



THE ESSENTIAL ELEMENTS OF MENTAL HEALTH DOCKETS IN VIRGINIA

VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH &
DEVELOPMENTAL SERVICES
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PREFACE

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) was awarded a three-year federal planning and implementation grant in October 2015 from the Bureau of Justice Assistance, through the Justice and Mental Health Collaboration Program. Through this grant, DBHDS was able to support its efforts to convene a Mental Health Docket Workgroup comprised of local and state-level professionals to review the available literature and research related to mental health dockets, provide their local experience and expertise, and develop a written tool that communities can use to begin planning for the development of mental health dockets in their localities. Additionally, the Virginia General Assembly, in Item 313 (S) of the appropriations act, ordered that DBHDS review existing mental health dockets, identify best practices, and develop an ideal model for mental health dockets in the Commonwealth. This is the purpose of this document. These essential elements are not intended to be a comprehensive set of requirements, but instead a list of common elements that DBHDS feels should be incorporated into the design of dockets that are established in the Commonwealth of Virginia.

The Mental Health Workgroup began its work towards completion of this document in February 2016. In March 2016, the Virginia General Assembly ordered the DBHDS to “review and evaluate existing mental health dockets used by courts in the Commonwealth to develop a model that can be replicated in other courts and jurisdictions that determine a need for such a docket.” The report that follows summarizes the existing literature and research on mental health dockets, describes the structure of existing dockets in Virginia, and outlines the funding practices used by local courts and governments to support these dockets. It is the hope of DBHDS that this document will serve as a guide for courts as they evaluate the appropriateness of starting a docket in their locality, and that it will inform future practices and policies related to mental health dockets in the Commonwealth of Virginia.

INTRODUCTION TO MENTAL HEALTH DOCKETS

I. Why Mental Health Dockets?

According to a 2006 Bureau of Justice Statistics report, approximately 76% of jail inmates met the criteria for a mental health disorder. An estimated 49% of jail inmates met the criteria for both a mental health and substance use disorder.¹ More recent national data indicates that approximately 15% of males and 30% of females booked into local jails had a *serious* mental illness such as schizophrenia, schizoaffective disorder, or bipolar disorder.²

In Virginia, a State Compensation Board survey conducted in July 2015 indicates that approximately 16.8% of inmates in the 58 reporting local and regional jails had a mental illness, and 50% of those individuals were reported to have a serious mental illness.³ That equates to 7,054 inmates in Virginia's jails who have a mental illness. This same survey indicated that the cost of providing psychotropic medications to those 7,054 inmates was \$5.1 million per year, an increase of \$1.5 million from 2014. The total cost of mental health treatment in Virginia local and regional jails was estimated at approximately \$14.2 million in FY15, with 68.22% of these costs funded by the locality, 7.94% funded by the state, 0.64% funded by the federal government, 23.21% by other funding sources.

It is clear that the local and regional jails in Virginia have a substantial number of persons with mental illness in their care, and that this care is costly to the localities and to the Commonwealth. Data has shown that individuals with mental illness can cost local and regional jails twice the amount it costs them to house a general population inmate each day.⁴ Additionally, individuals with mental illness remain incarcerated on average two times longer than those without mental illness charged with the same offenses.⁵ Further, individuals with mental illness in jails have been shown to result in higher rates of correctional staff contacts, administrative segregation episodes, and crisis services (such as hospitalization) than inmates without mental illnesses.⁶ This not only creates higher costs for the jails, but the entire continuum of local and state mental health services, law enforcement, and medical care providers, as individuals incur more injuries, more psychiatric crisis episodes, and repeated law enforcement contacts following re-entry.

The 2015 *Mental Illness in Jails Report* reported that 22.04% of the individuals in jail identified as having a mental illness were being held in jail on a misdemeanor offense. An additional 2.12% were being held for an ordinance violation. Thus nearly 1 in 4 of individuals in jail with mental illness are facing charges for which there likely are alternatives to incarceration which could be utilized without significantly increasing risk to public safety. The *Mental Illness in Jails Report* also reports that 49% of the individuals with mental illness were incarcerated on a non-violent crime. An additional 22% were incarcerated on a drug offense. Only 29% of the mentally ill defendants were facing what constitutes a violent offense. Anecdotally we hear that at times individuals with mental illness are not granted pre-trial release/bond/bail due to fears they will not comply with conditions, because of a lack of

available supports in the community, and/or because of the impression they are safer being kept in jail.

Addressing the issues raised by the high number of individuals with serious mental illnesses in the criminal justice system should include mechanisms that give police, prosecutors and judges effective options for alternatives to arrest or incarceration when appropriate (does not significantly compromise public safety). In Virginia, progress has been made in some areas, including Crisis Intervention Team (CIT) programs, the expansion of CIT assessment sites, as well as some very limited diversion and re-entry programming. Despite these developments, the number of persons with mental illness in Virginia jails has not declined, and both the criminal justice system and mental health safety net systems have continued to bear the burden of treating these individuals in a system that was never designed to do so. The individuals with mental illness in jails are not accessing the necessary treatment and supports that will effectively keep them out of jail in the future and often this process actually creates additional trauma and psychiatric decompensation.

Virginia has seen less advancement in terms of options available within Virginia courts. Generally, attorneys and judges have had limited options for obtaining adequate mental health needs assessments and little to no training about the mental health system in Virginia and the availability of services in their localities. Even when options exist, the court still has limited ability to monitor an individual's compliance with mental health treatment once the criminal charges are resolved, and more often than not the courts will see the same individuals return time and again with new charges.

Some Virginia communities have acknowledged the need for additional options for court cases involving defendants with serious mental health needs, and have successfully implemented alternative models of criminal case processing. This document outlines one of the options that Virginia communities have chosen to explore in an effort to close the revolving door of criminal justice involvement for persons with mental illness, who the system is poorly equipped to manage and for whom the traditional criminal case processing has been proven ineffective.

II. What IS a Mental Health Docket?

Mental health dockets are not a recent phenomenon, but are a rapidly expanding practice throughout the country and the Commonwealth of Virginia. Despite their growth, defining mental health dockets has historically been difficult, as they can look very different from one locality to another. In recent years as they have proliferated and as research has been published touting the positive outcomes for the courts and the defendants who participate, some consistency in docket structure has emerged.

At their most basic, these specialized court dockets are part of an innovative model in which defendants are held accountable for their actions while gaining the tools they need to better manage

their mental health needs and live healthier and happier lives without criminal justice involvement. The goals of most mental health dockets are: (1) to reduce mental health symptoms and use of crisis services, by enhancing access and engagement with treatment; (2) to address other defendant needs through clinical assessment and effective case management; and (3) to reduce recidivism and enhance public safety.

These dockets are created within the existing structure of a criminal court*, and are designed to quickly identify and treat individuals with mental illnesses to improve criminal justice and clinical outcomes. Defendants who meet defined eligibility criteria and who voluntarily agree to participate are then subject to special conditions and treatment requirements designed to address the root cause of their criminal justice involvement, which often is symptoms of their mental illness. Because these courts are located within General District Court, the dockets tend to target defendants with misdemeanor offenses or felony offenses which can be plead down to misdemeanor offenses. Specialized court supervision strategies are employed, along with sanctions and rewards, all designed to manage the defendant's criminogenic risk (i.e., risk of reoffending and risk of failing to appear in court) and maintain public safety. Typically there is some agreement about the outcome of the defendant's criminal charges and/or potential sentence for successful completion of docket requirement.

While individual dockets may choose to employ more strict eligibility criteria, at a minimum they require the presence of a serious mental illness and a connection between the mental illness and past or present criminal behavior. Serious Mental Illness is defined by the Substance Abuse & Mental Health Services Administration (SAMHSA) as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment.

Other common elements that can be found consistently from docket to docket are listed below:

- Defendant must voluntarily agree to participate and must be capable of voluntarily consenting to participate in the docket
- Requirements placed on participants generally include compliance with mental health treatment, abstinence from substances, and compliance with other conditions such as employment/daytime activities
- Periodic appearances in court are required of the defendant – the frequency varies from docket to docket but generally starts with more frequent appearances which are reduced over time as the participants demonstrate success and greater management of their illness

* Currently all of Virginia's Mental Health Dockets exist at the General District Court level.

- A Mental Health Docket Team is present, and typically include at a minimum the judge, a mental health treatment coordinator, community supervision entity, and representation from the Defense Bar and the Office of the Commonwealth’s Attorney
- The Docket Team convenes regularly to discuss new referrals, assess eligibility and make decisions related to acceptance of new cases into the docket, as well as update the court on existing defendants’ progress and set-backs
- There is a balance of sanctions and rewards, and when violations are rooted in symptoms of the mental illness, efforts are made to address treatment needs rather than imposing punishment (unless the violation poses a significant risk to public safety)
- There are pre-established agreements about the resolution of a case when the participant successfully completes the requirements - this may include a reduction in the charge, a reduction in the sentence, case dismissal, or a nolle prosequi of the charges
- In cases where individuals are unsuccessful, most dockets will withdraw previous terms and return the individual to the normal criminal court dockets for traditional court processing of the case

III. What a Mental Health Docket IS NOT

There are a variety of terms that have been used in Virginia to describe this particular form of specialty docket, such as “Behavioral Health Docket” or “Therapeutic Docket” or “Problem-Solving Docket.” For the purposes of this report, DBHDS has decided to use the term “Mental Health Docket,” as this is the term used more widely at a national level to capture the essence of what these dockets are doing. To give the reader a better sense of what mental health dockets are, it may be helpful to describe what they *are not*.

- **Mental health dockets *are not* the same as mental health courts.** In Virginia, only the General Assembly has authority to create new courts. Therefore, DBHDS has been careful *not* to refer to these as Mental Health Courts. However, judges do have the authority to create dockets within their courts. The creation of dockets allows judges to hear cases with similar characteristics at the same time. They can improve the flow and scheduling of court cases, and can enable treatment providers, community supervision officers, attorneys, and other parties who carry multiple cases to be more accessible to the court. Nationally, mental health courts are located both in General District and Circuit Courts, but again in Virginia there is only one formally recognized mental health court but several mental health dockets. Additionally, nationally mental health courts have been found to be effective interventions (to decrease recidivism, to increase engagement in treatment, etc.) for defendants facing felony offenses but again because Virginia utilizes primarily dockets most defendants with pending felony charges are excluded for docket eligibility.

- **Mental health dockets *are not* preferential treatment.** The requirements imposed are often more stringent and as a result the potential for sanctions is in fact higher for individuals who participate in these dockets. The length of participation often reaches the maximum potential sentence that a defendant might face should they opt to proceed to trial in the traditional court process, and expectations of them are higher.

- **Mental health dockets *do not* excuse criminal behavior or “go soft on crime”.** Rather, they do acknowledge that at times individuals with mental illness do not “fit” within the traditional court structure and the traditional sanctions imposed can have the opposite effect from that which is intended. By holding the defendant accountable for their offenses, while addressing the underlying factors that result in repeated criminal justice contacts, the dockets can actually have a greater impact on the individual’s likelihood of re-offending and can also enhance the social and economic outcomes.

- **Mental health dockets *are not* exactly like drug courts.** While there are similarities that exist between the structure and intent of mental health dockets and drug courts, there also exist many differences. Most significantly, there is a different approach to violations of docket conditions. Where drug courts seek to apply the same sanctions for the same violations, mental health dockets recognize that some violations are, at their root, caused by the symptoms of a mental illness and should not be subject to sanctions but instead modification of treatment requirements and adjustment of court conditions as appropriate. As a result, the rewards and sanctions in a mental health docket are highly individualized and prevent the development of a pre-defined “matrix” for responding to these events.

- **Mental health dockets *are not* all alike.** Despite the similarities described above, the operation of each mental health docket is unique. Each court employs its own manner of balancing concerns for public safety with the needs of the defendant. The differences that exist between dockets may range from the point in the process where cases are diverted, to the consequences for successful or unsuccessful completion. This document will outline some of the variances that localities may consider when determining the best structure for their docket.

IV. Mental Health Docket Objectives and Outcomes

Research into the impact of mental health dockets or courts has only recently been widely available, due to the limited number of dockets that existed in earlier years, and due to the great differences in size and scope. In 2008 Old Dominion University conducted a study on the outcomes of the Norfolk Mental Health Court, the only established and recognized full mental health court in the Commonwealth. The researchers found that participants in the mental health court were more engaged in behavioral health care, had fewer arrests after having been engaged in the program, and

that participation resulted in a significant decrease in jail days. While this research was specific to a mental health court, the results are similar to studies completed in other states regarding the effectiveness of mental health dockets. Due to the expansion of these dockets in the past ten years, researchers have finally been able to generate data and provide comment on the potential that these dockets have for improving outcomes for defendants and communities.

Mental health dockets are often created with the following **OBJECTIVES** in mind:

- **Increased public safety** – by linking to necessary treatment, the likelihood of reoffending is reduced
- **Increased treatment engagement** – by providing positive reinforcement for participation in treatment and services the likelihood of long-term engagement increases
- **Improved quality of life for participants** – by providing comprehensive treatment and supports, long-term recovery is more likely
- **Reduced costs** – by providing treatment in the community and decreasing the need for crisis services, communities should see savings

Research to date has demonstrated the following promising **OUTCOMES**:

- **Impact on Crime⁷:**
 - New Charges – Participants in mental health dockets are less likely to receive new charges post participation
 - Length of Time to New Charges – For those defendants who did re-offend they did so much later than those who had not participated
 - Rate of Arrest – Persons who participated in mental health dockets had a significant decrease in rate of arrest compared to their rate of arrest prior to participation
 - Jail Days – Mental health docket participants had fewer jail days post enrollment than matched controls
 - Reduced recidivism rates for mental health docket defendants were greater than decreases in recidivism for drug court defendants- Drug Courts report recidivism rate of 25%; Mental health dockets report recidivism rates of 10-15%
- **Impact on Mental Health Treatment Engagement⁸:**
 - Mental health docket defendants accessed treatment more quickly
 - Treatment received by mental health docket defendants was more intensive
 - There was no relationship between type of treatment and recidivism
 - Factors which reduce recidivism have not been identified but are hypothesized to be related to intensive monitoring and strong therapeutic relationships provided by participating in mental health dockets

- **Impact on Cost Savings to a Community⁹:**
 - Results in this area are mixed. Some single site studies have reported overall savings (generally realized in 2nd year of operation), but meta-analyses (which aggregate data from multiple sources) did not find consistent savings
 - Mixed results may be related to eligibility – some MH Dockets accept those with more severe illnesses and in need of more intensive services

Only one existing docket in Virginia has completed a formal analysis of their outcomes thus far. Norfolk’s Mental Health Court, with the assistance of Old Dominion University, conducted a study from 2006 to 2007, and found that the Court enhanced access to therapeutic and social services for mentally ill offenders, reduced the number of times that mentally ill offenders came into contact with the criminal justice system, reduced the number of days that mentally ill offenders spent in jail, and promoted effective interactions between the criminal justice and mental health systems. Among the most significant findings of the study was that the recidivism rates for individuals who graduated from the program were considerably lower than baseline rates for both mentally ill and non-mentally ill offenders and that total estimated savings to the jail were \$1.63 Million.¹⁰

Much research is still needed to truly understand the impact that these specialty dockets have upon the criminal justice and clinical outcomes for defendants, as well as the impact they have upon public safety, recidivism rates, and cost savings. The existing research is encouraging, however, and demonstrates the mental health dockets have the possibility of becoming an effective strategy for addressing the complex needs of these defendants.

V. Mental Health Dockets in Virginia

While mental health dockets have increased exponentially throughout the United States, Virginia has been more cautious in developing and expanding mental health dockets due to concerns regarding differential justice, judicial advocacy, and concern about the overall effectiveness of such programs. There currently exist only 7 known mental health dockets in the Commonwealth of Virginia. The first of which was created in Norfolk Circuit Court in 2004. That is the one and only Mental Health Court that exists on the Circuit Court level in Virginia. Since that time, no other specialty mental health courts have been approved by the General Assembly. On the other hand, several courts have followed in Norfolk’s footsteps and implemented mental health dockets.

Virginia mental health dockets vary in size and scope, and often have differences in areas of docket structure, approach to supervision, types of sanctions and rewards, and resolution of cases. There are also some commonalities between each docket, such as the required presence of a serious mental illness, quick and easy access to outpatient mental health treatment and support services, the presence of a team of professionals that work together to coordinate cases, and regular interpersonal interactions between judge and defendant. The complexity of comparing Virginia dockets to one

another can be seen in the following graphic. The matrix below was developed by DBHDS after conducting site visits and reviewing collateral materials provided by the dockets.

The majority of dockets described on the graphic below have come about within the past 5 years, and many more courts are currently exploring the feasibility of implanting a mental health docket in their locality. While Norfolk's Mental Health Court has conducted analysis of their outcomes, the remaining dockets have only just begun to produce real data, therefore outcomes will be difficult to assess until more time has passed and more defendants have participated. Anecdotal reports from the judges presiding over these dockets are very positive, and many report that their dockets have been life-changing not only for the defendants involved, but for the teams that work with the defendants as well. Much more data is needed to truly assess the impact of mental health dockets in Virginia, but the initial findings in Norfolk, coupled with national data, suggest that this is a model worth expanding.

Virginia Mental Health Docket Matrix

Court	Eligibility Criteria	Docket Structure (Pre-Adjudication, Post-Plea, or Probation-Based)	Team Composition	Frequency of Team Meetings	Frequency of Court Appearances	Length of Docket Participation	Outcome for Successful or Unsuccessful Completion
<p>Norfolk Circuit</p>	<ul style="list-style-type: none"> ▪ All participants must be approved by the Commonwealth's Attorney ▪ Defendants have non-violent felony charges or misdemeanor appeals and are diagnosed with a serious mental illness. ▪ There must be a link between mental illness and the arrest. ▪ Sex offenses and DUIs not eligible, as well as persons with prior violent charges or sex offenses 	<p><u>Probation-Based:</u> All participants plead guilty to charges and participation is an agreed upon condition of participation.</p>	<ul style="list-style-type: none"> ▪ Judge ▪ Commonwealth's Attorney ▪ CSB Staff ▪ Probation & Parole Staff ▪ Defendant's Attorney can participate if desired, but this generally only happens if the defendant is facing penalties or expulsion from the MH Court 	<ul style="list-style-type: none"> ▪ Court is scheduled weekly ▪ Weekly pre-docket interdisciplinary team meeting to go over cases scheduled that day and any progress/issues ▪ The judge attends the end of the meeting to hear brief summary of recommendations on each case ▪ Meetings run by the Commonwealth's Attorney 	<ul style="list-style-type: none"> ▪ Defendants have weekly court appearances that eventually reduce to every other month over the course of the 5 phases of the program. 	<ul style="list-style-type: none"> ▪ The court has 5 phases, each 90 days with different expectations at each (in terms of frequency of court hearings, visits with p.o., drug screens, etc.). ▪ After graduation (following the 4th phase), the defendant enters the 5th phase, where they remain on supervised probation for 6 months then return to court for case closure. 	<ul style="list-style-type: none"> ▪ Charges are reviewed for reduction or dismissal if defendants successfully complete the program, or the sentence is reduced. ▪ Defendants face jail time and return to the original court of jurisdiction if unsuccessful. ▪ Sanctions are reviewed individually and imposed only if efforts to redesign the treatment interventions are unsuccessful.
<p>Norfolk General District</p>	<ul style="list-style-type: none"> ▪ Defendants with misdemeanor or pre-trial felony charges are accepted ▪ Must be seriously mentally ill and the illness contributed to the arrest ▪ Also used as a monitoring docket to keep track of cases referred for competency evaluation and restoration 	<p><u>Pre-Adjudication:</u> Defendants are seen pre-trial</p>	<ul style="list-style-type: none"> ▪ Judge ▪ Public Defender ▪ CSB Staff ▪ Jail social worker ▪ Sheriff's office (jail administrator) ▪ Pre-Trial Officer ▪ Commonwealth's Attorney can participate if desired, but this generally only happens if the case is a pre-trial felony. 	<ul style="list-style-type: none"> ▪ Court scheduled weekly ▪ Weekly pre-docket interdisciplinary team meeting to go over cases scheduled that day and any progress/issues ▪ Judge participates in the entire meeting ▪ Meetings run by the Public Defender 	<ul style="list-style-type: none"> ▪ Docket meets weekly, defendants attend as ordered by the judge, varies by individual 	<ul style="list-style-type: none"> ▪ No structured phases, defendants are monitored for varying lengths of time depending on charges and compliance with conditions 	<ul style="list-style-type: none"> ▪ Typically, if successful the charges will be dismissed, pled down to a less serious charge, or result in time served/no additional jail time ▪ Sanctions are case by case, but non-compliance may result in a return to the original court for traditional case processing

Court	Eligibility Criteria	Docket Structure (Pre-Adjudication, Post-Plea, or Probation-Based)	Team Composition	Frequency of Team Meetings	Frequency of Court Appearances	Length of Docket Participation	Outcome for Successful or Unsuccessful Completion
Petersburg General District	<ul style="list-style-type: none"> ▪ Defendants with misdemeanor or pre-trial felony charges are accepted ▪ Must be seriously mentally ill and the illness contributed to the arrest 	<p><u>Pre-Adjudication:</u></p> <ul style="list-style-type: none"> ▪ Charges are held under advisement until completion of the docket program ▪ Defendants sign agreement to participate/understanding of their rights and are placed under pre-trial supervision 	<ul style="list-style-type: none"> ▪ Judge ▪ Public Defender ▪ CSB Staff ▪ Pre-Trial Officer ▪ Commonwealth's Attorney ▪ Docket Coordinator (vacant at this time) 	<ul style="list-style-type: none"> ▪ Court scheduled every other week ▪ Pre-docket interdisciplinary team meeting to go over cases scheduled that day and any progress/issues ▪ Judge participates in the entire meeting. ▪ Meetings run by the docket coordinator 	<ul style="list-style-type: none"> ▪ Defendants have twice monthly court appearances that eventually reduce to once monthly, then less frequently over the course of the 3 phases of the program (each approximately 60 days) 	<ul style="list-style-type: none"> ▪ The court has 3 phases, each 60 days with different expectations at each (in terms of frequency of court hearings, visits with p.o., drug screens, etc.) 	<ul style="list-style-type: none"> ▪ Charges are reviewed for reduction or dismissal if defendants successfully complete the program ▪ Defendants face jail time and return to the original court of jurisdiction if unsuccessful ▪ Sanctions are reviewed individually and imposed only if efforts to redesign the treatment interventions are unsuccessful
Prince William General District	<ul style="list-style-type: none"> ▪ The Prince William DIVERT Docket is currently in the early phases of implementation ▪ Individuals must have charges currently in GDC ▪ Pretrial misdemeanor and select felony charges are eligible during the pre-trial phase ▪ Appropriateness for the docket is assessed case by case, and there are no exclusionary charges at this time ▪ Must be seriously mentally ill, determined by the 	<p>The Docket allows for both pre-adjudication and post-plea cases. It has three tracks: 1) for individuals who are ordered for mental health eval or restoration (monitoring track only); 2) pre-trial track for individuals with pending misdemeanor or felony charges; 3) post-plea track for defendants with felony charges who were placed on the docket pre-trial and then had charges reduced to misdemeanors</p>	<ul style="list-style-type: none"> ▪ Commonwealth's Attorney ▪ Public Defender ▪ CSB Staff ▪ Jail administrator ▪ Pre-Trial Services staff 	<ul style="list-style-type: none"> ▪ Currently the docket meets monthly ▪ Pre-docket interdisciplinary team meeting to go over cases that day 	<ul style="list-style-type: none"> ▪ Defendants return to monthly court appearances for the duration of their time on the docket 	<ul style="list-style-type: none"> ▪ Varies by defendant. This will become clearer as the docket develops. 	<ul style="list-style-type: none"> ▪ Dismissal of charges (for misdemeanor cases), or time served/probation for felony cases ▪ Varies by defendant

	CSB						
Court	Eligibility Criteria	Docket Structure (Pre-Adjudication, Post-Plea, or Probation-Based)	Team Composition	Frequency of Team Meetings	Frequency of Court Appearances	Length of Docket Participation	Outcome for Successful or Unsuccessful Completion
Richmond General District	<ul style="list-style-type: none"> Defendants with a serious mental illness who have misdemeanor charges or felonies that can be reduced No violent charges or history of such allowed 	<p><u>Pre-Adjudication or Probation-Based:</u> Depending on the case and the charges, this is determined by the Commonwealth's Attorney</p> <ul style="list-style-type: none"> There are two tracks for defendants: <ol style="list-style-type: none"> Alternative Sentencing Program run through pre-trial. Defendants meet with pre-trial officers and clinicians based out of pre-trial. That program is for med/high risk consumers. This option would be pre-adjudication. The other option is where clients enter a guilty plea and work with probation officers. 	<ul style="list-style-type: none"> Public Defender CSB Staff (CSB docket coordinator and CSB staff who work with alternative sentencing program) Pre-Trial & Probation Officers Commonwealth's Attorney 	<ul style="list-style-type: none"> Docket held weekly Weekly pre-docket interdisciplinary team meeting to go over cases and review new referrals Judge does not participate Commonwealth's Attorney runs the meetings and makes final decisions 	<ul style="list-style-type: none"> After acceptance to the Docket, defendants have a status hearing in 45-60 days. They then have a final date, for an average total of six months on the docket. Defendants not complying with court conditions may be brought before the court more often. 	<ul style="list-style-type: none"> No defined duration Cases are adjusted on a case by case basis depending on progress 	<ul style="list-style-type: none"> In the pre-adjudication track, defendants may have their charges dismissed or reduced after successful completion In the probation-based track, defendants may receive reduced sentences Unsuccessful completion will result in a return to the court of origin and traditional case processing Sanctions are reviewed individually and imposed only if efforts to redesign the treatment interventions are unsuccessful
Roanoke & Salem General District	<ul style="list-style-type: none"> Defendants with misdemeanor charges or felonies that are pled down to misdemeanors Must be diagnosed with a serious mental illness 	<p><u>Post-Plea:</u></p> <ul style="list-style-type: none"> All defendants enter guilty pleas as a condition of participation The judge takes the plea under advisement until the conclusion of participation 	<ul style="list-style-type: none"> Judge CSB staff Probation Officer 	<ul style="list-style-type: none"> Docket meets every other week in Salem, Roanoke County, City of Roanoke GDCs Judge The same CSB and probation staff attend all Pre-docket interdisciplinary team meeting to go over cases and review new 	<ul style="list-style-type: none"> Defendants attend as ordered by the judge, varies by individual Begins more intensive and as progress is made court appearances are required less frequently 	<ul style="list-style-type: none"> 12-month program, no formal phases 	<ul style="list-style-type: none"> Upon successful completion, sentences are reduced or are given time-served Defendants face jail time if unsuccessful Sanctions are reviewed individually and imposed only if efforts to redesign the treatment interventions are unsuccessful

				referrals			
Court	Eligibility Criteria	Docket Structure (Pre-Adjudication, Post-Plea, or Probation-Based)	Team Composition	Frequency of Team Meetings	Frequency of Court Appearances	Length of Docket Participation	Outcome for Successful or Unsuccessful Completion
Staunton & Augusta General District	<ul style="list-style-type: none"> Defendants with misdemeanor charges. Must be diagnosed with a major mental illness. 	<u>Post-Plea:</u> <ul style="list-style-type: none"> Plea is held under advisement until conclusion of the case CWA and defense attorney and defendant sign a plea agreement prior to participation, which may be presented if defendant is removed from the docket All defendants agree to community supervision with local community corrections as a condition of participation. 	<ul style="list-style-type: none"> Judge CSB staff Community Corrections Commonwealth's Attorney Defense Attorney 	<ul style="list-style-type: none"> Docket meets every other week Pre-docket interdisciplinary team meeting to go over cases and review new referrals The Community Corrections officer coordinates the docket scheduling and referral process 	<ul style="list-style-type: none"> Defendants attend as ordered by the judge, varies by individual Begins more intensive and as progress is made court appearances are required less frequently 	<ul style="list-style-type: none"> Length and frequency of court appearances vary Typically a 12-month program, with 3 formal phases 	<ul style="list-style-type: none"> Upon successful completion, charges are reviewed for possible dismissal or reduction Defendants face execution of the plea agreement and possible jail time if unsuccessful Sanctions are reviewed individually and imposed only if efforts to redesign the treatment interventions are unsuccessful

VI. Funding Structure of Mental Health Dockets in Virginia

Virginia dockets have traditionally operated with little political and financial support. The General Assembly has historically not looked favorably on the creation of specialty dockets, and as a result no state funding has been allocated for this purpose to date. Localities have had to be creative in the blending and braiding of various funding sources to support the creation of their dockets. Many have implemented dockets with only the commitment of existing staff time from the local Community Services Board and Community Correction, and a willing judge to preside over the docket.

In some cases, mental health dockets have sought outside sources of funding, from federal grants to grants from local non-profit agencies. Norfolk now has three problem-solving courts (mental health, drug treatment, and re-entry) and has recently secured federal funding to centralize and expand legal and clinical screening and assessment for all three courts; expand access to intensive outpatient treatment services for all three courts; conduct additional process and outcome evaluations of the mental health court; advance the quality of services and the skill set of individual providers by providing trauma informed training for practitioners; and increase the use of incentives and develop sanctioning/incentive grids. However, during the initial planning period for the mental health court, Norfolk applied for federal funds but none were received and the program has been funded totally with local funds through reallocation of existing positions and resources. Petersburg General District Court sought out funding from local non-profits and was successful in obtaining a grant through the Cameron Foundation to hire a part-time docket coordinator to oversee the scheduling and coordination of the docket team's work. This funding has since ended, and existing team members have absorbed the docket coordinator's responsibilities.

Dockets in Roanoke/Salem, Staunton/Augusta, Richmond, and Norfolk General District Court have all carved out time from existing staff positions to staff the docket teams and, in some cases have reallocated some funds to ensure access to treatment services.

Recently DBHDS was able to reallocate some existing funding for Prince William County to transform their existing "monitoring" docket into a fully operational mental health docket, and through its Bureau of Justice Assistance grant DBHDS was able to fund the Roanoke/Salem and Staunton/Augusta dockets for the purposes of expansion. While the BJA funding is time-limited, the use of these and the DBHDS funds to support these programs will enable DBHDS to collect and analyze the data produced by these three programs.

Estimating the total actual costs of running a mental health docket is difficult, due to the variations that exist among Virginia dockets in their size and scope. Additionally the cost to operate successful dockets is dependent on the availability of community based behavioral health services and participants ability to access those services. Based upon its research, DBHDS has determined that the creation of a Docket Coordinator position is a key component in the successful operation of a

docket. While most localities have been able to start their dockets with reallocation of existing staff time, they are limited in how many defendants can be served, in the quality and amount of services that can be provided, and in how much data can be collected. Based upon the DBHDS review of existing dockets, it estimates that a full-functional mental health docket which uses a combination of existing positions and resources, creates a new Docket Coordinator position, and enhances access to and intensity of mental health and social services for docket defendants, would require approximately \$250,000 per year to operate.

VII. Application to Other Problem-Solving Docket Models

The basic principles and approaches used by mental health dockets in Virginia and nationally have a wide range of applications for other diversion programming. A somewhat newer phenomenon, the veterans' treatment docket utilizes a very similar approach to managing cases of justice-involved veterans. In essence, these veterans' treatment dockets are treating the same conditions that might be treated in a mental health docket, with the additional requirement that the individual have a military service record. While mental health dockets usually don't prohibit the acceptance of military veterans, one major distinction between the two is that participation in veterans' treatment dockets does not necessarily require the presence of a mental illness. Participants may be eligible based upon the presence of a substance use disorder on its own, or based upon traumatic brain injuries or other service-related injuries that connect to the criminal behavior. Additionally, some research has found that some veteran's will decline participation in a generic mental health docket due to the stigma associated with mental illness. With that said, however, the vast majority of defendants who participate in veterans treatment dockets have service-related mental health injuries such as Post-Traumatic Stress Disorder, which have impacted their lives to the point that they incur criminal charges.¹¹

As in mental health dockets, veterans treatment dockets provide a coordinated approach to supervision, quick access to community services and supports, linkage with other providers such as the Veterans Administration, and agreed upon outcomes for successful/unsuccessful completion. One additional component of veterans' treatment dockets is often the linkage to a "Veteran Mentor," who works individually with the defendant to ensure they have additional support when needed to be successful.¹²

In Virginia, despite the high rate of mental health issues in the justice-involved veteran populations, many of the existing veterans' treatment dockets are considered specialized "tracks" within existing drug courts. In Hampton Circuit Court, for instance, in 2014 the court implemented a veterans' track within the adult drug treatment court in August of 2014.¹³ Similarly, Norfolk has established a veterans' track in the city's larger drug court system.¹⁴ Fairfax County, on the other hand, established a stand-alone veteran's treatment docket in February of 2015. Unlike the Hampton and Norfolk

programs, the docket in Fairfax is a “hybrid drug and mental health docket,” that serves veterans with both addiction and mental illness.¹⁵

Just as in mental health dockets, research on veterans treatment dockets is limited but promising. Thus far, the studies conducted on existing veterans dockets have shown that they impact recidivism, and result in better clinical outcomes.¹⁶ Based upon existing models in Virginia and across the country, it appears that veterans’ dockets, drug courts, and mental health dockets share substantial similarities, with minor differences in target population and location within the court system. The opportunity for expansion of these specialty problem-solving dockets will allow for continued opportunities to study their impacts and improve diversion options for individuals with special needs in the criminal justice system.

THE ESSENTIAL ELEMENTS OF MENTAL HEALTH DOCKETS IN VIRGINIA

There are and will continue to be differences among individual mental health docket programs based upon the unique needs and operational environments of the local jurisdictions and the target populations to be served. However, there is also a need for overall uniformity as to basic program components and principles. Therefore, this document is an attempt to outline those fundamental practices to which all mental health dockets in the Commonwealth of Virginia should subscribe.

ELEMENT 1: MENTAL HEALTH DOCKET PLANNING COMMITTEE AND HEALTH DOCKET ADVISORY BOARD

- Prior to the implementation of a mental health docket program, localities should convene a Mental Health Docket Planning Committee to review this document for guidance as they make decisions about the docket they plan to create.
- At a minimum, this Committee should include a judge, a representative from the Office of the Commonwealth’s Attorney, a representative of the Defense Bar, and a representative from the local Behavioral Health Authority/Community Services Board (BHA/CSB), and a representative from community corrections. Committees should also consider the inclusion of local law enforcement, jail representatives, peers, community corrections, and other community treatment and support providers as appropriate.
- The judge is a crucial component of the Planning Committee and ultimately the Docket itself – he/she must support the planning process, evaluate and approve the processes and procedures, and be involved in the implementation and ongoing evaluation of the Docket structure.
- It is recommended that the Mental Health Docket Planning Committee complete *Developing a Mental Health Court: An Interdisciplinary Curriculum*, which is an online educational tool made available by the Council of State Governments. Ideally, this tool would be completed as a group, to allow for discussion and interactions during each module. The Council of State Governments does provide, upon request, a facilitator who may help the team complete this curriculum. The tool can be found at: <https://csgjusticecenter.org/courts/mhc-curriculum/>

- The Mental Health Docket Planning Committee will be responsible for making initial decisions about eligibility criteria, referral process, screening and assessment tools to be used, court supervision strategies, rewards and sanctions, requirements for successful completion, etc. Once these decisions are made, the Committee should develop a written Policies and Procedures manual, participant agreements, Memoranda of Agreement/Memoranda of Understanding, and participant handbooks.
- The Mental Health Docket Planning Committee should also be the entity that submits the necessary application for permission to establish a docket to the Office of the Executive Secretary at the Supreme Court of Virginia.
- The Committee should determine the composition/staffing of the Mental Health Docket Team and this should be incorporated into the Policies and Procedures that are developed before the docket is implemented. This Team should consist of individuals who were represented on the Mental Health Docket Planning Committee.
- The Mental Health Docket Planning Committee may conclude its work upon implementation of the docket, or may convert into a Mental Health Docket Advisory Board to provide ongoing oversight of the docket. Regardless, each docket should have a Docket Advisory Board who routinely monitors the outcomes from the docket and provides recommendations regarding any suggested changes in how the docket operates in order to enhance efficiency & effectiveness of the docket. The Advisory Board also serves as a venue to discuss any challenges facing the docket and as a forum to discuss any disagreements between partner agencies.

ELEMENT 2: MULTIDISCIPLINARY MENTAL HEALTH DOCKET TEAM

- This Team should be composed of staff from all agencies that have a direct role in the defendant's entrance into the program and progression through the docket. Recommended staffing includes a judge, defense attorney, prosecutor, BHA/CSB representative, Community Corrections (i.e., Pretrial or Probation), and a Docket Coordinator.
- The Mental Health Docket Team will work collaboratively to monitor the progress of defendants who are selected to participate in the docket, and to ensure all defendants are treated fairly.
- A **Docket Coordinator** should be identified. This role may be given to one of the existing Team members in addition to their regular duties or can be a separate and distinct position. Docket Coordinator duties should include managing the scheduling of cases on the docket, coordinating the scheduling and agenda for Docket Team meetings, reminding Team members of upcoming hearings, and collecting and distributing information needed for the Team to make decisions. The Docket Coordinator should also be the central point for data collection. The Docket Coordinator should be the primary point of contact for referrals and should ensure that referrals

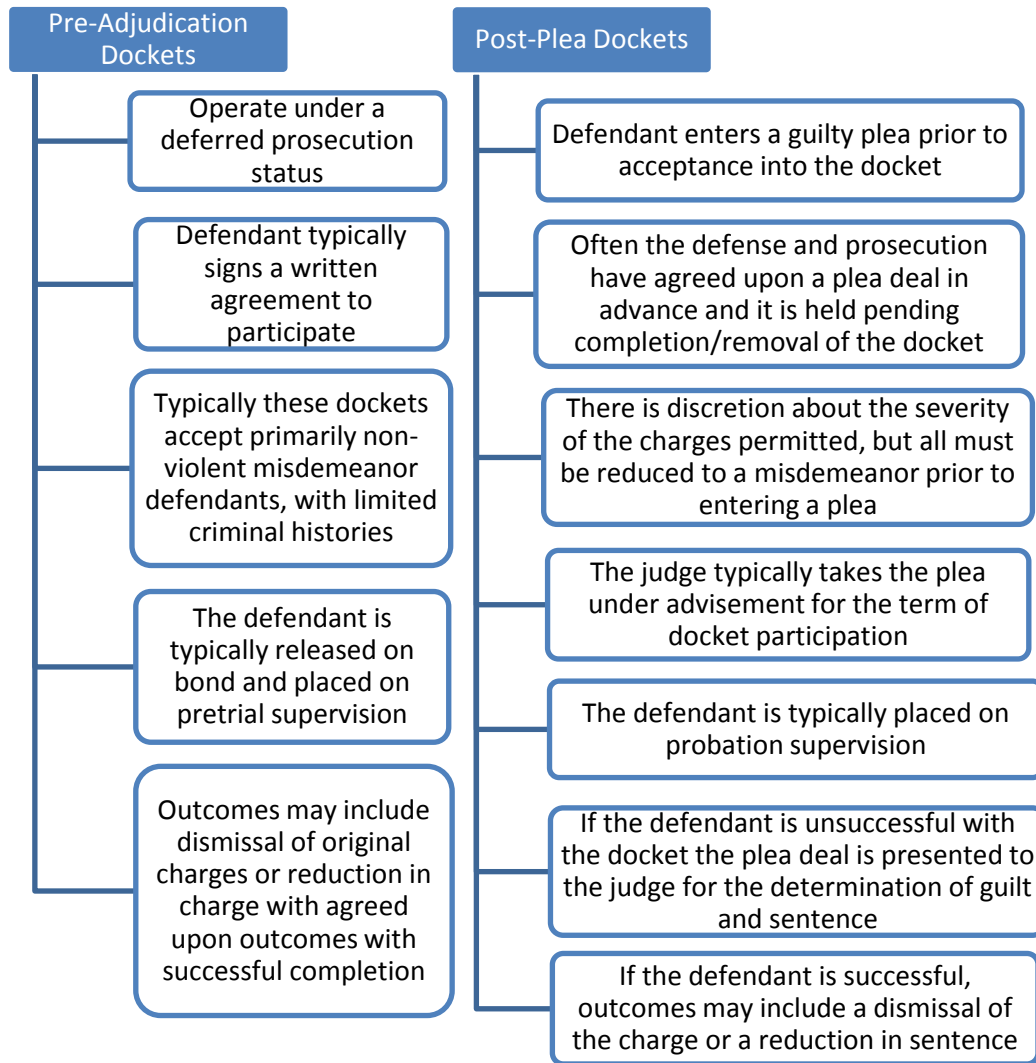
are sent to the Team in a timely manner, and initiate screening and assessment for docket eligibility by Team members.

- The **Judge's** role is central to the success of the docket. He/she oversees the work of the Docket Team, presides over hearings, has therapeutic interactions with the defendants, and provides incentives and sanctions. The Judge may decide to participate in every Team meeting, or may elect to remove him/herself from that discussion and hear Team recommendations from the bench. Either way, the research has demonstrated that reductions in recidivism from participation in dockets are caused in part by the judge's role in conveying elements of procedural justice, such as treating defendants with dignity and giving them a voice, holding them accountable, and making transparent and fair decisions. In these cases, defendants are more likely to believe in the legitimacy of the judge's decisions and incorporate the values of the docket as their own.¹⁷
- The **Commonwealth's Attorney** represents the voice of the community and victims, and their role is to ensure that justice is achieved. The Commonwealth's Attorney may participate actively in the Docket Team meetings and attend all hearings, or may elect to be involved only at the point of eligibility/acceptance decisions and defendant removal or successful completion of the docket.
- **Defense Attorneys** should also have representation on the Team. At a minimum, they should be present during hearings where decisions about entrance into the docket and removal from the docket occur. The Defense Attorney plays a crucial role in explaining the Docket to their client prior to agreeing to participate – this includes explanation of the process, their legal rights, ramifications of participation, and possible consequences for any non-compliance.
- The BHA/CSB should be represented on the Team as well. Often this representative or representatives will serve as the **Treatment Coordinator**, by arranging for any necessary treatment and services either at the CSB or with other providers. Services coordinated may include mental health case management, substance abuse treatment, residential, educational, employment assistance, or other social services. This role may involve providing direct services to docket participants, or the coordination and reporting about those services by maintaining regular contact with the defendant and providers to obtain updates on progress and non-compliance. This role will include the provision of the Mental Health Screening/Assessment at the point of referral and make recommendations about eligibility based on prescribed mental health criteria.
- Community supervision should be provided as a condition of participation in the docket. Typically this will involve the local **Community Corrections** office/entity (pretrial or probation agency). This role involves the provision of the court-ordered case supervision of the defendant's compliance with terms and conditions of the docket. This will require regular contact with the defendant and providers and routine substance use testing. This role will include the provision of the Risk Screening/Assessment and case planning related to reducing criminogenic risk.
- The MH Docket Team should meet regularly. It is recommended that the Team meet prior to each scheduled docket. The Team should review all cases scheduled on the docket for that day, and review and make decisions about new referrals that have been made.
- The MH Docket Team will also be responsible for making recommendations about use of incentives/sanctions/removal from the docket/successful completion of the docket.

- All Team members should be cross-trained in the screening and identification of mental illness, the criminal justice process in general, and procedures of the mental health docket in particular. As noted in **Element 1**, there is a structured online training course that each Team member should review at the outset of the docket. The Team will determine how often and what trainings should be completed from that point forward, and should include this in the Policies and Procedures Manual. This will ensure that the docket is utilizing the most current evidence-based practices.

ELEMENT 3: PRE-DEFINED DOCKET STRUCTURE

- There are currently three basic models that have been used in Mental Health Dockets around the country: (1) the pre-adjudication model, which defers prosecution upon the defendant's decision to participate in the docket.; (2) the post-plea model, requiring a plea of guilt from the defendant which is then taken under advisement and sentencing is deferred; and (3) the probation-based model, which convicts the defendant and sentences him or her to probation, while prescribing treatment as a condition of probation.¹⁸ The post-plea model is the most commonly used model in Virginia.
- The decision of which structure to use will impact the referral process, eligibility criteria, Docket Team composition, docket requirements, and provision of treatment and supervision.
- Below is a diagram of pre-adjudication and post-plea model similarities and differences. The biggest distinction is often the potential outcomes for the defendant with successful completion. Another difference is often the charge levels that are accepted for participation.



- In making the decision on how to structure the docket, localities should determine their comfort level with given outcomes, public safety concerns, public opinion/perception, and existing court practices that may impact the feasibility of one over the other.

ELEMENT 4: SIMPLE AND STRAIGHTFORWARD REFERRAL PROCESS

- Policies and Procedures should clearly specify how referrals to the docket will be made (i.e., completion of specific referral forms and provision of specific information), by whom they will be made, and to whom they will be sent.
- The Team should utilize a simple and straightforward process for receiving referrals. This is accomplished by ensuring that all potential sources of referrals understand the process, can do so easily and quickly, that referrals can be done by individuals with or without a background in mental health, and that there are multiple avenues from which referrals might come.

- Mechanisms should be in place to allow for referral from multiple entities, to ensure that there are opportunities to evaluate program eligibility at any point in the criminal justice process. This includes law enforcement, magistrates, jail booking staff, jail or community mental health providers, court personnel, or Docket Team members.
- The referral process requirements should involve the completion of a screening tool that non-mental health professionals/entities can administer to determine if a referral is warranted. This tool should screen for the possible presence of a mental illness, and should be brief and easily administered by non-clinical staff. An example of a validated screening tool that is widely used in Virginia and beyond is the *Brief Jail Mental Health Screen*. This is a free screening tool that can be located online, along with supporting documents for training purposes.¹⁹
- The tool should serve as a trigger for referral to the Mental Health Docket, which will then prompt additional assessment by trained professionals and final determinations of eligibility for docket participation.
- Selected screening tools should be validated and should be used with fidelity (i.e., individuals administering the tool adhere to the appropriate methodology and do not modify the tool or delivery methods).
- Policies and Procedures should address the timeliness of response to referrals received, including initiation of formal assessment of program eligibility.

ELEMENT 5: TIMELY ASSESSMENT AND ACCEPTANCE INTO THE DOCKET

- Assessment for program eligibility should occur as soon as possible after a referral is made. All efforts should be made to respond to referrals, complete eligibility determinations, and make Docket enrollment decisions within 7 working days of receipt of referral.
- Assessment should include the use of validated tools that have a demonstrated evidence base and that are appropriate for the target population. The assessment process should include formal evaluation of mental health, substance use, criminogenic risk, and needs.
- Various tools are available and should be thoroughly researched before the selection is made. The National GAINS Center has created a list of available tools for mental health and substance abuse assessment of individuals with mental illness in the criminal justice system.²⁰
- Assessment tools for criminogenic risk should be used in conjunction with the behavioral health assessment. These tools should also be validated for the target population. Often, these tools will be used by Community Corrections staff that have been trained in the administration and interpretation of the tools. Examples include the Virginia Pretrial Risk Assessment Instrument (VPRAI), the Offender Screening Tool (OST) and the Modified Offender Screening Tool (MOST). Which tool is used will depend on the structure of the docket (pre-adjudication or post-plea), and the supervising agency (pretrial or probation). The VPRAI assesses risk level alone, while the OST and MOST assess both criminogenic risk and criminogenic needs.
- Results of the assessments should guide decisions about eligibility and acceptance onto the docket. These assessments should be done quickly, and the results should be provided to the entire Docket Team to allow for a decision on acceptance within 7 working days of referral.

- Protocols should be established which allow for the Team to accept new defendants into the program even if a Docket Team meeting is not scheduled within 7 days of referral, to reduce unnecessary delays.
- Programs should also determine who will have authority to make final acceptance decisions – whether the decision will be made based on group consensus or by a single individual such as the Commonwealth’s Attorney, the Docket Coordinator, or the Judge. Should there be differences of opinion, the party with final acceptance authority will make the decision to accept or not accept the defendant into the docket.

ELEMENT 6: VOLUNTARY AND INFORMED PARTICIPATION

- Potential docket participants should be provided with a clear explanation of the docket process, including but not limited to: expectations around treatment participation and court appearances, potential incentives and sanctions that may be imposed, and length of participation required and possible outcomes for success/failure on the docket.
- Depending on the terms of participation, the defense attorney should take the lead in providing this information to their client. However, the Docket Coordinator or another member of the Docket Team may also review this information with the defendant. The Judge may also wish to review this with the defendant at the first docket hearing to ensure their understanding.
- Participation in the docket should be completely voluntary. All attempts should be made to ensure that there is no coercion or intimidation used to convince defendants to participate.
- Defendants should have capacity to consent to participate in the docket. If there are doubts about the defendant’s ability to consent or competency to stand trial, further assessment may be needed before acceptance into the program. If competency is raised by any party, whether it is competency to consent or to stand trial, no further decision should be made about the case until those concerns are addressed.

ELEMENT 7: WELL-DEFINED ELIGIBILITY CRITERIA

- Eligibility criteria should be established prior to the implementation of the docket, and they should be clear and easily assessed. At a minimum, eligibility criteria should address the following:
 - The defendant’s assessed level of criminogenic risk (risk for re-offending and/or risk of failure to appear in court).
 - The defendant’s diagnosis, level of impairment, and mental health treatment needs.
 - The defendant’s past and present criminal charges.
- When determining eligibility criteria, it is necessary to consider the community’s capacity for treatment and the availability of interventions that address the needs of the target population. It

is important to avoid establishing a program for defendants whose needs cannot be met with existing resources:

- In their analyses, communities should create a profile of their target population (i.e., defendants' level of risk, level of functioning, and level of responsivity to treatment) and identify the supervision and treatment needs of the target population.
- Simultaneously, communities should conduct a thorough assessment of community treatment capacity to see if the needs of the identified target population and available services align. If not, services/interventions may need to be added or adjusted to meet the needs of the target population before the docket becomes operational.
- Dockets should allow for both non-violent misdemeanor and felony *charge levels*. However, dockets may choose to delineate specific qualifying or exclusionary *charge types*.
 - It is recommended that dockets not be overly restrictive regarding qualifying charge levels or types, but instead have a system of evaluating eligibility based upon the circumstances of the present offense, legal history, level of risk, and link between the mental illness and offending.
 - The structure of the docket (i.e., pre-adjudication vs. post-plea) may dictate certain limitations on qualifying charge types, but every effort should be made to make decisions based on the entire picture of the defendant's circumstances.
 - The Docket Planning Committee should establish the admission criteria before implementation so that all team members are clear as to who is/ is not eligible for admission into the docket.
- **Diagnostic criteria** should also be established, and Dockets should make a decision whether they will include qualifying or exclusionary diagnoses.
 - While it is recommended that eligibility criteria always include Serious Mental Illnesses, this is not intended to limit a Docket's ability to also accept defendants with significant impairments stemming from other diagnoses. Other defendants may be considered if they meet other functional, legal, and risk/needs criteria.
 - Dockets should not exclude defendants from participation solely based upon the presence of substance abuse disorders, but substance use disorders alone should not be eligible for participation. There must be a mental illness and an established link between the mental illness and the offense to qualify.
- Criteria should require an **established link** between the defendant's criminal behaviors and mental illness. A direct causal relationship does not need to be present, but it is necessary to establish that the mental illness played a role in past, current, or potential future criminal justice involvement. Just because an individual has a mental illness does not qualify them for participation. Mental Health Dockets should target their resources on individuals whose mental illness has played a role in criminal justice system contacts, and for whom intervention might be necessary to prevent a recurring cycle of involvement.
- Docket eligibility criteria must also address the acceptable levels of **criminogenic risk**. Criminogenic risk involves risk for re-offending and risk of failure to appear in court. As mentioned earlier in this section, the mental health planning committee should complete a

thorough assessment of their target population, necessary services for that population, and community capacity to serve that population. Part of that assessment will include the risk levels that a community is able and willing to support in its docket. It is encouraged that programs target defendants of moderate to high risk (risk of failing to appear and incurring new charges while on release) as research has found those with moderate to high risk benefit most from dockets.

ELEMENT 8: EVIDENCE-BASED DECISION MAKING IN PRIORITIZING DEFENDANTS

- The **“Risk-Need-Responsivity”** (RNR) Model²¹ should be used as a guide to identify and prioritize defendants for participation in the docket, as well as the intensity of supervision and clinical interventions.
- Criminogenic needs (i.e., antisocial thinking, antisocial peer associations, poor family relationships, substance use) should be assessed using validated assessment instruments such as those used by Community Corrections and/or Pretrial Services Agencies.
- Clinical or treatment needs (i.e., mental health case management, psychiatric services, substance abuse treatment, individual or group therapy) and responsivity factors should be established during the clinical assessment, which should consist of a combination of structured clinical interview and validated assessment instruments.²²
- As emphasized in Element 6, communities should perform a system analysis to ensure that the available services and interventions meet the needs of the target population, and then adjust services or eligibility criteria based upon this analysis.
 - **Criminogenic Risk** (i.e., Risk of Re-Offending or Risk of Failure to Return to Court)
 - Nothing should prohibit a Docket from accepting particular risk levels, but it is strongly recommended that programs thoroughly assess their program capacity prior to establishing risk level criteria. The risk level that a Docket will decide to target for participation will depend upon the needs of the community, public safety concerns, and capacity of programming to work with certain risk levels.
 - More important than the defendant’s assessed risk level is the ability of the docket to adjust the intensity of supervision and length of participation that will be required based upon the defendant’s assessed level of risk. Data has shown that overprescribing services for low risk defendants may increase rather than decrease their risk, and there are clear dangers in accepting defendants with a higher level of risk than a program is capable of serving.²³
 - **Needs** (i.e., criminogenic and behavioral health treatment)
 - Assessments should be conducted to determine type and level of programming required for each individual defendant. Programs should decide prior to implementation whether they will limit eligibility based on assessed need.

- Careful assessment of a community’s capacity to meet certain need levels should inform decisions related to eligibility criteria prior to implementation. Dockets should not accept defendants with high behavioral health needs if their available treatment programming is not equipped to provide that level of service.
- Dockets should make every effort to adjust the participation requirements for defendants based upon their assessed level of need to avoid under or overprescribing treatment and support services.
- **Responsivity**
 - Case planning should address the responsivity issues that may impact successful program participation and completion. Potential responsivity challenges should be considered when making acceptance decisions.
 - Mental illness is not a criminogenic risk factor, meaning that mental illness alone does not impact likelihood of re-offending or failing to appear. However, mental illness and its accompanying symptoms may be a responsivity factor. Dockets should carefully consider the level of functional impairment that can be accommodated by the programs offered. This may be decided on a case-by-case basis.
 - Substance use is a significant criminogenic risk factor, but also a major responsivity factor. Careful consideration should be given to the defendant’s ability to effectively participate in treatment and respond to the required interventions. The presence of substance use or dependence itself should not exclude an individual from participation in a docket, but it should be addressed carefully in the case plan (both as a risk factor and responsivity factor).

ELEMENT 9: INDIVIDUALIZED CASE PLANNING

- Case plans should be developed for every defendant selected to participate in the docket.
- Case plans should be developed with input from mental health treatment providers, community corrections/supervision providers, and other Docket Team members.
- The plan should take into consideration the phases that the defendant will experience during docket participation. Phases can generally be divided into the following categories: orientation, stabilization, community reintegration, maintenance and successful completion/transition. While the docket may not make the distinction between each phase in a formal way, the case plan should be approached with this in mind to ensure that the plan meets the defendant’s need at that particular point in the process.
- Case plans should also include input from the defendant and they should acknowledge understanding of the case plan components and consequences of noncompliance.
- Case plans should identify the type and frequency of interventions, who will provide the intervention, the expected outcome(s) of the intervention, and how non-compliance should be addressed.

- Case plans should address all pertinent criminogenic risk factors and mental health needs that the individual has, based upon the results of careful assessment.
- Case plans should also incorporate non-clinical requirements, such as court appearances, substance testing, employment, etc.
- Case plans should be regularly reviewed and revised as the defendant moves through the process. Changes should be discussed and agreed upon by the entire Docket Team.
- Appropriate documentation should be maintained to adequately record progress or challenges that the defendant experiences.
- Any records generated (both clinical and legal) pertaining to the mental illness or treatment interventions identified on the case plan should remain confidential and be maintained according to the applicable protocols. In many cases, issues surrounding the exchange of information between parties can be resolved by obtaining release of information from the defendant or by entering into a Business Associates Agreement, Memorandum of Understanding, or Memorandum of Agreement with involved parties. However, protocols related to exchange of information are not often as stringent as providers might suppose, and there are helpful resources that have been published to help clarify the rules.²⁴
- The case plan should be the guide for addressing compliance and non-compliance, and provision of incentives and sanctions.
- The goal of treatment during docket participation is to stabilize, provide intensive treatment, and address transition planning.
- Programs should draft case plans with the end in mind – not only focusing on the immediate needs and requirements of the defendant, but also how they will transition from supervision once the process is completed.

ELEMENT 10: PROMPT, EFFECTIVE, AND EVIDENCE-BASED TREATMENT AND SUPPORT SERVICES

- Mental Health Dockets should provide rapid admission to continuous, comprehensive, and evidence-based treatment and supports to ensure the best possible outcomes.
- Agreements should be made, prior to implementation of the docket, that local BHA/CSB providers will be available to provide expedited linkage to psychiatric and case management services upon a defendant's acceptance into the docket.
- Some dockets may opt to utilize private behavioral health providers for participants. In those cases caution should be taken to ensure clear, consistent communication between the private provider and the docket team.
- Services provided should be evidence-based, individualized, and adjustable based on a defendant's response, rather than tied to the docket's programmatic structure.

- Treatment and support services should target all of the identified risk factors and behavioral health and social service needs that were identified at the point of assessment. The mental health issues alone should not be the only focus of treatment interventions.
- Evidence-based interventions should be well-researched, and appropriate for the target population. There are numerous examples of Evidence-Based Practices that can be utilized, such as Cognitive Behavioral Therapy, Motivational Interviewing, Thinking for a Change, etc. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation has published helpful articles that define these practices and direct providers to resources and training opportunities.²⁵
- Regardless of the supervision practices and treatment programs that are implemented, it is essential that staff is appropriately trained to implement these programs and do so with fidelity to the model in order for them to be effective.

ELEMENT 11: COLLABORATIVE MONITORING & INDIVIDUALIZED APPROACH TO INCENTIVES/SANCTIONS

- Monitoring of a defendant's compliance with docket conditions, including adherence to medications, participation in treatment, and any compliance with other court requirements should be done on a collaborative basis.
- Defendants should be informed that the usual confidentiality between client/mental health provider will not exist and that some information will be shared with the docket team.
- Monitoring should be done both by mental health practitioners and community corrections officers (i.e., probation or pretrial). Frequent communication between Docket Team members between scheduled hearings should take place to ensure timely sharing of information, prompt response, and use of effective interventions.
- All responses to defendants' behaviors, whether positive or negative, should be individualized. Incentives, sanctions, and treatment modifications, which if not applied correctly, can have adverse effects and may not achieve the intended goal. They should be imposed judiciously, and with input from mental health professionals.
- The Mental Health Docket Team, in its regular meetings, should review successes and challenges of all defendants, and develop approaches based on team input and based upon the individual defendant.
- Working with individuals with mental illness will involve an expected degree of relapse (of mental health symptoms) and treatment noncompliance. Teams should first review the underlying cause, and responses may simply involve a modification of the case plan. The response should be tailored to the type and origin of noncompliance and the impact on the individual's level of risk.
- Regular hearings allow dockets to publicly acknowledge successes and address challenges that defendants are experiencing. These hearings also allow for regular interaction with all members of the Docket Team. These hearings should be frequent at the outset of the program and should decrease as defendants progress positively.

- Defendants should be given advance notice about the specific behaviors that may trigger incentives, therapeutic adjustments, or sanctions and this should be reiterated throughout their participation. They must also be given advance notice of circumstances that may result in their termination from the program.
- Defendants should be afforded the opportunity to be heard, whenever possible, to express themselves during the issuing of incentives or sanctions.
- Responses to compliance or non-compliance should be fairly and consistently applied and proportionate to the behavior.
- It is imperative that consequences (both positive and negative) be delivered in close proximity to the target behavior.
- Ensuring that sanctions/incentives are applied fairly, are well explained, and that the defendant has a voice in the process will help the defendant to accept the consequence, believe in its fairness, and internalize the values the docket is attempting to instill.²⁶
- The types of incentives and sanctions should be established prior to starting a docket. They may vary from docket to docket and individual defendant to defendant. Some examples are listed below:

<u>Incentives</u>	<u>Sanctions</u>
<ul style="list-style-type: none"> • Postive feedback from the judge in court • Bus token/travel vouchers • Gift cards • Courtroom applause and recognition • Gradual reduction in court ordered provider visits • Gradual reduction in required court appearances • Graduation ceremony or hearing to acknowledge the defendan't successful completion 	<ul style="list-style-type: none"> • Verbal reprimand from the judge • Assignment of homework, such as writing an apology, or essay for the court • Brief jail stay for 24-48 hours following administrative violation • Increase in frequency of substance use screenings • Increase in frequency of required court hearings • Removal from the docket and return to original docket for case processing

ELEMENT 12: COLLECTION OF DATA AND PROGRAM EVALUATION

- Outcome data has a large impact on funding and sustainability, and is part and parcel of the Risk-Needs-Responsivity Model – by applying the right services and supervision to the right people, communities should see an impact on the clinical and legal outcomes for participants. If

no impact is observed, Teams should assess their program structure and look for ways to modify as appropriate.

- Data collected should address procedural components, availability and quality of interventions, appropriateness of interventions for the population served, as well as clinical and legal outcomes.
- The data should be used to perform regular outcome and process evaluations of the program, and to inform any decisions about modifications to program structure or policies and procedures.
- Program evaluation should be based on reliable and valid processes for collecting and analyzing the data.
- All outcome measures should correlate with the goals that the Docket Planning Committee and Docket Team establish upon creation of the docket. These goals should be clear and measurable.
- Often, Mental Health Docket data addresses the following goals: reducing recidivism, improving clinical outcomes, enhanced engagement in treatment, improving quality of life for the defendants, and reducing costs.
- Generally, data should be collected in the following categories:
 - Characteristics of the Participants – Including but not limited to: number of individuals referred, number of individuals screened, number of individuals accepted, length of time between referral and screening and acceptance, age, gender, race, diagnoses, charge level, charge type, number of days spent in jail on current charges criminal history, risk level, reason for non-acceptance, and reasons for refusal to participate.
 - Clinical Outcomes – Including but not limited to: number of appointments scheduled vs. appointments kept, utilization of crisis services pre-, during, and post-participation, number of days in crisis stabilization or inpatient hospitalization during participation, self-reported quality of life upon admission and at conclusion of participation, types of services offered vs. types of services utilized, level of utilization of services post-program completion, residential stability, and access to entitlements/benefits.
 - Legal Outcomes – Including but not limited to: jail days prior to and after completion of the docket, number of administrative violations incurred during participation, number of sanctions applied during participation, number of new charges incurred during participation, jail days for sanctions during participation, jail days for new offenses during participation, new charges incurred post-program completion, types and level of new charges incurred post-program completion, length of time between program completion and new charges.
- Other areas for data collection include cost savings and public safety. Cost savings are generally estimated by calculating the amount of jail bed days that were saved as a result of participation and the cost of services and supports received in the community. Public safety can be captured in different ways depending on how the Team defines public safety. This might include public perception surveys, reduction in crime rates, reduced recidivism of participants, etc. The Team may decide to include other measures beyond those listed here, in order to measure the areas that are important to that locality.

- Data collection should be done from the time of the docket inception and maintained over time. The Team should consider the means in which it wishes to collect and analyze this data, and the costs associated with data collection and evaluation when planning for their docket. It should involve forethought, rather than being an afterthought. Data should be gathered for participants after they have completed participation in the formal docket program in order to assess the longer term clinical and criminal justice outcomes associated with participation in the docket.
- Data should be reported regularly to regulating bodies, including the locality's own Docket Team, Docket Advisory Group, and the Office of the Executive Secretary of the Supreme Court of Virginia as required.

CONCLUSION

The Virginia Department of Behavioral Health and Developmental Services hopes that all existing and newly forming mental health dockets in Virginia will consider the information provided in this report as they craft the policies and procedures for their programs. It is also the hope of DBHDS that policy-makers will consider the evidence supporting these dockets in future policy and funding decisions. Without additional support, Virginia will be greatly limited in its ability to increase its number of available dockets, and limited in the number of people that could benefit from the dockets that already operate in the Commonwealth.

It is important to note, however, that while mental health dockets may be a helpful tool for filling in the gaps where comprehensive community outreach programs fall short, such alternative court systems should never be the only way, or even the primary way, to assure jail diversion of persons with mental illness in the criminal justice system. Communities should conduct thorough analyses of their programs, services, and existing resources; they should develop comprehensive action plans that address diversion opportunities at every point in the criminal justice process. Crisis Intervention Team (CIT) training, opportunities for police diversions such as CIT Assessment Sites, education of Magistrates and post-booking diversion programs, comprehensive mental health discharge planning from the jail, and specialized probation/parole programs for individuals with mental health issues should all be available within a community. Mental Health Dockets should be only one option along the spectrum of diversion opportunities in order to truly have an impact.

These essential elements, if implemented in dockets throughout the Commonwealth, will ensure that there is consistency in levels of access, fairness, timeliness, and accountability and will lead to even greater success moving forward. Communities have benefited, just as the defendants have, from the presence of these programs. Reductions in recidivism, higher levels of treatment engagement, and improved quality of life have resulted in happier, healthier, and productive individuals that have obtained the treatment they need to be functioning members of society. The Department of Behavioral Health and Developmental Services supports the expansion of these dockets, and is honored to have had the opportunity to develop this guiding document for localities to use as they look for alternative ways to help justice-involved individuals with mental illness.

CITATIONS

- ¹ James, D. J. and Glaze, L. E. (2006). *Mental Health Problems of Prisons and Jails*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. Available at: <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>
- ² Steadman, E.J., Osher, F.C., Robbins, P.C., Case, B., & Samuels, S. (2009) Prevalence of Serious Mental Illness Among Jail Inmates. *Psychiatric Services*, 60(6). Available at: <http://www.pacenterofexcellence.pitt.edu/documents/PsySJailMHStudy.pdf>
- ³ Virginia Compensation Board. 2015 Mental Illness in Jails Report. November, 2015. Available at: <http://www.scb.virginia.gov/docs/2015mentalhealthreport.pdf>
- ⁴ Torrey, E.F., Kennard, A.D., Eslinger, D., Lamb, R., Pavle, J.(2010).More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States. Treatment Advocacy Center. Available at: http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf
- ⁵ Criminal Justice/Mental Health Consensus Project Report. (2002). Available at: <https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf>
Turner, C. (2007). Ethical issues in criminal justice administration. *American Jails*, 20(6), p. 51.
- ⁶ Lovell, D. (2008). Patterns of disturbed behavior in a supermax prison. *Criminal Justice and Behavior*. 35:8, pp.985-1004.
O'Keefe, M.L. and Schnell, M.J. (2007). Offenders with mental illness in the correctional system. *Journal of Offender Rehabilitation*,45(1), pp. 81-104.
- ⁷ Steadman, H. J., Redlich, A. D., Callahan, L., Robbins, P. C., & Vesselinov, R. (2011). Assessing the impact of mental health courts on arrests and jail days: A multi-site study. *Archives of General Psychiatry*, 68, pp. 167-172. Available at: <http://gainscenter.samhsa.gov/cms-assets/documents/62075-221384.effectsofmhconarrestsandjaildays.pdf>
Rossman, S. B., Willison, J. B., Mallik-Kane, K., Kim, K., Debus-Sherill, S., & Downey, P. M. (2012). *Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn*. New York, NY: The Urban Institute. Available at: <https://www.ncjrs.gov/pdffiles1/nij/grants/238264.pdf>
Hiday, V. A., Wales, H. W., & Ray, B. (2013). Effectiveness of a Short-Term Mental Health Court: Criminal Recidivism One Year Postexit. *Law & Human Behavior*, 37(6), pp. 401-11. Available at: http://socant.chass.ncsu.edu/documents/Aldige_4.pdf
Goodale, G., Callahan, L., & Steadman, H. J. (2013). What Can We Say About Mental Health Courts Today?. *Psychiatric Services*, 64(4), 298-300. Available at: <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300049>
Marlow, D. B. (2010). *Research Update on Adult Drug Courts*. Alexandria, VA: National Association of Drug Court Professionals. Available at: <http://www.nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Adult%20Drug%20Courts%20-%20NADCP.pdf>

-
- Ray, B. (2014). Long-Term Recidivism of Mental Health Court Defendants. *International Journal of Law & Psychiatry*, 37(5), pp. 448-454.
- ⁸ Keator, K. J., Callahan, L., Steadman, H. J., & Vesselinov, R. (2013). The Impact of Treatment on the Public Safety Outcomes of Mental Health Court Participants. *American Behavioral Scientist*, 57(2), pp. 231-243.
- Boothroyd, R. A., Poythress, N. G., McGaha, A., & Petrila, J. (2003). The Broward Mental Health Court: Process, outcomes, and Service Utilization. *International Journal of Law and Psychiatry*, 26, pp. 55-71. Available at: http://www.floridatac.com/files/document/MHC_Jan03_Boothroyd.pdf
- Herincks, H. A., Swart, S. C., Ama, S. M., Dolezal, C. D., & King, S. (2005). Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program. *Psychiatric Services*, 56, pp. 853-857. Available at: <http://psychiatryonline.org/doi/full/10.1176/appi.ps.56.7.853>
- Cosden, M., Ellens, J., Schnell, J. L., & Yamini-Diouf, Y. (2005). Efficacy of a Mental Health Treatment Court with Assertive Community Treatment. *Behavioral Sciences and the Law*, 23(2), pp. 199-214.
- ⁹ Ridgely, M. S., Engberg, J., Greenberg, M. D., Turner, S., DeMartini, C., & Dembosky, J. W. (2007). *Justice, Treatment and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court*. Santa Monica, CA: RAND Corporation.
- Lindberg, A. J. (2009). *Examining the Program Costs and Outcomes of San Francisco's Behavioral Health Court: Predicting Success*. San Francisco, CA: Prepared for the Office of Collaborative Justice Programs of the Supreme Court of California. Available at: <http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2417%20Examine%20Program%20Costs%20and%20Outcomes.pdf>
- ¹⁰ Norfolk Mental Health Court Evaluation Study (2007). The Social Science Research Center, Old Dominion University. Available at: <http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/odu-norfolk-mental-health-court-study.pdf/>
- Philips, M. (2004). Norfolk Starts Virginia's First Mental Health Court. *Virginia Law Weekly*.
- Messina, D. (2008). ODU Study Touts Success of Norfolk's Mental Health Courts. *The Virginia Pilot*. available at http://pilotonline.com/news/local/health/odu-study-touts-success-of-norfolk-s-mental-health-courts/article_2d6373cb-a881-50db-a6e6-6a2988f43bc4.html.
- ¹¹ Hawkings, M.D. (2009). Coming Home: Accommodating the Special Needs of Military Veterans to the Criminal Justice System. *Ohio State Journal of Criminal Law*, 7, p. 563.
- ¹² Information about veteran mentors can be found at: <http://justiceforvets.org/veteran-mentors>
- ¹³ News Release, Hampton Virginia, Veterans Court Has Its First Graduate (Sept. 26, 2015), <http://www.hampton.gov/ArchiveCenter/ViewFile/Item/2319>
- ¹⁴ City of Norfolk, Building a Well-Managed Government: Approved Fiscal Year 2016 Budget, 197 (2015). Available at: <http://www.norfolk.gov/DocumentCenter/View/21857>

-
- 15 Dvorak, P. A Judge in Fairfax Wants to Help Virginia's Veterans, *The Washington Post*, June 2, 2014. Available at: https://www.washingtonpost.com/local/a-judge-in-fairfax-wants-to-help-virginias-veterans/2014/06/02/59e30902-e2c2-11e3-9743-bb9b59cde7b9_story.html.
- About the Veterans Treatment Docket, FAIRFAX COUNTY VIRGINIA WEBSITE, <http://www.fairfaxcounty.gov/courts/gdc/veterans-treatment-docket/about.htm>;
- 16 Knudsen, K.J. & Wingenfeld, S. (2016). A Specialized Treatment Court for Veterans with Trauma Exposure: Implications for the Field. *Community Mental Health Journal*, 52(2), pp/ 127-135.
- Cavanaugh, J. Helping Those Who Serve: Veterans Treatment Courts Foster Rehabilitation and Reduce Recidivism for Offending Combat Veterans. (2007). *New England Law Review*, 45, p. 163.
- 17 Wales, H.W., et al.. (2010). Procedural justice and the mental health court judge's role in reducing recidivism. *International Journal of Law and Psychiatry*. Available at: <http://www.sciencedirect.com/science/article/pii/S0160252710000555>
- 18 Shoaf, L. (2005). Executive Summary on Mental Health Courts, Ohio Office of Criminal Justice Services. 2005. Available at: http://ocjs.ohio.gov/resources_reports.stm
- Sheila Moheb (2010). Jamming the Revolving Door: Legislative Setbacks for Mental Health Court Systems in Virginia. 14 *Rich. J. L. & Pub. Int.* 29. Available at: <http://scholarship.richmond.edu/law-student-publications/60/>
- 19 Brief Jail Mental Health Screen tool and instructions available at: <http://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf>;
- Policy Research Associates, Inc. created the tool and information about the BJMHS can be found at: <http://www.prainc.com/resources/criminal-justice/>
- 20 Roger H. Peters, Marla G. Bartoi, and Pattie B. Sherman. (2008). *Screening and Assessment of Co-Occurring Disorders in the Justice System*. Delmar, NY: CMHS National GAINS Center. Available at <https://csgjusticecenter.org/wp-content/uploads/2014/12/ScreeningAndAssessment.pdf>
- 21 Andrews D. A., Bonta J. (2010). *The psychology of criminal conduct*. 5th ed. Cincinnati, OH: Anderson.
- Andrews D. A., Dowden C. (2005). Managing correctional treatment for reduced recidivism: A meta-analytic review of program integrity. *Legal and Criminological Psychology*, pp. 173–187
- Osher, F., D'Amora, D.A., Plotkin, M., Jarrett, N., Eggleston, A. (2012). *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. New York, NY: Council of State Governments Justice Center. At: https://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12_Behavioral-Health-Framework-final.pdf
- 22 Peters, R.H., Bartoi, M.G., and Sherman, P.B. (2008). *Screening and Assessment of Co-Occurring Disorders in the Justice System*. Delmar, NY: CMHS National GAINS Center. Available at: <https://csgjusticecenter.org/wp-content/uploads/2014/12/ScreeningAndAssessment.pdf>

-
- ²³ Andrews D. A., Bonta J., Wormith J. S., Guzzo L., Brews A., Rettinger J., Rowe R. (2011). Sources of variability in estimates of predictive validity: A specification with level of service general risk and need. *Criminal Justice and Behavior*, pp. 413–432.
- ²⁴ Petrila, J. (2007). *Dispelling the Myths about Information Sharing between the Mental Health and Criminal Justice Systems*. New York, New York. CMHS National Gains Center. Available at: <http://www.sfsuperiorcourt.org/sites/default/files/pdfs/1957%20Dispelling%20Myths%20about%20Information%20Sharing.pdf>
- Sharing Information between Behavioral Health and Criminal Justice Systems. Presented by the Council of State Governments Justice Center in May 2016. Available at: <https://csgjusticecenter.org/wp-content/uploads/2016/03/JMHCP-Info-Sharing-Webinar.pdf>
- Petrila, J., Fader-Towe, H. (2010). *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*. New York, New York. Council of State Governments Justice Center. Available at: https://www.bja.gov/publications/csg_cjmh_info_sharing.pdf
- ²⁵ Blanford, A., and Osher, F. A. (2012). Checklist for Implementing Evidence-Based Practices and Programs for Justice-Involved Adults with Behavioral Health Disorders. SAMHSA’s Gains Center for Behavioral Health and Justice Transformation. Available at: <https://csgjusticecenter.org/wp-content/uploads/2013/04/SAMHSA-GAINS.pdf>
- ²⁶ Wales, H.W., et al. (2010). Procedural justice and the mental health court judge's role in reducing recidivism, *International Journal of Law and Psychiatry*. Available at: <http://www.sciencedirect.com/science/article/pii/S0160252710000555>