

# *Forensic Work Group*

November 7, 2012

Department of Behavioral Health & Developmental  
Services

James W. Stewart, III Commissioner

Work Group Convener:

Michael Schaefer, Ph.D.  
Director- DBHDS Office of Forensic Services

## **Executive Summary: Forensic Work Group Report**

*Issue:* In the summer of 2012, the Department of Behavioral Health and Developmental Services (DBHDS) convened a workgroup to conduct a review of the challenges faced in providing comprehensive outpatient and inpatient mental health services to forensic consumers in Virginia. The tasks of the workgroup were an extension of the Forensic Subgroup of the Creating Opportunities workgroup established in 2011. The impetus for the workgroup was an appreciation of the unique challenges, resource demands, and barriers to providing services for this specialty population.

*Group Membership:* The workgroup was comprised of 24 members representing a variety of stakeholder groups including consumers, advocates, Community Services Boards (CSBs), private providers, defense attorneys, state psychiatric hospitals, and DBHDS administration. Members were solicited from recommendations from VACSB and DBHDS personnel. The group met a total of three times over the summer prior to drafting this preliminary report. Early in the process the decision was made to have this first workgroup comprised mainly of individuals familiar and involved with the public mental health system (both inpatient and outpatient) with a realization that eventually the group would need to be expanded to include representatives from other stakeholder groups (such as jails, attorneys, Department of Corrections) to ensure representation and input from all parties.

*Findings & Conclusions:* The group found there are a variety of barriers to providing comprehensive mental health services to forensic consumers. These barriers include policy barriers, funding/resource barriers, legislative barriers, and stigma barriers. The group concluded that a comprehensive approach to addressing the issues was needed, as a piecemeal approach likely was doomed for failure. Additionally the group concluded that a focus on existing systems needed to be balanced with a focus on the creation of diversion alternatives to prevent individuals with mental health issues from having to enter the criminal justice system.

### *Recommendations:*

- Create a system of oversight of forensic mental health evaluations throughout Virginia
- Analyze the current rate of reimbursement for various pre-trial evaluations to determine if rate increase is warranted
- Continue to enhance the collaborative work between the criminal justice and mental health systems through the provision of cross systems training
- Enhance data collection systems to get a better understanding of the unique challenges for forensic mental health services
- Identify elements in the Code of Virginia which create barriers to effective and efficient mental health treatment and recommend modifications/revisions
- Identify those services which currently are unfunded, estimate the cost of funding those services, and then investigate funding sources to address these needs
- Collaborate across agencies/departments to minimize the barriers to accessing or restarting state/federal entitlements/benefits (Medicaid/Medicare/SSI/SSDI)

- Form subgroups, which include criminal justice stakeholders, to address mental health services in jails and other issues which impact across agencies and for which there are identified barriers to efficient/effective service delivery
- Establish guidelines to make treatment decisions for forensic consumers more uniform across treatment teams/hospitals
- Investigate feasibility of system of oversight of the management of NGRI consumers who are on Conditional Release to improve consistency
- Improve discharge planning both from state hospitals and from jails to enhance the likelihood the individual will remain connected to treatment providers
- The Forensic Subgroup of the DBHDS Creating Opportunities Workgroup should continue to meet on a regular basis to monitor progress on above recommendations.

WORKGROUP MEMBERSHIP

NAME	AGENCY
Burke, Kristie	Cumberland Mountain CSB
Cole, Mary	Cumberland Mountain CSB
Dool, John	Health Planning Region V
Fair, Kaye	Fairfax CSB
Frank, Will	VACSB
Head, Alfred	Consumer Representative
Hyatt, Lynda	Gateway Homes
Lindstrom, John	Richmond Behavioral Health Authority
Longo, Dan	Colonial CSB
Lowther, Robert	SVMHI/ Consumer Representative
Lowther, Vicki	SVMHI/ Consumer Representative
Moore, Donna	Central State Hospital
Murrie, Dan	University of Virginia ILPPP
Poindexter, Katherine	Defense Attorney (private)
Rafferty, Beth	Richmond Behavioral Health Authority
Rawls, David	Western State Hospital
Ruffin, Selena	Mental Health America (Virginia)
Sadler, Kathleen	DBHDS
Schaefer, Michael	DBHDS
Signer, Mira	National Alliance on Mental Illness
Sizemore, Mike	VACSB
Stredny, Rebecca	Eastern State Hospital
Torres, Angela	Central State Hospital
Wright, Richard	DBHDS

## **BACKGROUND OF WORK GROUP:**

In Fall 2011, the Virginia Association of Community Services Board (VACSB) approached the Department of Behavioral Health & Development Services (DBHDS) about conducting a review of the challenges faced in providing comprehensive mental health services to forensic consumers in Virginia. As DBHDS had just recently completed a work group to investigate these issues and had issued a report regarding forensic issues, it was determined that DBHDS would re-enlist the members from the Creating Opportunities workgroup to re-open an analysis of forensic issues. DBHDS also agreed to expand the workgroup to include more Community Services Board (CSB) representation, more consumer representation, and more representation from advocacy groups. The final workgroup was comprised of 24 individuals representing a wide array of experiences and perspectives about the forensic mental health system. The decision was made not to convene the workgroup until after the 2012 legislative session in case there were legislative changes the group needed to address. A series of three meetings were held which ended in July 2012. This report summarizes the findings/ recommendations of the workgroup and also outlines further action steps required to complete this review of forensic mental health issues.

## **PREMISES/ MUTUAL AGREEMENTS:**

It was agreed that clinically, forensic consumers often have identical treatment needs as other consumers who enter our treatment system(s); however, their forensic status can override their clinical need and create impediments to effective service delivery. Forensic status often becomes an impediment to entry, transfer, and discharge from mental health treatment systems. There is an over-representation of persons with mental illness in the criminal justice system and often their presence in that system is directly related to symptoms of their mental illness. Additionally, the group agreed that the development, implementation, and support of statewide best practice diversion activities to facilitate the diversion of persons with mental health from the criminal justice system when it is appropriate and safe to do so should be an overarching theme of the process. The group recommended that DBHDS should continue to assume a statewide leadership role in forensic mental health issues and enhance its presence as a forensic resource center/ clearinghouse of information and expertise. In that role, it was recommended that DBHDS develop, implement and monitor best practices across the continuum of forensics. The workgroup recommended that DBHDS engage in data collection and analysis towards the establishment of best practice standards. Finally, the group agreed that forensic issues are complex and interconnected with other issues and that in order to make a significant impact, a comprehensive approach, addressing issues at various levels, is necessary to effect change. For real systemic change to occur, comprehensive reform would need to take place rather than piecemeal, isolated changes being made.

## **TYPES/ CATEGORIES OF FORENSIC CONSUMERS:**

There are six categories of adult forensic clients for which DBDHS facilities and CSBs provide services: Not Guilty by Reason of Insanity Acquittees (NGRI); Evaluations (Eval); Persons found Incompetent to Stand Trial by the court (IST); Jail inmates who have mental health needs (Jail/ Emergency Treatment); Persons found Unrestorably Incompetent to Stand Trial but also found to need some further evaluation or treatment (URIST); and persons discharged from the Virginia Department of Corrections on some form of supervised release who have need for inpatient or outpatient mental health care (DOC). Currently, approximately 36% of inpatient, adult, state hospital beds are occupied by forensic consumers. The following is a brief explanation of the different forensic categories:

- NGRI (Virginia Code §19.2-182.2 - §19.2-182.16) – means the person committed some sort of crime but a judge or jury decided the person did not know what they were doing or did not appreciate they were doing wrong because of the symptoms of mental illness. After an NGRI finding, the Code of Virginia specifies that the individual must be admitted to the Temporary Custody of the Commissioner of DBHDS. Individuals under this legal status can only be discharged once their risk factors for future aggression are adequately addressed and the Court (where they were found NGRI) authorizes discharge. DBHDS utilizes a “demonstration model” of risk management whereby the individual is gradually given more freedoms and opportunities to demonstrate the ability to manage identified risk factors. Most often NGRI patients are discharged on a Conditional Release Plan which mandates compliance with certain treatment. CSBs/BHAs are required to provide treatment and report back to the Court on the person’s progress. CSBs can recommend removal of particular conditions of the plan and/or that the individual be Unconditionally Released (about 50% of NGRIs who have been Conditionally Released have been subsequently Unconditionally Released). While NGRI admissions are not the most frequent forensic admissions to DBHDS facilities, they account for a significant portion of bed days as NGRIs average length of stay is 6 ½ years. Currently, NGRIs account for 20% of the DBHDS inpatient census. In FY 2012 66 new NGRI patients were admitted to DBHDS hospitals. NGRI patients are very resource intensive for state facilities and CSBs. Some CSBs receive Discharge Assistance Planning (DAP) money specifically to aid NGRI discharges.
- Evaluations (Virginia Code §19.2-169.1 & §19.2-169.5) – Virginia Code allows courts to order several types of forensic mental health evaluations during or prior to a person’s trial. The ones which most directly affect DBHDS and CSBs are Competency to Stand Trial (§19.2-169.1) and Sanity at the Time of the Offense

(§19.2-169.5) evaluations. The Code of Virginia specifies evaluations are to be performed on an outpatient basis unless the Court makes a special finding that inpatient evaluation is needed (which can include the lack of available practitioners to complete the evaluation on an outpatient basis). The vast majority of evaluations are completed on an outpatient basis (in FY '12 there were 2367 outpatient evaluations completed compared to 76 inpatient evaluations). Outpatient evaluations generally are completed by independent practitioners, although some CSBs have staff devoted to complete court ordered evaluations. Completion of evaluations is reimbursable by the Supreme Court of Virginia; although practitioners often complain about the low reimbursement rate (last rate increase was in 2007). Rate of referral for inpatient evaluations in DBHDS facilities is fairly steady (FY 12 = 76). On average, individuals admitted under an "evaluation" status are hospitalized an average of 30 days.

- Incompetent to Stand Trial (IST) (Virginia Code §19.2-169.2) – If the Court finds a defendant incompetent to stand trial, it must order treatment in an attempt to restore the individual's competency to stand trial. The Code of Virginia dictates preference for outpatient treatment but the Court can order inpatient treatment if it finds this is needed. If restoration is provided on an outpatient basis, CSBs provide this service for defendants either in jail or at their clinics (for individuals who were granted bond). Unlike evaluations, there is no funding stream for providing outpatient restoration services (although DBHDS recently reallocated a small amount of money to partially fund outpatient competency restoration services). IST is the most frequent reason for forensic admission to DBHDS hospitals (FY 12 = 493). The average inpatient length of stay is approximately 60 days. The vast majority (90%+) of ISTs are eventually restored. We have no figures about average time period required for outpatient restoration nor the success rate for attempting restoration on an outpatient bases (although HPR IV jail team and HPR V report approximately a 20-25% success rate for defendants in jail – with success defined as the Court reaching final resolution of the case).
- Unrestorably Incompetent to Stand Trial (URIST) (Virginia Code §19.2-169.3) – If a person is found by the Court to be unrestorably incompetent even after having received inpatient treatment, but the individual is found to be in need of further evaluation/treatment (for some other issue other than their competency to stand trial), that individual may continue to be held in DBHDS custody. If the person is found unrestorably incompetent to stand trial after receiving outpatient restoration services the individual will most likely just continue to receive outpatient treatment (although it will no longer be court mandated). While this category of forensic clients is small, often there is much confusion

about the criminal court's jurisdiction over length of stay and the hospital's ability to discharge. If the individual is deemed to be unrestorably incompetent to stand trial, but by statute must be referred for possible commitment as a Sexually Violent Predator (SVP), then the individual must remain in DBHDS custody until a determination is made, which can take up to one year or longer from the date of referral.

- Jail/Emergency Treatment (Virginia Code §19.2-169.6) – National statistics suggest 16-25% of jail inmates have some diagnosable mental health issue. Additionally, a portion of active CSB clients are arrested and jailed each year. CSBs vary on what level of services they are able and funded to provide and to whom they will provide services in the local or regional jails. Jails vary in mental health services they offer and there are great disparities in jail formularies across Virginia. When individuals are jailed over 30 days, their benefits (Medicaid, SSDI, etc.) are terminated/suspended creating a barrier to accessing housing and services due to lack of funding. Virginia Code §19.2-169.6 provides for inpatient mental health treatment if an inmate becomes seriously symptomatic. Most often, this treatment is provided in DBHDS facilities as jail detention status often is an exclusionary criterion for admission to a private psychiatric hospital or unit. As of July 1, 2012 the criteria for admission of jail inmates was broadened to more closely resemble the civil commitment criteria. The impact of this code change remains yet to be seen as the change only became effective July 1, 2012. The average length of stay in a DBHDS facility under this legal status is 20 days. Jail transfers are the second most frequent forensic admission type to DBHDS facilities (FY 12 = 233). Any inmate admitted to a DBHDS facility and subsequently discharged must be offered follow-up services from the CSB. The level of follow up services varies depending on a variety of factors to include the CSB's relationship with the local/regional jail.
- DOC (Virginia Code §53.1-40.9 & §37.2-814) – When Department of Corrections (DOC) inmates are released from prison they sometimes need outpatient mental health care from CSBs. DOC is putting much focus on inmate release through reentry efforts. Additionally, DOC is now able to aid inmates in applying for resumption of benefits four months before their actual release date so that benefits will be available immediately upon release. However, if a DOC inmate is nearing the end of his/her period of confinement, but is felt to need inpatient care there is a mechanism in place to have them committed to DBHDS. This process is used fairly infrequently (FY 12= 17). On occasion upon admission to a DBHDS facility, DBHDS staff opine the individual's psychiatric acuity was not the outpatient resources was what precipitated the admission.

## **ISSUES/PROBLEMS & RECOMMENDED STRATEGIES FOR CHANGE:**

The workgroup used a systematic approach to identify issues and problems in providing effective, efficient mental health services for the above mentioned forensic groups. The process started with a semi-structured, free-recall, listing of problems/issues. This large list was then solidified into common themes/issues. The group then worked collaboratively to identify possible strategies for addressing the specific issues. In cases where there was more than one recommended solution, the group tried to prioritize the solutions and reach consensus, when possible. Finally, for some issues it was determined the group did not have sufficient data to fully understand the nature of the problem(s). In those cases, the group identified data sources necessary for the group to provide viable recommendations for change.

With regard to recommended strategies for change, the recommendations were categorized by type. The group identified whether the needed change was a policy change (either DBHDS, CSB, or other agency policy change), resource change (new resource or increased funding for resource), a legislative change to the Code of Virginia, or a combination of all three. In some cases, the issues were very complex and it was clear representatives from other groups (such as sheriffs' association, defense bar, etc) needed to be present to identify viable solutions as the current group was comprised mainly of professionals who work in the publically funded mental health system and thus our group did not have expertise in certain other essential areas. In those cases, the group's recommendations were for a sub-workgroup to be formed (with broad membership to include members from the criminal justice systems) to address the issue.

### **Competency to Stand Trial Evaluations (§19.2-169.1)**

**Issue:** Presently, there is no system for qualitative oversight of competency evaluations completed by practitioners in the field to insure that standards of practice are being met. Additionally, the Code of Virginia is somewhat vague (and inconsistent with other similar sections of the Code) as to the professional qualifications for evaluators, thus contributing to the lack of oversight. At times, courts appoint practitioners who appear to lack the requisite education and experience to perform such evaluations and there is no agency/body designated to regulate practice. Similar to any profession, there is great variability in the quality of work product and members of the workgroup have reviewed work samples which fall below the standard of practice. While ultimately it is the judge who determines the ultimate issue before the Court, research has found a high concordance rate between evaluator opinions and judicial rulings. The consequences of evaluations that do not meet standards of practice are significant, regardless of the direction of error. If an evaluator mistakenly opines an incompetent defendant is actually competent, the defendant (and his attorney) is forced to move forward in resolving the criminal case even though the defendant may have significant impediments in his

rational and/or factual understanding of courtroom issues. If an evaluator mistakenly opines a competent defendant is incompetent, there will likely be a significant delay in resolving the case and the Commonwealth will incur a significant financial expense by having to further evaluate/treat an individual who may not really be in need of treatment.

**Recommendations:** There was consensus within the group that it would be prudent to propose a system of oversight of evaluators and the evaluations they produce. While many options for oversight were discussed, the consensus of the group was to recommend exploration of the possibility of the Commissioner of DBHDS establishing and maintaining a list of approved evaluators and explore the feasibility of amending the Code to require that courts only appoint evaluators who are on the approved list. Additionally, the group recommended exploration of the feasibility of amending the Code to require evaluators to submit their evaluations to the Commissioner to enable peer review.

**Issue:** There are locations in Virginia where there are few or no qualified and willing evaluators. While part of this issue is related to geography and the presence/absence of psychiatrist/psychologists in various regions of the state, the rate of reimbursement has a significant impact on the availability of evaluators. Currently, evaluators who complete a Competency to Stand Trial evaluation (§19.2-169.1) are reimbursed \$400 for the evaluation. Given the number of hours generally required to complete a quality, comprehensive competency to stand trial evaluation, this rate is often well below the hourly rate professionals can charge for providing other services. The reimbursement rate has not been adjusted since 2007 and consequently the rate has fallen well behind the market rate.

**Recommendations:** The workgroup recommended that data be gathered from other states about rates of pay for comparable evaluations. An analysis should also be undertaken as to the average amount of time required to complete a competency to stand trial evaluation and the current hourly market rate for psychiatrists and psychologists with specialized forensic experience. A subgroup will then recommend a new reimbursement rate and complete an analysis (based on the number of competency evaluations completed in prior years) of the financial impact of increasing the reimbursement rate.

**Issue:** At times attorneys (both Commonwealth and defense) do not send the requisite collateral materials in a timely manner which can lead to delays in completing the evaluation and/or result in incomplete evaluations. Although §19.2-169.1 is very clear about the responsibility for sending collateral materials and provides for rapid sharing of collateral materials (i.e. should be provided to the evaluator within 96 hours of issuance of the Court Order), delays in receipt of collateral materials remains an ongoing problem.

**Recommendations:** It was recommended that training materials be developed for attorneys (both Commonwealth & defense) about competency to stand trial evaluations which will include reference to the requirement to provide the collateral materials to the evaluator and an explanation of the need for such materials. It was recommended that DBHDS partner with CSBs to schedule training sessions with various Virginia Bar Associations to disseminate this information. DBHDS has already secured Continuing Legal Education (CLE) credits for those attorneys who participate and has also applied for a federal grant to support this activity.

**Issue:** Not all evaluators complete the Forensic Evaluation Information System (FEIS) form (A summary report about the type of evaluation, processes utilized to complete the evaluation, and the evaluator's outcome opinions) therefore, the Commonwealth has no aggregate data about the evaluations which are being prepared for the Courts. As a result, there is no data available that can be utilized to monitor outcomes of court ordered evaluations.

**Recommendations:** The group recommended exploration of the feasibility of amending the Code of Virginia to require the completion of the FEIS as a condition of receiving reimbursement from the Supreme Court. Specifically, the group recommended that consideration be given to amending §19.2-175 to include this requirement. There was also some discussion of streamlining the FEIS as some evaluators have complained it is too time consuming to complete. The workgroup recommended that DBHDS appoint staff to collaborate with the Institute of Law Psychiatry and Public Policy (ILPPP) to review the FEIS and streamline, where possible.

**Issue:** At times attorneys raise the issue of a defendant's competency to stand trial for relatively minor offenses which leads to the defendant spending more time detained either in a jail or in a hospital because often judges will not allow bond for individuals for whom an evaluation is ordered. The group discussed the fact that attorneys are bound by legal ethics to raise issues when there is doubt about a defendant's competency to stand trial, even if the matter may result in a period of further detention. Failure to do so could result in an ineffective assistance of counsel claim. The group also acknowledged that what constitutes the best outcome for a defendant is debatable and that length of detention is not the only factor which determines whether an outcome was best. The workgroup did agree that attorneys would benefit from more information about the likely outcomes for their defendants should the issue of competency to stand trial be raised (as occasionally attorneys will appear shocked by the fact their client's case will be significantly delayed) to ensure that attorneys are making informed decisions.

**Recommendations:** It was recommended that training materials be developed for attorneys (both Commonwealth & defense) about competency to stand trial evaluations which will

include reference to the time requirements and possible outcomes of competency evaluations. It was recommended that DBHDS partner with CSBs to schedule training sessions with various Virginia Bar Associations to disseminate this information.

**Issue:** Because §19.2-169.2 reads “upon finding that the defendant is incompetent, the court shall order that the defendant receive treatment to restore his competency...” courts must refer for treatment any defendant found incompetent to stand trial, even if it is clear the defendant is unlikely to be restored and/or even if the defendant has previously been found to be unrestorable. This especially becomes an issue for persons with intellectual disabilities, developmental disabilities, cognitive disorders, and progressive neurological issues.

**Recommendations:** Explore feasibility of modifying §19.2-169.2 to afford the Court three options upon a finding of incompetency: 1) Order the defendant to receive treatment (either outpatient or inpatient) in an attempt to restore his/her competency to stand trial; 2) If there is doubt about the findings of the initial evaluation, afford the Court the latitude to order a second competency to stand trial evaluation; or 3) Allow the Court to find the defendant unrestorably incompetent to stand trial and to dispose of the case in a manner consistent with §19.2-169.3.

#### Sanity at the Time of the Offense Evaluations (§19.2-169.5 & §19.2-168.1)

**Issue:** Presently, there is no system for qualitative oversight of sanity evaluations completed by practitioners in the field. There is no mechanism in place to provide any level of peer review or feedback to evaluators regarding comparison of their work to standard of practice. At times, courts appoint practitioners who appear to lack the requisite education and experience to perform such evaluations and there is no agency/body designated to regulate this practice. Like in any profession, there is great variability in the quality of work product and members of the workgroup have observed instances in which evaluations fall below the standard of practice. While ultimately the judge or jury determines the issue of insanity, research has found a high concordance rate between evaluator opinion and judge/ jury rulings, especially if there is only one opinion that is uncontested. The consequences of evaluations that do not meet practice standards are significant, regardless of the direction of error. If an evaluator incorrectly opines a defendant was not insane at the time of the offense (when in fact he/she was), the defendant (if convicted) will face sanctions and there is little room for mitigation. If an evaluator mistakenly opines a defendant was insane at the time of the offense (when in fact he was not), the defendant is absolved of criminal responsibility (when maybe he shouldn't have been), but could face an indefinite period of commitment to DBHDS. The Commonwealth will incur a significant financial expense by having to detain and treat an individual who otherwise is not in need of this level of care.

**Recommendations:** There was consensus within the group that it would be prudent to recommend some system of oversight of evaluators and the evaluations they produce. While many options for oversight were discussed, the consensus of the group was to recommend exploration of the possibility of the Commissioner of DBHDS establishing and maintaining a list of approved evaluators and explore the feasibility of amending the Code to require that courts only appoint evaluators who are on the approved list. Additionally, the group recommended exploration of the feasibility of amending the Code to require evaluators to submit their evaluations to the Commissioner to enable peer review.

**Issue:** Some locations in Virginia have few or no qualified and willing evaluators. While part of this issue is related to geography and the absence of psychiatrists/psychologists, the rate of reimbursement has a significant impact on the availability of evaluators. Currently, evaluators who complete a Sanity at the Time of the Offense evaluation (§19.2-169.5 or §19.2-168.1) are reimbursed \$500 for the evaluation (\$750 for a combined Competency & Sanity Evaluation). Given the number of hours it generally takes to complete a quality, comprehensive sanity at the time of the offense evaluation, this rate is often well below the hourly rate professionals can charge for providing other services. The reimbursement rate has not been adjusted since 2007 and consequently has fallen well behind the market rate.

**Recommendations:** The workgroup recommended that data be gathered from other states about rates of pay for comparable evaluations. An analysis should also be undertaken as to the average amount of time required to complete sanity at the time of the offense evaluations and the current hourly market rate for psychiatrists and psychologists with specialized forensic experience. A subgroup will then recommend a new reimbursement rate and complete a fiscal impact analysis based on the number of sanity evaluations completed in prior years.

**Issue:** At times attorneys (both Commonwealth and defense) do not send the requisite collateral materials in a timely manner which can lead to delays in completing the evaluation and/or result in incomplete evaluations. Although §19.2-169.5 and §19.2-168.1 are very clear about the responsibility for sending collateral materials, delays in sending collateral materials continue to be an issue.

**Recommendations:** It was recommended that training materials be developed for attorneys (both Commonwealth & defense) covering sanity at the time of the offense evaluations which will include reference to the requirement to provide the collateral materials to the evaluator and an explanation of the need for such materials. It was recommended that DBHDS partner with CSBs to schedule training sessions with various Virginia Bar Associations to disseminate this information. DBHDS has already secured Continuing Legal Education (CLE) credits for those attorneys who participate and has also applied for a federal grant to support this activity.

**Issue:** Not all evaluators complete the Forensic Evaluation Information System (FEIS) form (A summary report about the type of evaluation, processes utilized to complete the evaluation, and the evaluator’s outcome opinions), therefore the Commonwealth has no aggregate data about the evaluations which are being prepared for the courts. As a result, there is no basis to monitor outcomes of the court ordered evaluations.

**Recommendations:** The group recommended exploration of the feasibility of amending the Code of Virginia to require the completion of the FEIS as a condition of receiving reimbursement from the Supreme Court. Specifically, the group recommended that consideration be given to amending §19.2-175 to include this requirement. There was also some discussion of streamlining the FEIS as some evaluators have complained it is too time consuming to complete. The workgroup recommended that DBHDS appoint staff to collaborate with the Institute of Law Psychiatry and Public Policy (ILPPP) to review the FEIS and streamline, where possible.

**Issue:** At times attorneys raise the issue of a defendant’s sanity at the time of the offense for relatively minor offenses which sometimes leads to defendants spending more time detained in DBHDS custody than would have been the case if they had simply plead guilty to the offense.

**Recommendations:** The group discussed the fact that attorneys are bound by legal ethics to raise issues when there is doubt about a defendant’s sanity at the time of the offense. To not do so, could form the basis of an ineffective assistance of counsel claim. The group also discussed the fact that what constitutes the best outcome for a particular defendant is debatable and that length of detention is not the only factor which determines whether an outcome was best. The workgroup did agree that attorneys would benefit from information about likely outcomes for their clients should they successfully pursue an insanity defense to ensure that attorneys (and defendants) are making informed decisions. It was recommended that training materials be developed for attorneys (both Commonwealth & defense) covering sanity at the time of the offense evaluations which will include information about the outcomes of a successful insanity defense, including information about the length of hospitalization. It was recommended that DBHDS partner with CSBs to schedule training sessions with various Virginia Bar Associations to disseminate this information. DBHDS has already secured Continuing Legal Education (CLE) credits for those attorneys who participate and has also applied for a federal grant to support this activity.

#### Treatment to Restore Competency to Stand Trial (§19.2-169.2)

**Issue:** §19.2-169.2 dictates that treatment to restore competency to stand trial shall occur on an outpatient basis unless the Court specifically finds that inpatient treatment is required. There is no funding stream for outpatient competency restoration services. Because a large number of these individuals are in jail, if they had benefits (Medicaid or Medicare), due to their detention status the benefits are inaccessible thus the provider cannot be paid for services. If the individual is out of jail on bond and happens to have Medicaid/Medicare, only a portion of services likely will be covered and many patients are unable to pay for those uncovered services. While it was noted DBHDS will begin (as of July 1, 2012) reimbursing CSBs for some services they provide for competency restoration, it was acknowledged the small amount of funding that DBHDS was able to designate for this purpose is not sufficient to fund all the requisite services.

**Recommendations:** The group recommended that a subgroup work with current providers (CSBs) to determine the types and frequency of services being provided so that an accurate prediction of actual costs can be made. It was recommended that DBHDS explore funding opportunities.

**Issue:** Often CSBs are ordered to provide competency restoration services, yet are not provided sufficient collateral materials to accomplish this task. Specifically, they often do not receive the original competency evaluation and/or collateral reports regarding the alleged instant offense. Similarly, on occasion CSBs are ordered to attempt to restore an individual who might have received services in another jurisdiction, but the CSB has no access to those records

**Recommendations:** Virginia Code §19.2-169.2 requires that the provider of restoration services be supplied a copy of the original competency evaluation, but there is no reference to the requirement of providing collateral information to the provider. The workgroup suggests exploration of the feasibility of amending §19.2-169.2 to specifically require the attorneys involved in the case to provide such collateral information as is required in §19.2-169.1. With regard to accessing prior treatment records/competency restoration outcome evaluations, the group discussed designating DBHDS the central repository of records from which CSBs would be able to access records.

**Issue:** There is no established standard of practice for outpatient competency restoration treatment in Virginia. There is much variability across CSBs as to the type, frequency, and intensity of services an individual will receive if ordered to receive outpatient competency restoration services. Part of this issue stems from the fact that many of the CSB restoration providers have had little or no training on providing competency restoration treatment.

**Recommendations:** It was recommended that DBHDS (given its extensive experience in providing inpatient competency restoration treatment) develop an introductory training program for individuals at CSBs who provide outpatient restoration services. It was recommended that this training be provided regionally and should be incorporated into the already established regional forensic meetings. It was further recommended that DBHDS investigate available national resources and attempt to provide some of these resources to the CSBs.

**Issue:** The Code of Virginia limits the provision of outpatient restoration services to Community Services Boards or Behavioral Health Authorities and does not allow for private providers to offer the service(s).

**Recommendations:** It was recommended that DBHDS monitor the status of statutory changes to §19.2-169.2. Should services become reimbursable, it is possible private practitioners might be interested in providing these services. At that point in time, it is recommended DBHDS collaborate with the Virginia Association of Community Services Boards (VACSB) to explore the feasibility of including private providers as acceptable providers of restoration services.

**Issue:** Virginia Code §19.2-169.3 limits the period of restoration to 45 days for three classes of misdemeanors. All other defendants charged with any other offenses may receive competency restoration treatment indefinitely in 180 day increments. By virtue of this arrangement, individuals charged with misdemeanor offenses (other than those already subject to the 45 day rule) can end up getting caught up in the criminal justice system by virtue of their incompetency when they likely would be better served receiving treatment through Community Services Boards.

**Recommendations:** Based on the workgroup's experience, it was the collective opinion that the number of offenses qualifying for the 45 day limit to competency restoration should be expanded to other non-violent misdemeanor offenses. It was recommended that a subgroup be formed to identify other offenses which reasonably should qualify for the 45 day limit to competency restoration. It was further recommended that this subgroup investigate the feasibility of amending §19.2-169.3 to incorporate these new offenses.

**Issue:** Often, after an individual has received treatment to restore his/her competency to stand trial and the treating provider is of the opinion the individual's competency to stand trial has been restored, there still is a long delay before a court hearing takes place which results in either extended periods of treatment and/or the individual having to wait in jail (and risk decompensation) needlessly. If the individual's mental status decompensates, they may require return to the state hospital for stabilization which ends up costing the Commonwealth more money and can cause irreparable damage to the individual.

**Recommendations:** The group recommends exploration of the feasibility of amending §19.2-169.2 to require the court to hold a hearing on an expedited basis when/if they receive notice that the provider is of the opinion the individual's competency to stand trial has been restored.

Persons Adjudicated Unrestorably Incompetent to Stand Trial (19.2-169.3)

**Issue:** Upon a finding (by the Court) that an individual is incompetent to stand trial and likely to remain so for the foreseeable future, the Court can either: 1) release the individual; 2) commit the individual for further psychiatric care pursuant to §37.2-814; 3) certify the person for admission to a DBHDS training center pursuant to §37.2-806; or 4) if the person is charged with a particular sex offense, refer for evaluation for possible commitment pursuant to §37.2-900. Often when the Court civilly commits the individual to DBHDS under §37.2-814 rather than dismissing the charges, the charges are continued out to some date in the future. The existence of these charges then becomes a barrier to discharge. Also, some courts feel they retain jurisdiction over the individual's civil commitment and write orders prohibiting DBHDS from discharging the individual. If the defendant happens to be charged with a sex offense and is referred for evaluation for possible commitment as a sexually violent predator, often times that evaluation process takes up to 1 year or longer. During that time the individual cannot be released and must remain in secure custody. At times the person is kept in the state hospital but this becomes problematic as they occupy one of the scarce few beds for up to one year. At other times the individual is transferred to the Virginia Center for Behavioral Rehabilitation (VCBR) for confinement while awaiting a decision as to whether civil commitment will be sought. Persons adjudicated unrestorably incompetent to stand trial can be vulnerable at VCBR and difficult to manage in this setting. Often the Commitment Review Committee (CRC) and Office of the Attorney General decide not to pursue commitment, yet the individual often remains in DBHDS custody as the Court remains reluctant to order discharge. Because of the length of time it takes just to determine whether the Commonwealth will seek commitment and the uncertainty about the outcome, it is often impractical for CSBs to locate services necessary for discharge

**Recommendations:** It was recommended that a subcommittee be formed to investigate treatment issues faced in working with individuals found URIST and that the subcommittee offer recommendations about procedural changes, resource needs, and legislative changes which might facilitate the timely provision of mental health services to this group.

## Mental Health Treatment for Individuals in Local & Regional Jails

**Issue:** There is no consistency across jails in the scope of mental health services provided. This includes both medications and non-medication treatments. While providing medical care (which includes psychiatric care) is a constitutional mandate, this mandate is interpreted differently by each jail. Large differences in services exist between local jails and regional jails. There is much variability in medication formularies in all jails. Following the 2011 General Assembly session, DBHDS was directed to convene a review of formulary practices among jails. The resulting interagency committee identified differences in formulary and recommended more uniform practices, but the barriers of funding, cross-jurisdictional, and contractual issues were also documented.

**Recommendations:** The workgroup recommends that there should be an established minimum standard for mental health care in jails. The method/strategy by which each jail would achieve this minimum standard likely will vary depending on jail size, CSB size, etc. A subgroup (to include representatives from local and regional jails, CSBs, state hospital staff, etc.) should be formed to establish best practice guidelines. This subgroup should also investigate the magnitude of the problem with associated cost estimates to provide the minimum level of psychiatric care. It was further recommended that this subgroup also consider the issue of divergent jail formularies and any means to bring more uniformity and improve treatment options.

**Issue:** Benefits (SSI/SSDI/Medicaid/Medicare) are suspended after being jailed for 30 days. This practice causes there to be no funding source for care. This practice also impedes resumption of care post release from jail as it generally takes several months to get benefits re-started (if the individual had benefits before being incarcerated).

**Recommendations:** The workgroup recommends that the public mental health system advocate for not-suspending benefits of individuals incarcerated and/or facilitate a process to have benefits rapidly reinstated upon discharge from jail. Additionally, it was recommended that jointly the agencies should approach DMAS about this practice and advocate for policy change (as this appears to be a state level decision rather than a federal mandate).

**Issue:** At times CSBs are unaware their clients have been incarcerated and similarly are not made aware when they are discharged, thus making it difficult to link clients to services. While many CSBs have Memorandums of Understanding (MOUs) with their local & regional jails, these do not always include a provision for sharing of information and/or despite these MOUs mental health consumers are either not identified or are released from jail without the benefit of having follow-up appointments.

**Recommendations:** It was recommended that all CSBs should have updated MOUs to facilitate sharing of information, notification when consumers are arrested, and agreements regarding release planning from jails. It was recommended that the discharge needs of individuals with mental health issues be taken into consideration when coordinating discharge/release plans. Jails and CSBs should collaborate on discharge planning prior to release, whenever possible.

**Issue:** Discharge planning for individuals admitted to DBHDS pursuant to §19.2-169.6 (but who are subsequently deemed ready for discharge) is difficult as often it is unclear how long the person will remain in the jail or whether the individual will be granted bond. As a result it is difficult to plan and coordinate services. CSBs are required to provide services to individuals discharged from state hospitals, but there is no funding source to provide for services and benefits likely have been suspended. Also, there is much variability between the CSBs about the type of services they will or can provide to individuals in the jails. Some jails contract with private providers and do not allow CSBs to provide services, thus impairing continuity of care (for those consumers who are already recipients of services at the CSB). It is virtually impossible to reserve services when it is not known if the person will actually immediately begin receiving services. Providers (ALFs, day programs, etc) will not hold housing and other services indefinitely. As mentioned above, often insurance (Medicaid or Medicare) has been suspended leaving no means to pay for services upon release from jail.

**Recommendations:** It was recommended that discharge plans from state hospitals should include *both* a plan for care if the individual remains in the jail *and* a plan for care if/when released from jail. The public mental health system should advocate for a mechanism to expedite resumption of benefits (for those who previously qualified for benefits) post release from jail/hospital. The group further recommended that an investigation be undertaken to determine the number of individuals for whom CSBs are providing services in jail, the types of services they are providing, and an estimate of the costs of providing these services.

**Issue:** Inmates ordered to receive treatment pursuant to §19.2-169.6 tend to be ordered into state hospitals as private facilities are often unwilling/ unable to provide the care even though often the individual's clinical needs are similar to those of individuals they already serve. Thus, at times a state hospital bed is occupied by someone who could otherwise (other than their legal status) be treated in a community hospital. In 2011, DBHDS licensed one private hospital as eligible to receive and treat patients under this legal status, but due to a variety of reasons not a single patient was ever admitted.

**Recommendations:** It was recommended that DBHDS should form a workgroup to explore the possibility of other private hospitals, providing treatment for inmates in need of treatment under §19.2-169.6. The workgroup should explore the reasons the prior pilot study did not

work and make recommendations as to whether it is prudent to again attempt to license a private hospital(s) for this purpose and/or what system changes would need to be put in place to enhance the likelihood of success of such a program.

Not Guilty by Reason of Insanity Acquittees (§19.2-182.2 thru §19.2-182.11)

**Issue:** There is much variability and confusion about how to manage individuals adjudicated Not Guilty by Reason of Insanity for misdemeanor offenses. While in 2002 §19.2-182.5 was amended to limit the period of time a misdemeanant NGRI could remain in the custody of DBHDS to one year from date of NGRI adjudication, there were no similar changes made to §19.2-182.7 or §19.2-182.8 thus there is much variability and confusion as to how long a misdemeanant NGRI can remain on Conditional Release. This leads to inconsistency in the application of the law across Virginia. Additionally, many misdemeanant NRIs remain on Conditional Release for extended periods of time – much longer than they could ever have remained incarcerated or on probation if convicted on their original offense. While there are some benefits of being on Conditional Release, this status also can become an impediment to receiving community based services and can result in unnecessary returns to state hospitals.

**Recommendations:** It is recommended that the feasibility of amending the Code of Virginia to limit the time a misdemeanant NGRI acquittee can either be in DBHDS custody and/or on Conditional Release to a total of one year be explored. The consensus was that the individual should be unconditionally released 365 days from the date of NGRI acquittal. It was recommended if the individual needs further inpatient treatment (either immediately or in the future), they access services through the established civil commitment procedures outlined in §37.2-814 thru §37.2-828.

**Issue:** There are inconsistencies across and within hospitals about the criteria for movement through the graduated release process. Often times it appears the decisions are idiosyncratic to the particular hospital team members' comfort level. While all treatment is individualized and each patient has unique risk factors which must be managed, there should be some uniform guidelines to suggest when an individual is ready for the next privilege level.

**Recommendations:** It is recommended that DBHDS provide some written guidelines about what behaviors would be expected for particular privilege levels. While treatment teams would still use clinical judgment, guidance would be in place for reference, realizing that particular individuals' risk factors will warrant deviation from the guidelines. It was recommended that DBHDS facility forensic coordinators work collaboratively to establish these guidelines which should be included in the next revision of *The Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity*. It was further recommended that DBHDS enhance its

system of oversight of individuals who are not progressing through the graduated release process to provide consultation to treatment teams.

**Issue:** There is great variability across Virginia as to when/if CSBs request/ support unconditional release (for individuals already on Conditional Release). This variability seems to stem from misinformation, CSB perception of relative risk of unconditionally releasing individual versus retaining individual on Conditional Release, and CSB familiarity with the NGRI graduated release process (appreciating that unconditional release is the last step of the graduated release process).

**Recommendations:** It is recommended that DBHDS should continue to provide ongoing training to CSB NGRI Coordinators and other staff about the principles and process of unconditional release. It was further recommended that DBHDS offer training to CSB leadership about NGRIs and the graduated release process to ensure CSBs are making informed decisions when working with NGRIs. Finally, it was recommend that a subgroup be formed to look at the various options for creating an oversight system to monitor NGRIs who are on Conditional Release and will forward their recommendations to the larger group.

**Issue:** Historically there has been much turn over in CSB NGRI Coordinators and often individuals are assigned this responsibility with little training or experience in working with NGRIs. Additionally, often the CSB NGRI coordinator job duties are an “add on” to an employee’s existing job duties because, for the most part, the work of the NGRI coordinator is non-billable – at least for individuals in the hospital. Therefore CSB NGRI Coordinators are not afforded sufficient time to perform all the ideal functions they should perform.

**Recommendations:** It is recommended that DBHDS develop a curriculum for CSB NGRI Coordinators and other CSB staff who work with forensic clients. It was further recommended that this curriculum be included in the existing case manager curriculum recently implemented by DBHDS. Additionally, the group recommended that DBHDS develop a comprehensive description of the duties associated with the NGRI Coordinator position and share this with CSB executives.

**Issue:** As individuals who were adjudicated NGRI benefits generally are suspended (if they were receiving them prior to hospitalization) there is no reliable funding source to fund both services needed for various privilege levels and for services needed on Conditional Release. While there was an infusion of NGRI Discharge Assistance Planning (DAP) funds many years ago, this has long ago been allocated and other than one-time expenses there is little ongoing money available for NGRIs.

**Recommendations:** It is recommended that a subgroup be formed to determine the types, levels, intensity, frequency, and cost of services which NGRI acquittees need both while transitioning through the graduated release process and immediately upon Conditional Release. The workgroup should estimate the immediate and projected long term ongoing funding needs.

**Issue:** Current practice mandates that once an individual is adjudicated NGRI they must come into a state hospital for “Temporary Custody” even if they are psychiatrically stable and were on bond. This can result in unnecessary hospitalization. This practice stems from language in 19.2-182.2 which states, “The court shall place the person so acquitted in temporary custody of Commissioner”. The Office of the Attorney General has opined that the Code does mandate inpatient admission.

**Recommendations:** It is recommended that DBHDS form a subgroup to investigate the feasibility of conducting a select subset of Temporary Custody evaluations on an outpatient basis. The subgroup should ensure they address screening procedures, resources, policy, and legislative changes that would be needed to support an alternative Temporary Custody system.

**Issue:** Currently §19.2-182.9 specifies if an NGRI acquittee who is on Conditional Release is placed in the emergency custody, detained, or hospitalized in a state hospital this constitutes a revocation of his/her Conditional Release. Given the chronic shortage of private beds coupled with private hospitals’ reluctance to accept patient with forensic backgrounds, often times the patient (while symptomatic) may not require revocation but because they were unable to access a community alternative and ended up in the state hospital, their Conditional Release is revoked. By virtue of having been revoked, the patient’s hospital stay is extended beyond what may be clinically necessary and it requires levels of approval to once again release the patient back into the community.

**Recommendations:** It is recommended that a subgroup be formed to address this issue. The subgroup will consider whether changes are needed to §19.2-182.9 to provide some leeway for NGRIs who end up in the state hospital not necessarily because of their risk to the community but rather due to administrative/procedural issues. The subgroup will also review the existing code language pertaining to revocation and investigate whether amending the code would facilitate better access to care. It is also recommended that this subgroup investigate whether there are some procedural changes (either DBHDS or CSB) which could help address some of these issues. Finally, it was further recommended that DBHDS continue to educate CSBs, courts, attorneys, and consumers about the voluntary admission option in lieu of violating Conditional Release.

**Issue:** There is much variability between DBHDS hospitals about when an NGRI should be placed on the Clinically Ready for Discharge list. While major, active symptoms may have abated, there often are risk issues which preclude the individual's discharge (yet by practice in some hospitals they are put on the list). This results in individuals appearing as if they are "clinically ready" when in reality there is little chance their teams would support their release until risk issues are sufficiently addressed.

**Recommendations:** It is recommended that DBHDS establish a workgroup to better define what it means to be "clinically ready for discharge" for NGRI patients and then share this definition with all facility forensic coordinators, facility administrators, and CSB NGRI Coordinators to ensure consistency of application.

#### Persons in Need of Mental Health Treatment Post Release from the Department of Corrections

**Issue:** When an inmate in a Virginia Department of Corrections facility is nearing the end of their sentence and they are felt to require inpatient treatment, they can be admitted to DBHDS under §37.2-814 if they meet the commitment criteria. On occasion individuals admitted to DBHDS from DOC do not have the psychiatric acuity often found in individuals requiring involuntary psychiatric admission, but rather it appears their admission was triggered due to inability to locate sufficient community resources to address the individual's complex psychiatric/ psychosocial needs. Often times, the individual can be rapidly discharged from DBHDS – presumably because DBHDS staff are better equipped to locate appropriate discharge services (as this is a DBHDS core function).

**Recommendations:** It is recommended that DBHDS collaborate with DOC to establish a Memorandum of Understanding regarding this issue. The purpose of the MOU should be to increase the cross agency collaboration to proactively locate services in the community in order to avoid an unnecessary DBHDS admission. It was noted that DBHDS already participates with the DOC on a Special Populations workgroup which has one of its focuses on discharge planning for inmates with mental illnesses.

**Issue:** When an individual is referred for admission from DOC to DBHDS pursuant to §37.2-814 it is unclear whether DOC staff are the petitioner, pre-admission screener, and independent evaluator. If so, the multiple roles would represent a conflict of interest.

**Recommendations:** It is recommended that a subgroup (to include DOC staff) be formed to investigate current practices to determine if conflict of interest exists. The subgroup should make recommendation (if any) to improve this process.

#### NEXT STEPS:

The workgroup agreed to produce an initial report and to share the report with their agencies and organizations. The group also agreed to then establish smaller workgroups to address those issues which were left unfinished in terms of discussion, recognizing additional members from agencies/stakeholders not currently represented in the workgroup might be needed for smaller workgroups. The larger group agreed to continue to meet routinely (although less frequently) to review any progress made, to share newly developed recommendations, and to identify any new issues/concerns which have arisen since the preparation of this report. As a preliminary step, this report offers several consensus agreements made by the group members and also outlines specific subgroups which will be formed to further the work of this larger group. DBHDS will spearhead the formation of these subgroups and will help coordinate these efforts.

**Attachment:** Forensic Work Grid