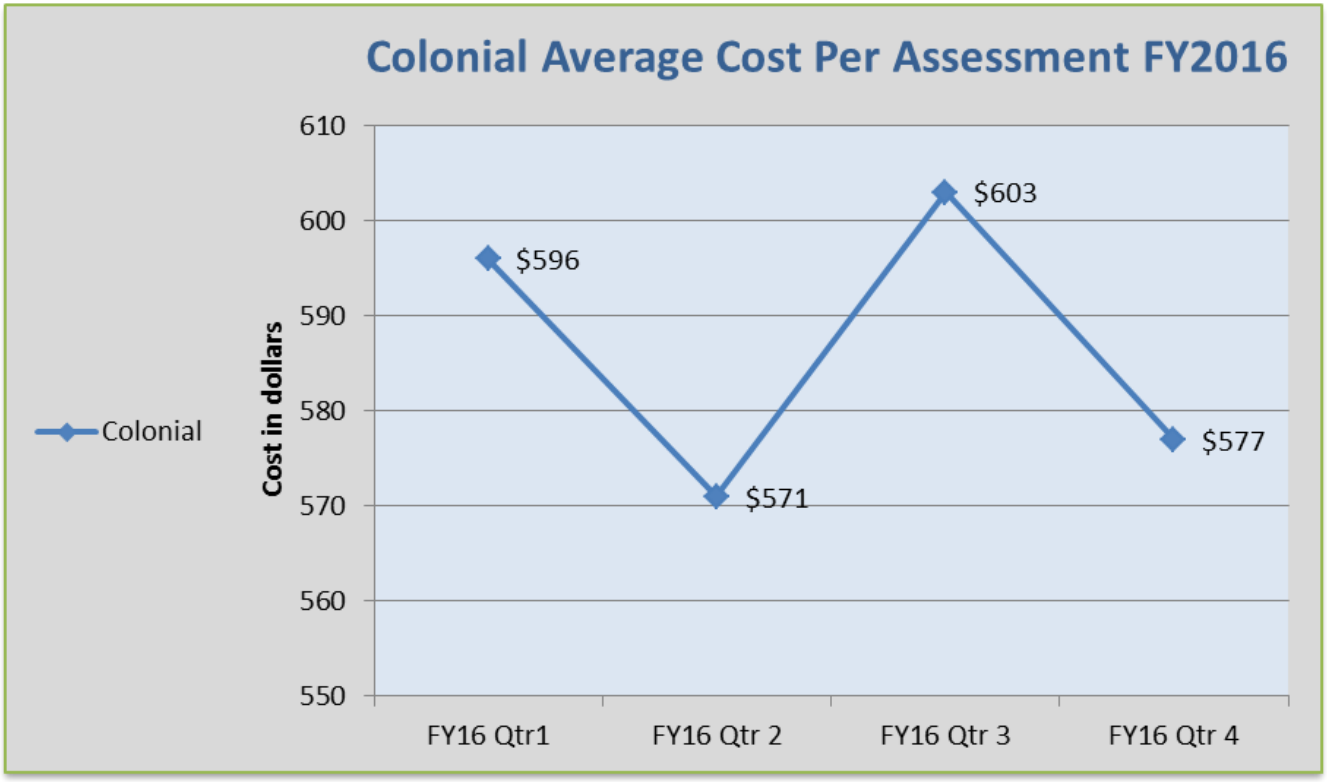

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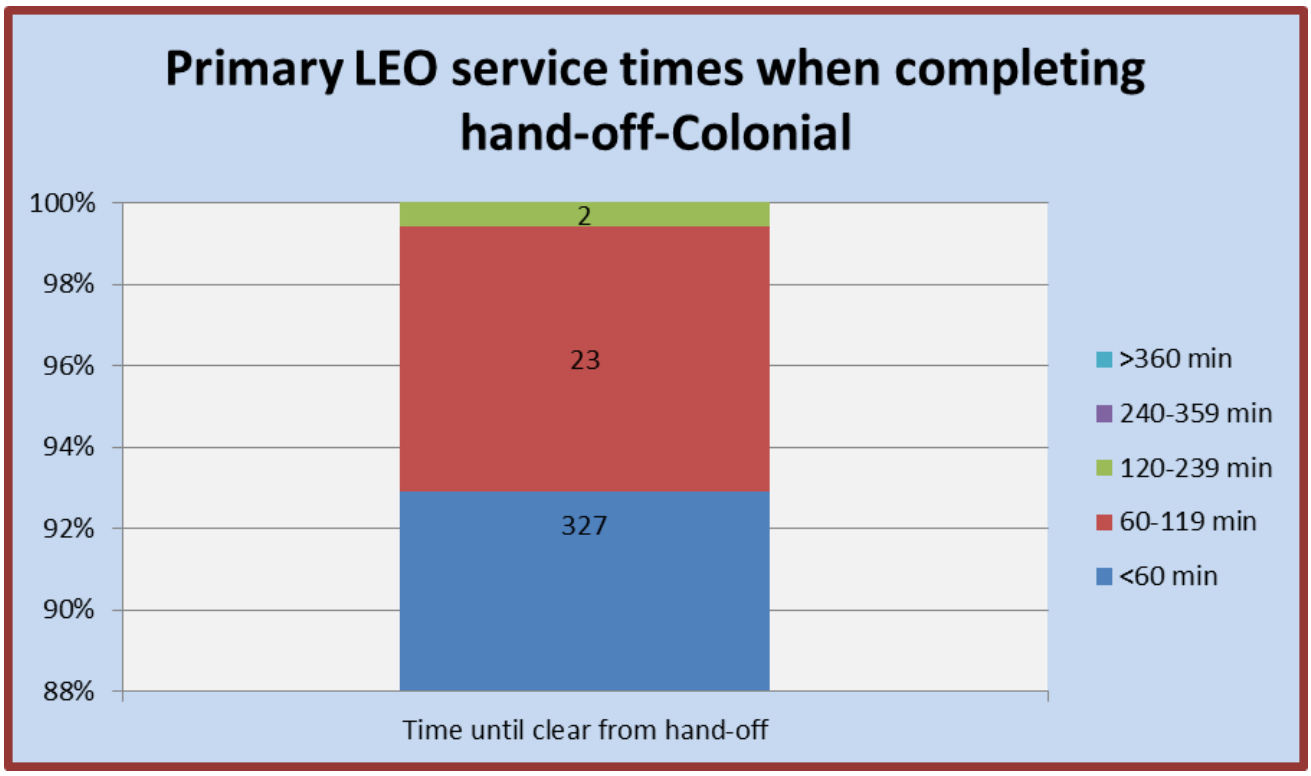

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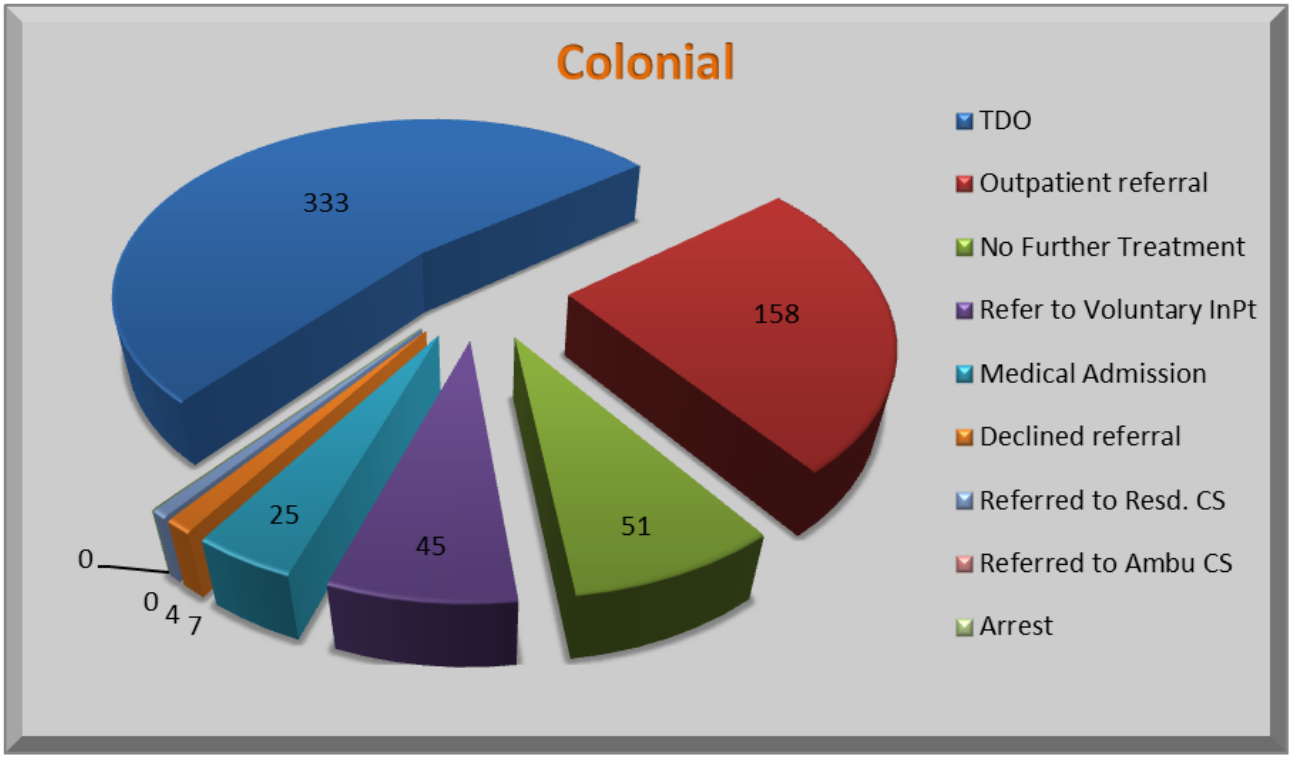

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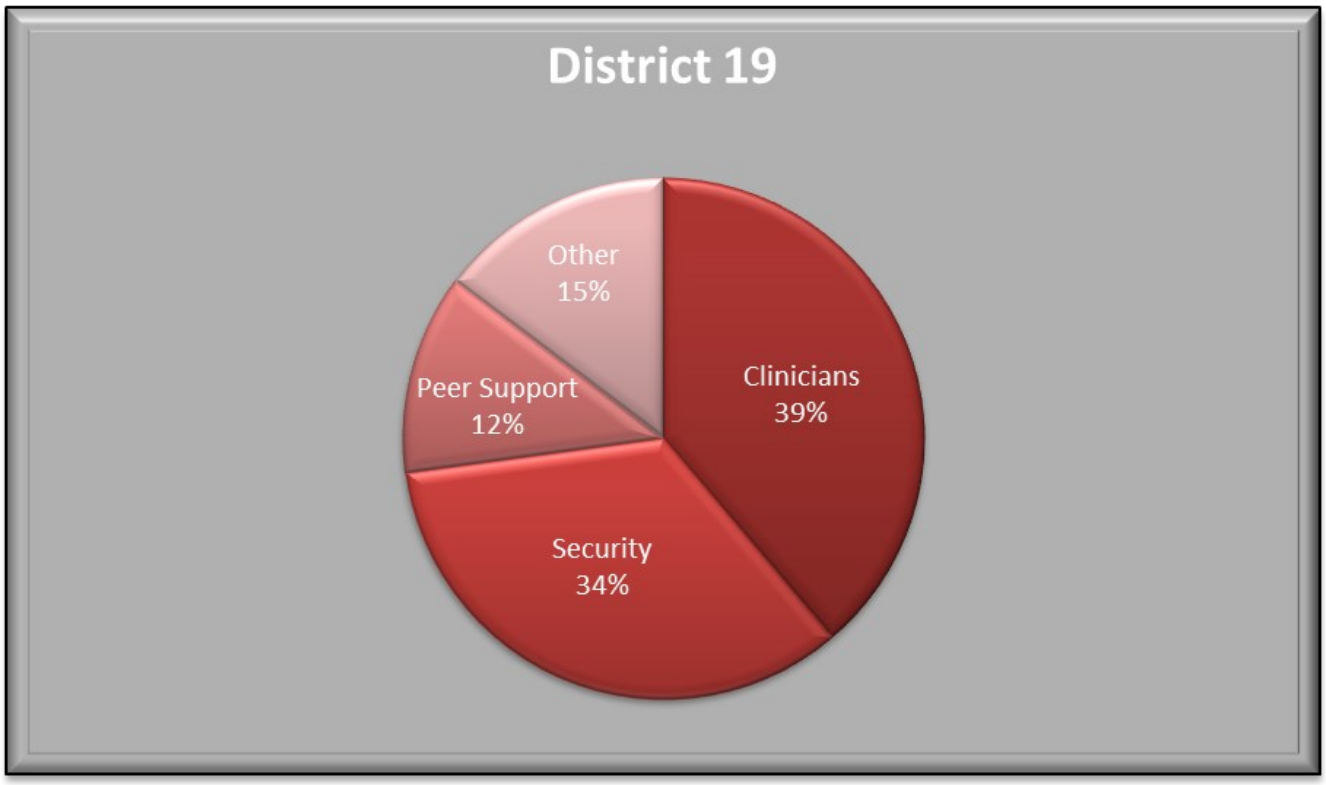

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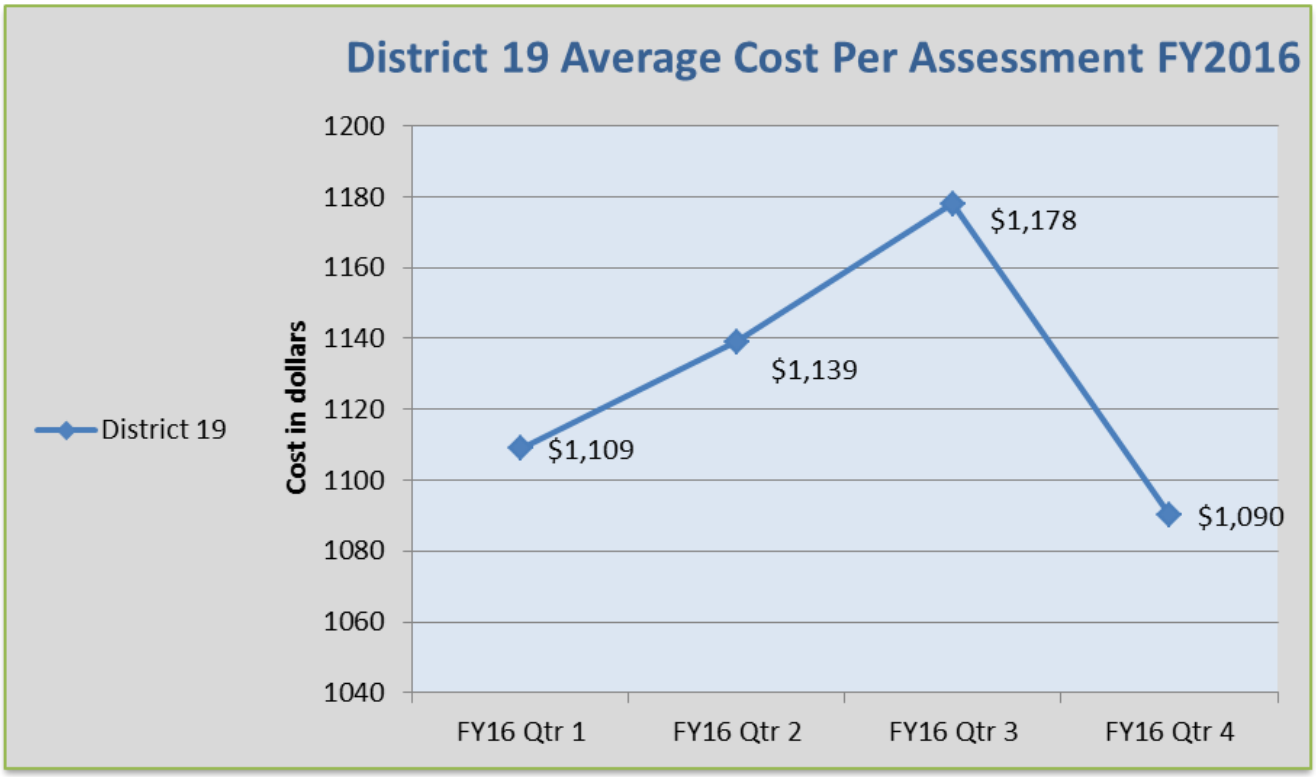

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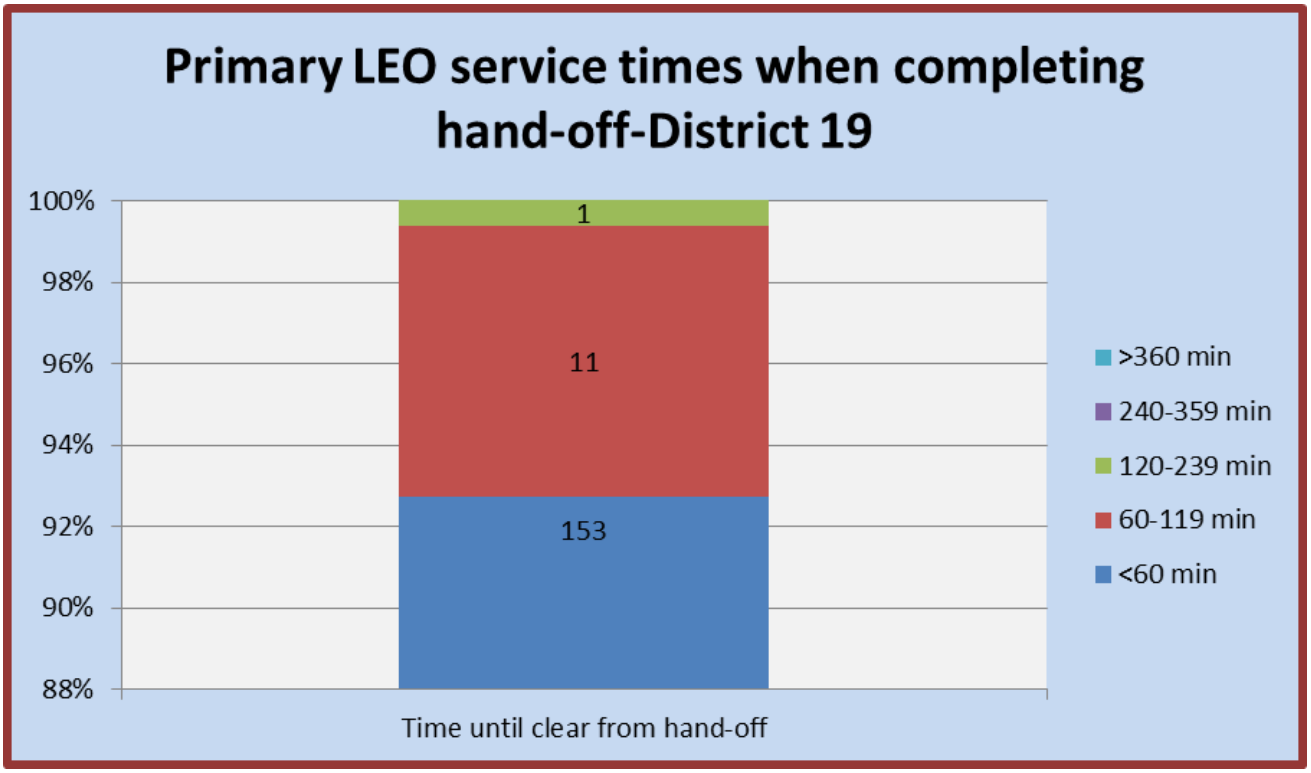

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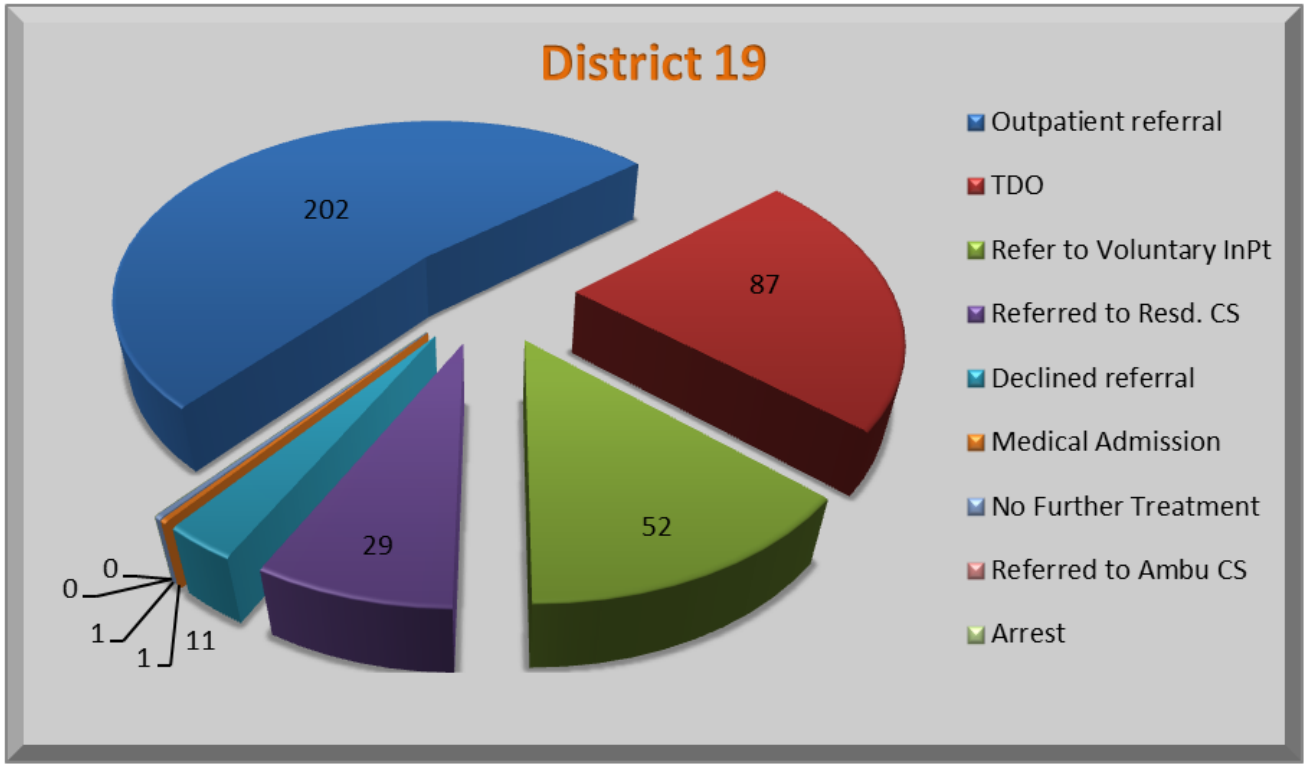

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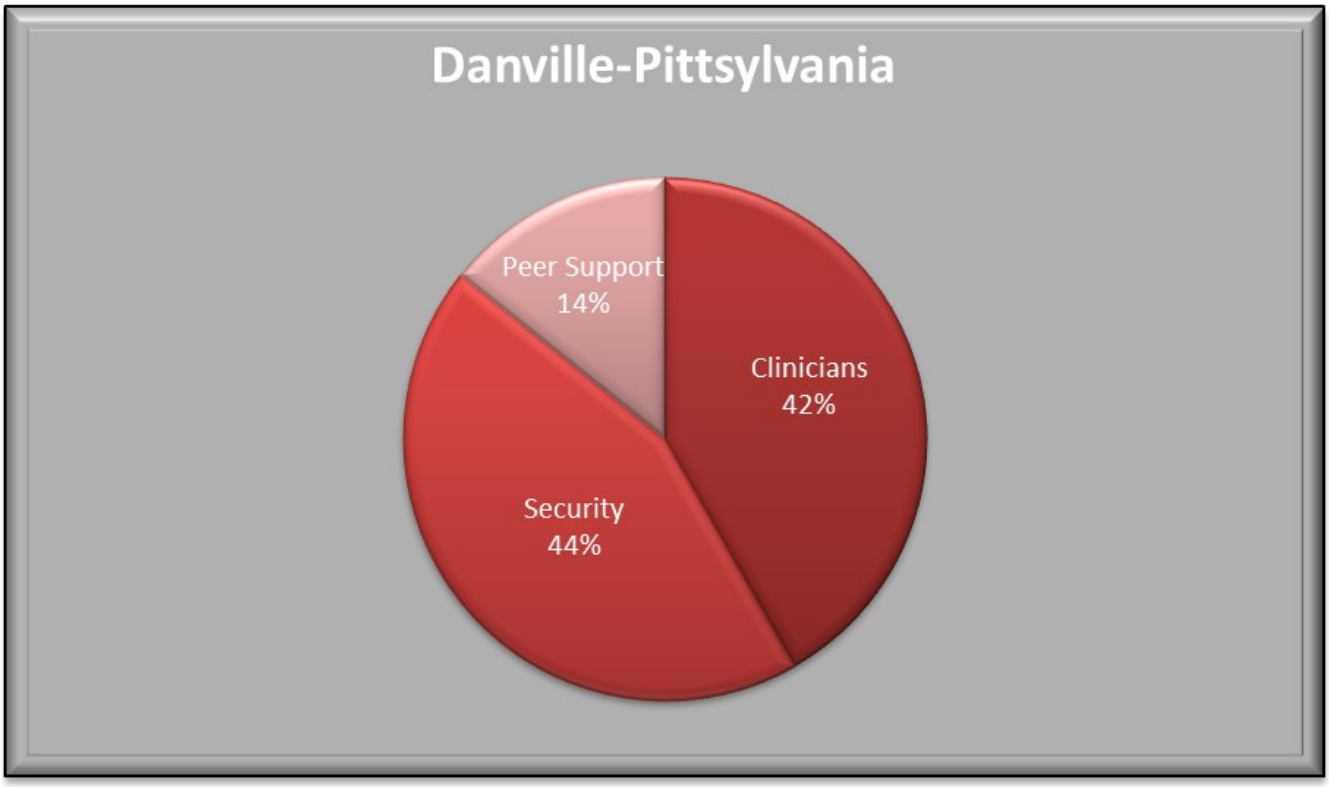

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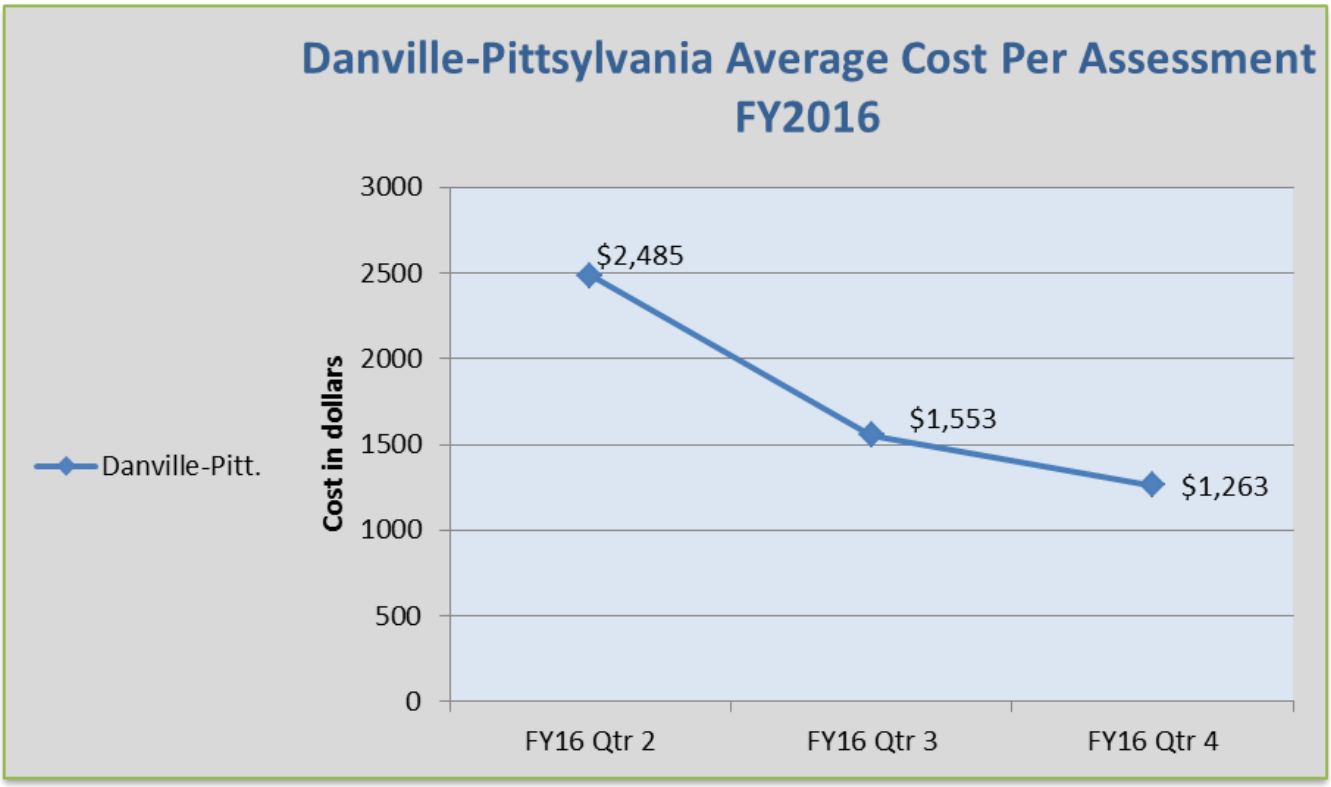

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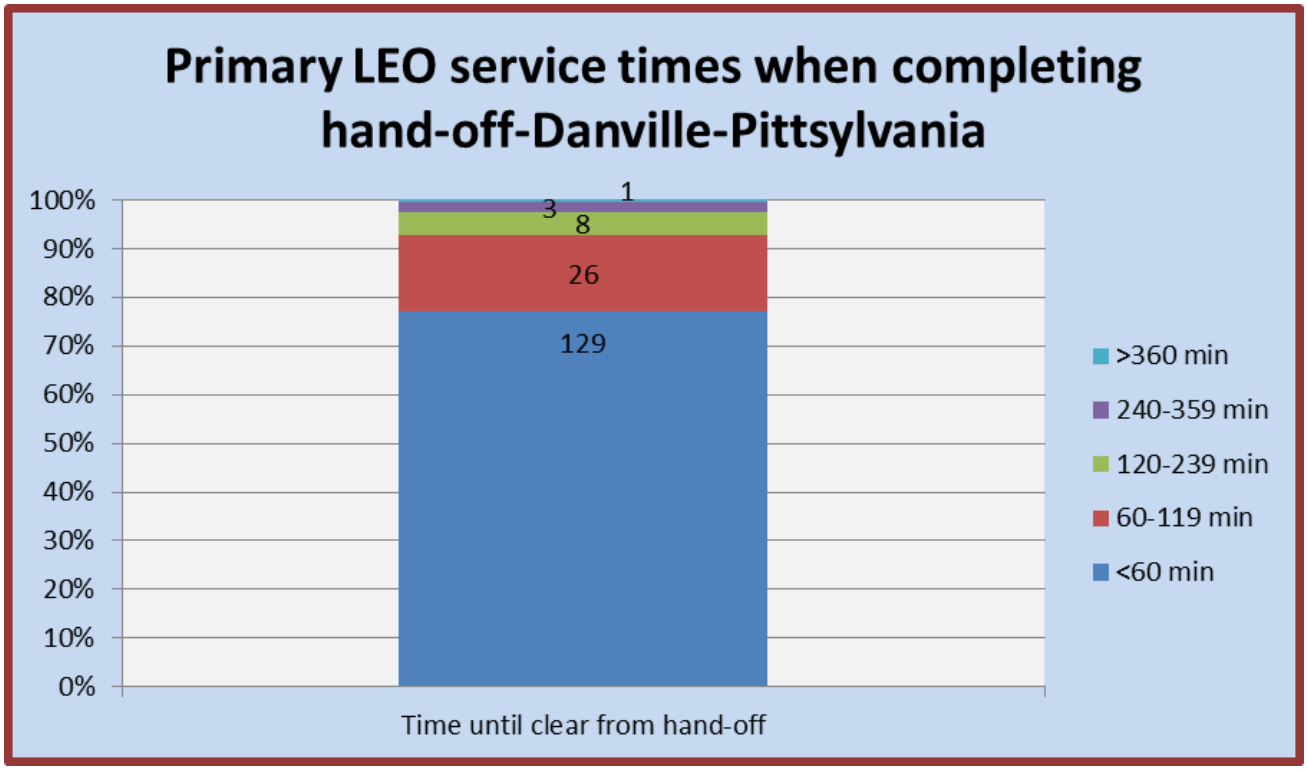

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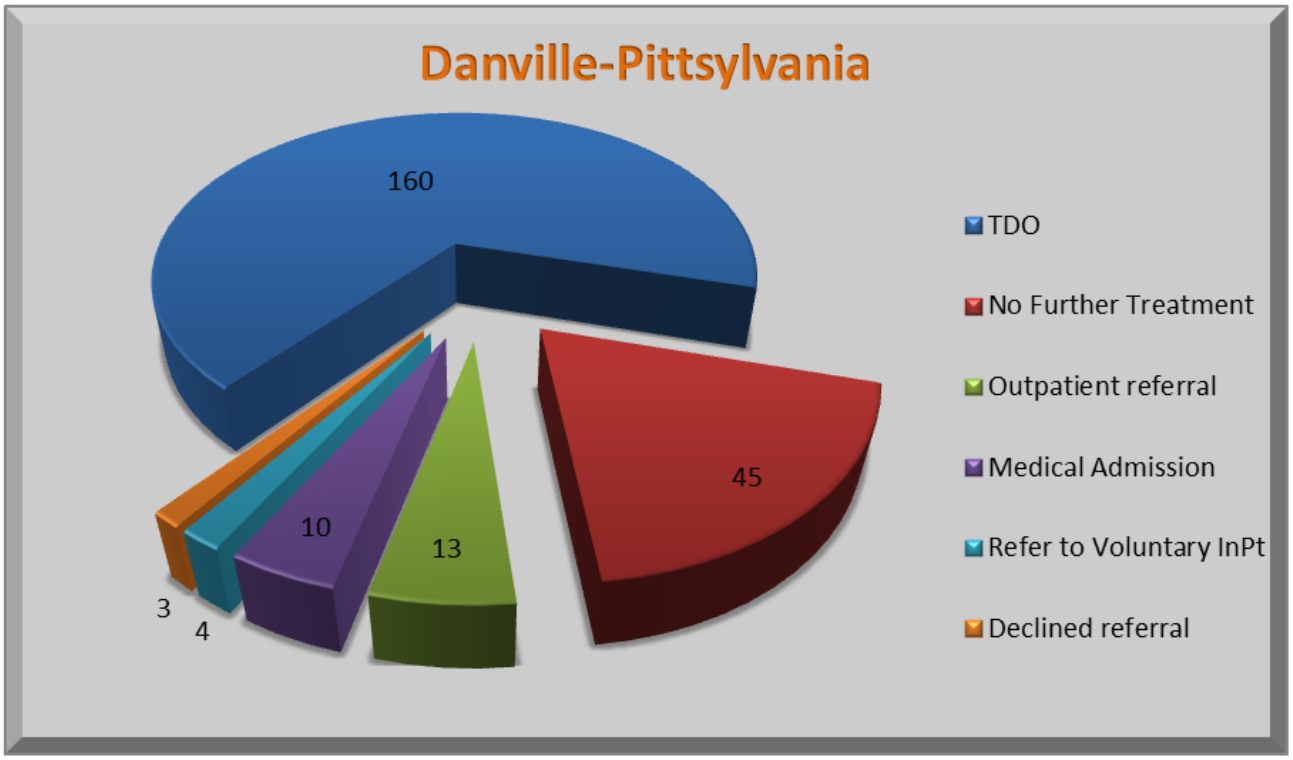

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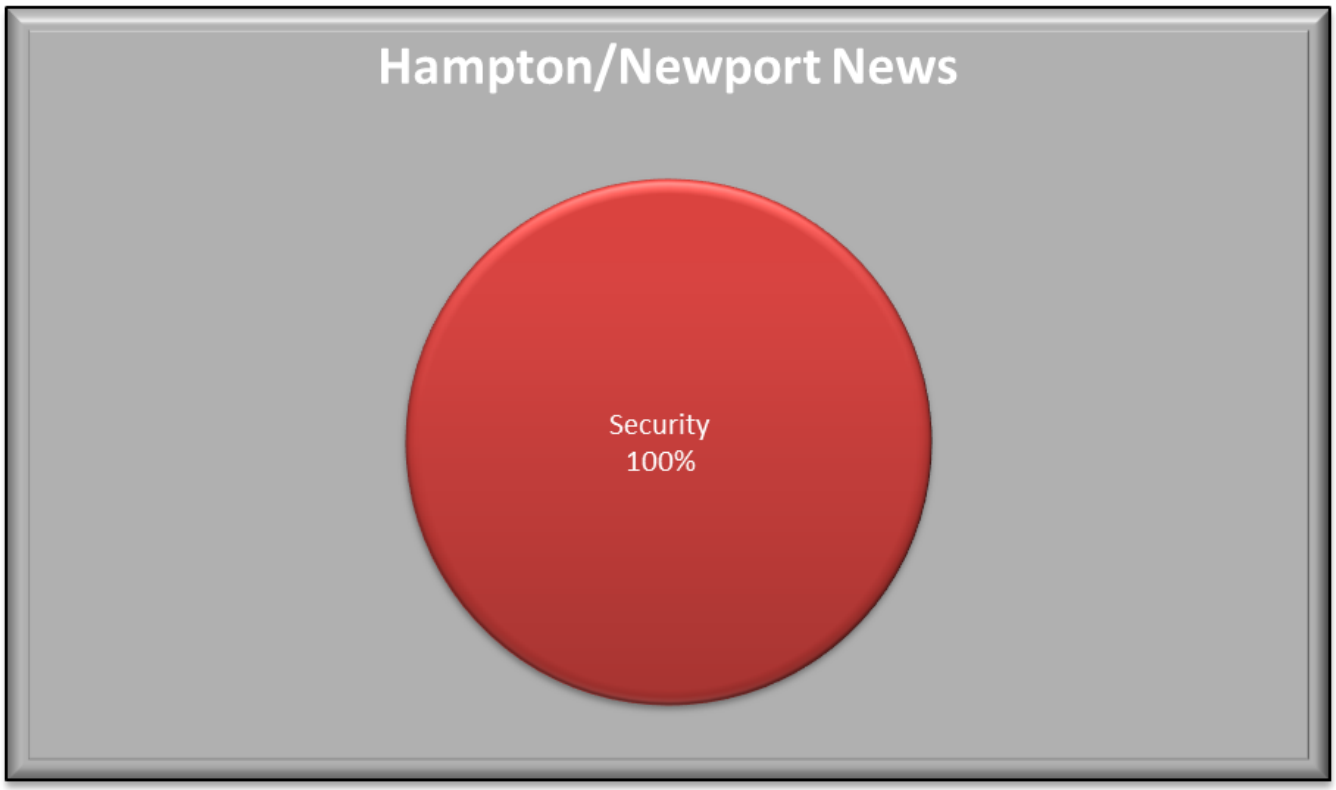

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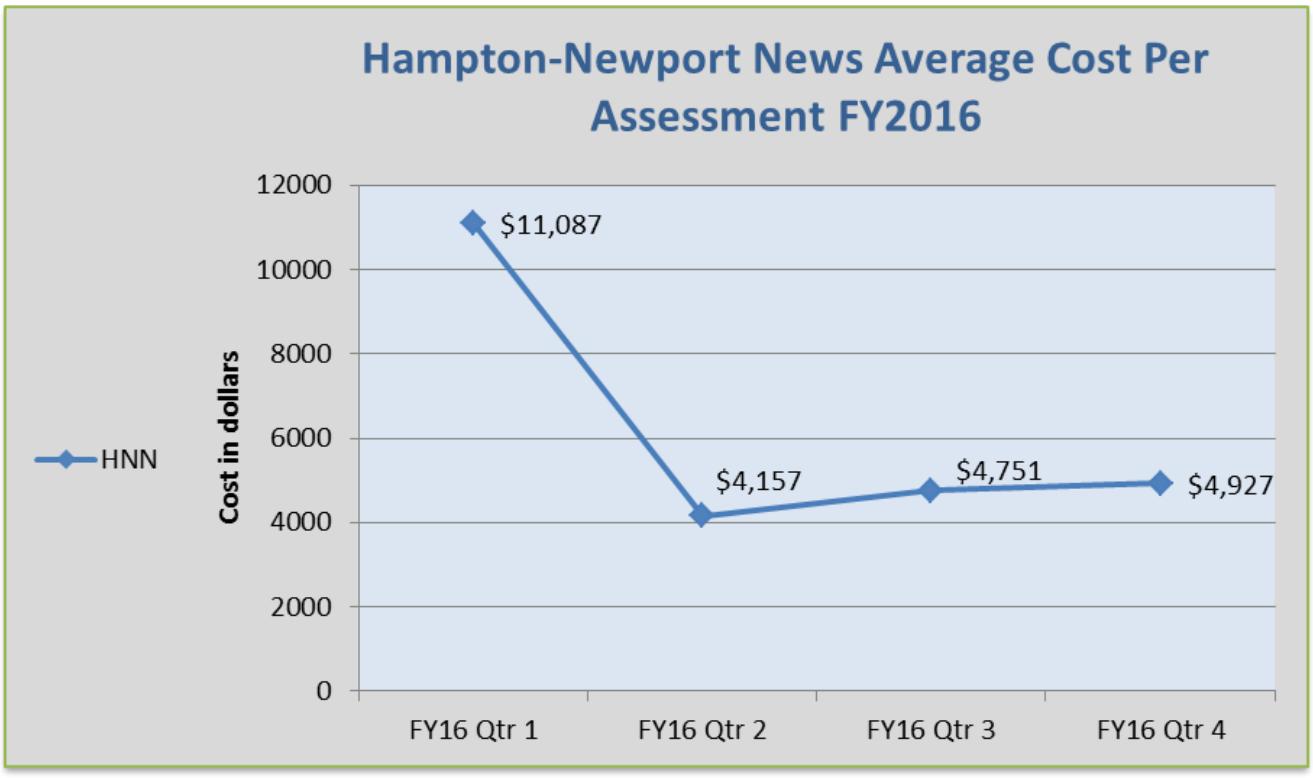

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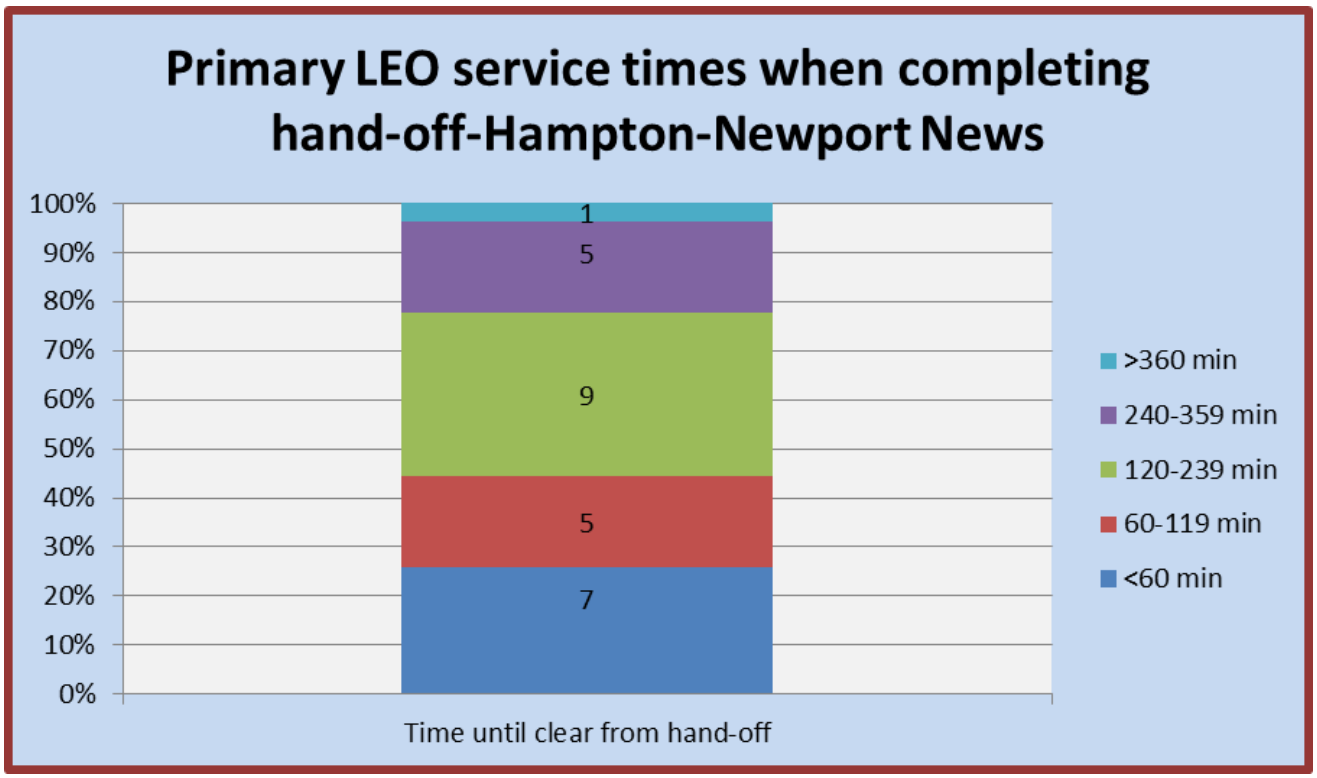
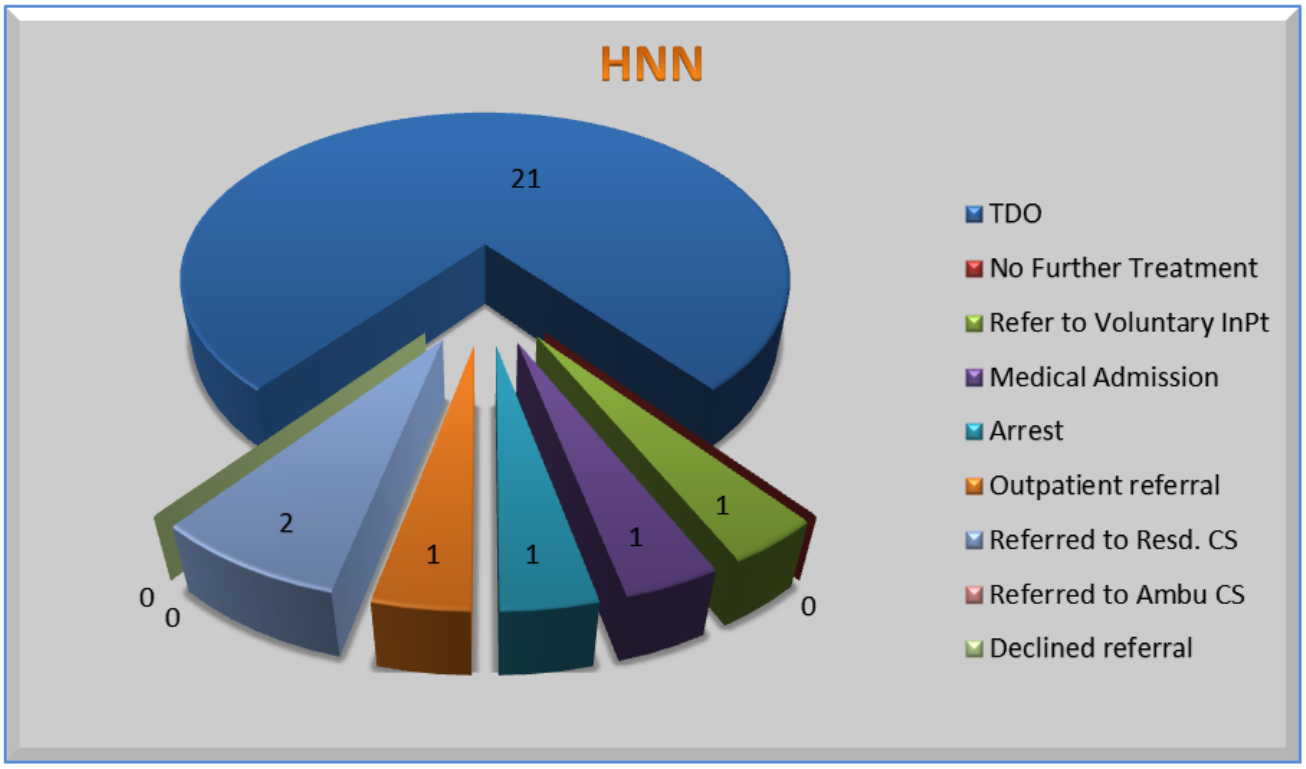
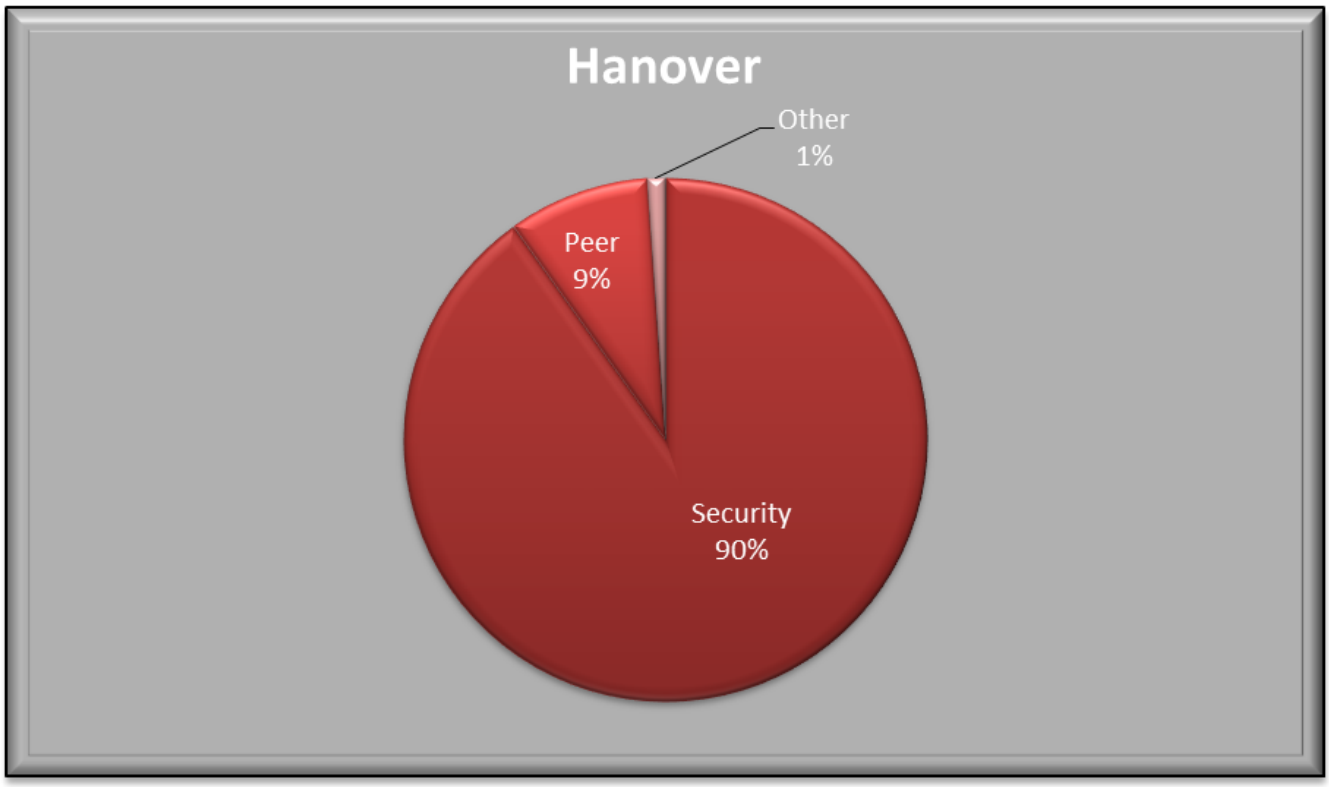


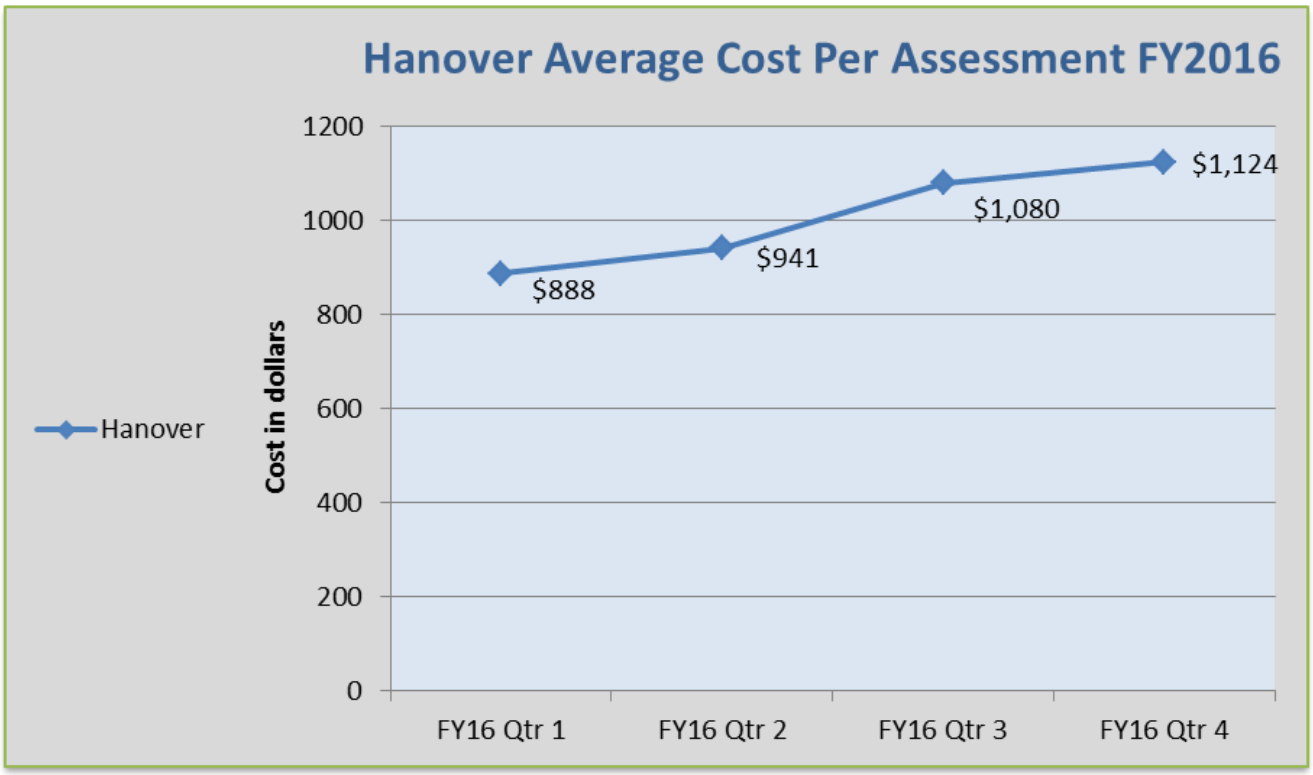
Clinical Dispositions



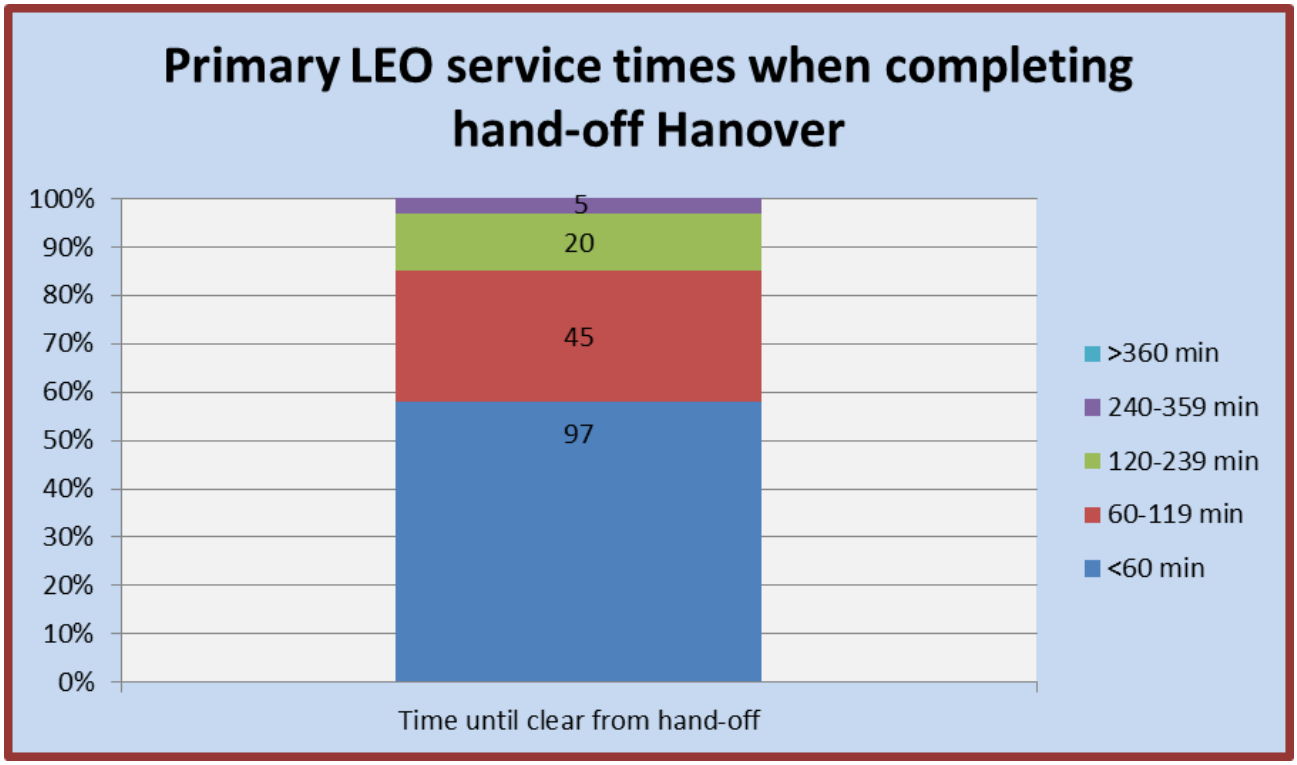
Allocation of Assessment Site Funds



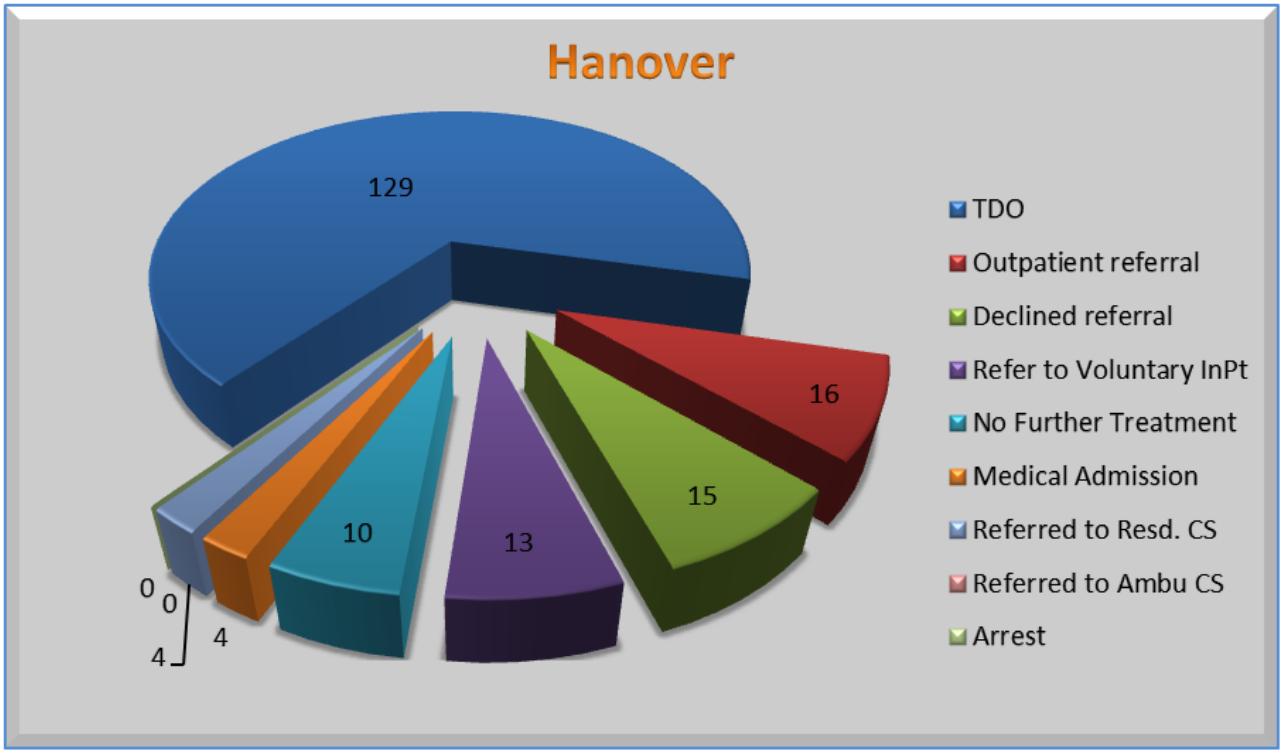
Quarterly Cost Per Assessment



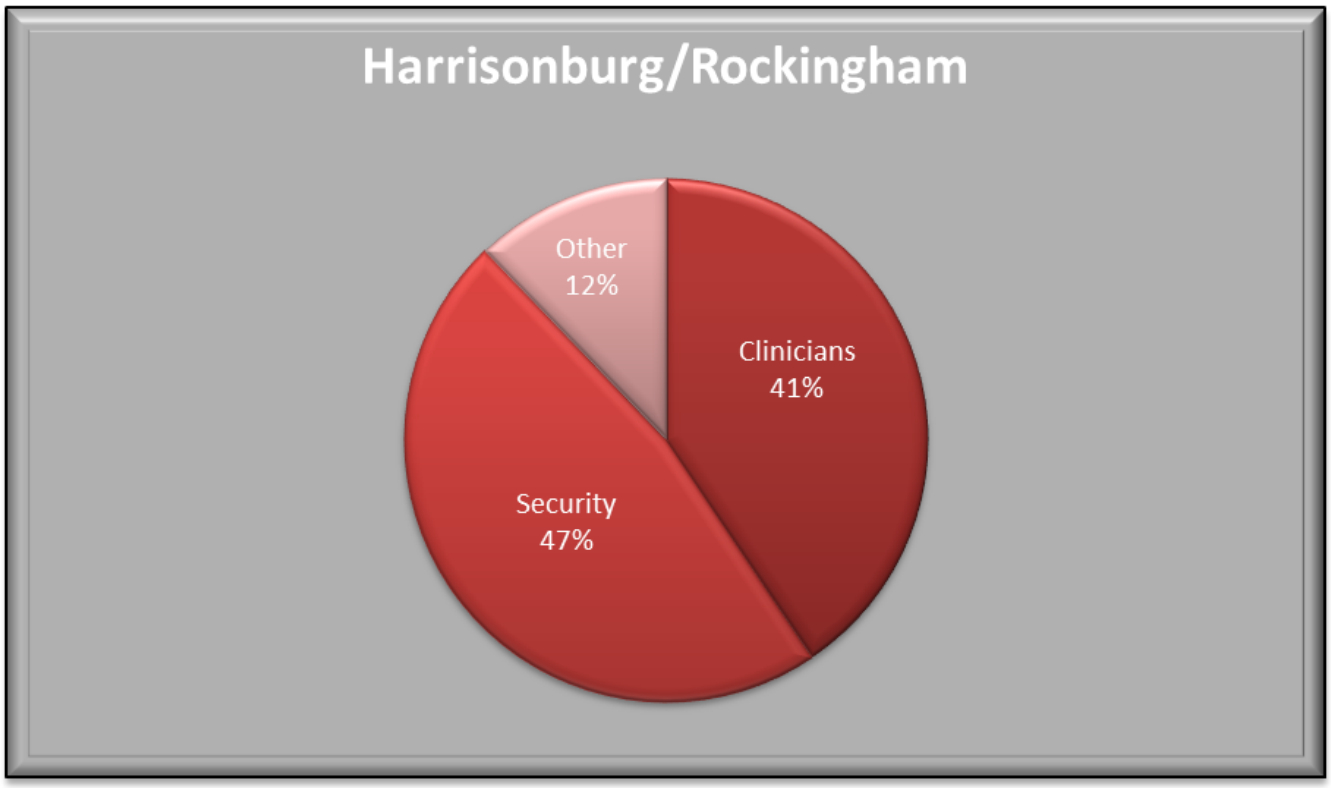
Officer Release to Service Times



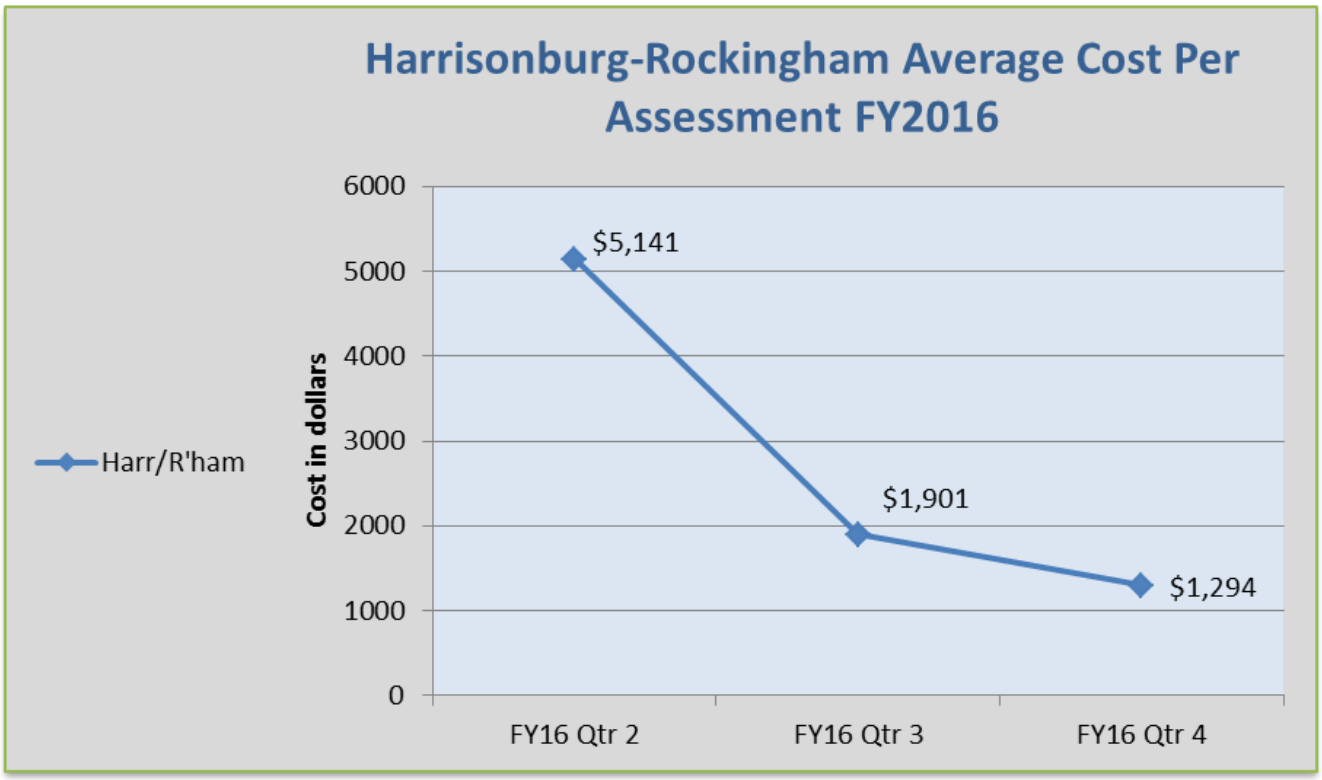
Clinical Dispositions



Allocation of Assessment Site Funds



Quarterly Cost Per Assessment



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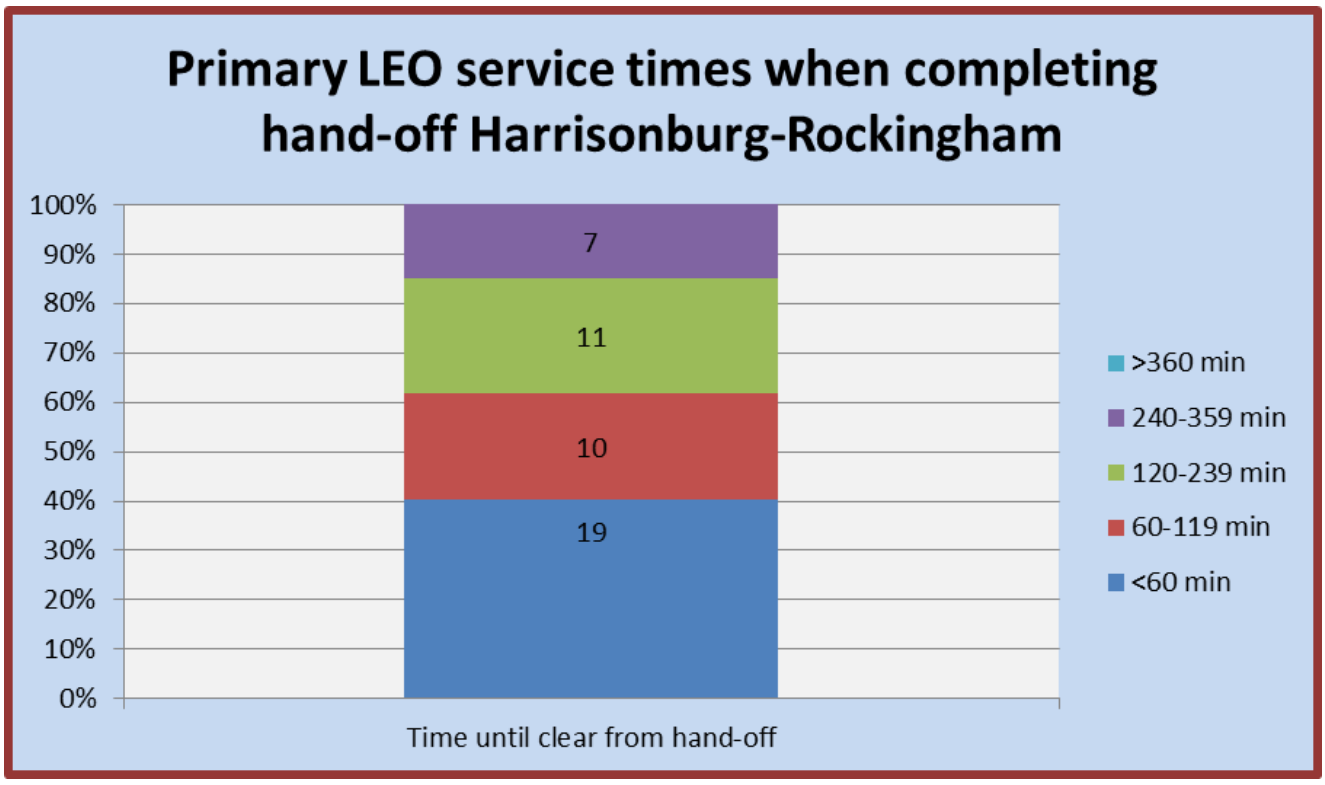

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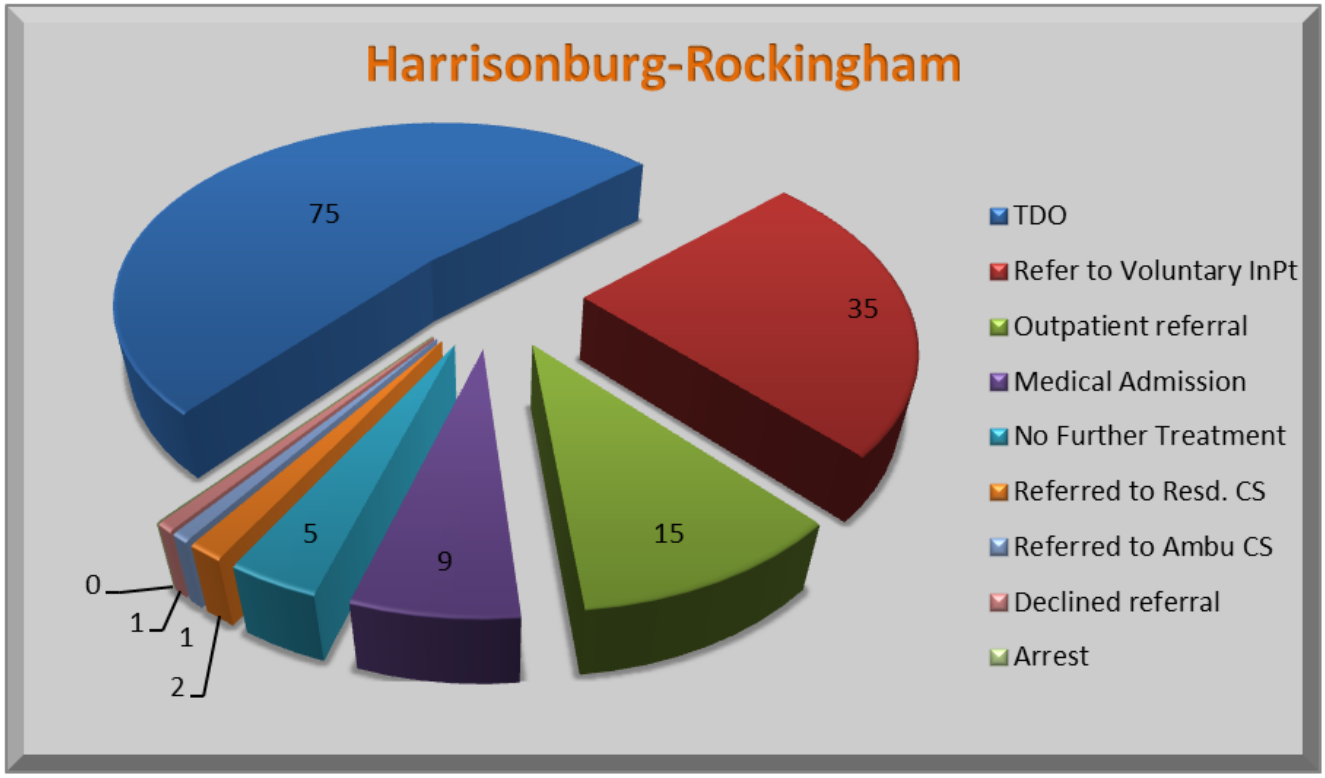

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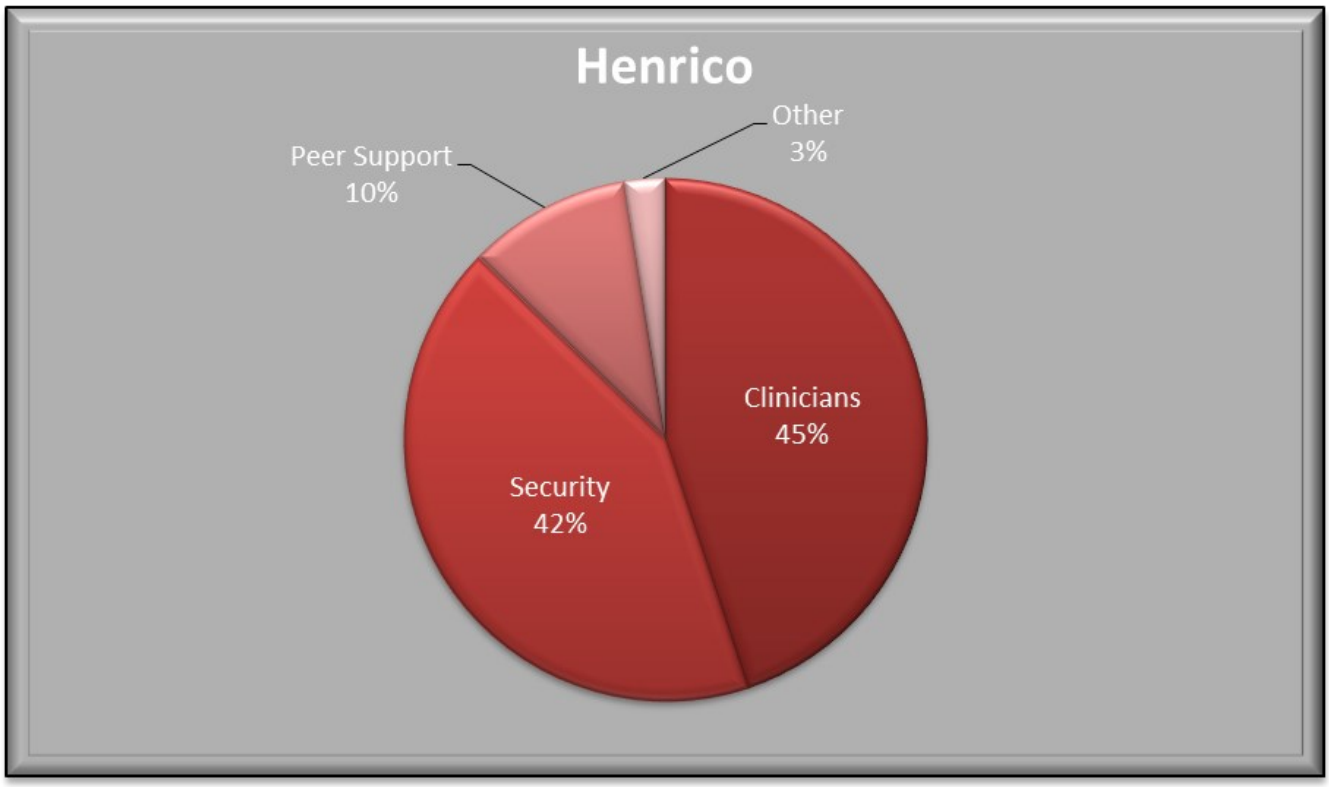

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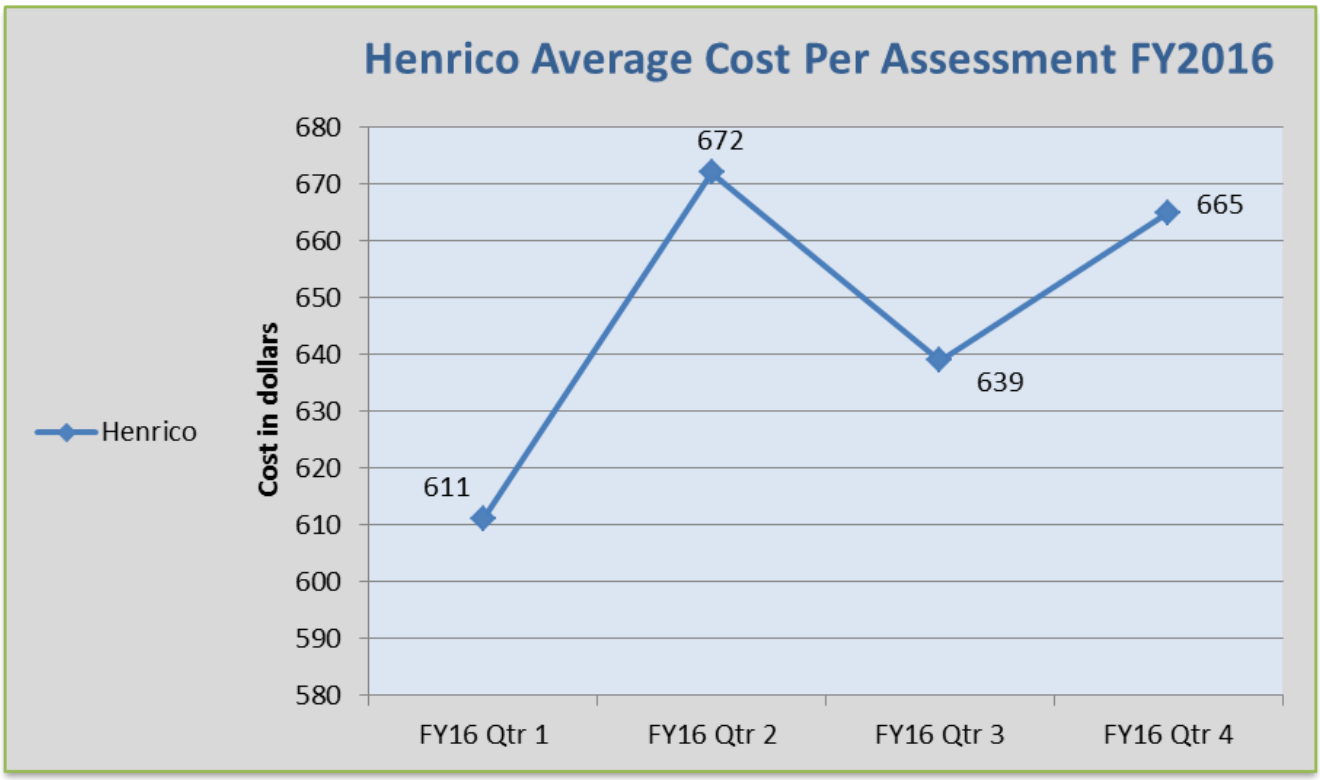

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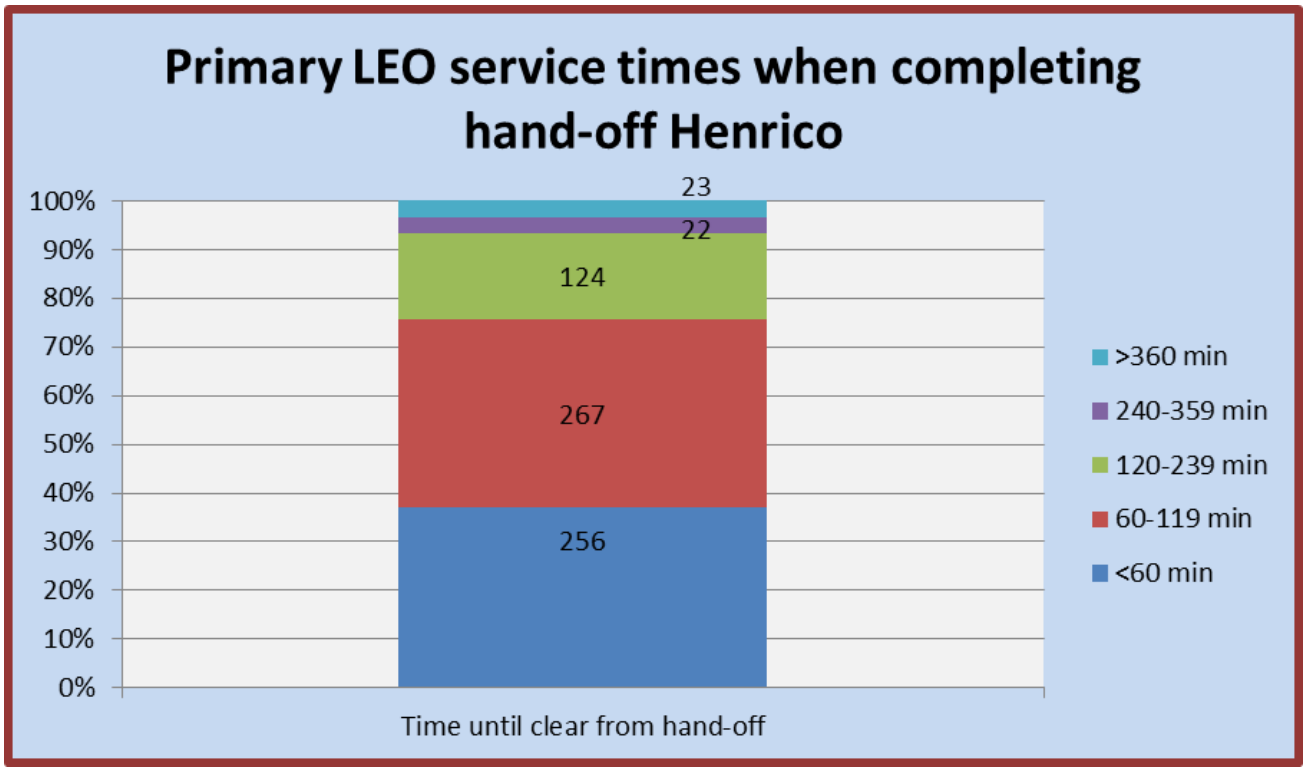

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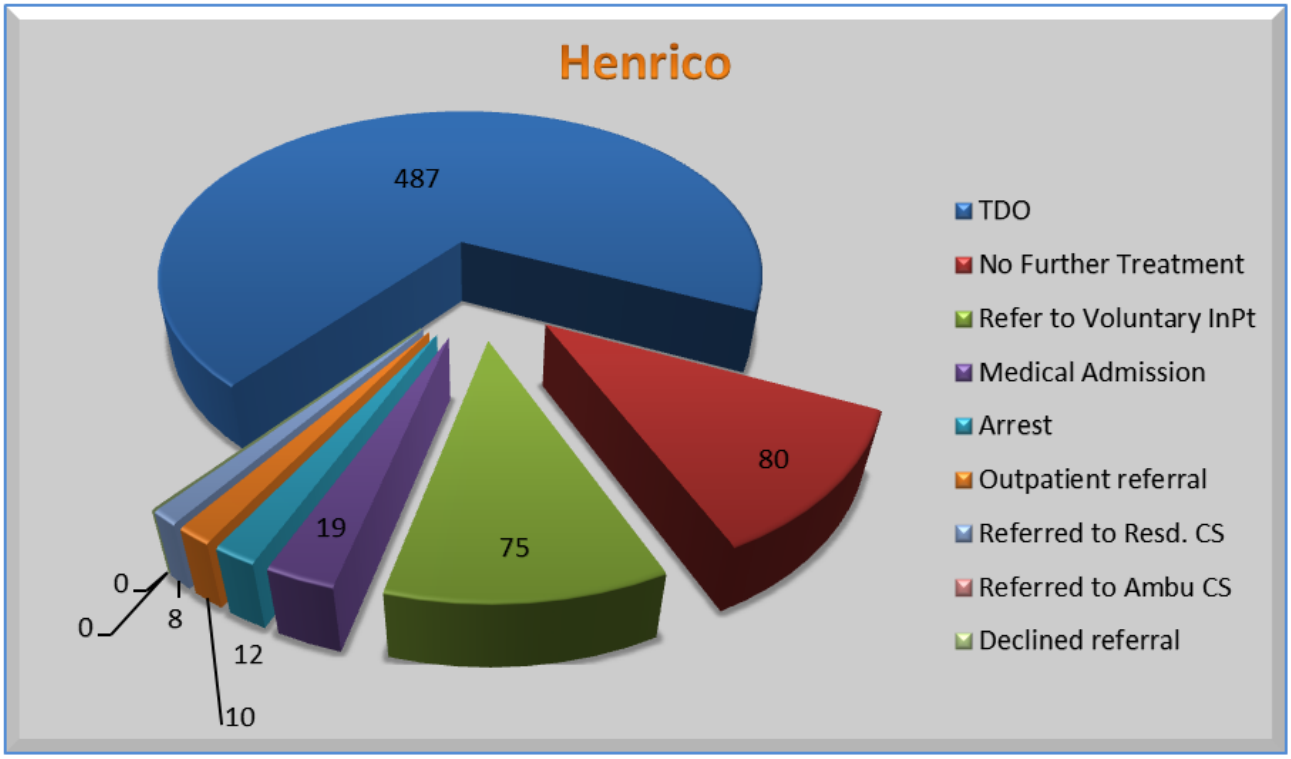

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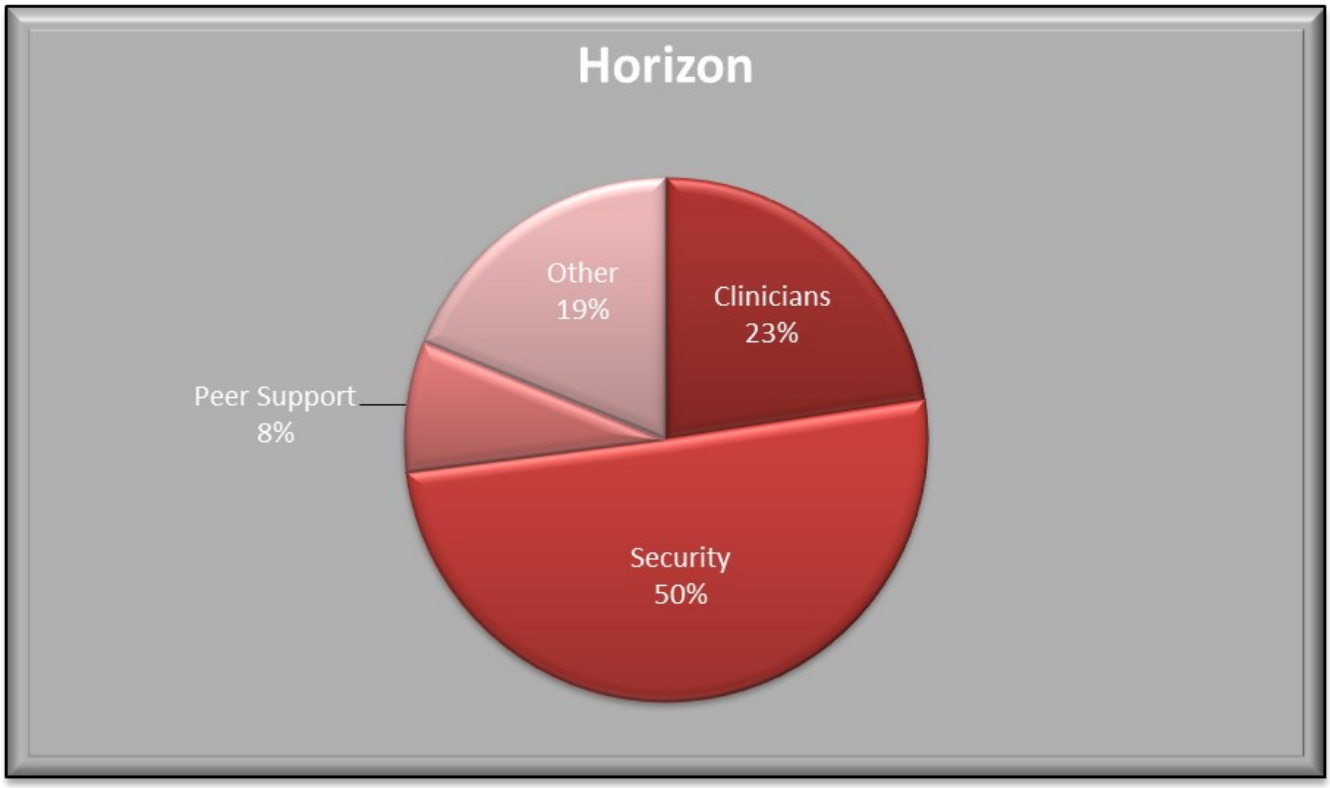

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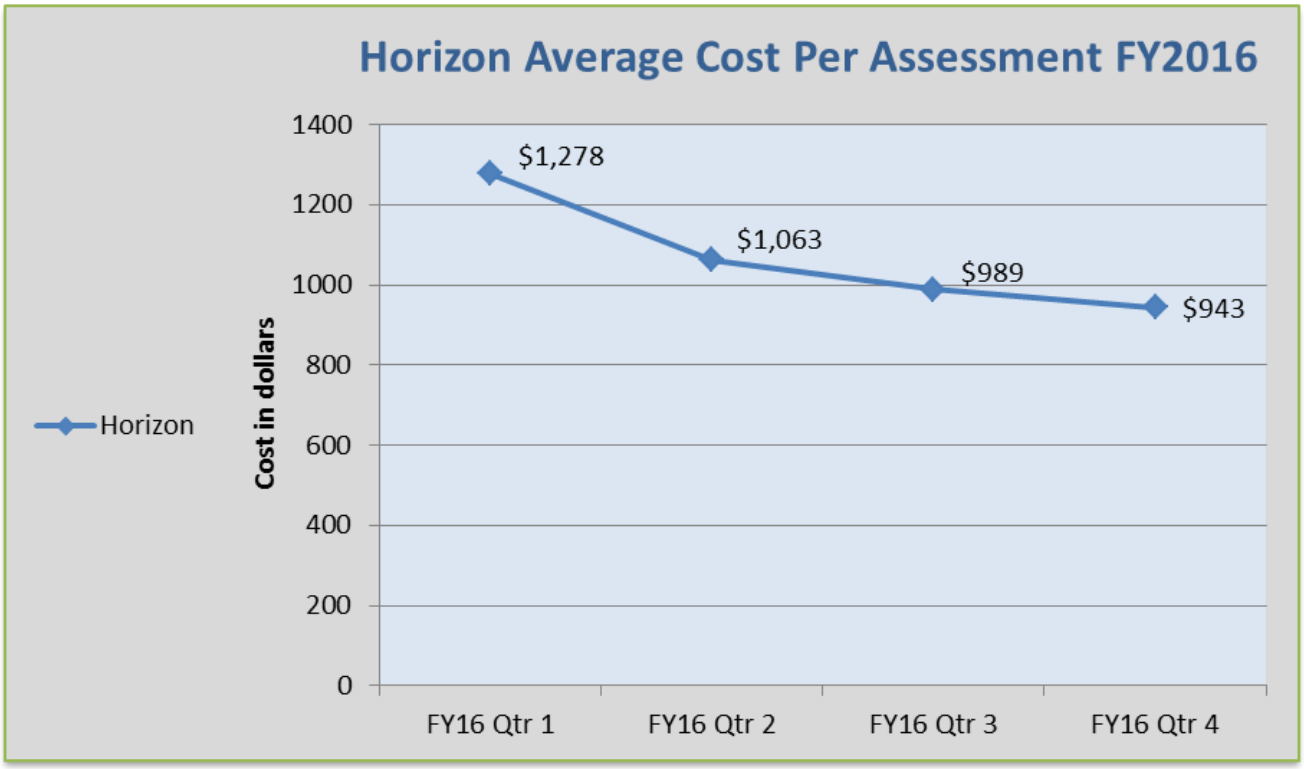

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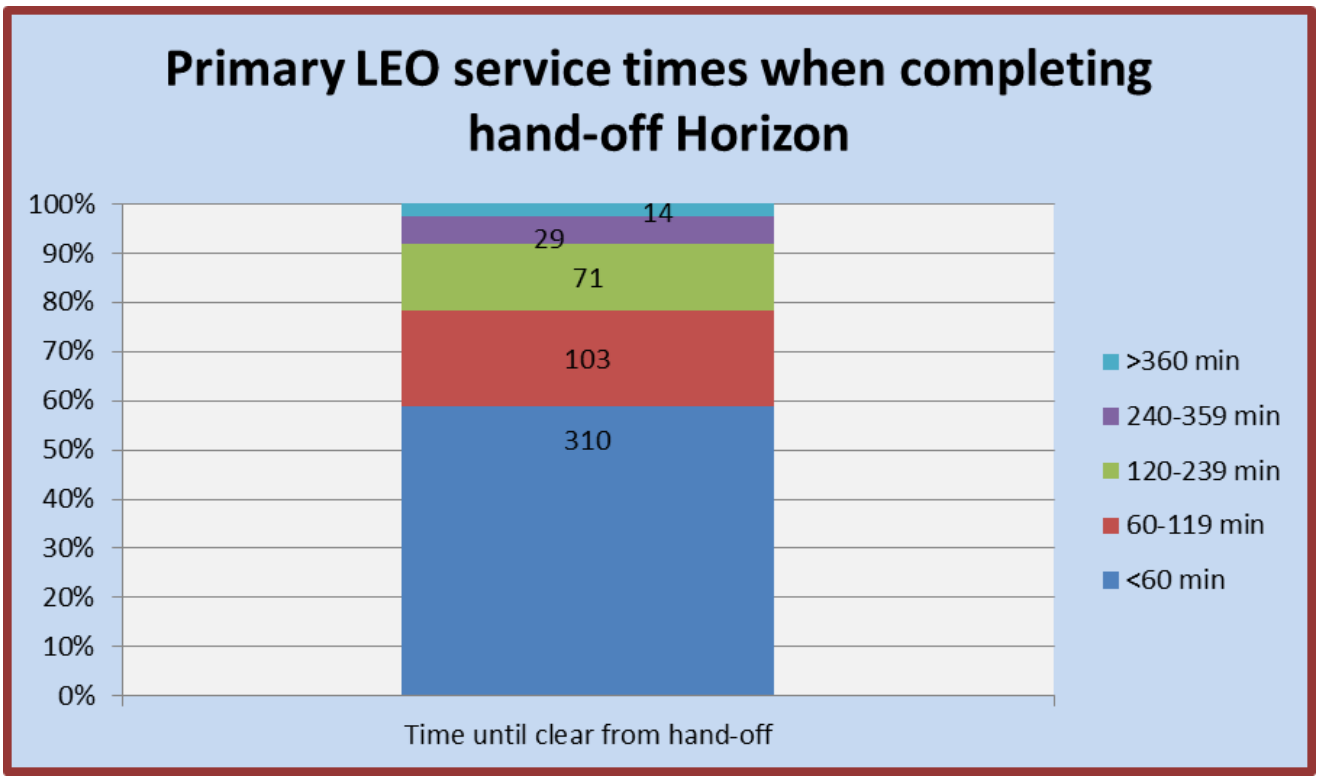

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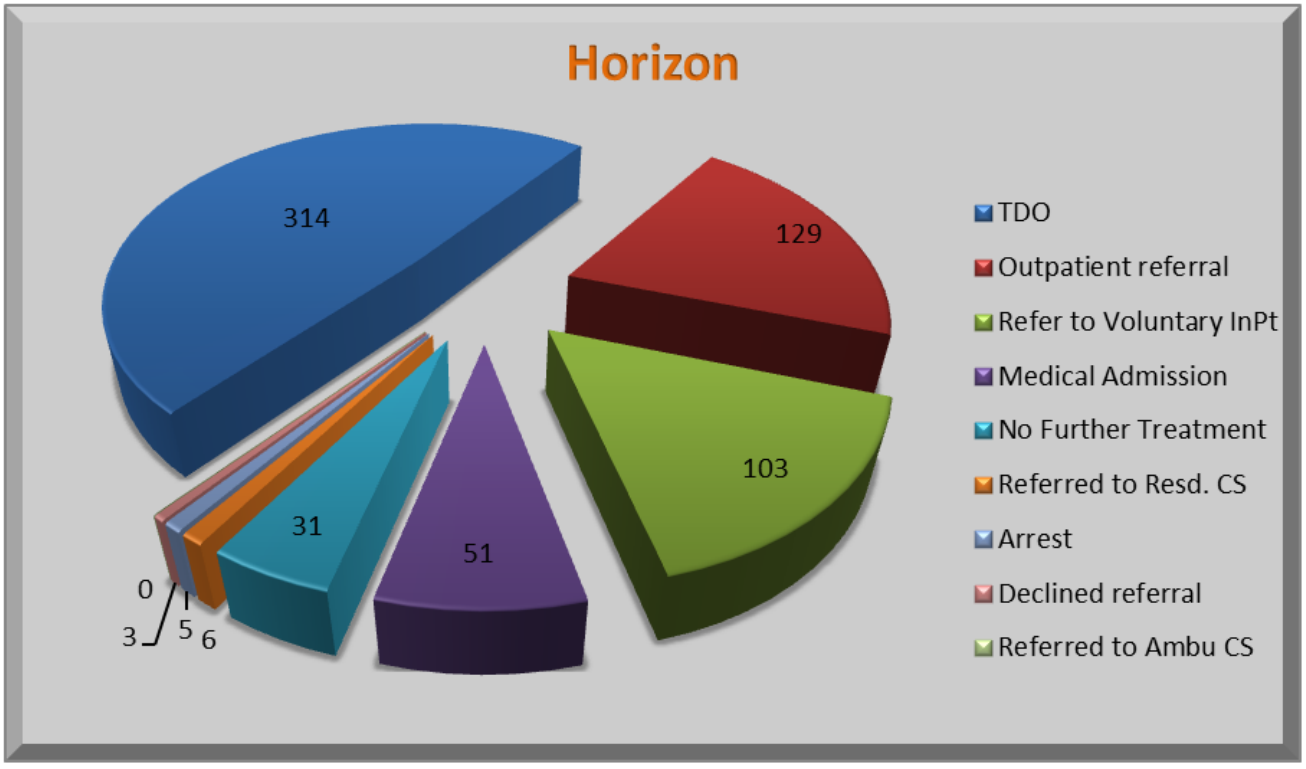

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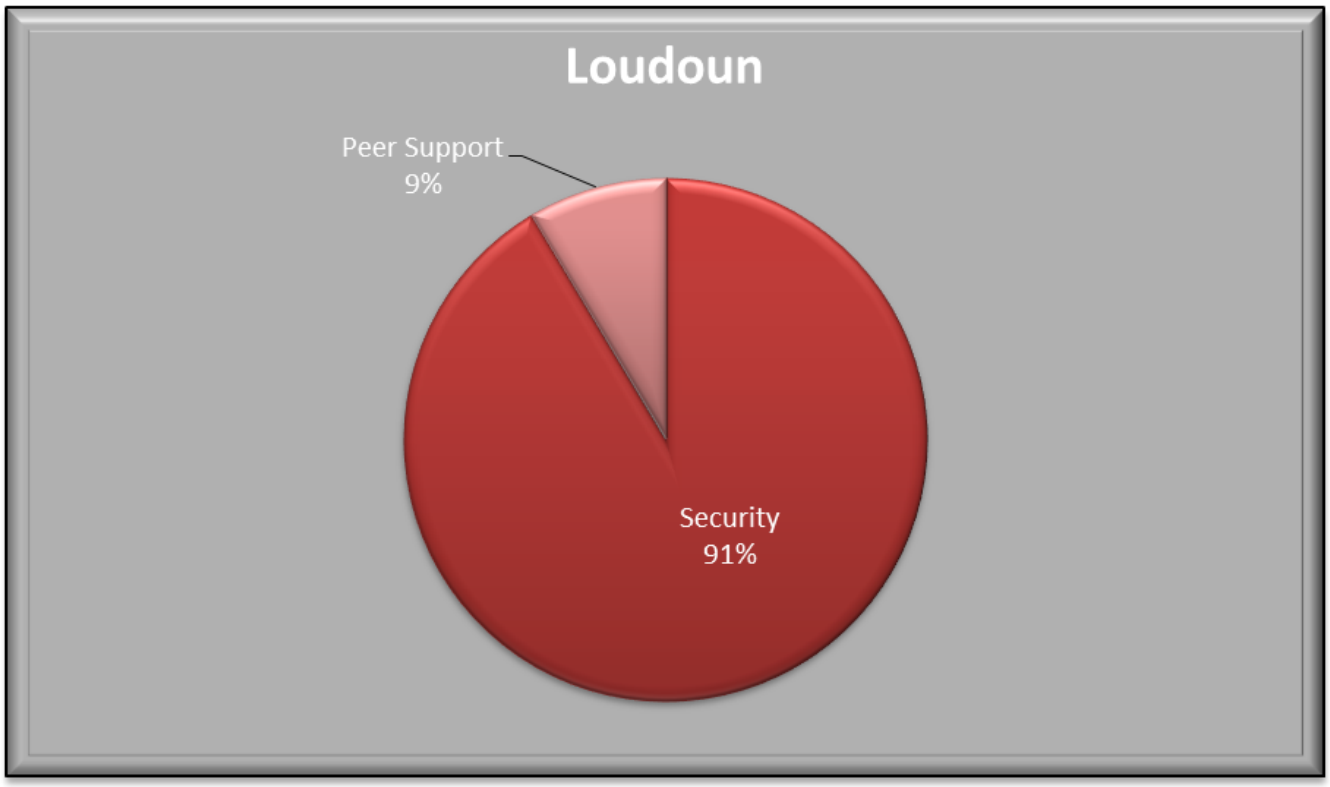

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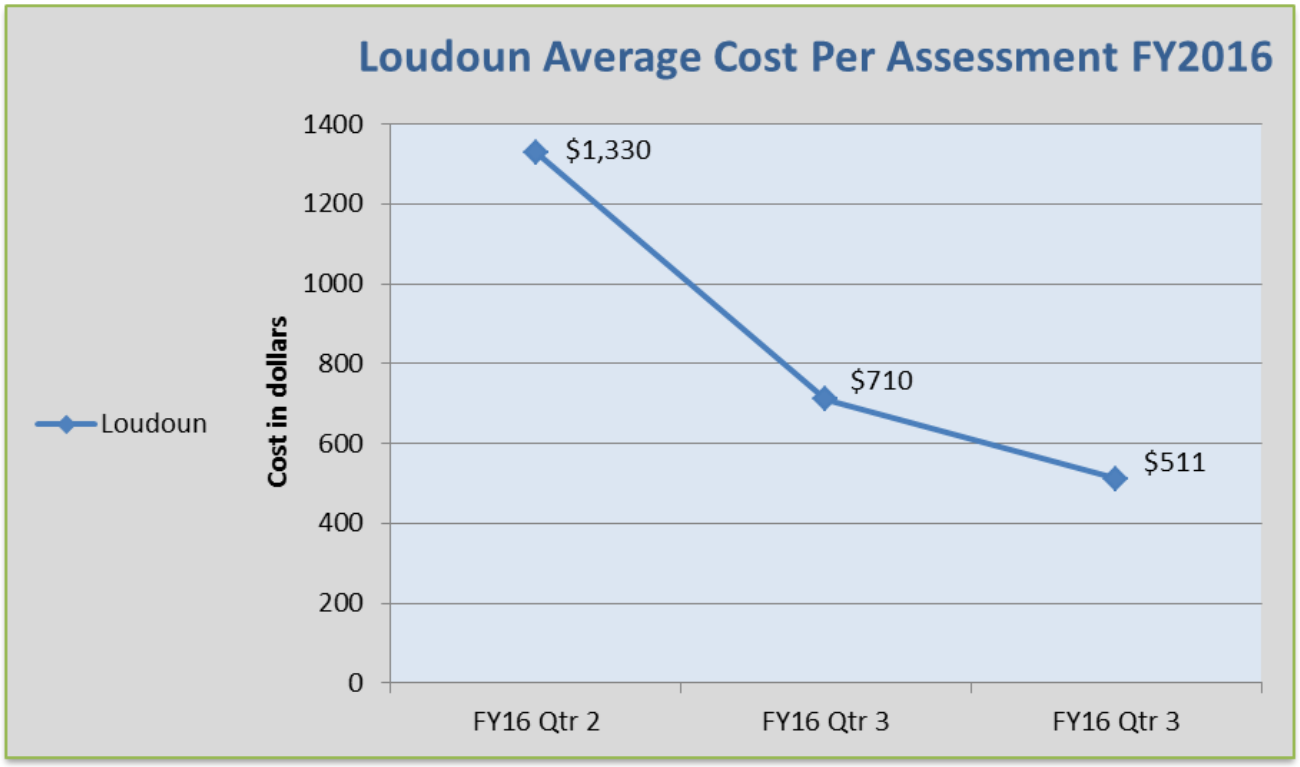

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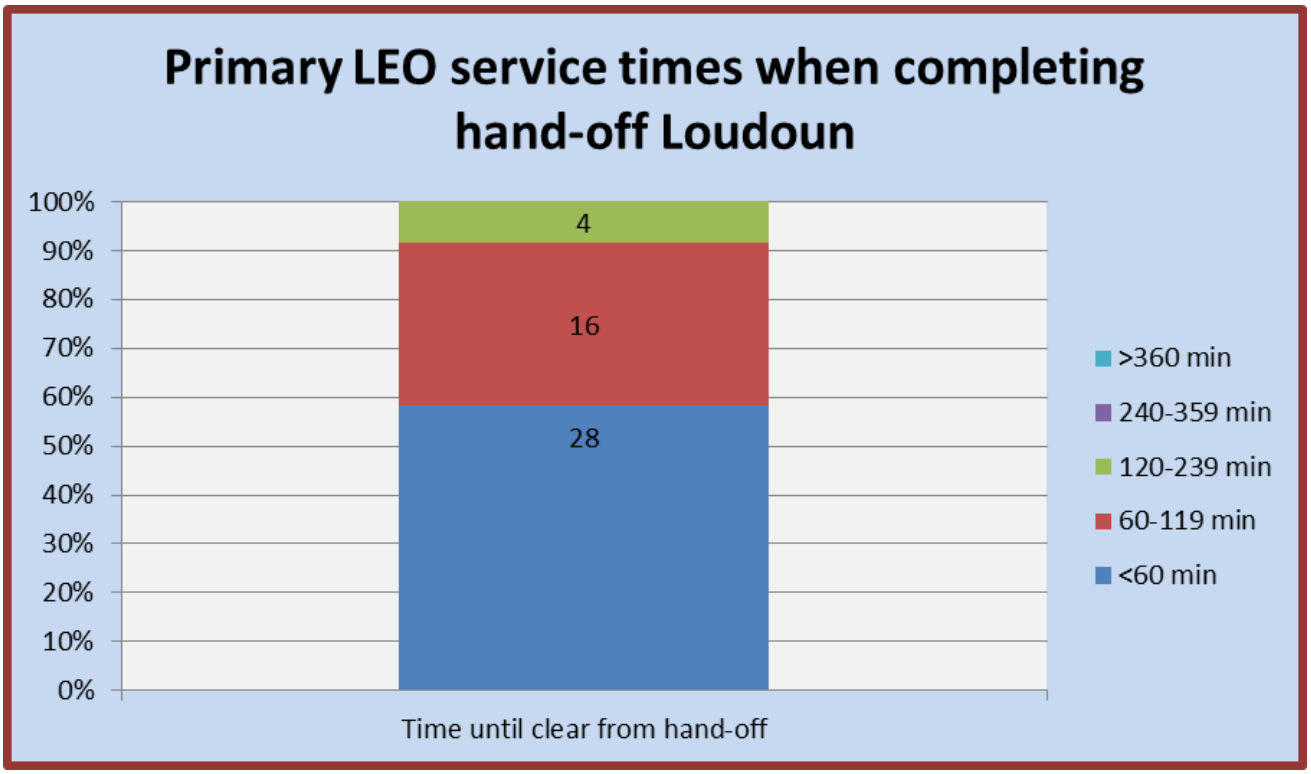
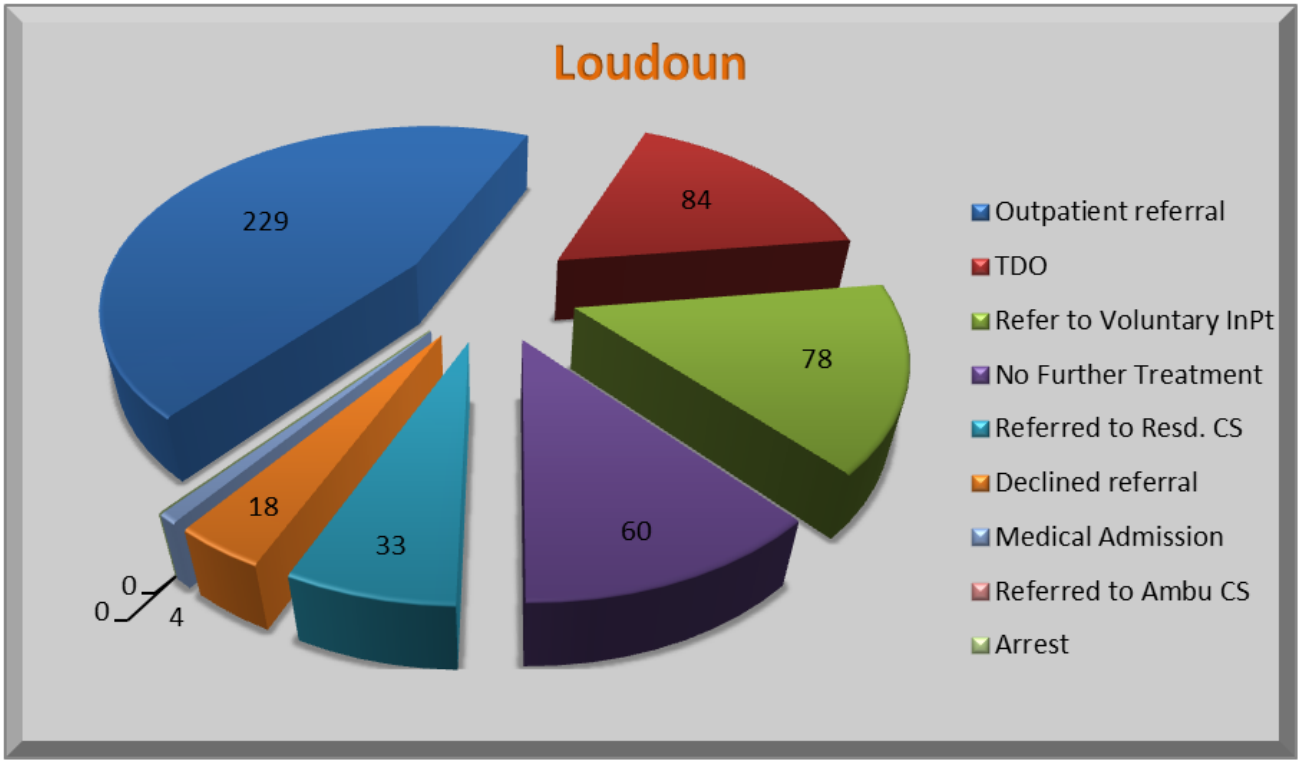


Clinical Dispositions



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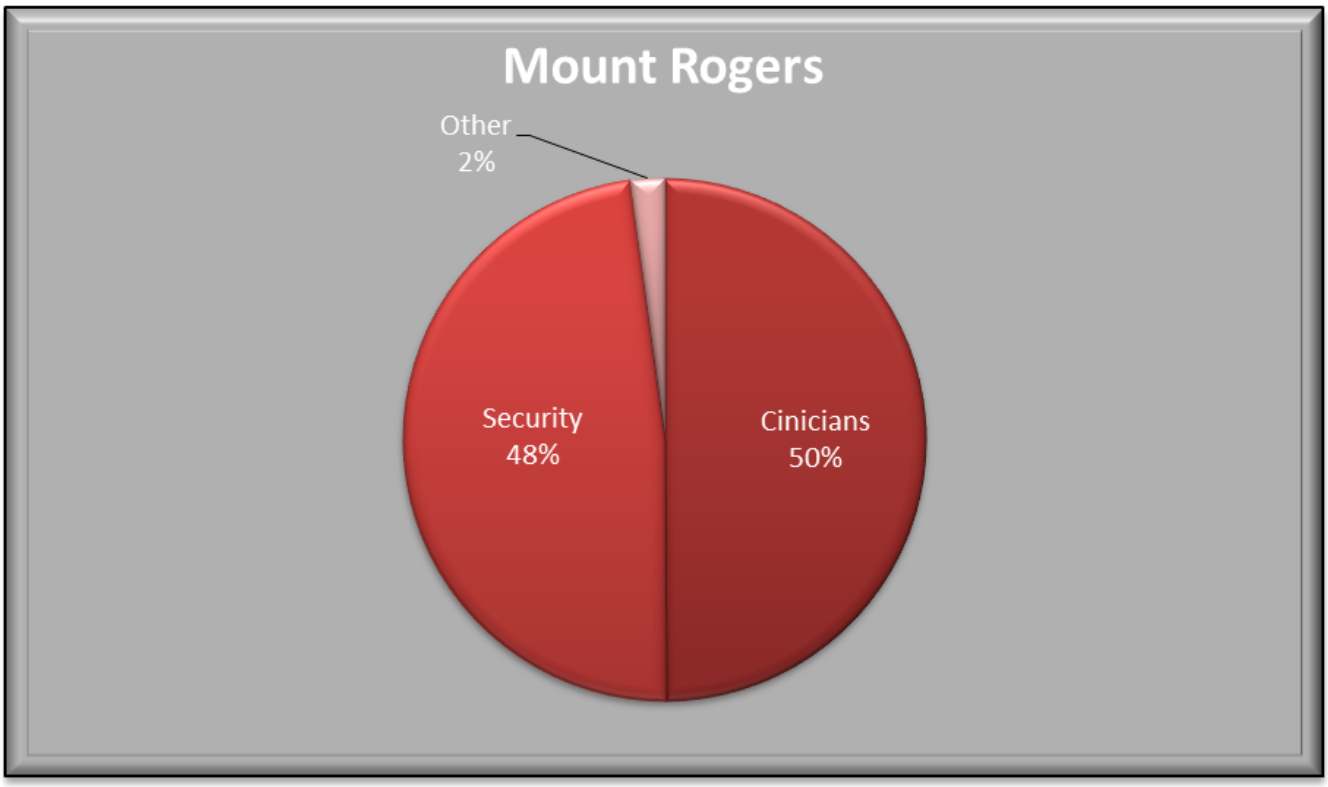

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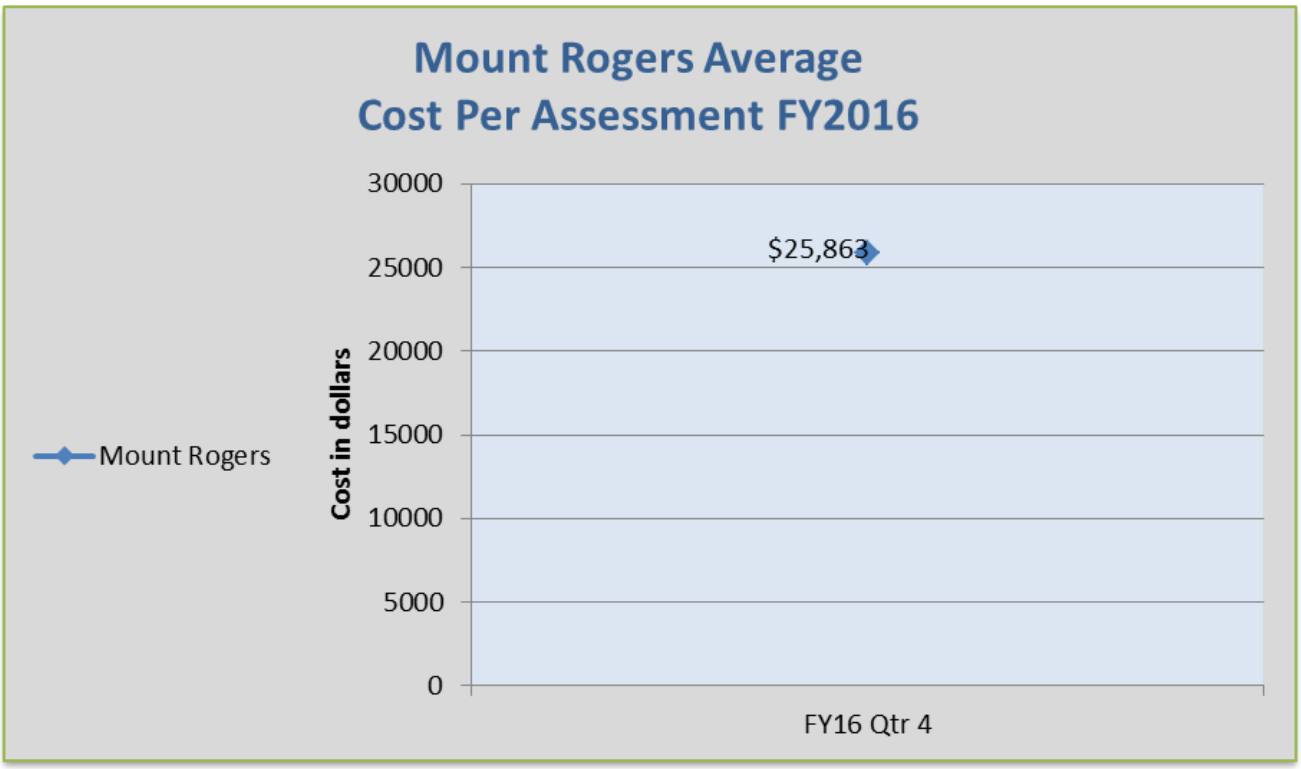

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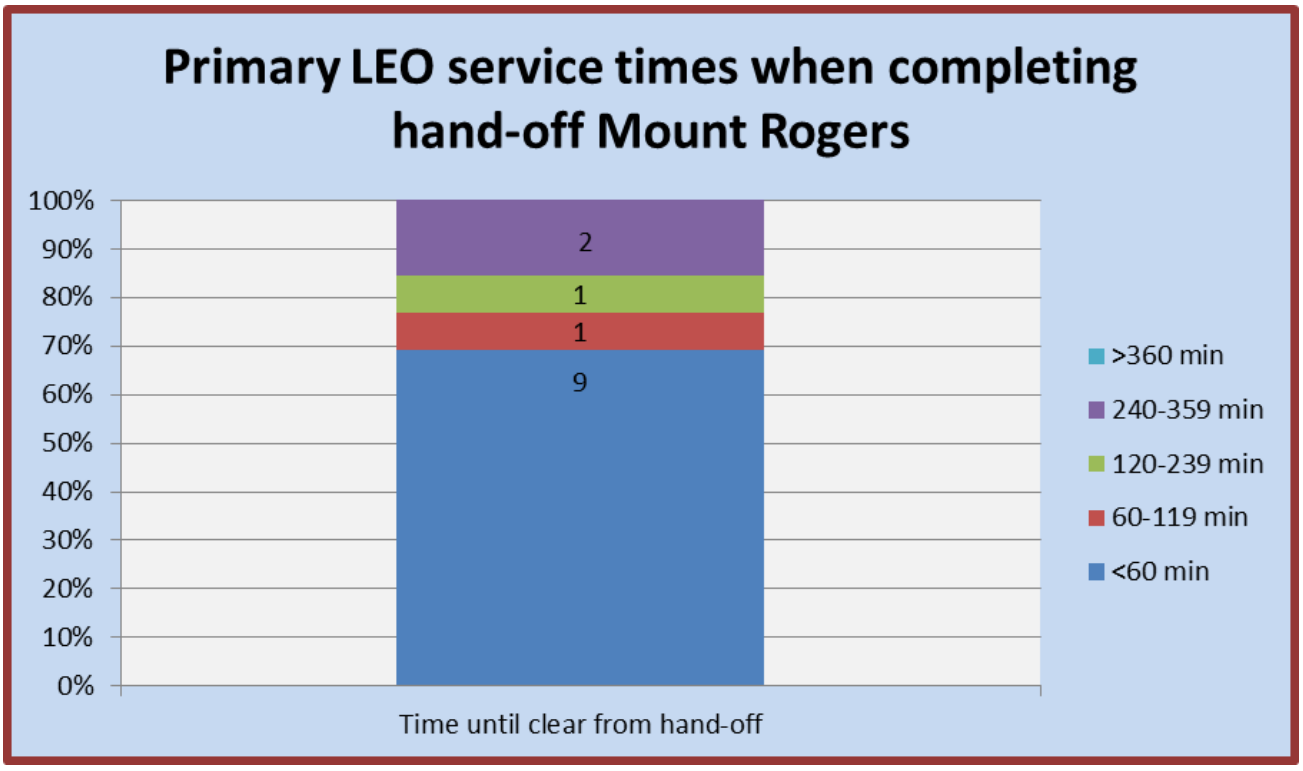

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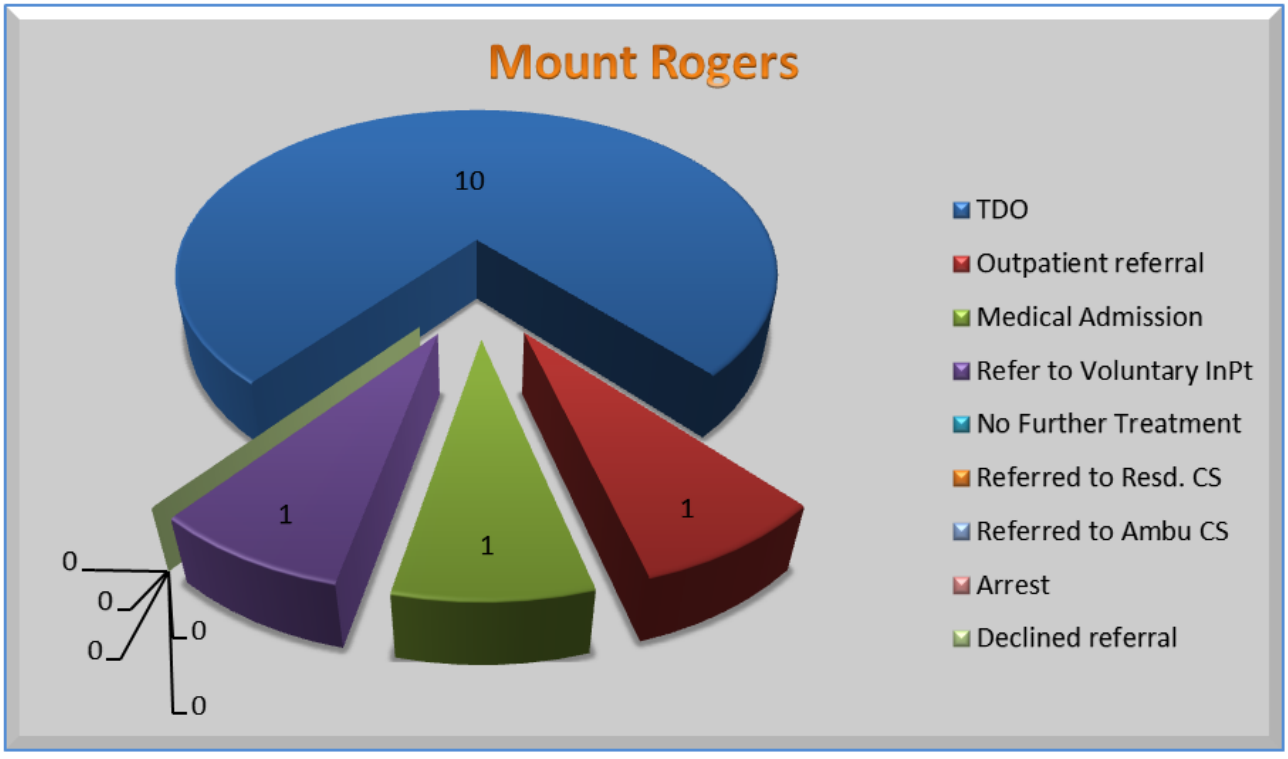

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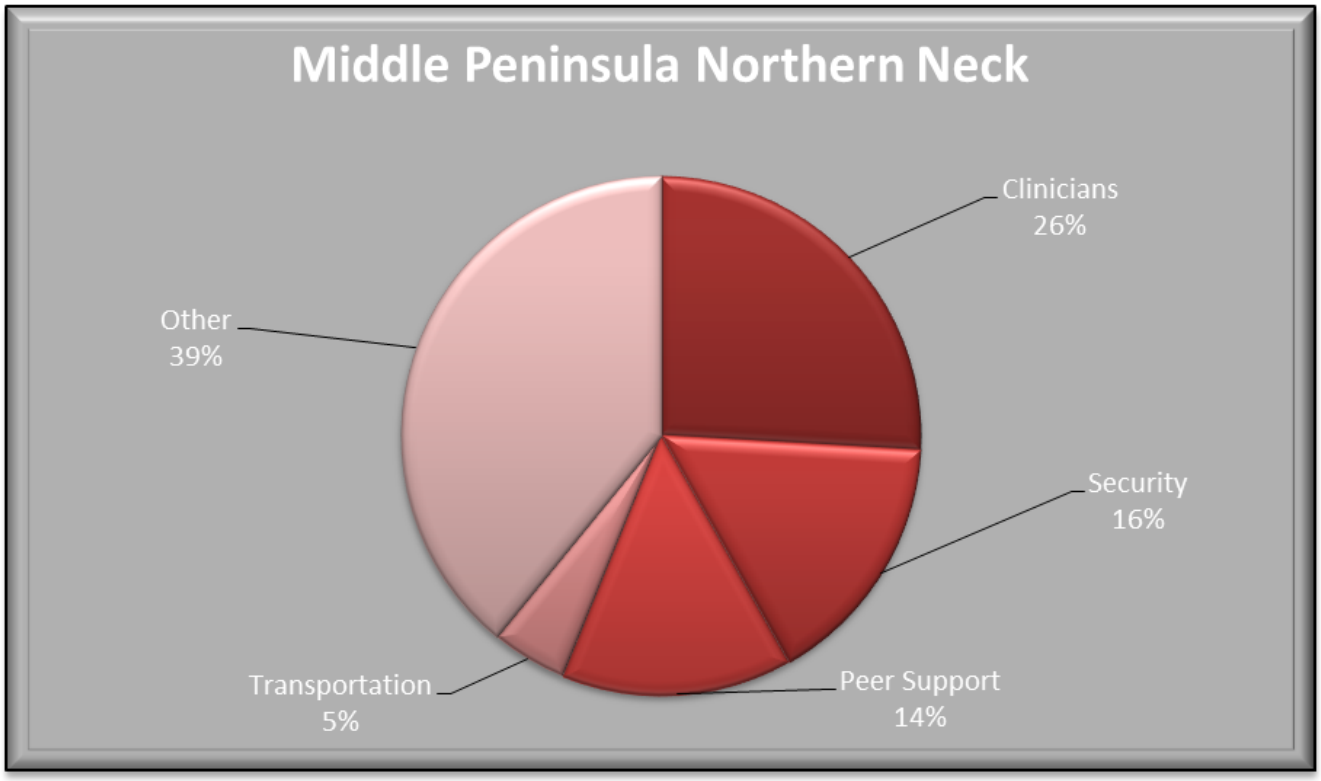

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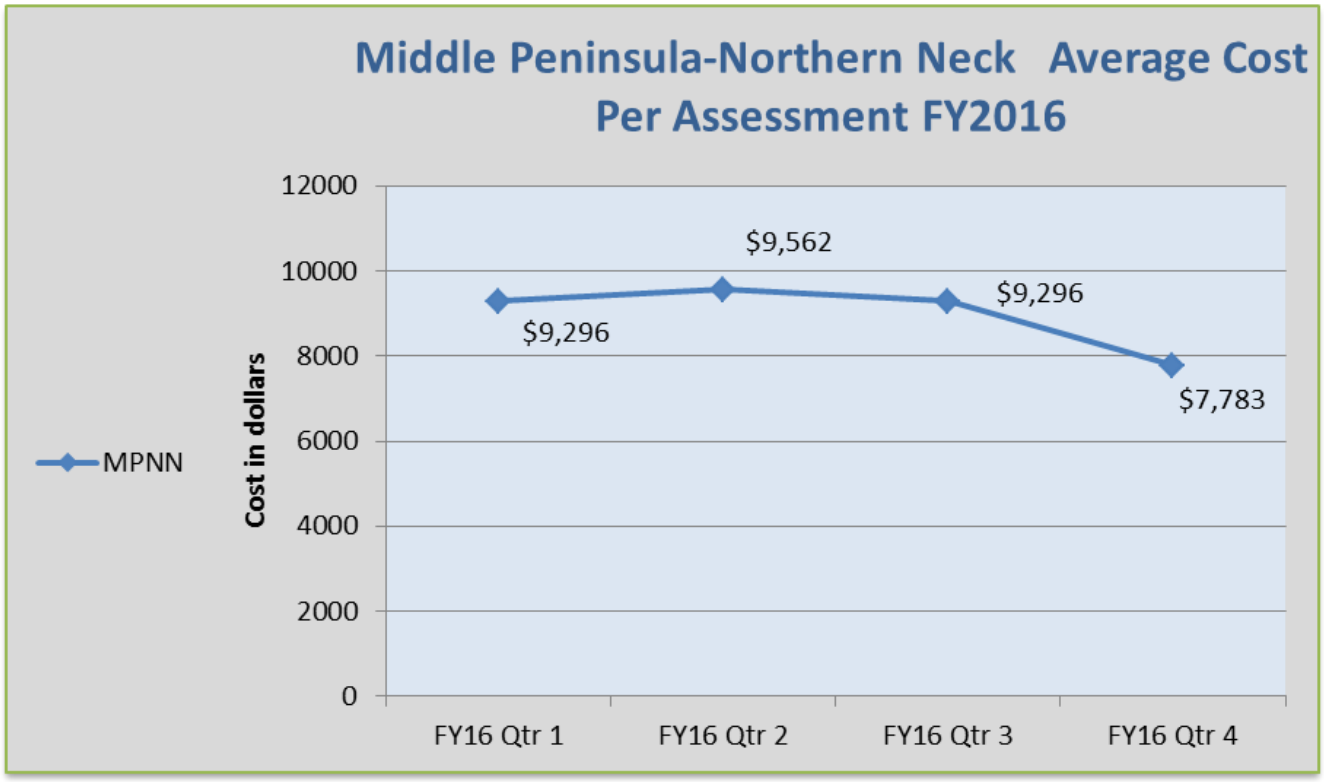

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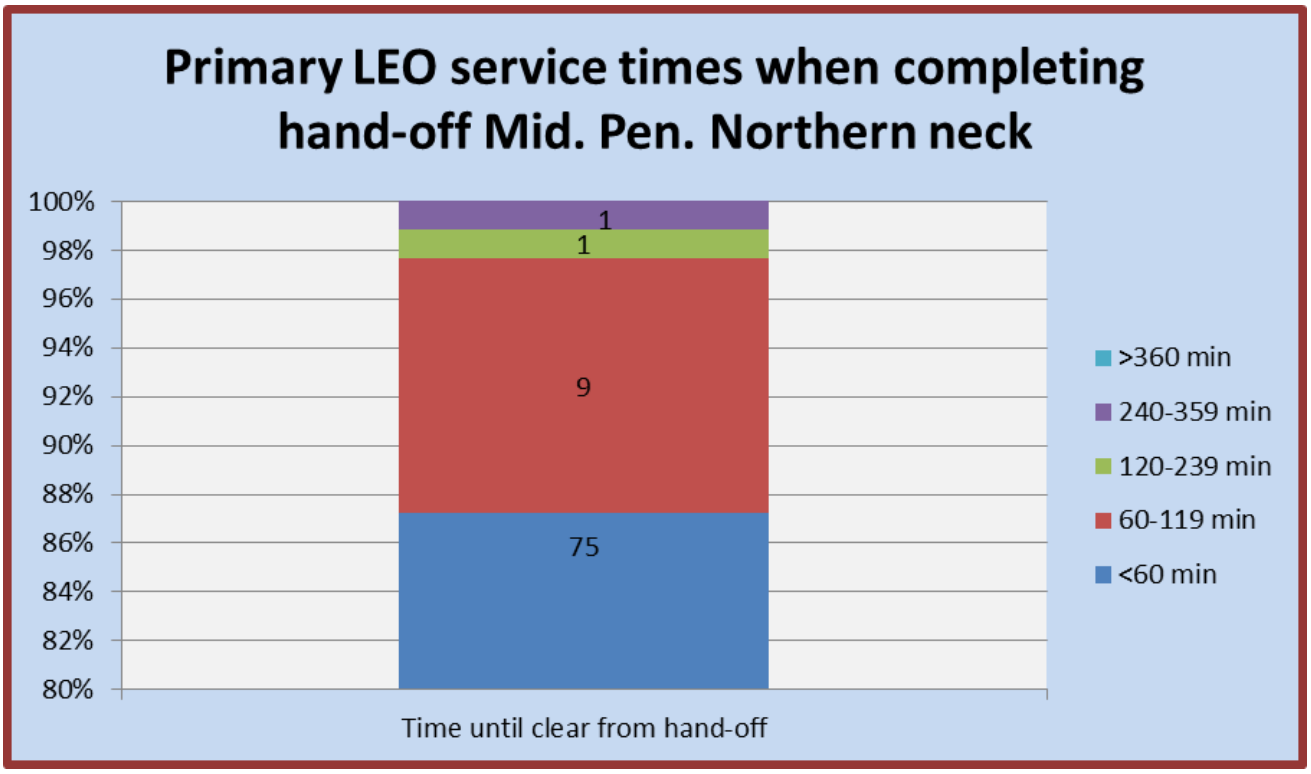

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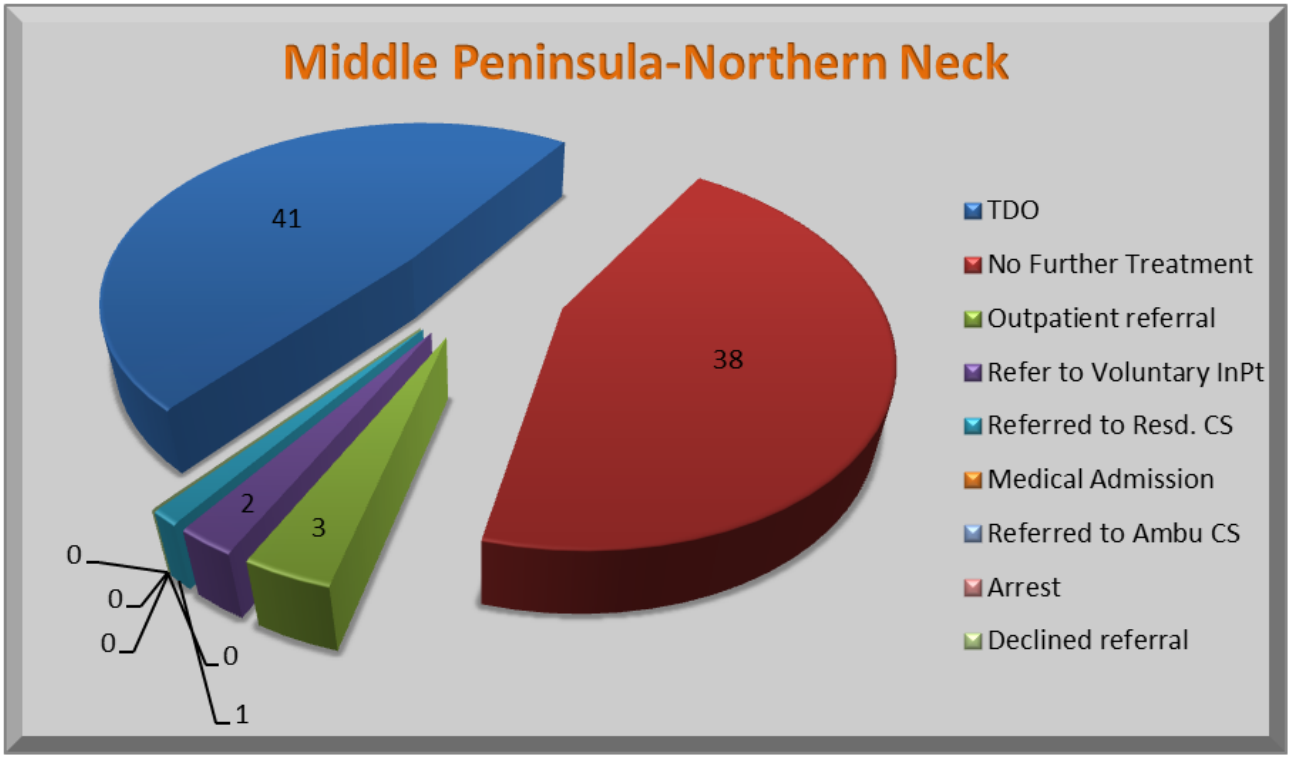

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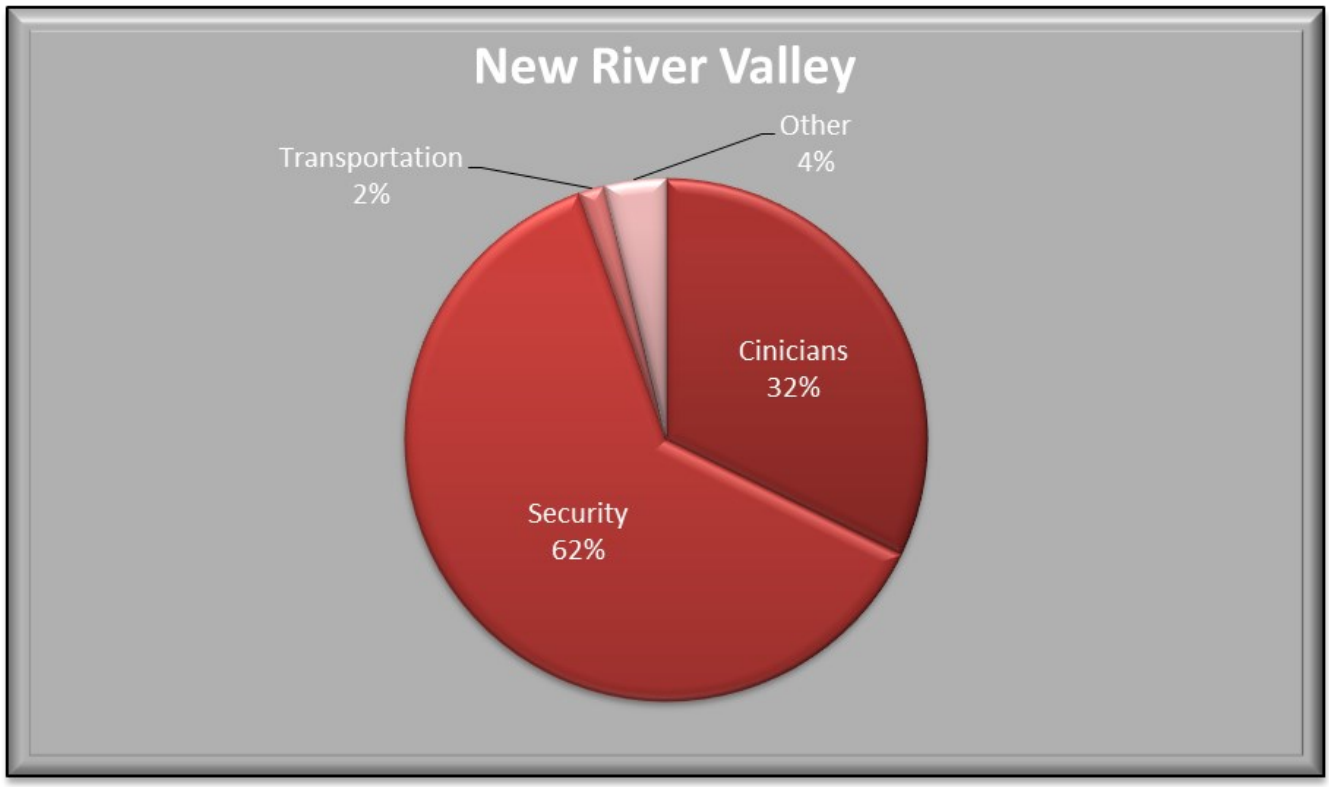

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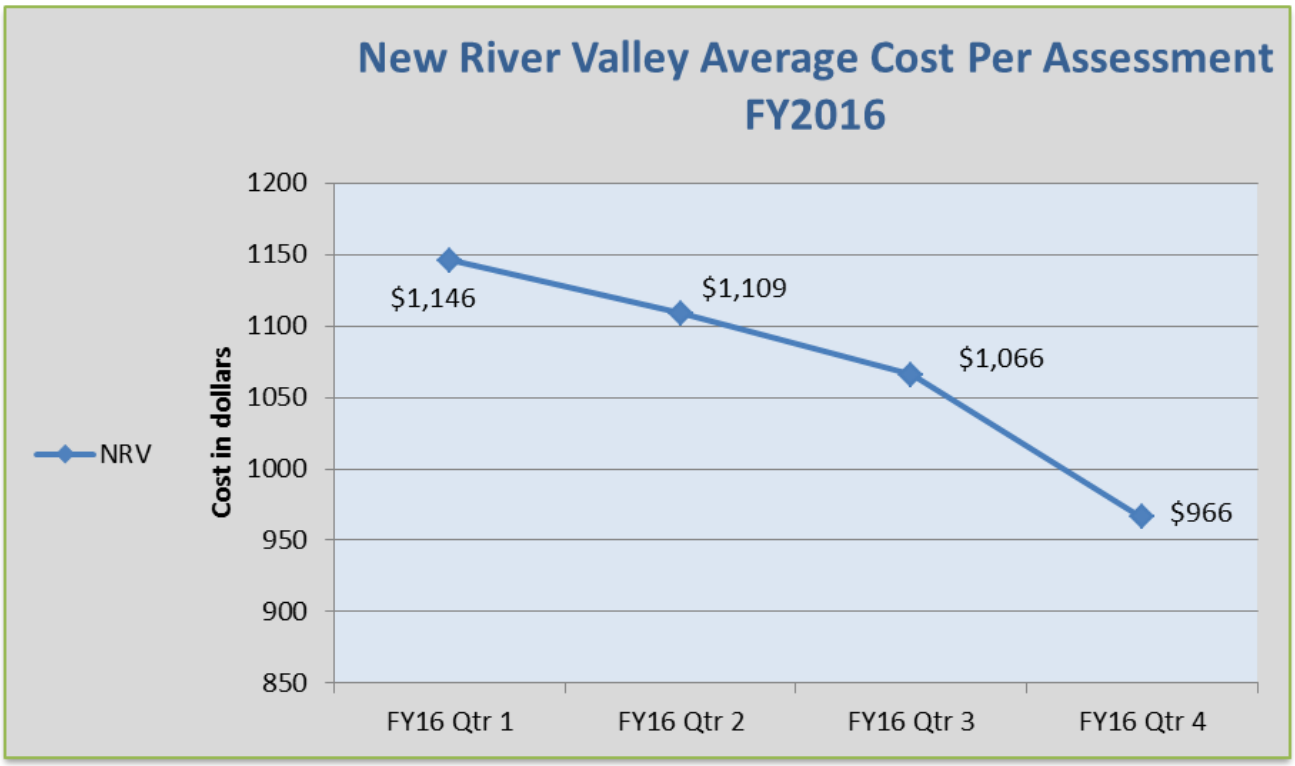

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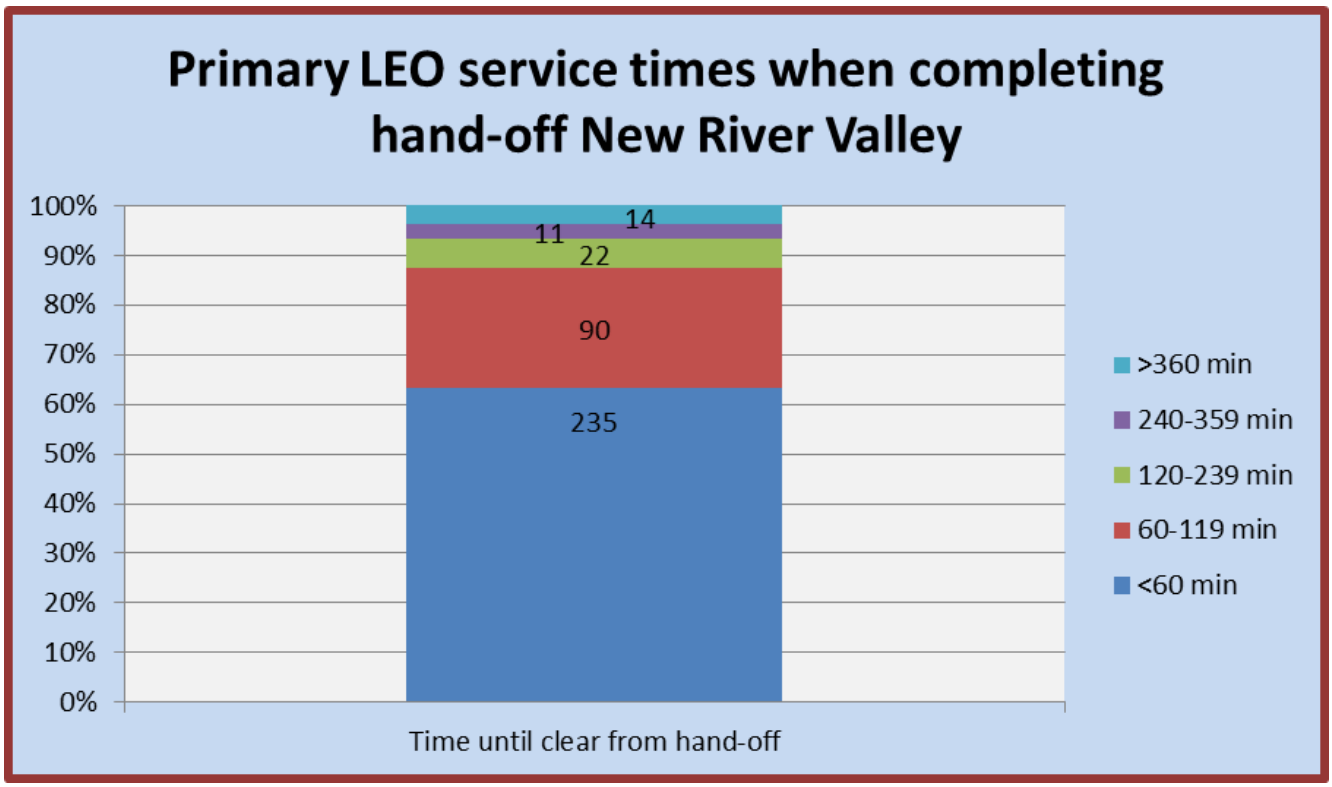

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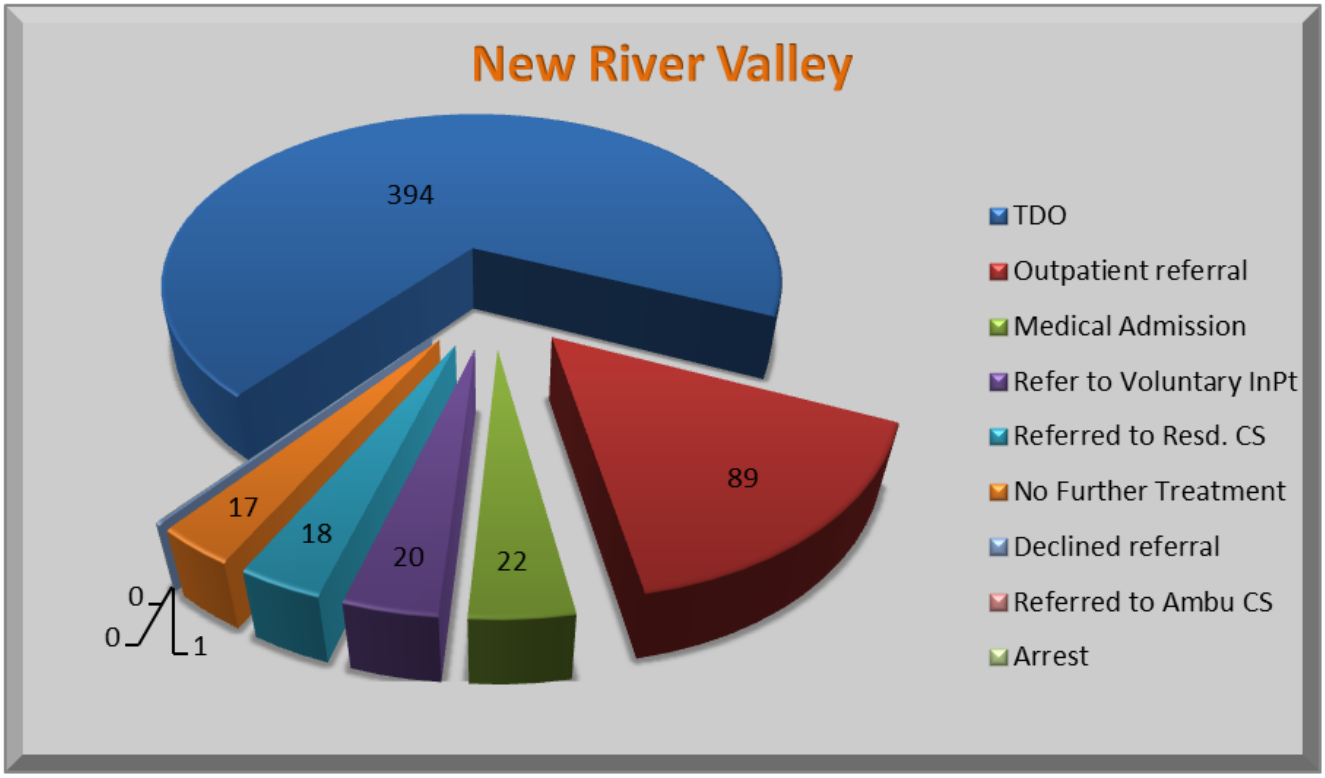

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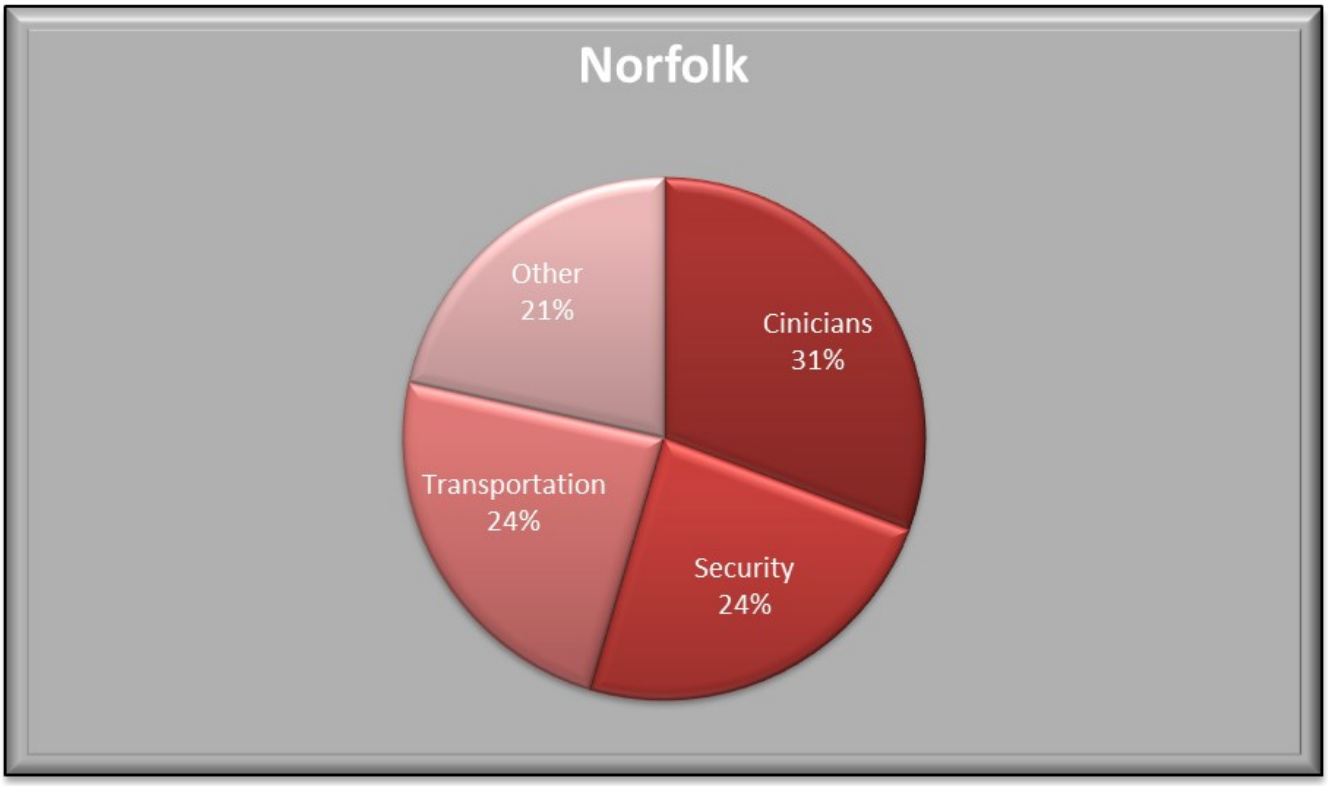

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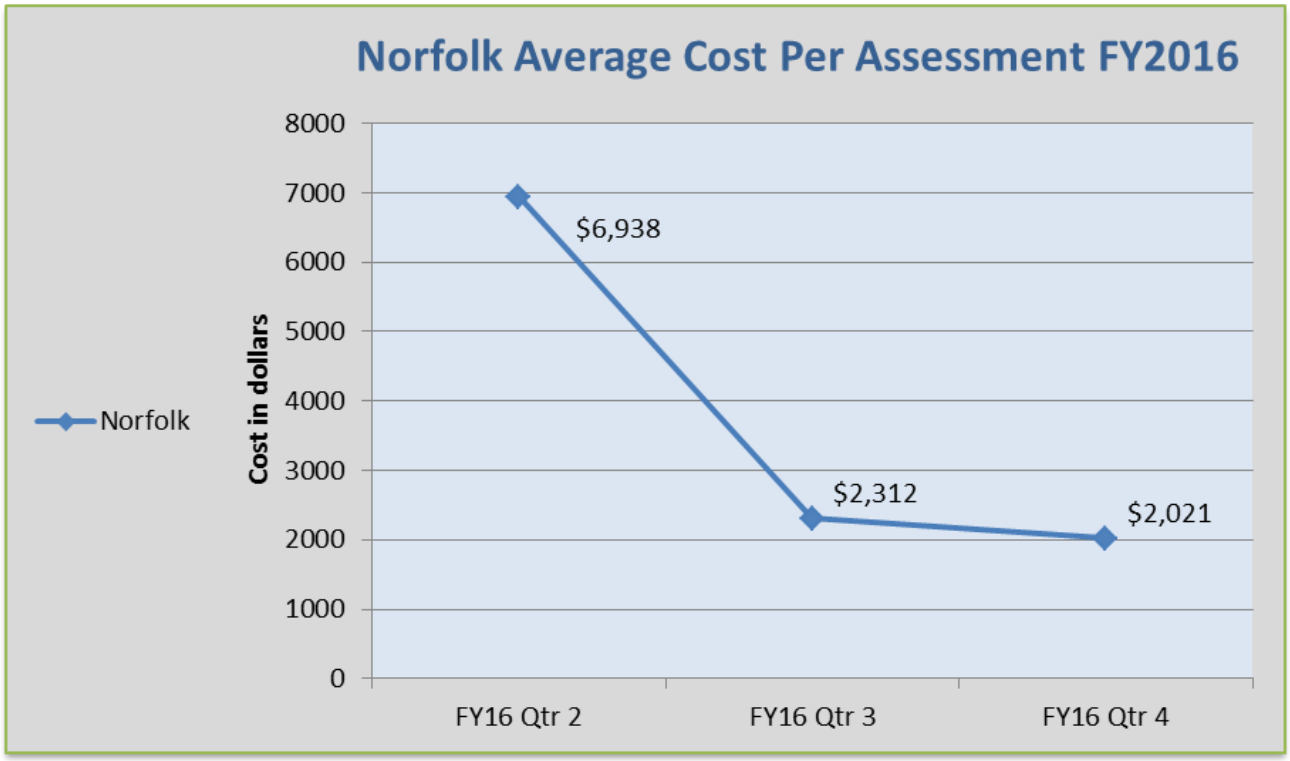

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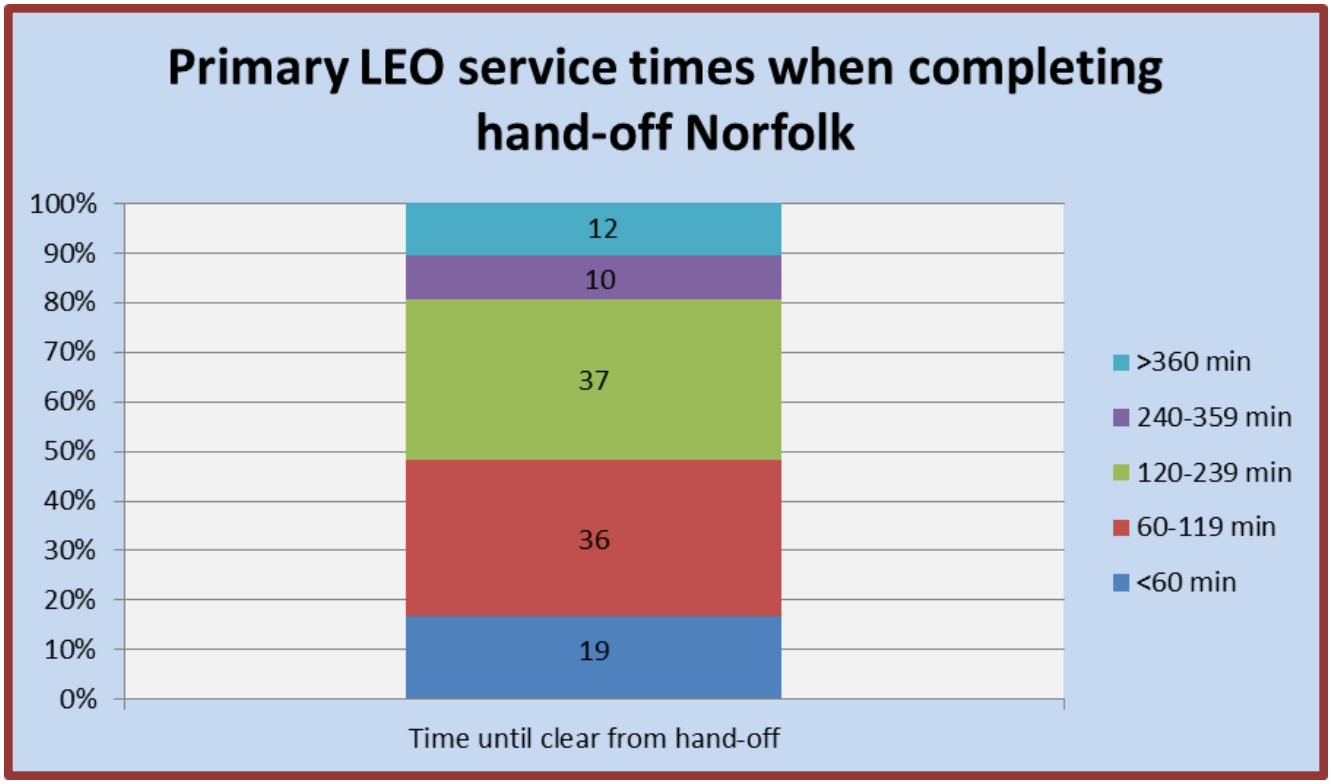

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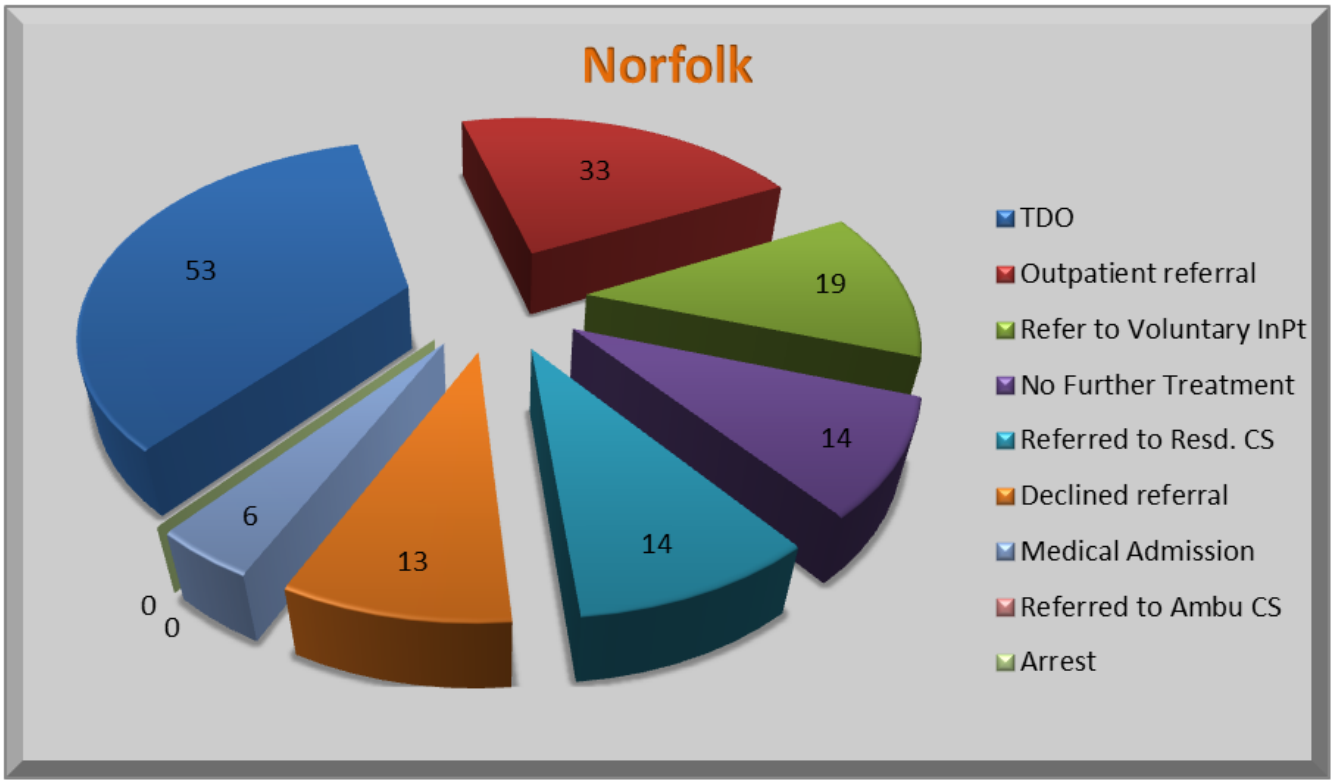

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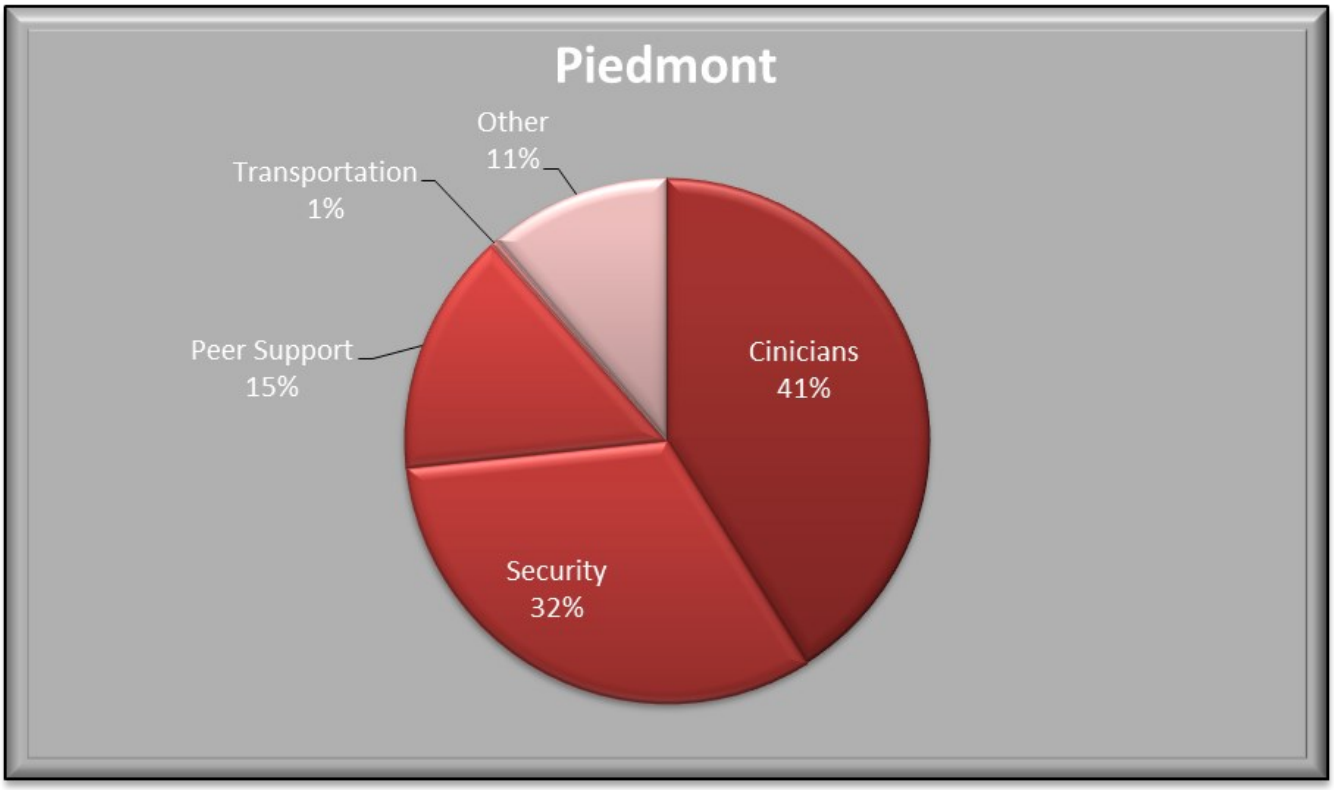

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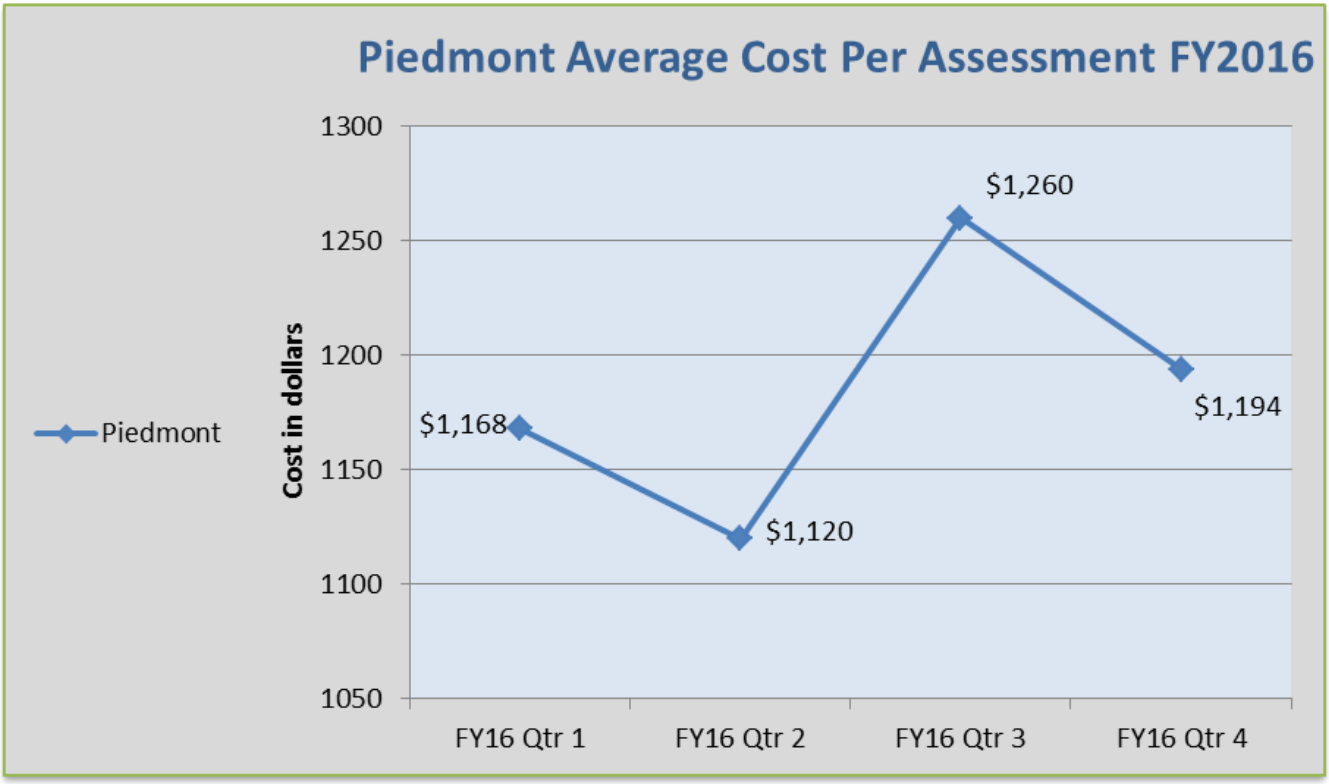

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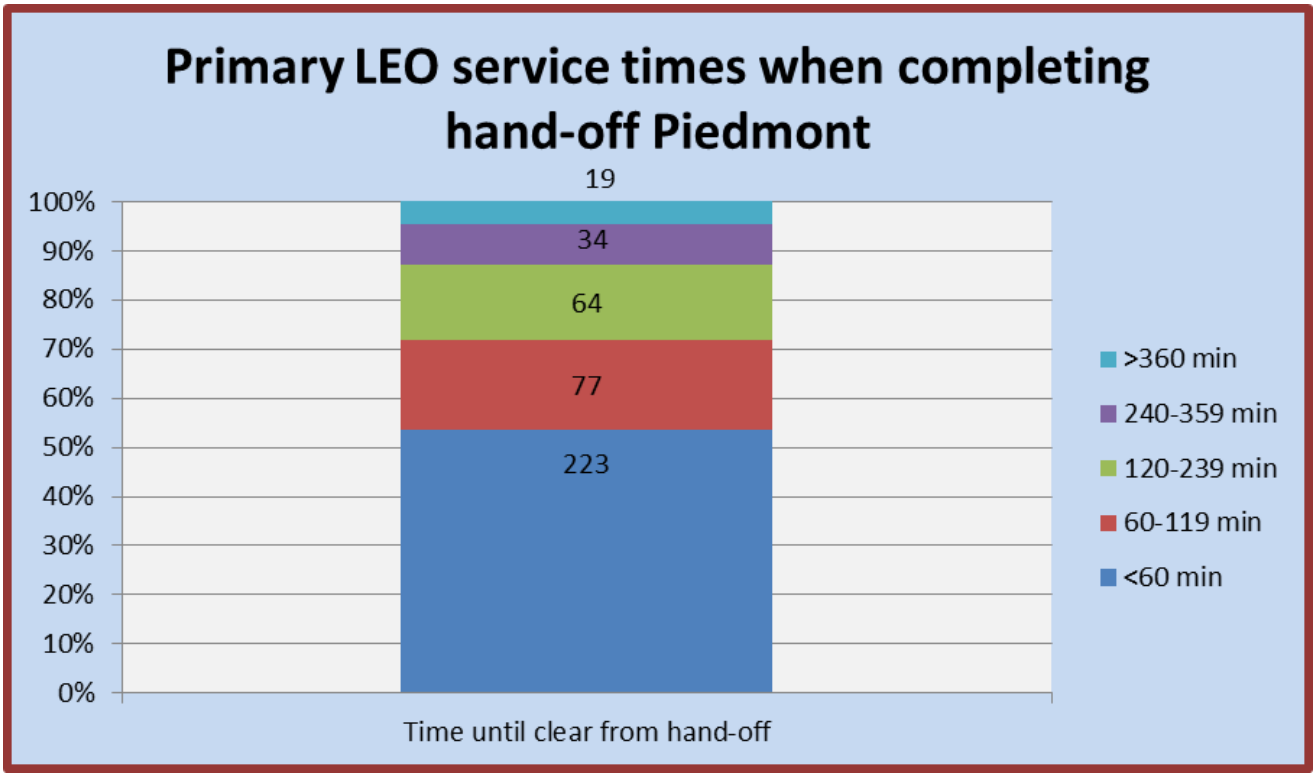

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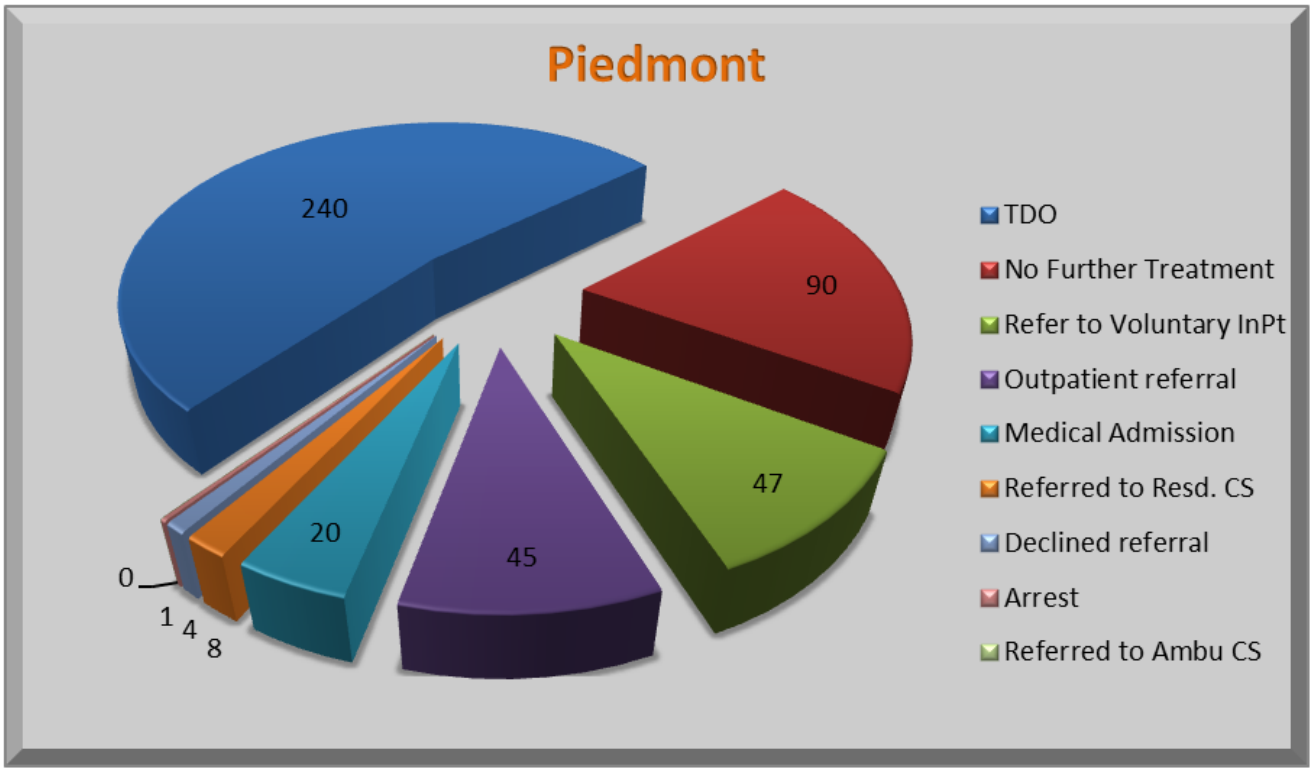

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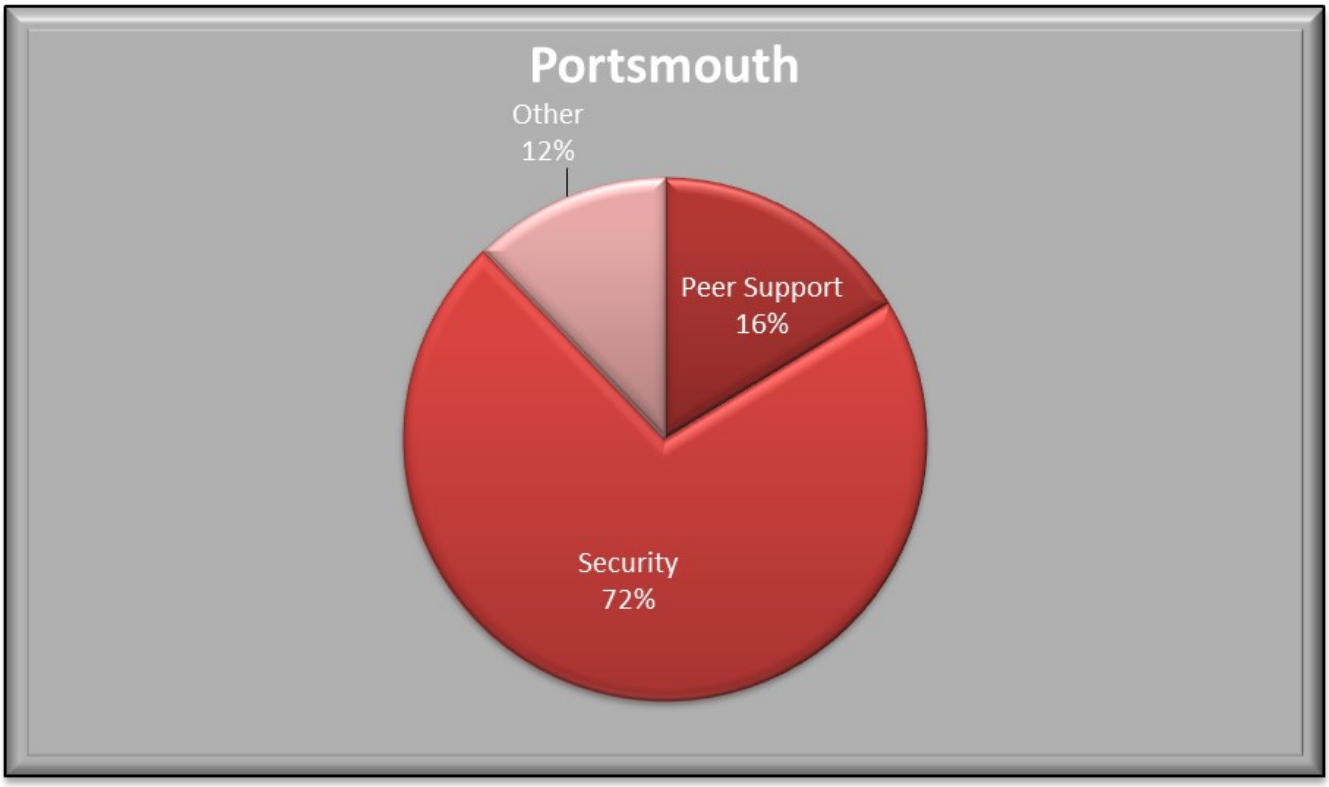

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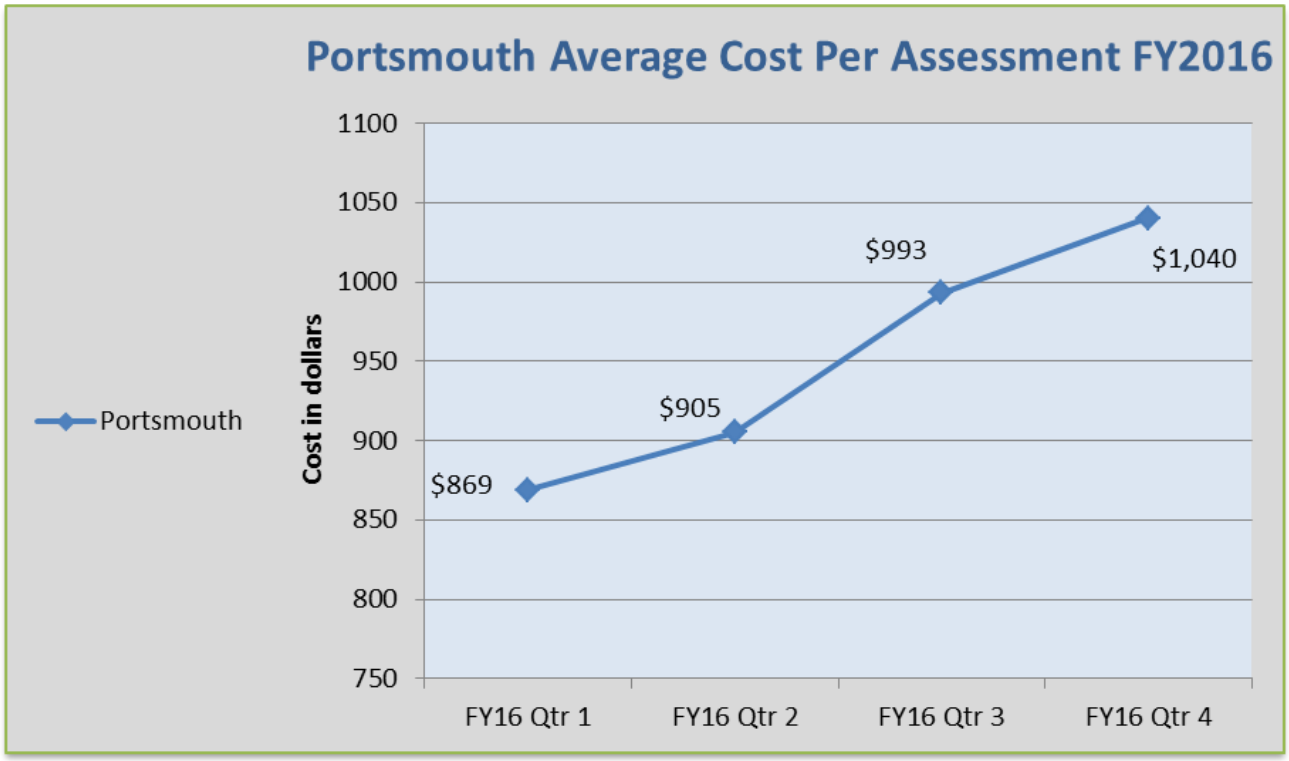

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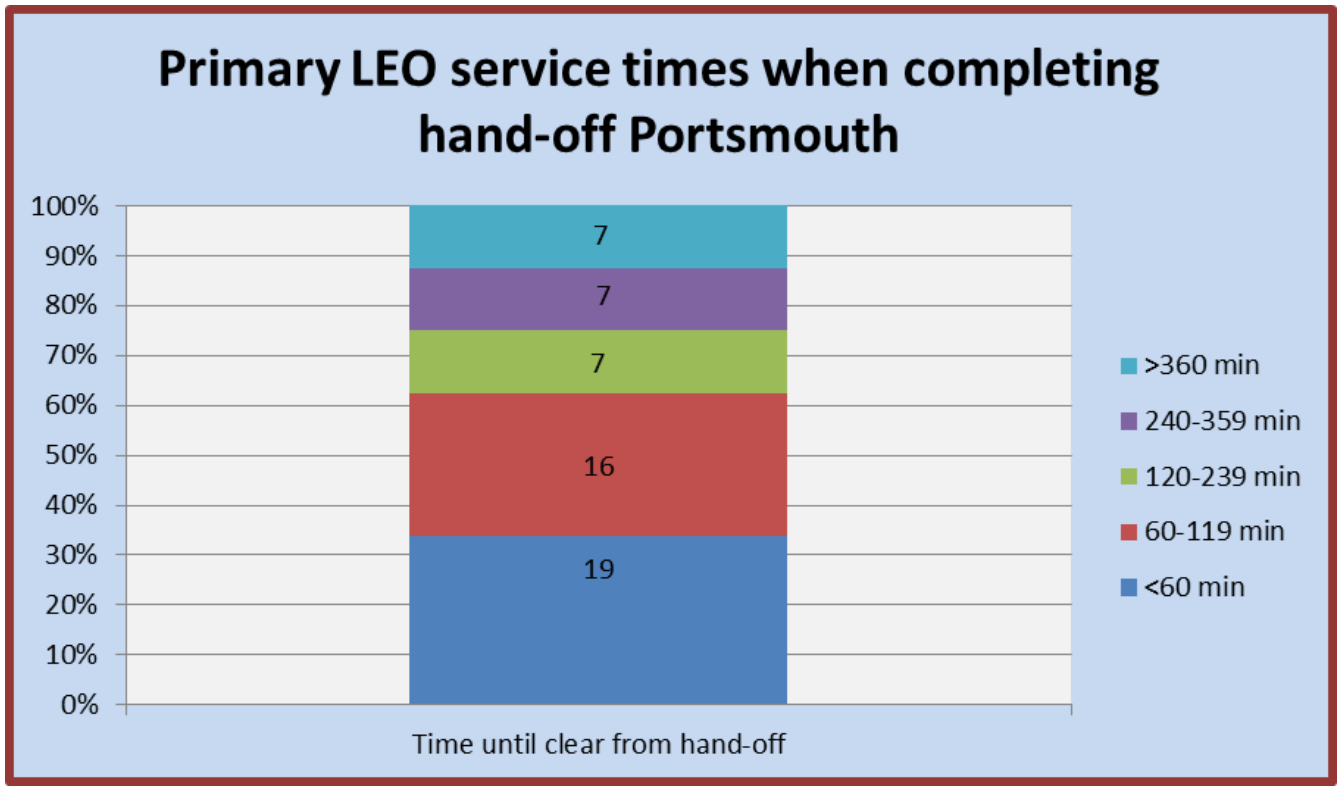

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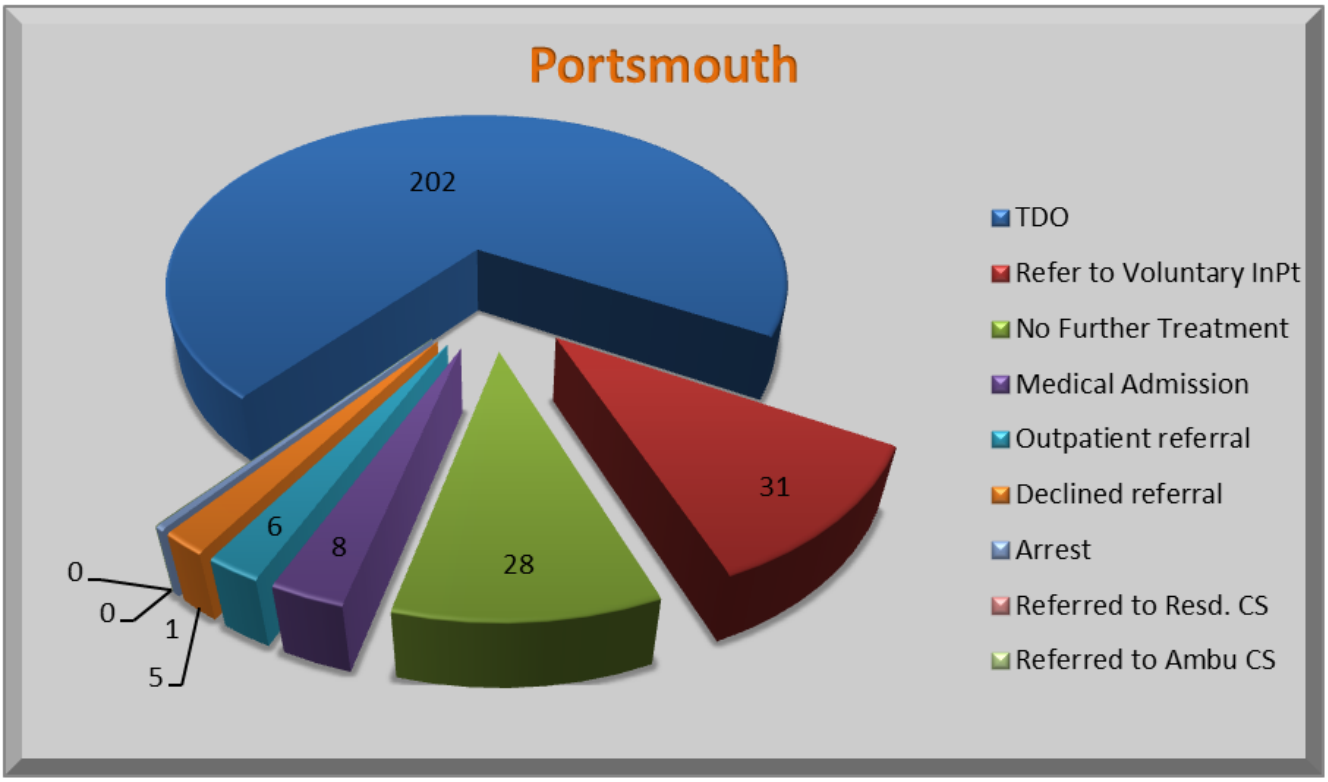

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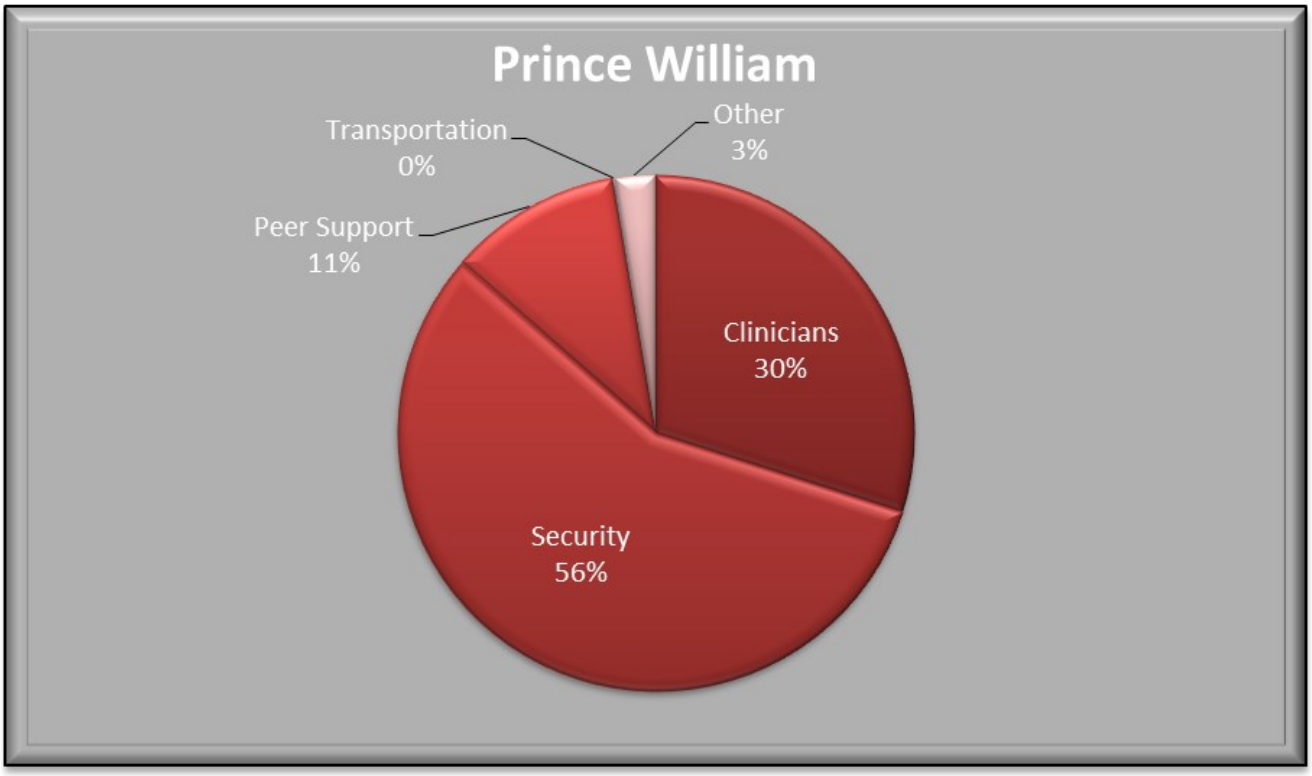

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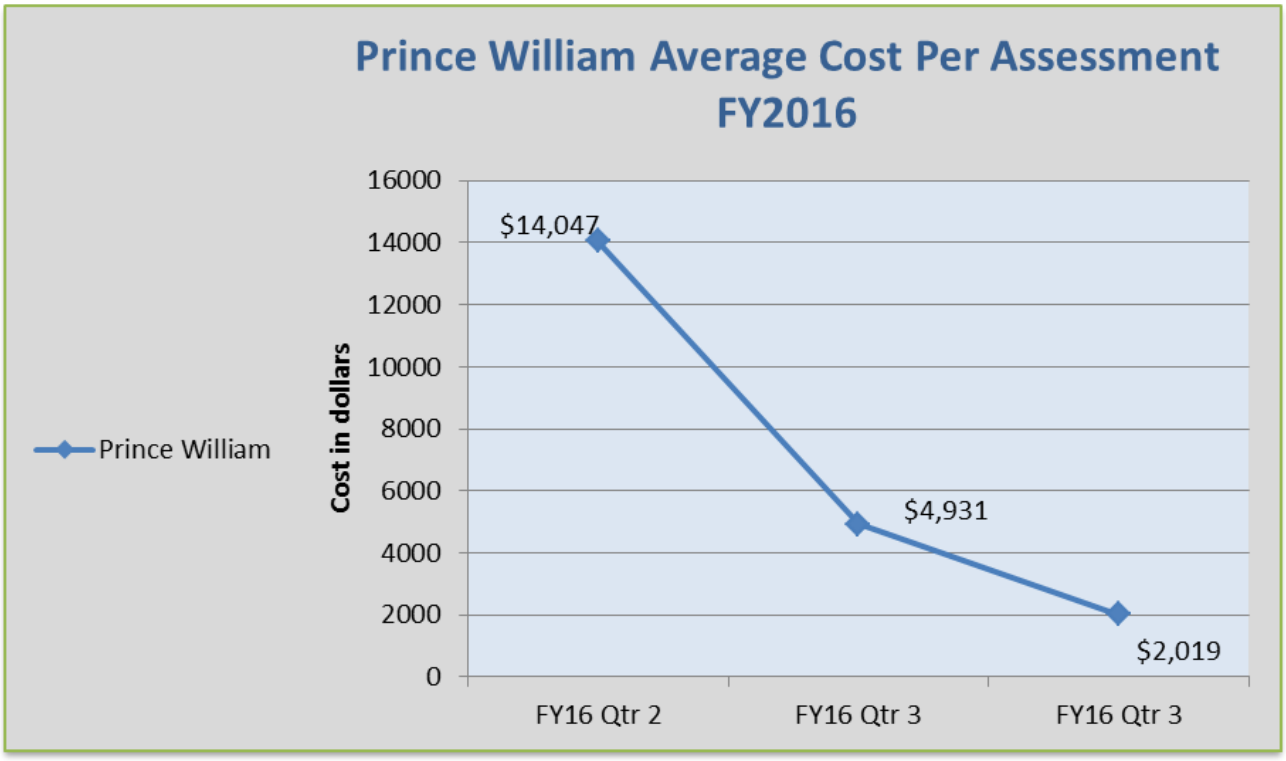

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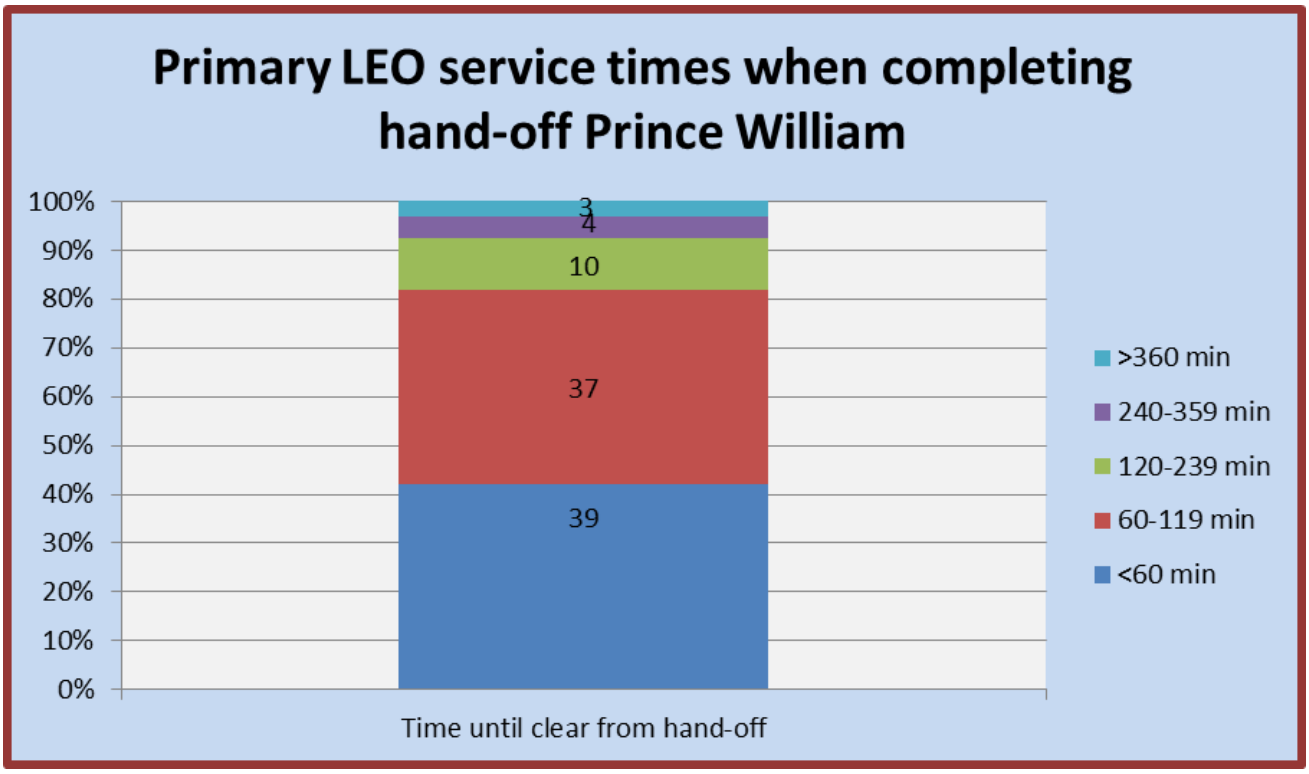

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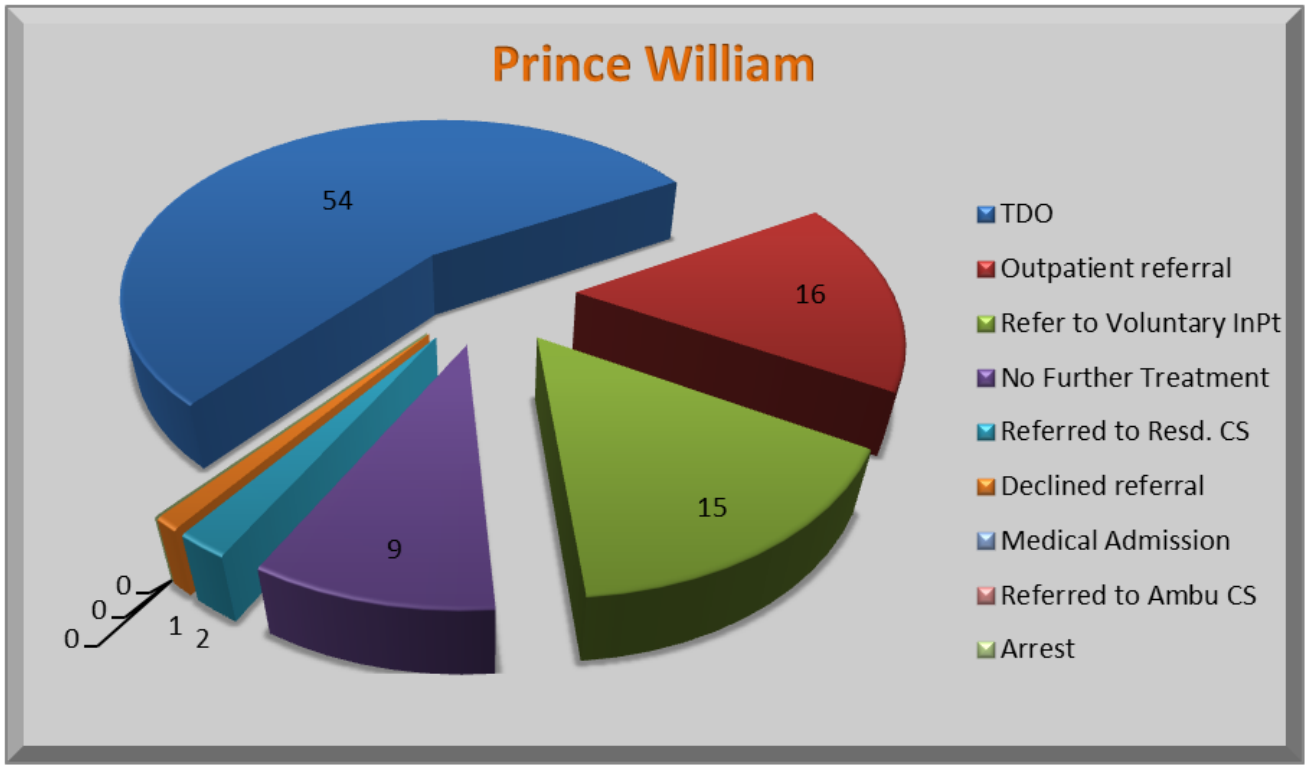

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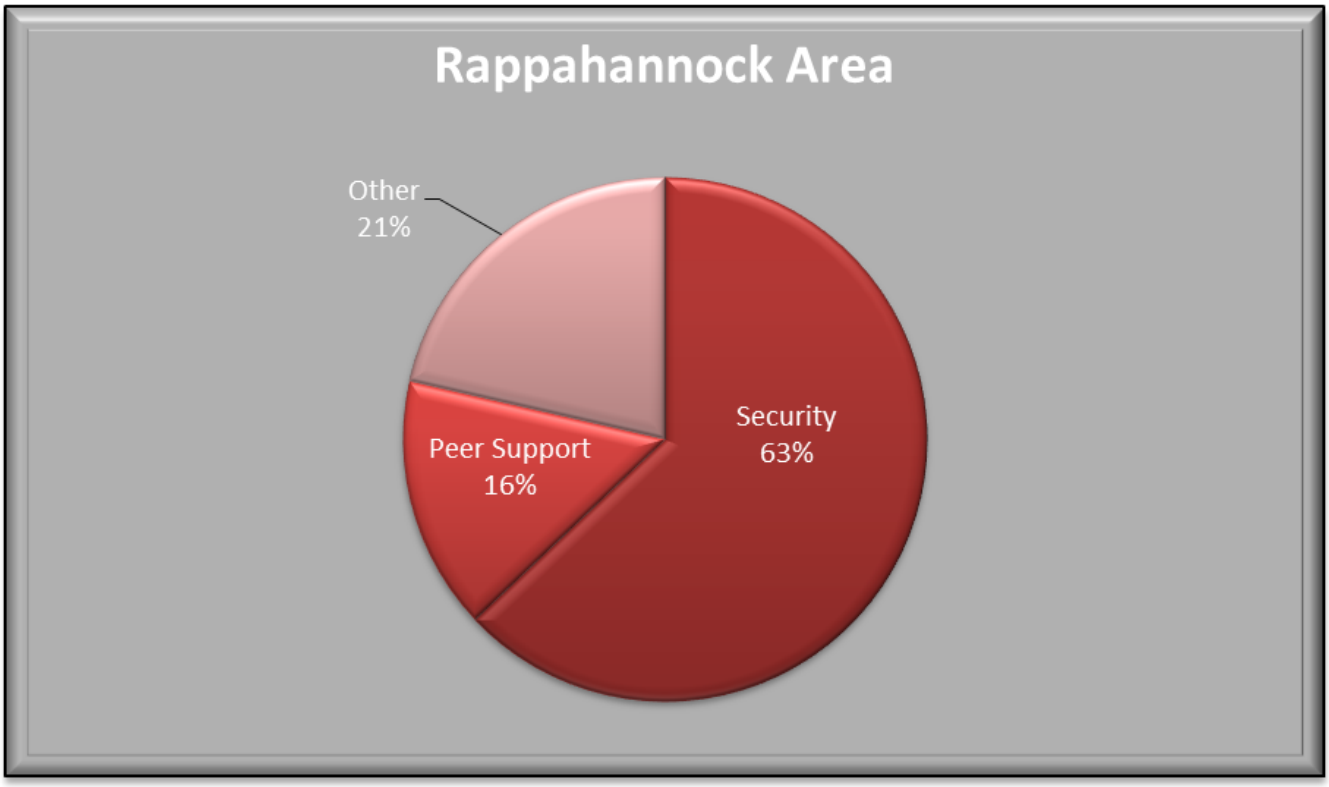

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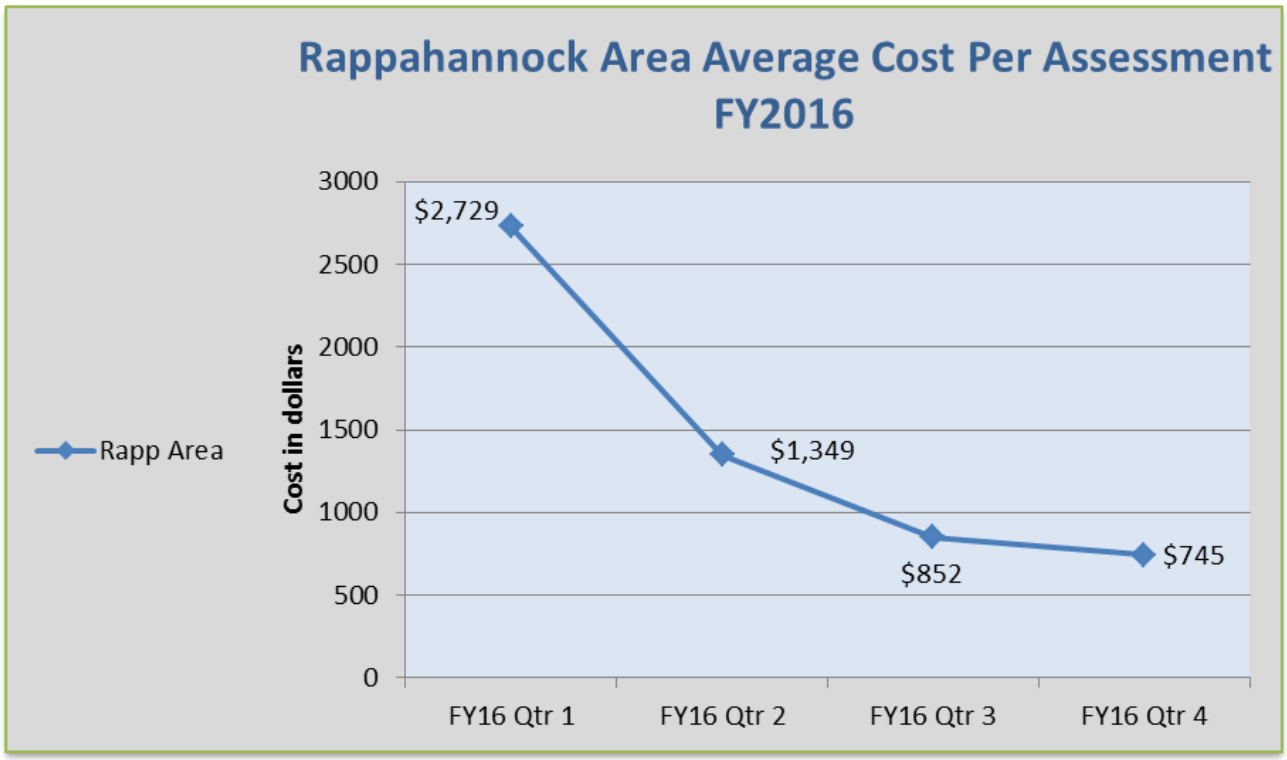

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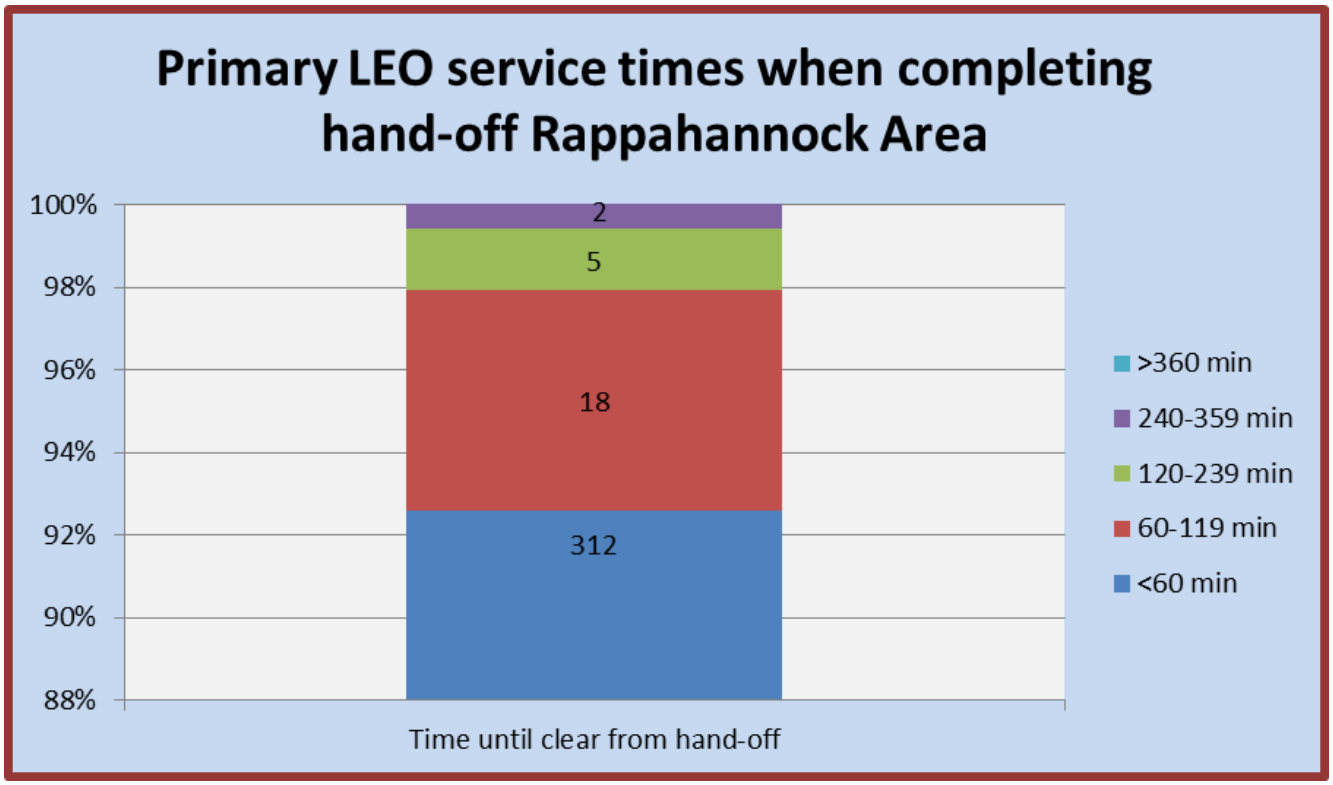

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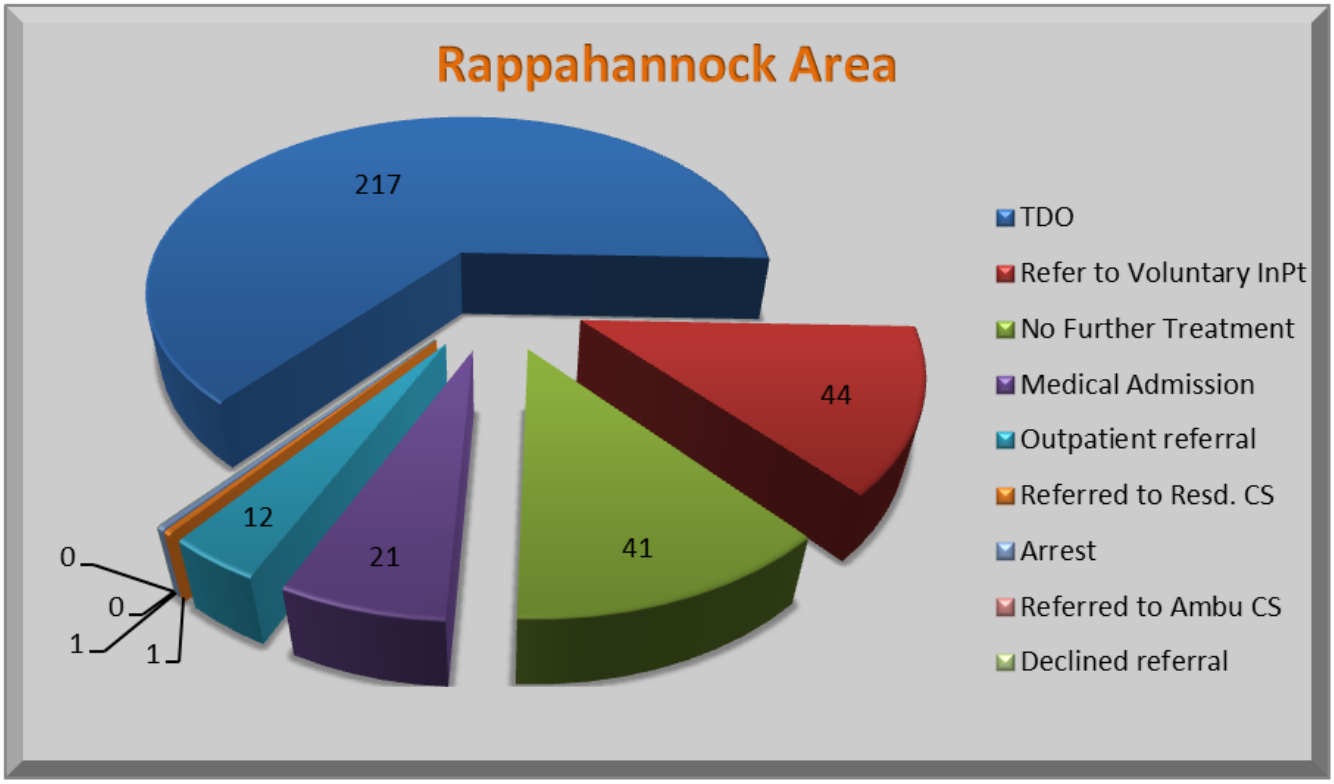

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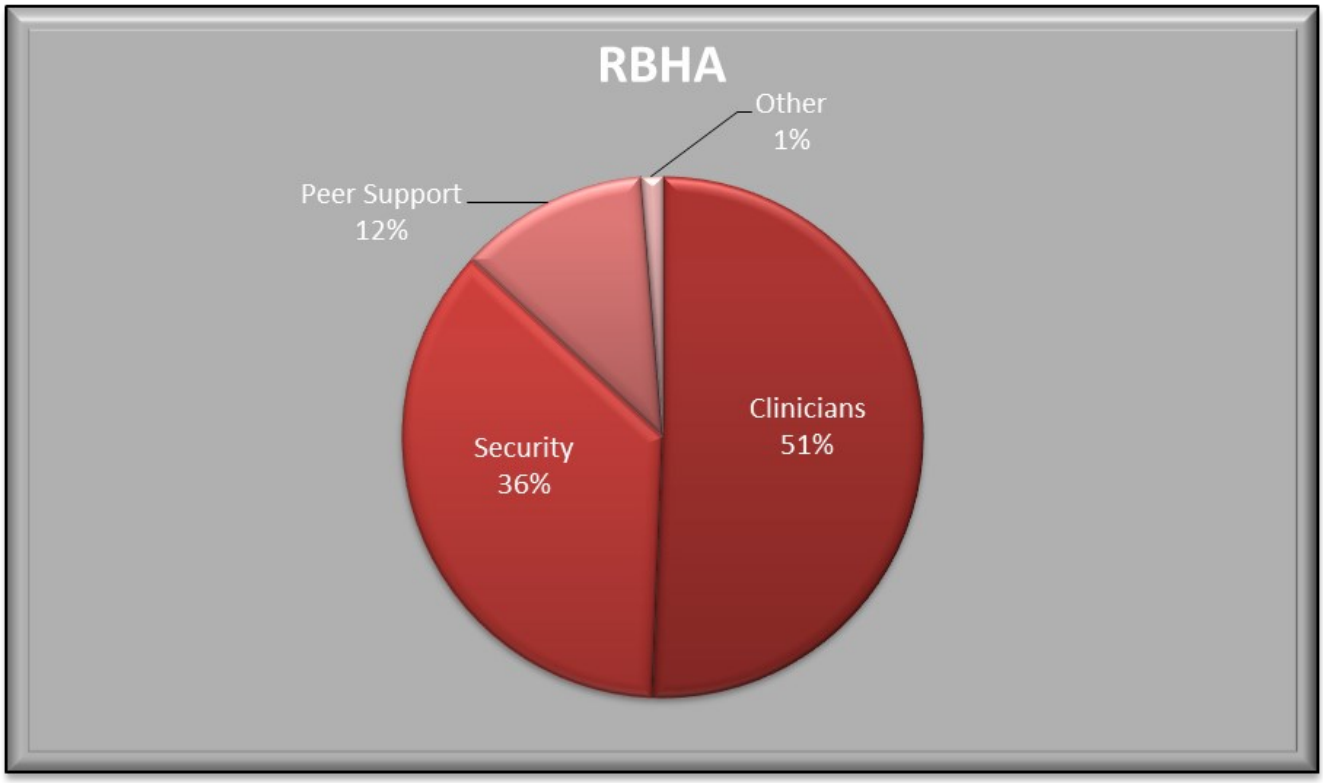

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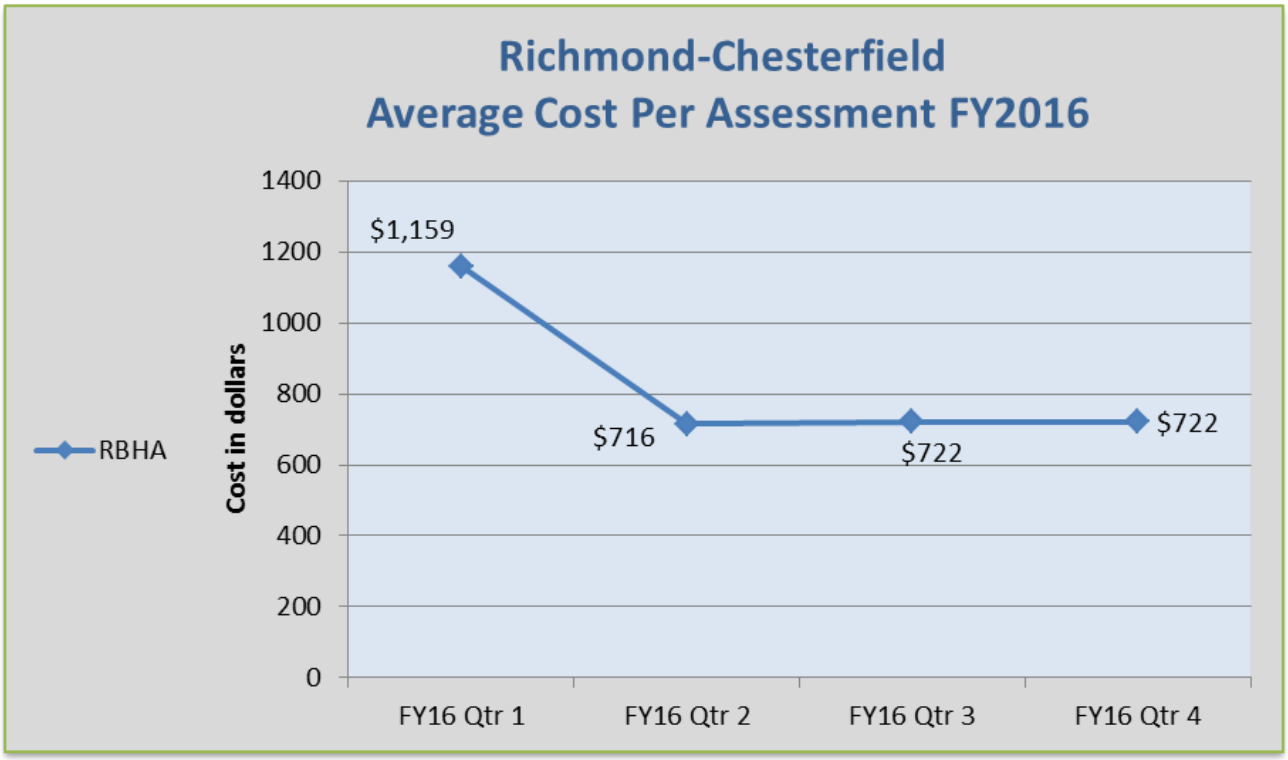

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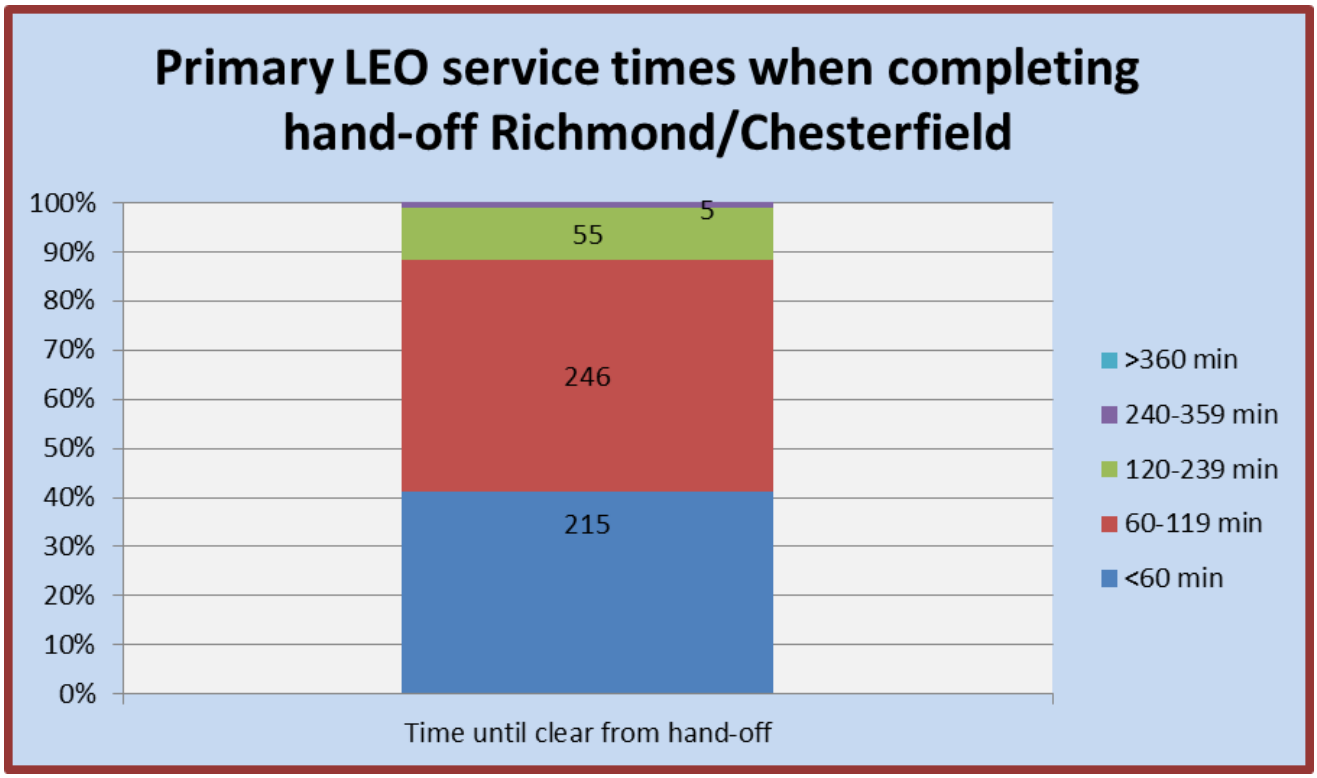

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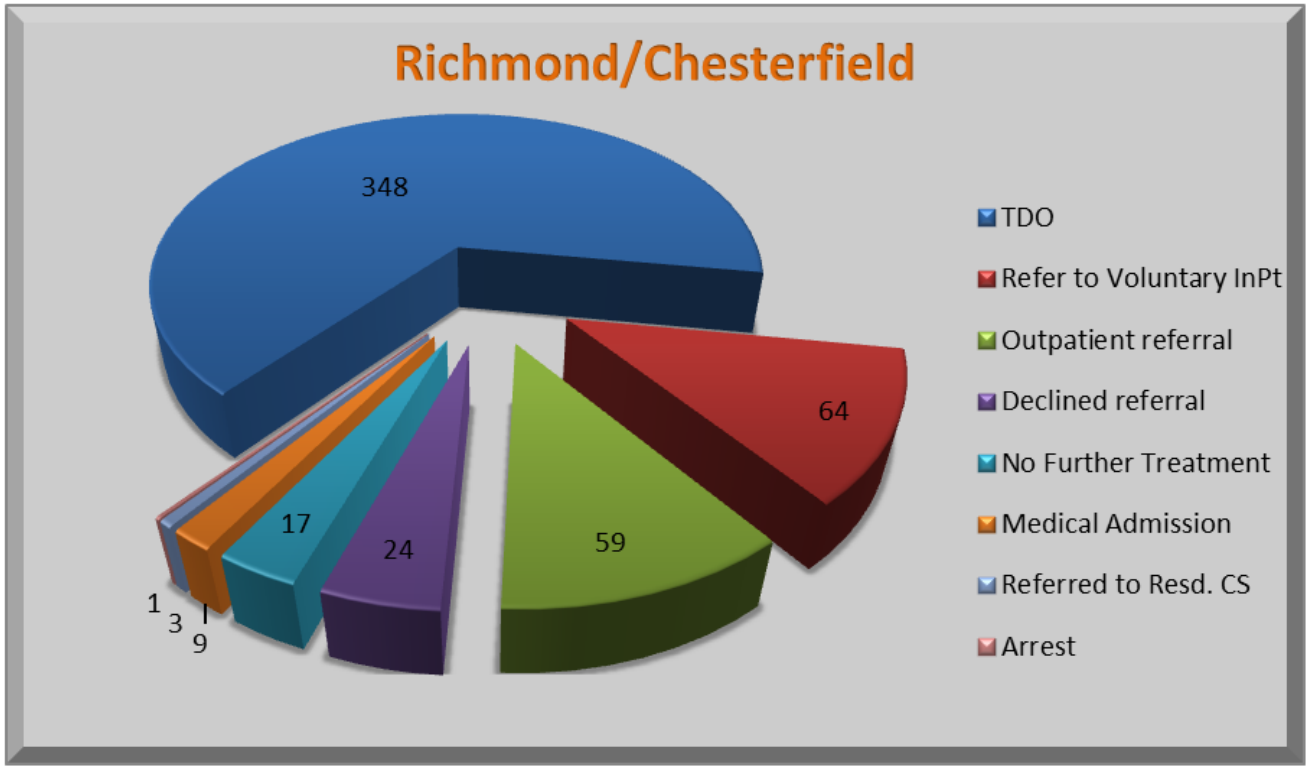

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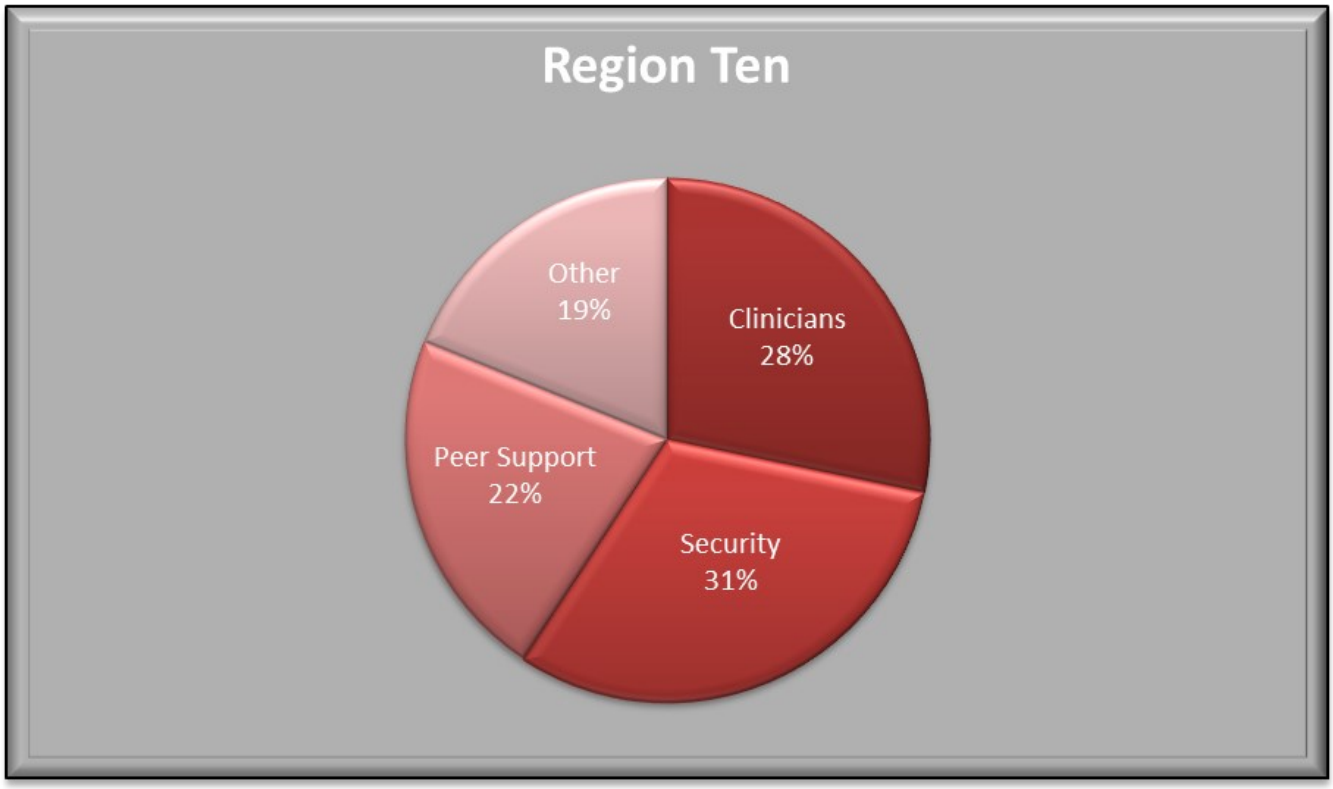

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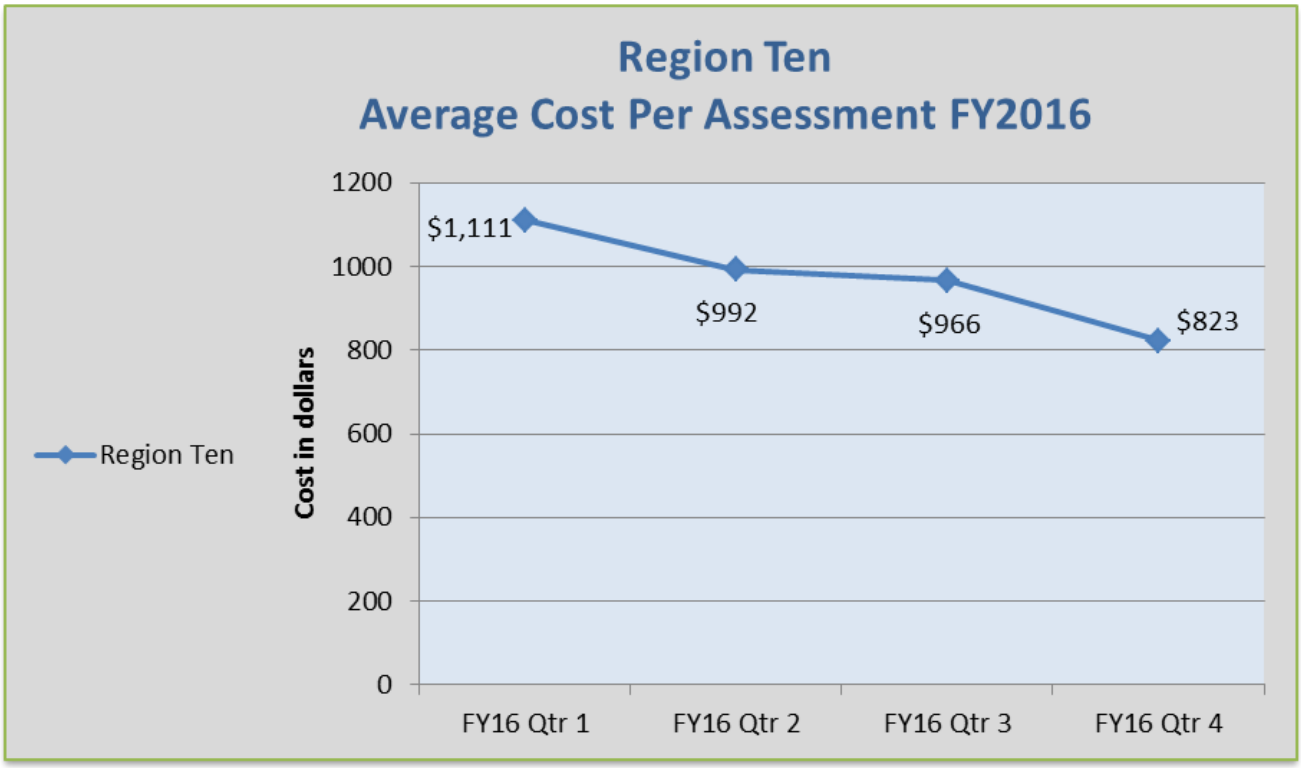

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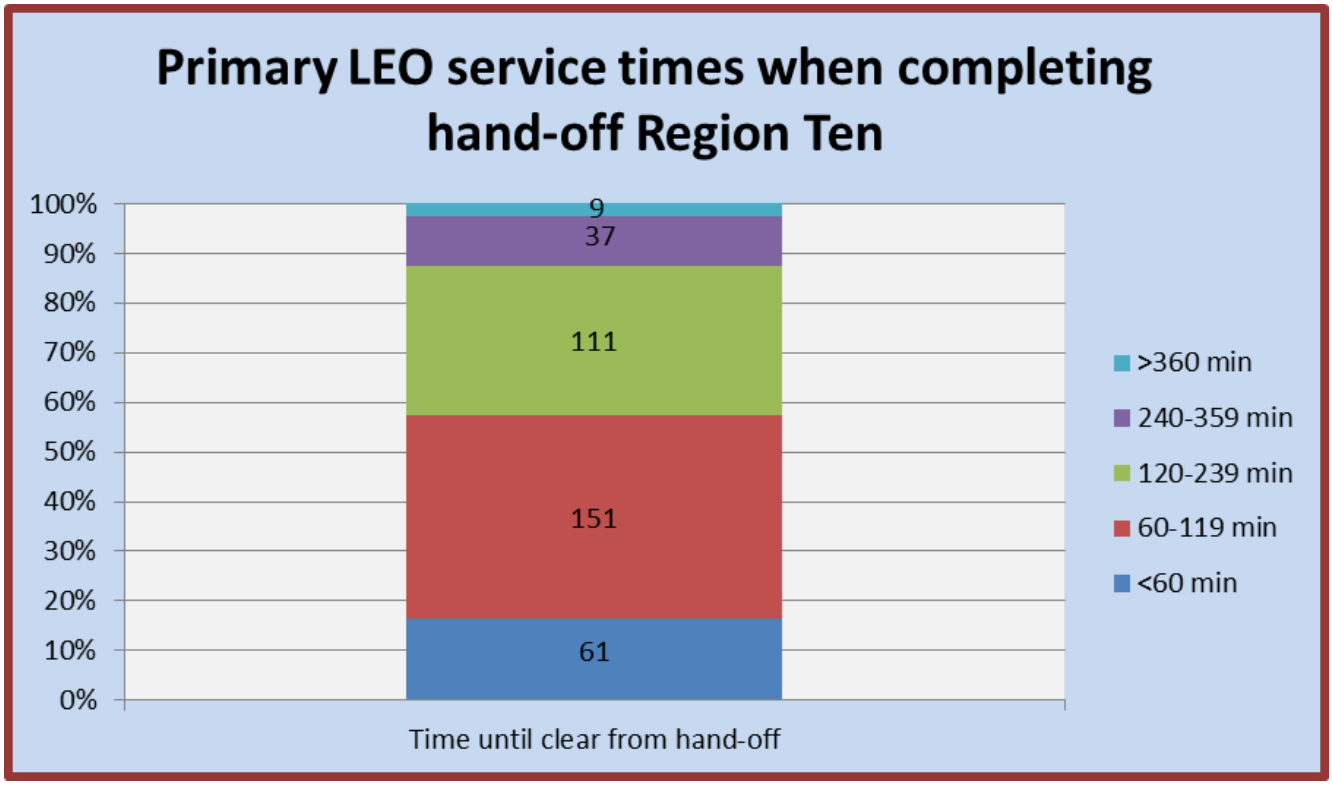
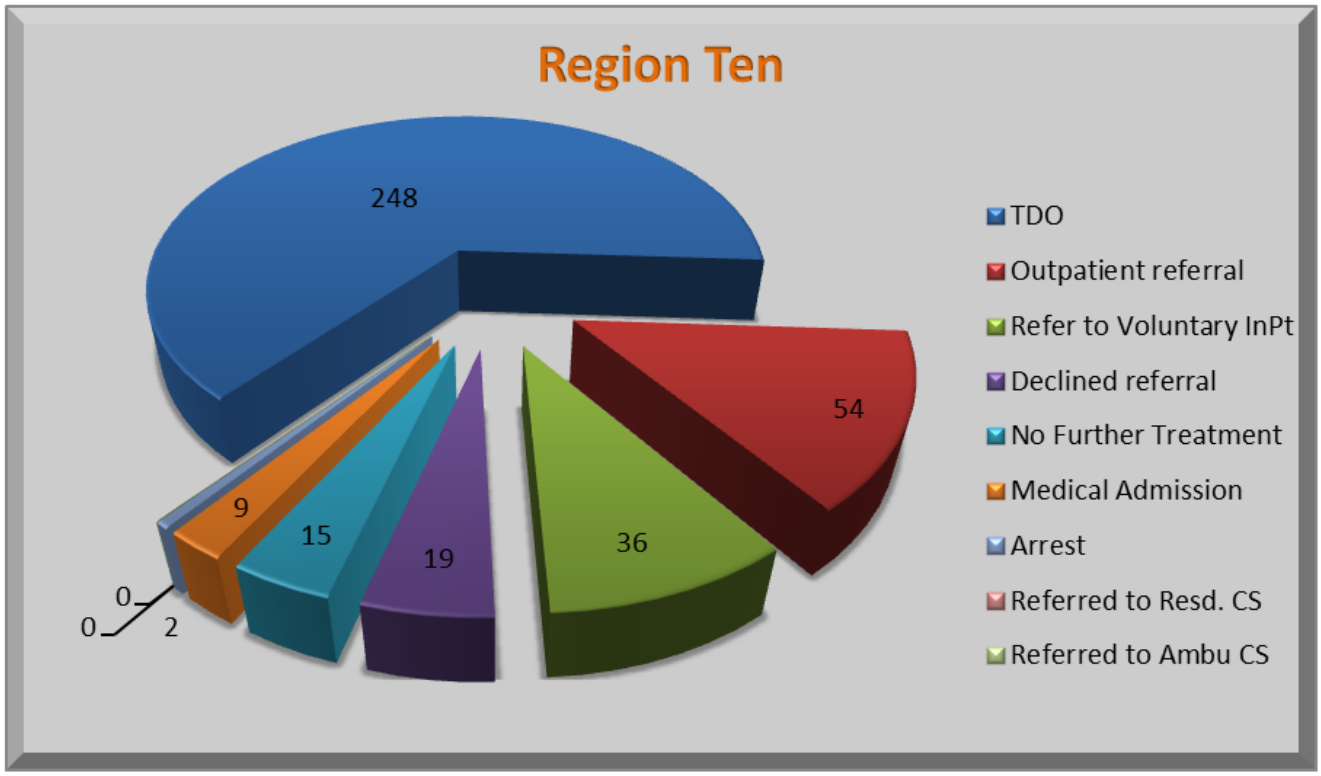
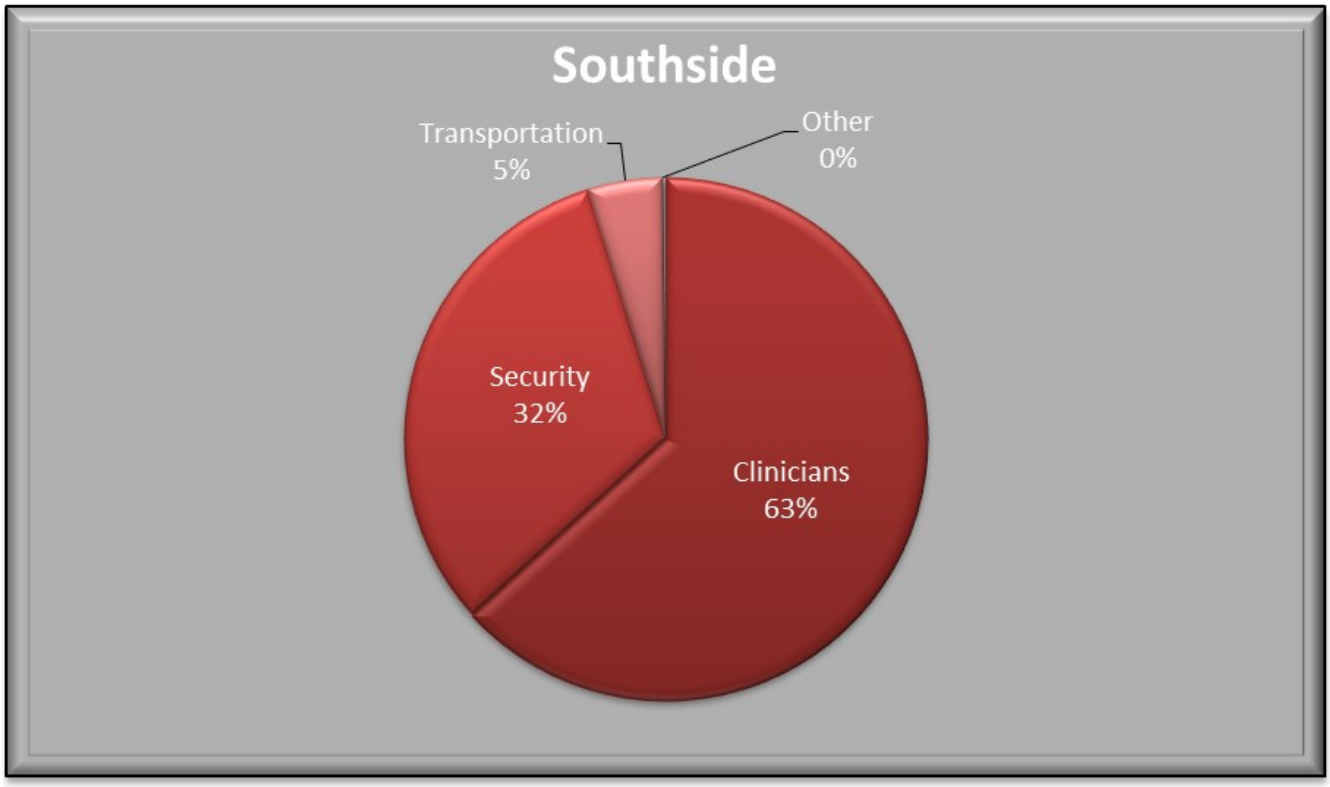


Clinical Dispositions



Allocation of Assessment Site Funds



Quarterly Cost Per Assessment

The Southside Assessment Site program was not able to conduct pre-screen assessments during FY'16 due to unforeseen circumstances with memorandums of agreement and legal concerns of partners after the awarding of funds.

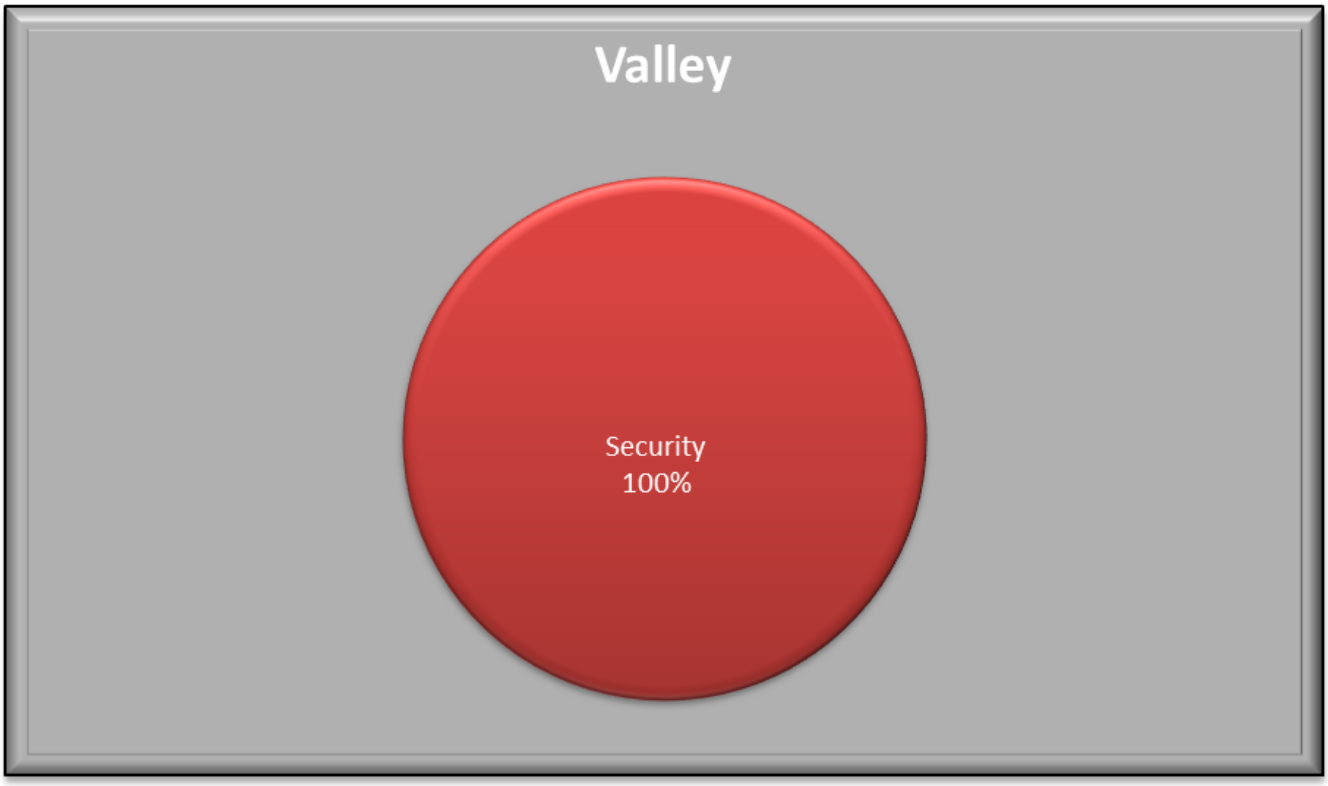
For this reason the cost per assessment on this page and release to service and clinical disposition charts are not included for this program.

The program has finalized all necessary agreements and has begun to assess Consumers at the site in FY'17.

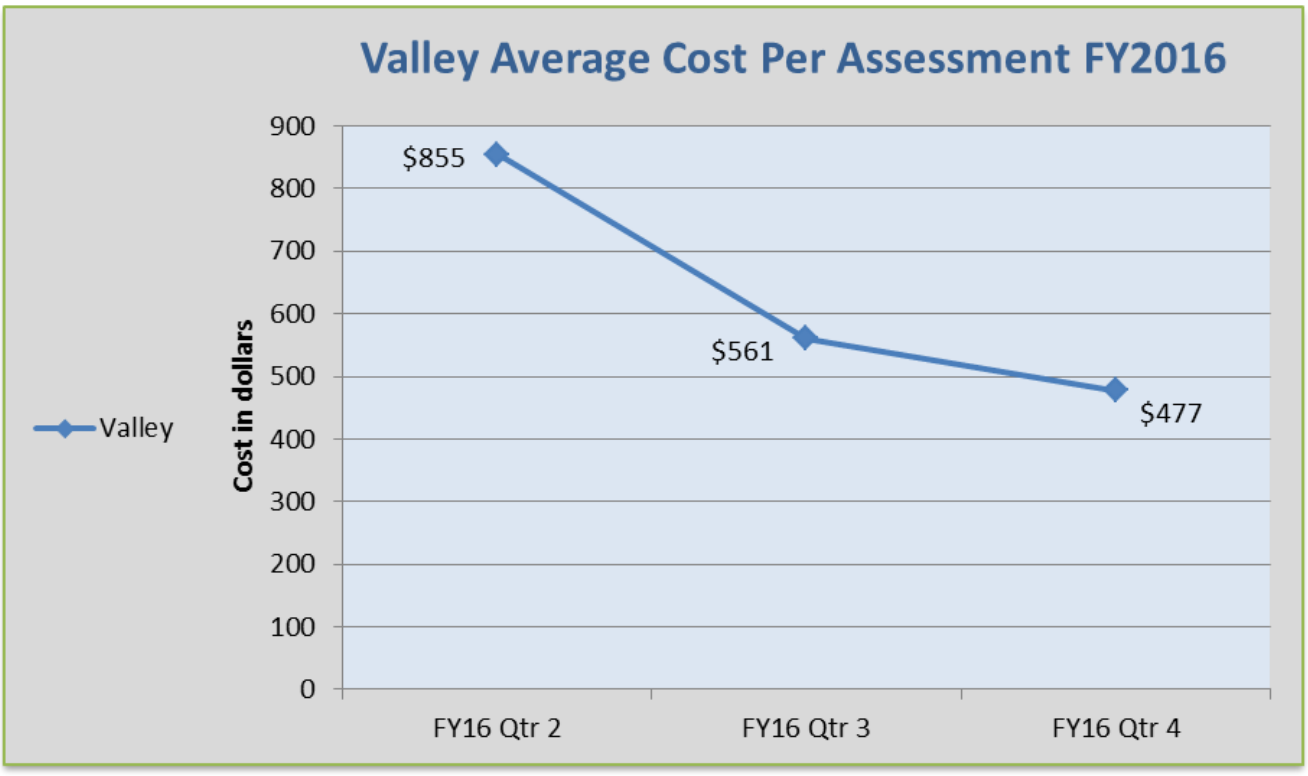
Officer Release to Service Times

Clinical Dispositions

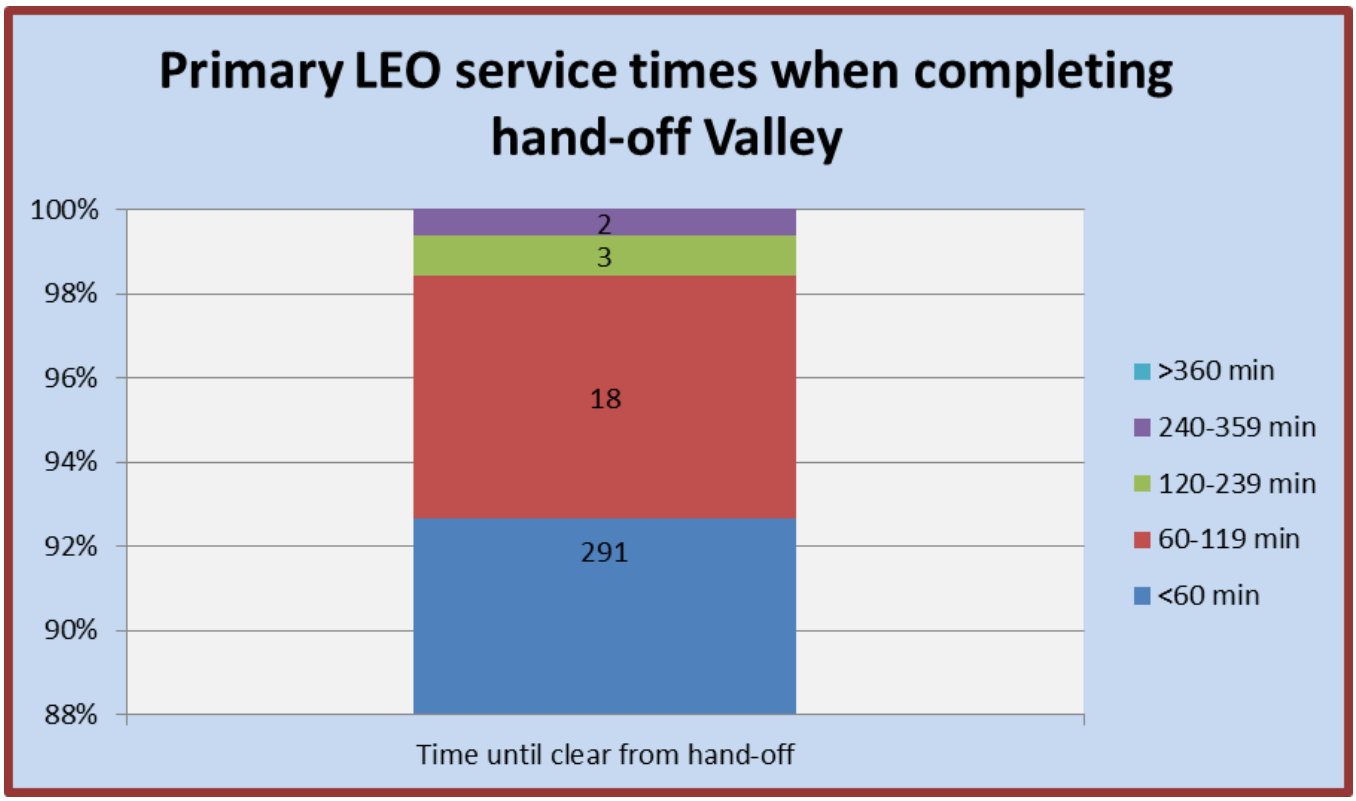
Allocation of Assessment Site Funds



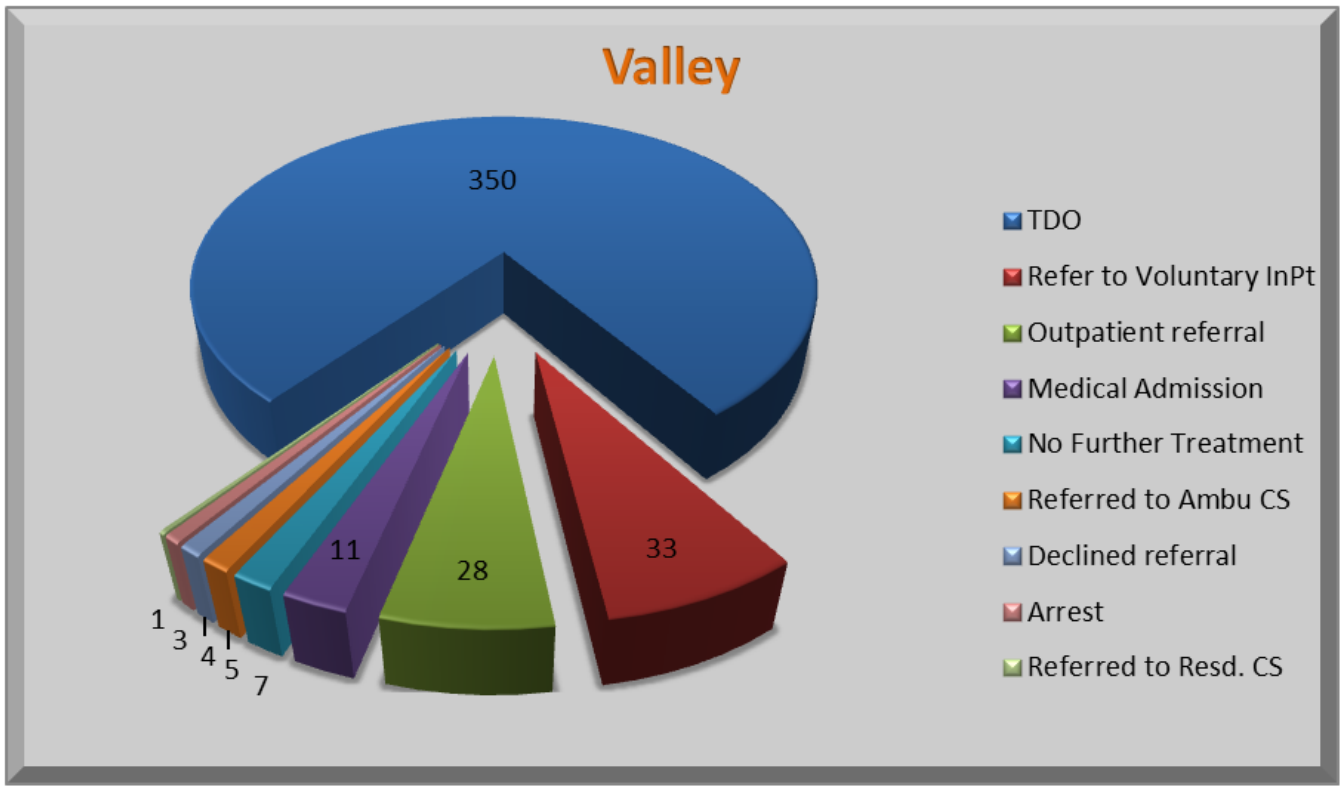
Quarterly Cost Per Assessment



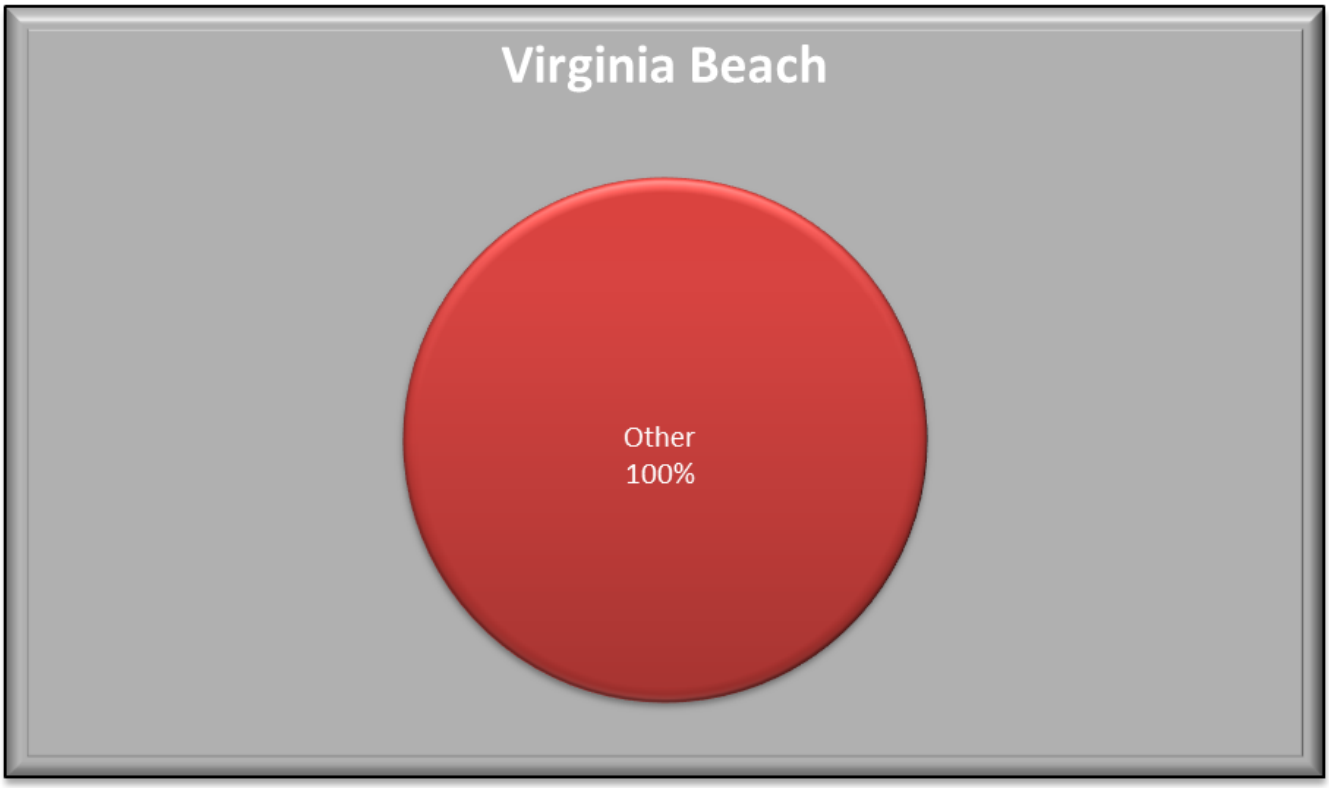
Officer Release to Service Times



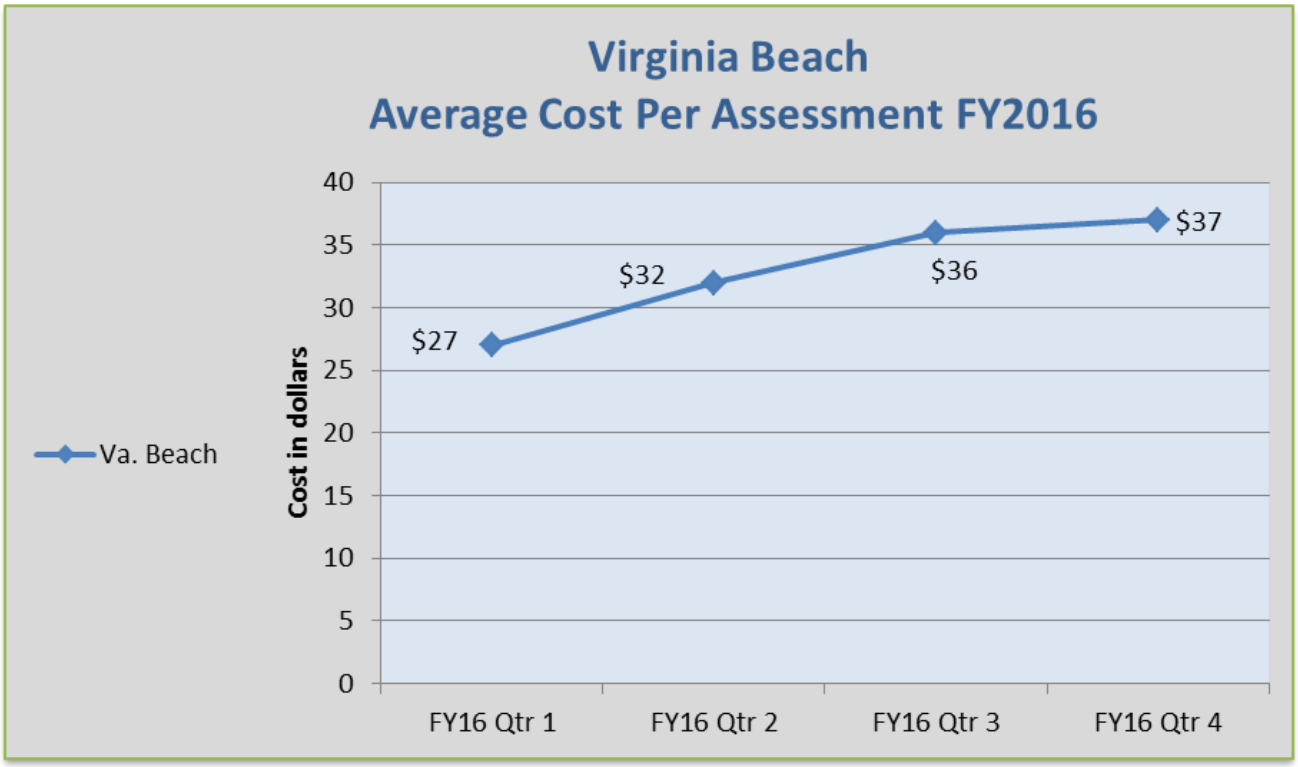
Clinical Dispositions



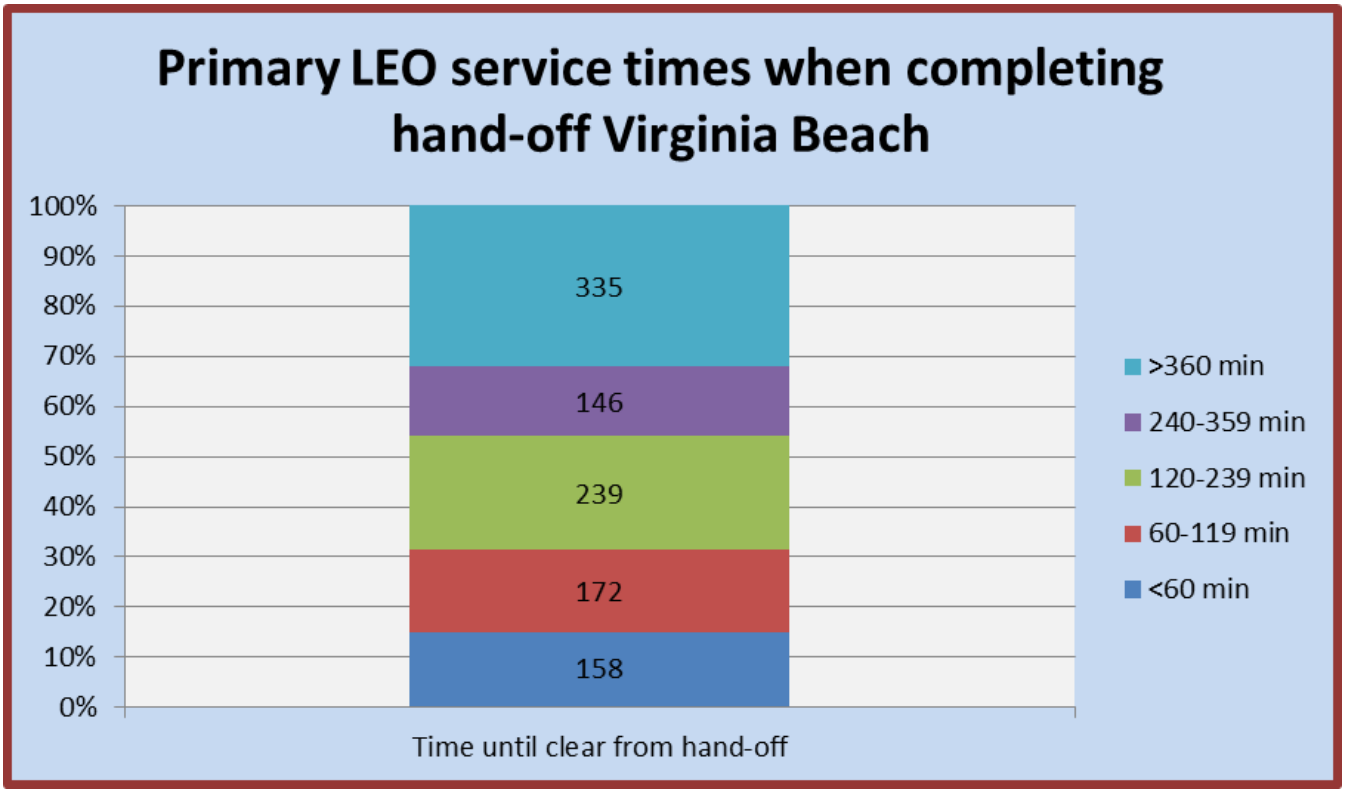
Allocation of Assessment Site Funds



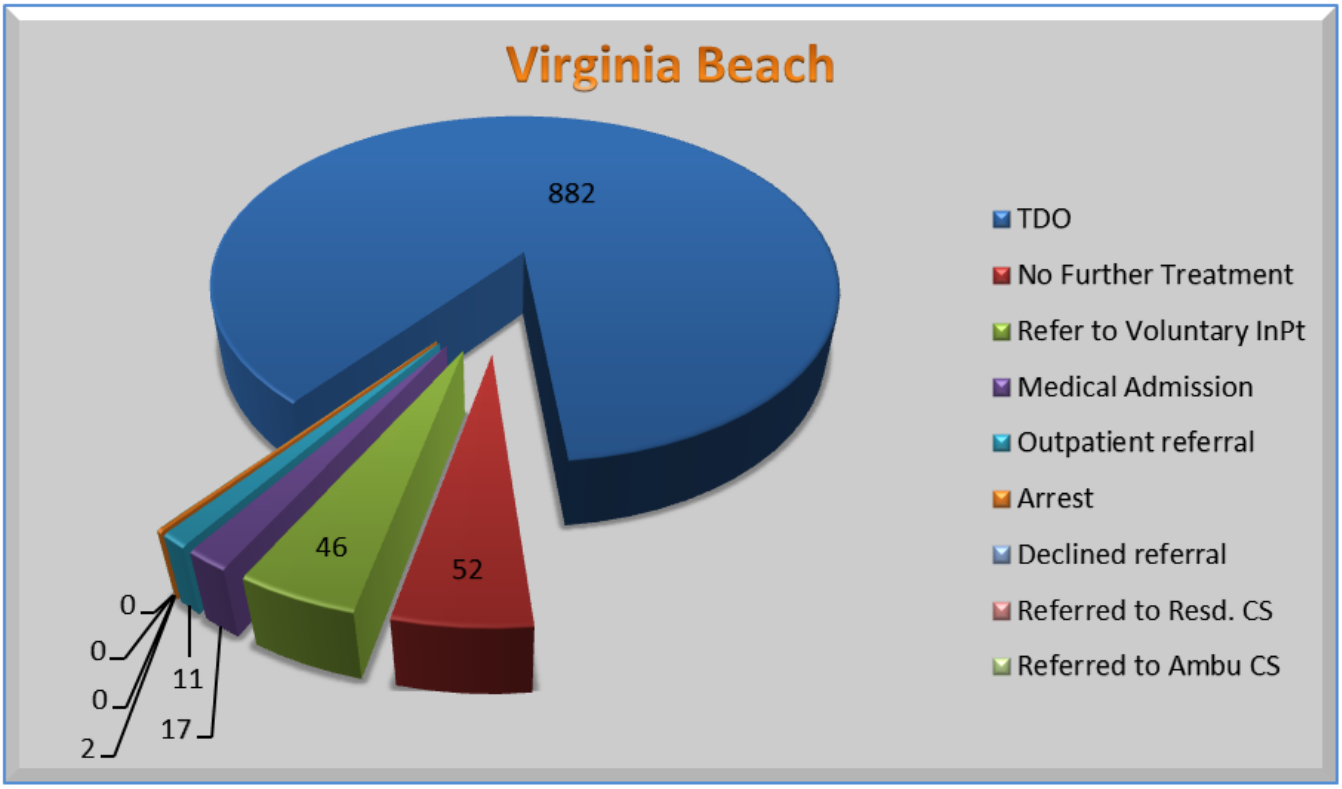
Quarterly Cost Per Assessment



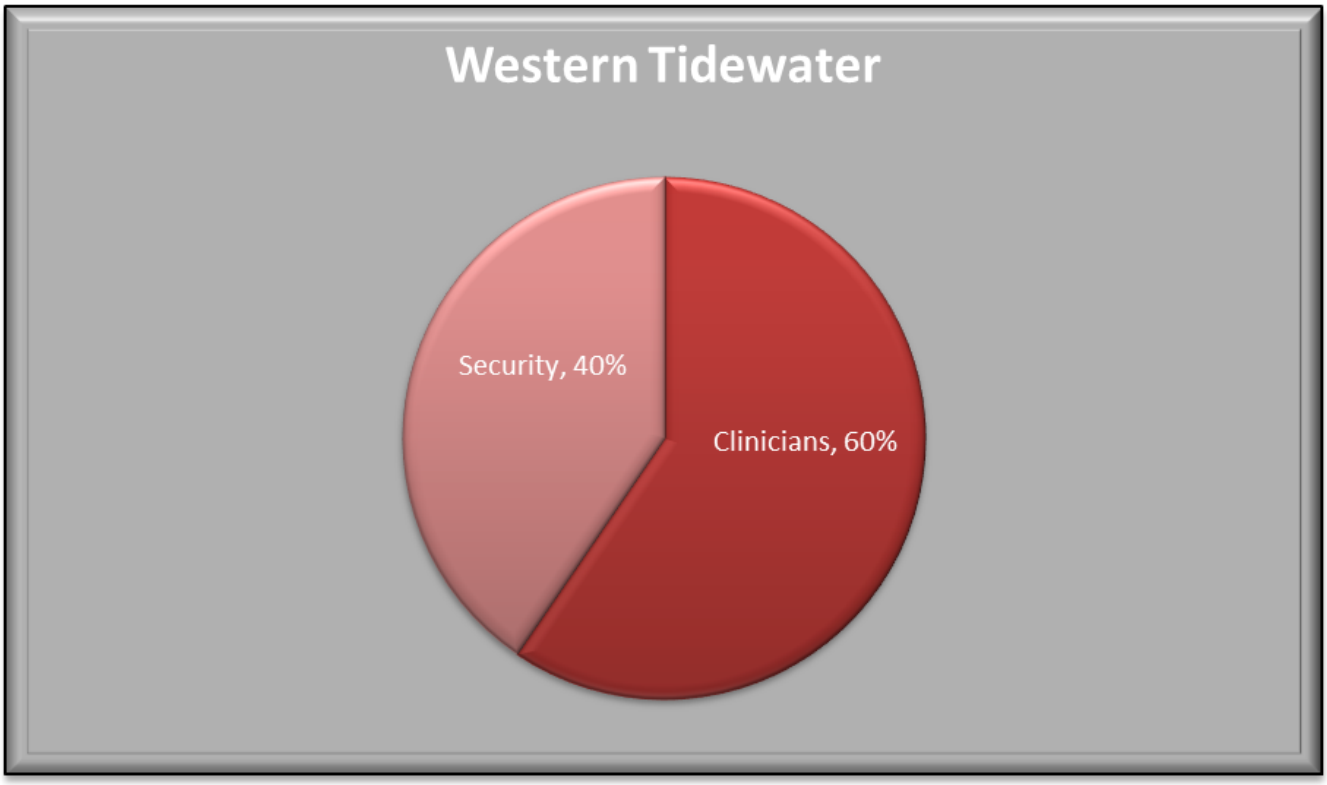
Officer Release to Service Times



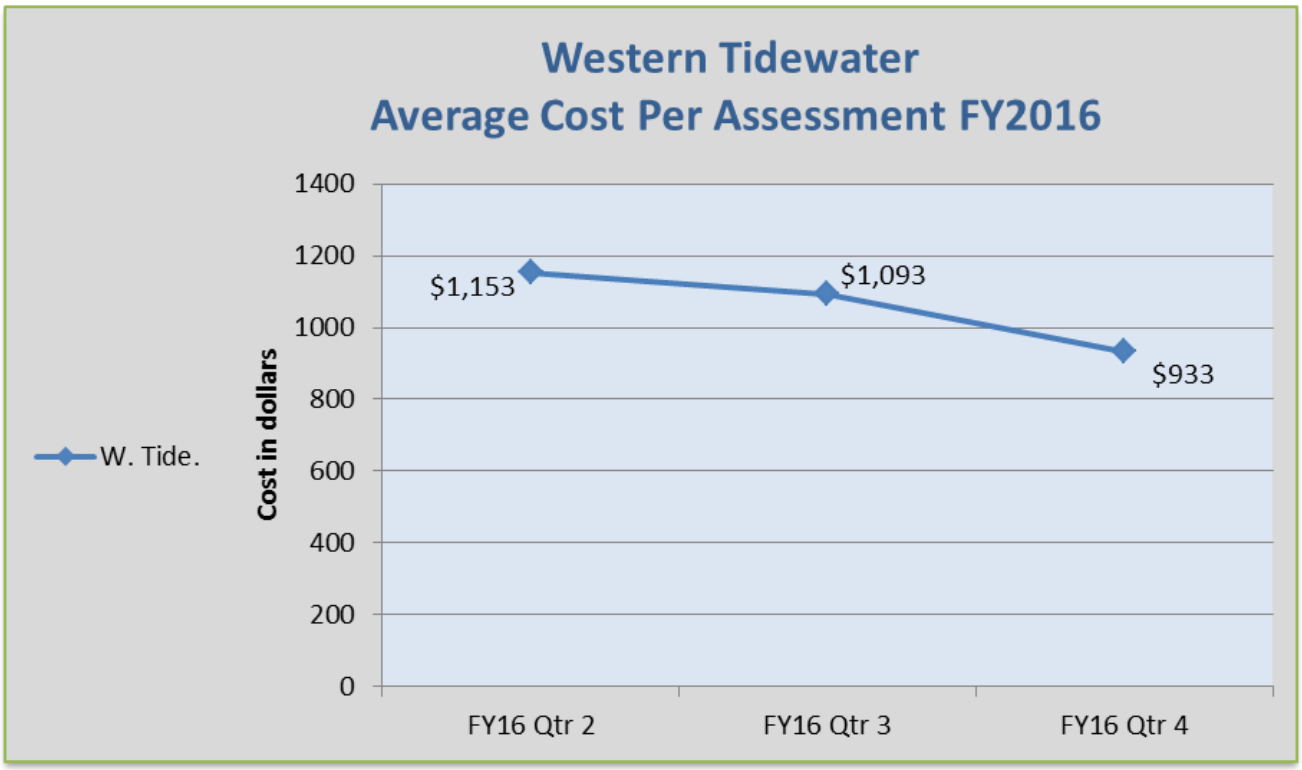
Clinical Dispositions



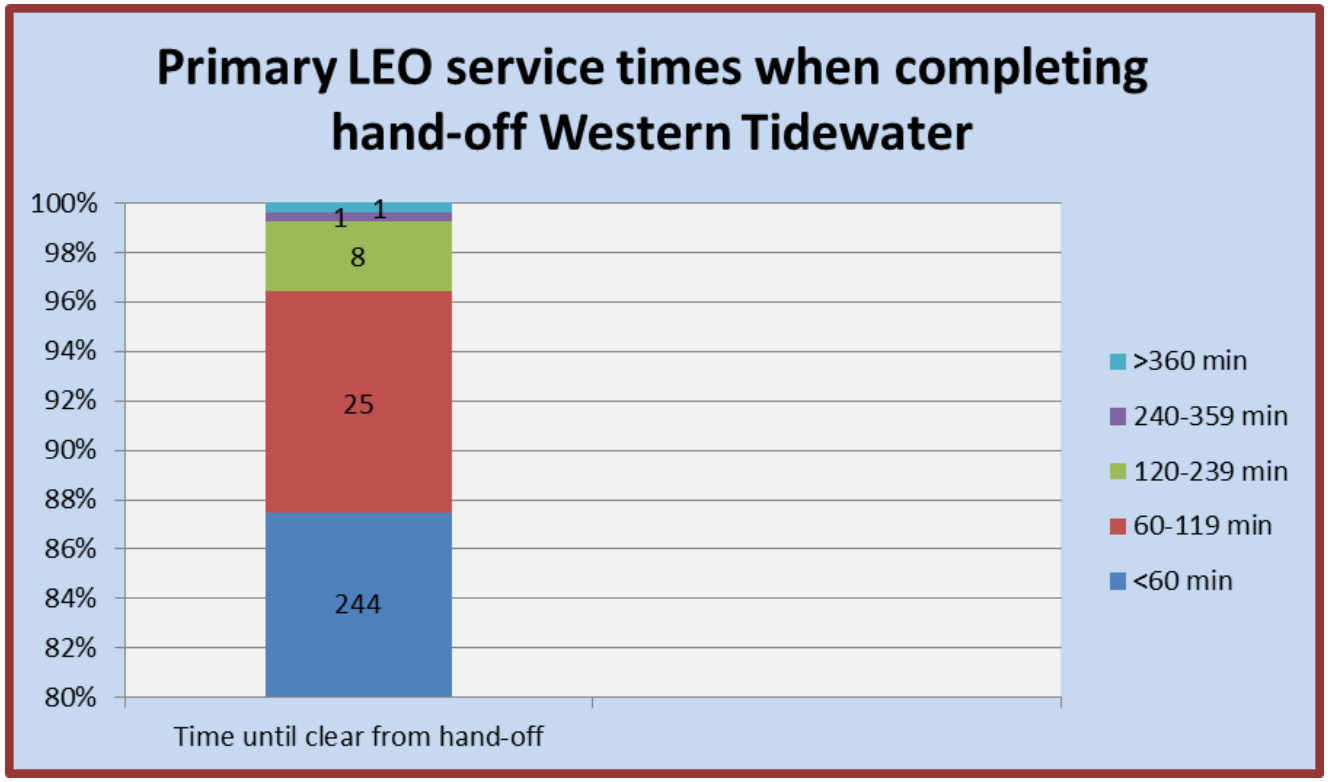
Allocation of Assessment Site Funds



Quarterly Cost Per Assessment



Officer Release to Service Times



Clinical Dispositions