Virginia Department of Behavioral Health & Developmental Services

Virginia's CIT Assessment Sites Annual Report Fiscal Year 2017

DBHDS Vision: A Life of Possibilities for All Virginians

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Virginia Department of Behavioral Health & Developmental Services

FY 2017 Virginia CIT & CIT Assessment Sites

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Executive Summary

As the primary agency for behavioral health services in Virginia, the Department of Behavioral Health and Developmental Services continues to support recovery in Virginia through the funding of CIT Assessment Sites. The Sites provide opportunities for diversion from inappropriate arrest for consumers in crisis with additional goals of supporting recovery while also relieving stress on the behavioral health and criminal justice systems.

A seminal concept in this field, the Sequential Intercept Model, developed by Mark Munetz, MD and Patricia A. Griffin, Ph.D., "provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with serious mental illness" [1]. The Model identifies intersections within the criminal justice system at which interventions are most appropriate and seeks to provide interventions beginning with the first law enforcement encounter to post conviction and community re-entry. CIT and CIT Assessment Sites provide skills and a process to support consumer recovery at or even before the earliest identified interaction with the criminal justice system (Intercept 1) by interacting with those in crisis during a law enforcement encounter but before the consumer is placed into the criminal justice system. Because of where they fall within the concept of the Sequential Intercept Model, CIT Assessment Sites, often called receiving centers, are also often considered a jail diversion initiative.

Virginia's network of receiving centers facilitated through DBHDS's Office of Forensic Services has worked to serve consumers in crisis since FY2013 with CIT Assessment Site funding awards. Over that time over $21 million has been distributed to provide funding for services to provide reasonable interventions and appropriate care for those in acute crisis. Virginia's approach to state funded partnerships for crisis and diversion efforts has recently been recognized around the nation as a model for collaborative state and local partners. DBHDS program staff have participated and presented at conferences and summits to support legislation about the creation and sustained success of our receiving centers. Advocates in other regions hope to gain experiential knowledge to build programs of their own to support diversion of those in acute mental health crisis from the justice system. At the same time, we continue to also seek new information to make evidence based decisions that can enhance and increase the services we provide in Virginia as well.

This report will provide an overview of CIT Assessment Sites, their purpose, operations, and funding for fiscal year 2017. In addition it demonstrates the annual progression of the jail diversion process that supports Assessment Sites including Crisis Intervention Team (CIT) training and stakeholder engagement. This report will provide explanations of several features of the Assessment Site process as well as historical and continued challenges to the expansion of this program's availability to all residents of the Commonwealth of Virginia.

1. Taken from the GAINS Centers description of the Sequential Intercept Model; Munetz,M.D., Mark R. and Patricia A. Griffin, Ph.D. "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness." Psychiatric Services 57: 544-548, 2006

Need Statement

Consumers of mental health services in Virginia continue to live within a health care system in constant fluctuation. This is not a new trend, nor is it contained to only Virginia. Changes in services and the availability of those services impacts referrals for consumers all over the Commonwealth.

In 2015, it was reported that as many as 17.9% of the U.S. adult population was living with a mental illness, and as many as 4% of the total population with an illness identified as a serious mental illness. [2,3] In 2014, 18% of the total adult population in Virginia was estimated to be living with a mental illness, almost a quarter of whom have what is considered a serious mental illness which results in serious functional impairment and interferes with or limits major life activites.[2] Between 1970 and 2016, Virginia's daily census for inpatient psychiatric beds has decreased from over 9,300 down to about 1,300.[4] These numbers are important because inpatient hospitalization is often necessary for recovery and highlight the importance having other available lesser restrictive outpatient programs.

To compound the issue of bed space, Virginia's Compensation Board report shows that of the total population represented, 7,451, or 17.63% of state inmates live with a mental illness. This report includes survey responses from 54 of Virginia's 59 detention facilities with an average daily incarcerated population of 27,477. [5] The report also pointed out that in just one month in 2017 over 11,000 psychotropic medications were dispensed to Virginia inmates, with the caveat that some receive more than one. In addition to what was dispensed, just under 13% of the jail population reporting mental illness refused medications, an increase over 2016 reported amounts. Although some jails reported incomplete costs, the preliminary figure indicates that at least $3.8 million was spent in 2017 on administered psychotropic medications.

Although CIT and its related initiatives are primarily focused on interventions prior to entrance into the criminal justice system, (Intercept 1 on the Sequential Intercept Model) understanding the prevalence of mental illness and its associated costs for those who end up incarcerated provides a better understanding for why individuals require better, consistent, and appropriate interventions to begin recovery.

CIT Assessment Sites provide the opportunity for consumers in crisis to be in an environment outside of the criminal justice system for proper intervention, assessment, and care. Additionally, the Sites offer front line law enforcement officers an opportunity to return to their duties in the community by allowing for the transfer of custody of consumers in crisis to other personnel, usually for the duration of the assessment process.

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2. National Institute of Mental Health https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml
3. American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders-V*
4. Virginia Senate Finance Committee Presentation, *State Mental Health Hospitals Under Pressure.* Nov 2016
5. Mental Illness in Jails Report. Virginia Compensation Board 2017

Virginia Crisis Intervention Teams

Thousands of law enforcement officers, mental health clinicians, peer specialists, judicial officers, medical staff, and others have participated in the CIT core curriculum in Virginia since its inception. In the early 2000s Virginia's first CIT training programs began with representatives learning the curriculum from those who had created it in Memphis, TN. Together, the Department of Criminal Justice Services (DCJS) and DBHDS continued to support the expansion of programs around the Commonwealth, and in 2014 worked together to support training with the asset forfeiture funds provided by the Office of the Attorney General. Following this, the growth of CIT programs continued into more communities with the help of the collaborative sharing by established programs, which has become a hallmark of CIT.

CIT programs fulfill several important purposes, the most well known being the intensive training for law enforcement officers to aid in the recognition of consumers in behavioral health crises. That knowledge is combined with de-escalation and intervention techniques to aid in delivering consumers to care, not the justice system. Stakeholder coalitions that create and support the training are crucial to the multi-disciplinary response and allow for the sharing of resources and programs within localities. There are many opinions surrounding the effectiveness of de-escalation techniques in law enforcement field operations, one concern being officer safety. A key point to understand about de-escalation techniques taught during CIT training is they are never meant to replace officer safety techniques, but are an important tool for use in appropriate situations. Admittedly, limited in-depth study has occurred on outcomes, but some researchers have already shown that CIT is a best practice as it has shown to "increase officer knowledge, improve attitudes toward mental illness, and improve skills in connecting with consumers of behavioral health services in crisis."[6]

A challenge with police field operations is the amount of manpower and time required to respond to the amount of calls for service from the public; for many years the ability to resolve situations quickly and move on to the next call was a key measure of success. A change for officers who have participated in CIT training is how well they understand the need to take time to connect with individuals in crisis. When officers and deputies demonstrate their willingness to listen and apply their knowledge of symptoms of illness, they can then not respond simply to a situation, but to the person crisis. This has been a momentous shift in mindset.

There are thousands of CIT programs around the nation that operate very closely to the Memphis model first established in 1988, including 34 in Virginia.[7] This model incorporates information about psychiatric diagnoses and symptoms, pharmacology, and legal process. The functions of the training program which have the biggest impact however, are typically modules within the program during which students experience the aural immersion training "Hearing Voices", tour local behavioral health resources, and hear directly from those with lived experiences and their families. Trainees also spend a significant amount of time engaged in peer reviewed role plays with trained role players designed to increase their comfort level in applying new recognition and de-escalation skills.

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6. *The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills* Psychiatry Services, ps.psychiatryonline.org
7. Memphis CIT program overview: http://www.cit.memphis.edu/overview.php?page=2

CIT Assessment Site Purpose: Better Care for Individuals in Virginia

There are many people involved in the proper functioning of intervention programs such as CIT, including law enforcement, mental health clinicians, nurses and doctors, magistrates, and others. All of the pieces of the development and management of a state emergency mental health diversion program are important and should be discussed. What should not be overlooked, however, is the efforts of so many who are already providing support for those in crisis. The work being done in the field, in the CIT Assessment Sites, and through all phases of crisis response are helping consumers receive timely assistance, appropriate levels of care, and retain dignity. This cannot be stressed enough for a population who continues to fight the stigma of what it means to live with a mental illness.

As is common with prevention based programs it is difficult to quantify successful outcomes. To highlight the importance of diversion efforts through Assessment Sites, below are highlights of interventions in local programs that emphasize how the functions of the Site aided the path to recovery.

A program providing a much needed support network:

-An adult female consumer experiencing increasing depression and off of medication came in to seek assistance. The individual indicated a lack of a support system and was visibly upset. The emergency services clinician realized the importance of peer services and had the peer specialist connect with the consumer. She recognized the specialist from previous crisis care she had received which then allowed for a smooth transition into discussion of personal journeys of recovery and opened up the ability to highlight available services. The consumers level of need led her to be admitted into a crisis stabilization program, and at the time of transfer to the program's location, a peer specialist was again requested to help with the transition through services.

Another program related the following experience:

- A male consumer had expressed suicidal ideations with factors present that increased the risk of imminent harm to himself. Police were able to locate him before harm had occurred and brought him to the Assessment Site. The man was angry and aggressive toward clinicians, peer support, and suggested violent actions if taken to the hospital from the site. The CIT officer, clinician, and peer specialist were able to assist the man in de-escalating and he was transported for further care without incident. Although the serious nature of this particular consumer's crisis made hospitalization necessary, he was soon eligible for screening to step down to less restrictive care. The screener was the same clinician from the crisis encounter, and the consumer shared with them that the collaborative efforts from the previous encounter particularly those with the peer specialist and clinician, had been helpful for him being more receptive to further treatment.

These are but two of many accounts that support the impact CIT Assessment Sites as a diversion program can make in the lives of individuals.

CIT Assessment Site Impact

The Virginia general assembly updated the Code in 2009, mandating the creation of Crisis Intervention Team (CIT) initiatives supported jointly by DBHDS and DCJS.[8] The stated goals of this growth and expansion of CIT around the Commonwealth included:

⇒ Specially trained law enforcement officers to respond to mental health emergencies
⇒ Equipping officers to de-escalate, which reduces resistance and the response to resistance, in turn reducing injuries for consumers and officers
⇒ Decreasing inappropriate arrests by keeping those in crisis out of the justice system and connecting them with effective assessment and referrals for treatment
⇒ By decreasing arrests, reducing the need for mental health treatment in jails

Virginia currently has just under 22,000 law enforcement officers from 329 agencies with front line law enforcement duties.[9] It is important to understand the impact that training even 25% of them can have on interactions with the public, especially those in crisis. In addition, 50 of Virginia's detention facilities report already having jailors trained in CIT. This provides evidence that correctional administrators recognize that those with mental illnesses do end up in jail, and the importance of developing skill sets to positively impact the lives of those inmates living with mental illness.

Having training, knowledge, and understanding are all crucial to a supportive system of care, but another critical facet of the CIT model is timely access to a crisis system. Having infrastructure in place to support crisis care allows not only for diversion from inappropriate arrest but allows for a "no wrong door" philosophy to consumer care with priority access for law enforcement. Officers may provide quick access to care and return to traditional policing duties more quickly than that traditional ED visits. Within this philosophy officers are able to ensure there are always connections to appropriate services for consumers.[10] Law enforcement or security personnel staff the Site to enable on-duty field personnel to transfer legal custody of consumers who have arrived through the involuntary emergency custody order process[11], then returning to law enforcement duties in the community.

Prior to the creation of CIT Assessment Sites in Virginia, consumers in crisis had limited options for where they could meet with clinicians to receive pre-screening assessment, frequently being conducted in emergency rooms. When Sites are utilized assessments can occur in a more calming environment that allows consumers space, time, and environment to work with clinicians. This environment additionally provides Peer Specialists more opportunity to connect with consumers in crisis than typically afforded in the chaos and confusion of traditional emergency rooms.

It should be noted that there is more than one way to ensure access to care including mobile crisis programs. The Assessment Site programs currently offer a plan and location for intervention in the majority of Virginia's localities through location based services.

8. Virginia Code §9.1-187; https://law.lis.virginia.gov/vacode/title9.1/chapter1/section9.1-187
9. Virginia Department of Criminal Justice Services, Law Enforcement Division
10. CIT International: A Five Legged Stool...A Model for CIT Program Success!!!
11. Virginia Code §37.2-808; https://law.lis.virginia.gov/vacode/title37.2/chapter8/section37.2-808

Assessment Site Consumer Usage

The primary goal of Assessment Sites is providing a safe place where consumers in crisis can de-escalate and receive an appropriate and effective assessment by a qualified clinician. The findings from the assessment determine the level of care needed by the consumer, be it inpatient, short term residential crisis stabilization, or some other lesser restrictive option that will best benefit the individual not only during the current crisis but for long term well being. It is important to note that because one goal of Assessment Sites is to operate under a "no wrong door" philosophy, those whose apparent needs are related to mental illness are not turned away even if the underlying cause of observed symptoms turns out to be something other than a diagnosed illness. This means that in addition to fostering and maintaining strong interagency relationships, those partners in Assessment Site programs must also ensure training that addresses additional needs including acquired brain injuries and other developmental disabilities.

Involuntary treatment is often necessary following effective law enforcement interaction with consumers even when robust services are in place . A primary goal however of the Assessment Site program, is that CIT skills practiced in the field by law enforcement, when combined with a strong slate of options at the time of evaluation during a crisis, will aid in lowering the future occurrence of acute crises. The numbers listed (Figure 1) show the number of pre-screen assessments occurring during DBHDS funded site hours by fiscal quarter between FY'16 and FY'17. The chart shows a continued increase in assessments and as previously stated, directly corresponds to increased sites and utilization.

In our current system, the need for inpatient hospitalization has become increasingly challenging for several reasons. These include the reduction in the number of inpatient mental health beds and the difficulty in locating existing available beds. Because community based treatment funding struggles to meet true needs, these sought after funds are consistently helping many localities expand or in some cases sustain Assessment Site services that aid in connecting consumers with a full continuum of care. These factors contribute to the necessity of successful solutions that support consumer wellness at many points along the intercept model.

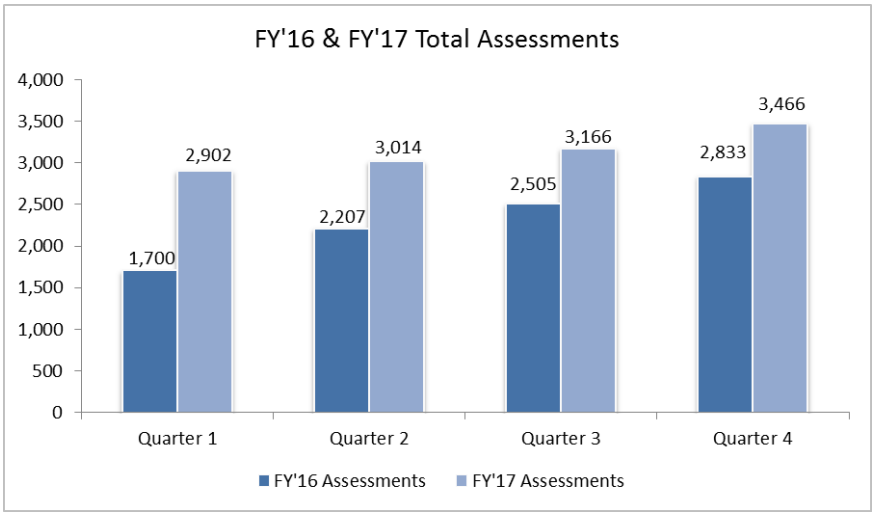

Figure 1

Law Enforcement Discretionary Hand-offs

Consumer care is the primary goal of CIT Assessment Sites. This means several things including the diversion from unnecessary arrest. This care is possible because of many different functions of the Assessment Site process, however it relies heavily on the discretion of law enforcement personnel in the field and their ability to recognize mental health crises and make supportive choices. Those in crisis often come into contact with law enforcement as a result of a member of the public calling police about concerning behavior that may appear criminal at first glance, and in some cases could even support a charge for a minor infraction, but the discretion of trained law enforcement professionals making choices to divert consumers from the criminal justice system is what makes the difference.

Although referrals to the Sites under this program are allowed some discretion, they are frequently as a result of the aforementioned calls for police service. CIT training and experience helps officers and deputies make these judgement calls and they made over 8,900 referrals in FY'17. They created opportunities for consumers to be at an Assessment Site and be evaluated by a qualified emergency services clinician instead of taking them to jail (Figure 2). These incidents during which officers show understanding and make a choice to support consumer recovery are recorded as discretionary law enforcement hand-offs.

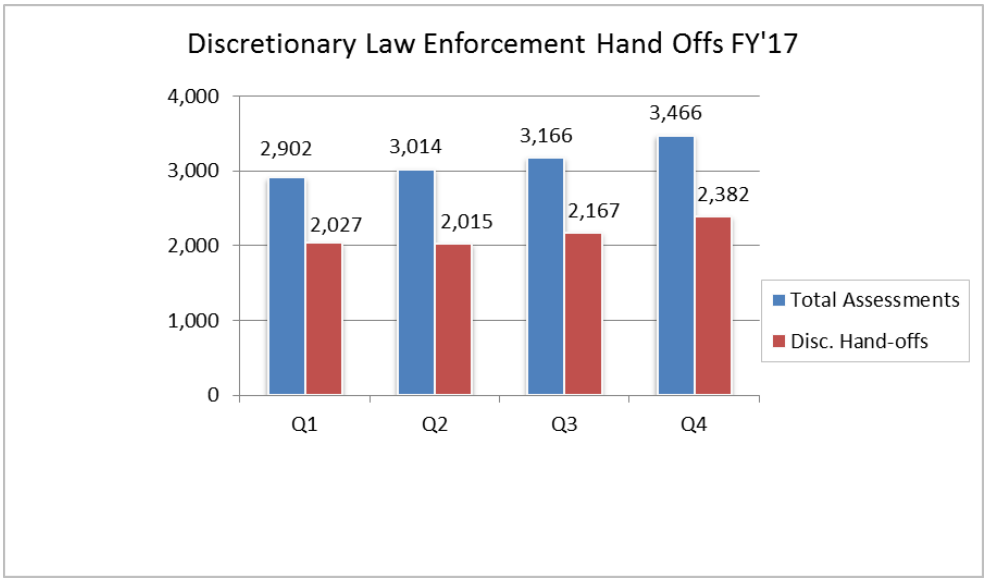

Figure 2

The ability of Assessment Sites to provide a calming environment outside of the criminal justice system, as discussed previously, is a key component of the program's success. Because of this, discretionary hand-offs from law enforcement officers are tracked to monitor any changes in the percentage of those who become justice involved who end up receiving behavioral health crisis care instead of jail. In FY'17 about 69% of the assessments occurring at an Assessment Site came as a result of law enforcement officers choosing to connect consumers with services.

Front line police officers and deputies are often tasked with responding to unknown situations. They are summoned by the public and the events to which they respond are not of their choosing. Occasionally, the location where they conclude that incident is another matter entirely.

Some incidents involve criminal acts and others do not; still more of these incidents involve acts that, were the subject involved not experiencing a behavioral health crisis, *could* fit into the legal definition of a crime. What becomes more apparent to CIT trained officers in these crisis situations is that the person they have encountered may have little or no intent to commit a violation of a criminal code or statue. Instead, they are acting in response to active symptoms of their own mental illness and often in ways they believe will help alleviate the confusion or discomfort of those symptoms. A simple example of this type of event may involve a subject who is refusing to leave a business after receiving multiple requests from employees. There may be no obviously dangerous or violent behavior, but the circumstances fit the basic criteria for a misdemeanor trespassing charge. By utilizing skills learned in CIT training officers are better equipped to make an informed determination regarding the crisis and choose diversion for a consumer which may include diversion to an Assessment Site. Once at the site, clinicians will conduct a pre-screen assessment and determine the level of care needed to provide appropriate services for the crisis at hand.

As the number of psychiatric beds available continues to decline, it becomes even more important to ensure consumers are receiving the care they need in ways that do not contribute to backlog in already overburdened inpatient psychiatric hospitals. The Assessment Sites accept consumers who are in acute and sub-acute crisis for diversion. Although about 60% of those who come to the Sites meet criteria for inpatient hospitalization, there are a significant subset of this group who may benefit from the ability to have a longer monitored de-escalation period. The time it takes to search for an appropriate inpatient bed for a consumer in Virginia continues to climb, however, and much of the time during an assessment is spent on this search. These difficulties, when combined with the understanding that treatment in one's own community and the *Olmstead* [12] decision lead Virginia to follow the example of localities in other states and begin to explore the ways the Assessment Site program could grow to provide more options.

12 *Olmstead v. L.C.,* 527 U.S. 581 (1999). The decision in *Olmstead* mandated that under the Americans with Disabilities Act, treatment for those with mental illness should occur in the least restrictive appropriate environment.

Alternative Transportation

In those situations when diversion from arrest has occurred there are many different possible outcomes for behavioral health consumers. Less restrictive options are sought, but in many cases are simply not appropriate because of the level of acute care required, meaning inpatient hospitalization under a temporary detention order (Va Code §37.2-809). The following section (§37.2-810.A) specifies the presumption that a law enforcement officer will transport the consumer to the destination of inpatient hospitalization, with a follow up in subsection B that the magistrate to whom the petition for temporary detention is submitted,

> "...shall consider any request to authorize transportation by an alternative transportation provider in accordance with this section, whenever an alternative transportation provider is identified to the magistrate, which may be a person, facility, or agency, including a family member or friend of the person who is the subject of the temporary detention order, a representative of the community services board, or other transportation provider with personnel trained to provide transportation in a safe manner upon determining, following consideration of information provided by the petitioner" [14]

Other existing challenges include the perceptions that law enforcement transport is a necessity for safety and security, as well as the belief that law enforcement transports are more efficient. Both of these points are addressed in the October 2017 Alternative Transportation Workgroup final report.[13] Additionally, the burden caused by working within these beliefs have continued to grow, and law enforcement agencies have increasing difficulty meeting these needs, which has lead to continued research into solutions following the initial pilot in the Mount Rogers CSB catchment area.

Alternative transportation has and will likely continue to be a point of much discussion, and has already been the subject of a pilot project in the Mount Rogers Community Services Board catchment area. This program, funded by DBHDS from 2015 through 2017, saw the use of trained alternative providers for approximately 41% of the total TDOs issued during the pilot program's duration. An additional 42% of those were not transported by the alternative provider because the destination facility was within several minutes drive and was not an efficient use of time.

It has become increasingly evident that, as a function of CIT related diversion efforts, alternative transportation will continue to be a focus of programs. Even those who have the resources to staff adequate clinical coverage often have a difficult time committing officers or deputies to lengthy consumer transports, knowing that personnel involved must adhere to stringent staffing policies to maintain safety in consumer care and in primary law enforcement duties.

13. Virginia Code §37.2-810.B
14. DBHDS Alternative Transportation Workgroup Final Report (Oct 1,2017),(HB1426,SB1221)

CIT Assessment Site Program Costs

Since its inception in FY'13 the Assessment Site program has grown rapidly through the use of general funds with continued support from the General Assembly. The number of localities served has increased, and in turn the total number of consumers served increased as well. As programs gain some distance from inception, there is a tendency to increase utilization within that locality. This often results from both increased numbers of CIT trained personnel as well as a better recognition of those in need of diversion by trained personnel.

As annual fund distributions for the ongoing Assessment Site awards has increased, there has also been an increase in the average per program spent. In the first year, the program began with a trial of three assessment sites and a total budget of $623,000 in ongoing program funds. The amount of funding applied to the program increased to $1,503,209, $3,095,789, $8,980,732, and $10,134,502 in fiscal years '14, '15, '16, and '17 respectively. Shown below, (Figure 3) are the program and individual site allocations since the funding began. As the program has expanded around the Commonwealth, the needs of programs in different localities have been revealed to differ greatly and in ways not anticipated. Some localities are able to offer in-kind contributions or direct funding in ways others cannot. Still others must confront challenges with geography and finding accessible partnerships. Additionally, the Assessment Site program began in urban/suburban communities with established CIT infrastructure. The program endeavors to reach into communities with fewer resources, and in doing so, recognizes that additional funding support is needed to reach a level of efficacy comparable to previous Sites.

Because of these challenges the costs per program and the per Site average costs have increased (Figure 3). Expenditures are monitored and compared on a quarterly basis as to ensure that communities with varying levels of resource availability maintain reasonable and consistent spending. Several programs operate two (2) Assessment Sites under one CSB's award, thus the chart represents the average spending of the funded CSB as well as the average for each individual Site throughout the Commonwealth.

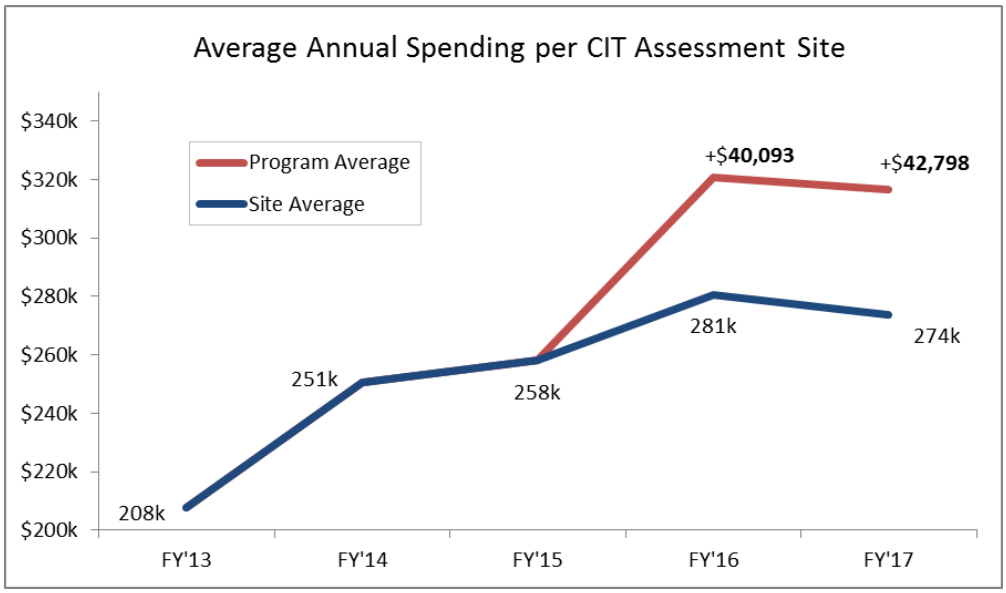

Figure 3

Assessment Site Expenditures

In the interest of inclusivity, CIT Assessment Sites may accept all members of the public in acute or sub-acute crisis. The foundational concept involves those in law enforcement custody, however it has been found that limiting acceptance in such strict terms overlooks many in crisis unnecessarily. The decision to accept non-ECO consumers at an Assessment Site is a local one based on individual program abilities to serve their local population. Other differences in local programs include geography, population density, and whether the location of a site is hospital or community based. These differences require flexibility and understanding, particularly with regards to the appropriate usage of program funds in ways that can achieve the best results.

The most prominent uses of DBHDS funding to support Assessment Sites is for law enforcement and security personnel to assume custody and provide a safe environment for consumers. The choice between using off-duty law enforcement officers or security staff is a local decision which is a product of hospital or law enforcement staffing levels or even local choice. Because the pre-screen assessment is code mandated to be conducted by an emergency services clinician from the CSB, ensuring adequate staffing for clinicians is the second highest expenditure from the funding awards. The responsibilities for ensuring program staffing, relationships with necessary stakeholders, and oversight of funding and data maintenance typically fall with a program coordinator, who may be a CSB or law enforcement employee, and is often funded through this award as well.

As previously explained, the importance of the involvement of Peer Specialists in the Assessment Site program cannot be overstated. For this reason, use of award funding for Peer salaries and training is encouraged in order to support this crucial role in the recovery process.

Because of the differences in localities, funding allowances also exist for facility and technology needs to support operations and efficiency of Assessment Sites. In areas without a viable hospital location; funding may include lease, renovation costs, and upkeep for spaces in the community to be obtained and be made more psychiatrically safe in which to establish Sites. These needs occasionally include computer and connectivity needs in order to access electronic health records to support consumer care.

Although another section of this report is dedicated to the importance and purposes of alternative transportation for consumers under temporary detention orders, it is important to also note that Assessment Site funding is used in some small part to address this issue currently as well. As programs receive funding and begin startup in their initial year of the award there is occasionally a fund overage in the first year. Feeling the burden created by increasing TDO transport distances and the strain this puts on employee staffing and budgets pushed some programs to utilize remaining first year funds to allow for off-duty law enforcement staff to operate in an on-call status to provide the necessary transportation and keep on-duty staff in the communities. While this is not the same solution as proposed in the SJ47 alternative transportation final report, it is a stopgap measure intended to bridge the gap temporarily while allowing for safe consumer transport by CIT trained personnel and not negatively impacting community safety.

FY'17 Quarterly Assessment Site Statistics

Statistical reporting for the Assessment Site program occurs on a quarterly basis through DBHDS's existing secure methods for collecting data from the CSBs. Data is collected from both field encounters that caused law enforcement to come into contact with consumers and also from the clinical contact at the time of the pre-screen evaluation and resulting disposition. As a best practice, and even more recently being considered as an evidence based practice, CIT related diversion efforts require appropriate data to demonstrate effective outcomes. Currently data collection includes times that consumers are involved in the process from the time of first encounter until the clinical disposition, as well as how the consumer was connected with the Assessment Site's services, be it through law enforcement, hospital referral, or another method. Although the purpose of the Assessment Site program is to divert consumers in crisis from the criminal justice system, limiting availability of services strictly to those in custody of a law enforcement officer discounts the truth that, although a large number of law enforcement encounters involved someone in crisis, there are many more who also experience symptoms of an acute crisis and are helped by a support network. Without these supports a law enforcement encounter is much more likely, therefore allowing consumers to be referred to Site services absent a direct law enforcement encounter may still be viewed as an even earlier intervention to divert from potential criminal charges.

Some key metrics showing the number of interventions are shown in the chart below (Figures 4,5). The first number is the total number of assessments that occurred over all Sites throughout each quarter.

These charts represent the total assessments occurring in FY'16 and FY'17 as well as the corresponding percentage that resulted in involuntary detention in a psychiatric facility for stabilization and treatment.

FY'16	Assessments	TDO	% of total
Quarter 1	1,700	1,096	64%
Quarter 2	2,207	1,338	61%
Quarter 3	2,505	1,498	60%
Quarter 4	2,833	1,709	60%
Total	9,245	5,641	61%

Figure 4

Year over year comparison, even with an increase in total assessments of about 39%, shows a slightly lower rate of involuntary detentions across the programs.

FY'17	Assessments	TDO	% of total
Quarter 1	2,902	1,751	60%
Quarter 2	3,014	1,690	56%
Quarter 3	3,166	1,747	55%
Quarter 4	3,466	1,881	54%
Total	12,864	7,279	57%

Figure 5

Assessment Site Program Ongoing Funding FY'17

Community Services Board Receiving Funding	Total Annual Ongoing Award
Alexandria Community Services Board	$217,792
Arlington Behavioral Healthcare	$503.225
Blue Ridge Behavioral Healthcare	$241,401
Chesapeake Integrated Behavioral Healthcare	$568,175*
Colonial Behavioral Health	$330,336
Cumberland Mountain Community Services Board	$116,590
Danville-Pittsylvania Community Services Board	$298,240
District 19 Community Services Board	$430,647
Eastern Shore Community Services Board	$109,700
Fairfax-Falls Church Community Services Board	$315,158
Hampton-Newport News Community Services Board	$133,053
Hanover Community Services Board	$220,379
Harrisonburg-Rockingham Community Services Board	$166,110
Henrico Mental Health & Developmental Services	$549,814
Horizon Behavioral Health	$608,355
Loudoun Mental Health, Substance Abuse & Disability Services	$266,160
Middle Peninsula-Northern Neck Community Services Board	$673,765
Mount Rogers Community Services Board	$335,889
New River Valley Community Services Board	$613,253
Norfolk Community Services Board	$305,295
Piedmont Community Services Board	$490,829
Portsmouth Community Services Board	$86,949
Prince William Community Services Board	$309,040
Rappahannock Area Community Services Board	$290,056
Rappahannock Rapidan Community Services Board	$253,534
Region Ten Community Services Board	$315,580
Richmond Behavioral Health Authority	$408,182
Rockbridge Area Community Services Board	$270,189
Southside Community Services Board	$293,014
Valley Community Services Board	$217,260
Virginia Beach Community Services Board	$150,857
Western Tidewater Community Services Board	$252,148

* Receives funds for partner program as fiscal agent

FY'17 Assessment Site Locations

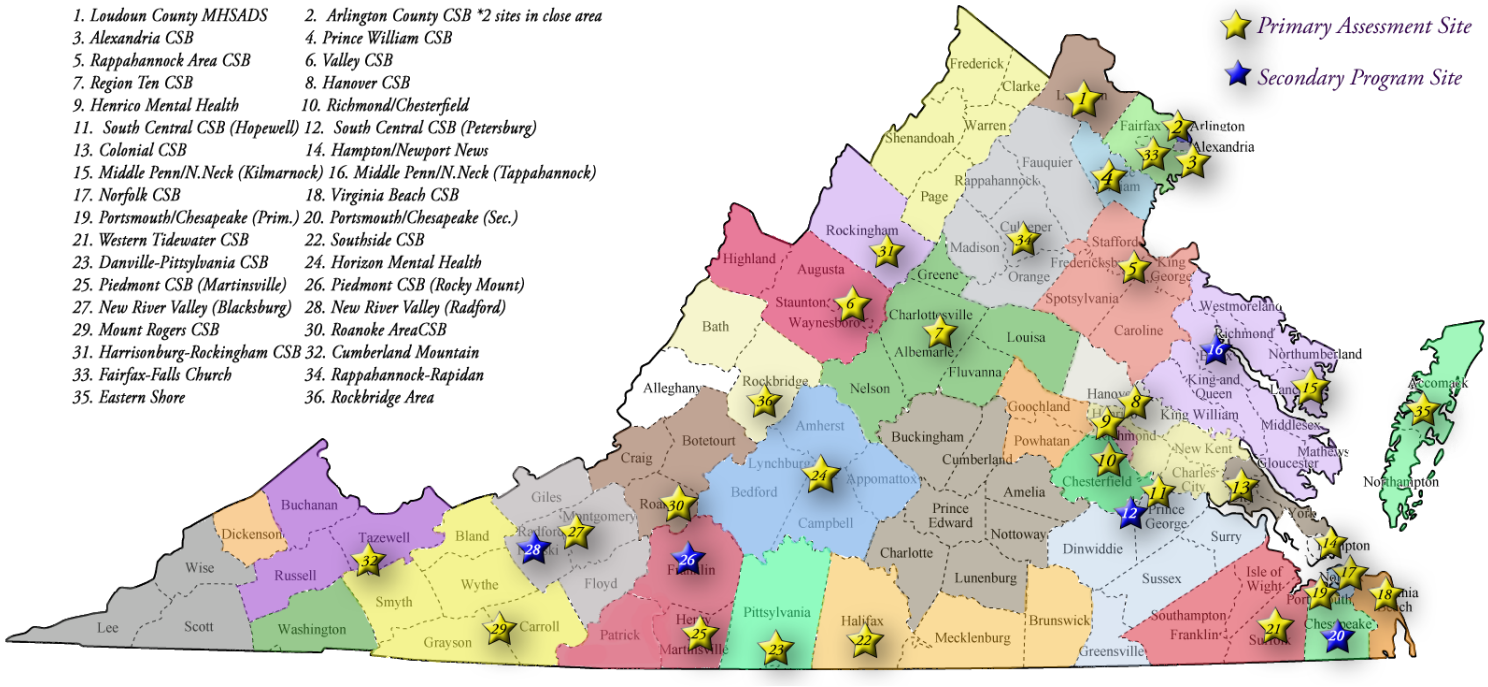

Figure 7

The map shown (Figure 7) lists the locations of DBHDS funded CIT Assessment Site programs through FY'17. The stars are located as close as reasonably possible within the CSB's catchment area to the actual location of the Site. Yellow stars indicate a primary (first) Assessment Site, then blue stars show the location of a secondary Site for programs that were awarded ongoing expansion funds. The one exception to this is Arlington county, which operates two locations, however the proximity does not allow for separate Site identification on the map shown.

Placement within a program's catchment area is often a challenge, and is dependent upon resources, willing partners, and feasibility to obtain maximum consumer and law enforcement benefit. Medical clearance is required to rule out medical reasons for observed symptoms as well as prior to placement within an inpatient hospital bed. The geography in some localities would make use of a Site on one end of a catchment area prohibitive because of the amount of travel time required.

The map above also reveals that some areas are still without operational CIT Assessment Site programs. The challenges in establishing and maintaining CIT programs and the accompanying infrastructure for CIT based interventions are part of an ongoing conversation within DBHDS, the Virginia CIT Coalition, and willing localities.

Future Outlook for Law Enforcement Interventions

There are many different types of programs that can have success with diverting consumers in crisis prior to entry into the criminal justice system. The CIT Assessment Site model is only one of the programs that meets the basic needs of many in the Commonwealth, however it is only one piece of a multi-faceted approach to intervention and care.

Diversion programs operate at all points of the Sequential Intercept model; Assessment Sites provide intervention and services at Intercept 1, some of which already exist within Virginia, to provide appropriate and effective interventions for those in crisis. Mobile crisis teams involving clinicians meeting the needs of consumers at the location of the crisis with or without law enforcement occurs in several communities, and is successful for some immediate psychiatric needs. Co-responder programs, pairing emergency services clinicians with law enforcement in the field has been used in Virginia as well as other states, and it provides immediate intervention for consumers in need while also reducing the need for psychiatric intervention on the part of law enforcement officers.

A number of localities around the country have created 23 hour care programs that have an entry point very similar to one of Virginia's Assessment sites. These particular programs, which operate under multiple names, provide immediate recovery support including access to a psychiatrist, medications, basic medical evaluation, and Peer Specialist services in an outpatient setting.

The continued difficulty in finding places for those in need of inpatient hospitalization makes it ever more necessary to continue to explore the connections between services within the greater mental health treatment system. It is important to understand the interrelationships between available bed space and the need for emergency placements of those in custody. In understanding the greater connections in systemic care it is also important to realize that finding less restrictive ways to care for consumers in the community keeps from unduly clogging misdemeanor criminal dockets and utilizing the scarce beds needed by those in need of more intensive inpatient care. Our Intercept One diversion programs create opportunities for consumers to start out in the right direction toward recovery and help consumers move toward other services that have just begun growing under the STEP Virginia plan.

The growth of CIT and the Assessment Site program in Virginia has been tremendous over the past few years. There are however, localities that are still in need of CIT training and infrastructure which has been able to be provided to many others through the Assessment Site funding program. As the general assembly, its work groups, and committees continue to explore new avenues of funding and program growth we will be able to determine how best to expand upon the services currently supported.

CIT & Diversion Programs

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Collaborate. Innovate. Transform.

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CIT Requires Multi-Agency Collaboration

The Office of Forensic Services manages the CIT Assessment Site award funding program however the Crisis Intervention Team program is result of local program stakeholders as well as state agency coordination. The collaboration that makes diversion programs successful on the local level is also required to successfully administer the program at the state level.

The Department of Criminal Justices Services provides support and technical assistance to CIT programs in individual localities as well as assistance to the office of Forensic Services.

The Virginia CIT Coalition is a non-profit organization of members from partnership regions around the Commonwealth. This group determines policy and guidance for voluntary members programs in over 30 localities. DBHDS maintains a close partnership with this body in order to ensure the direction and progress of CIT Assessment Sites align with the needs of Virginia's consumers and with the best practices shared through training programs.

In addition to relationships and coordination within the Commonwealth, we have been able to share knowledge with programs across the country by participating in and presenting at conferences, forums, and summits. The collaborative effects of CIT and its components are what has allowed it to grow from a single city in 1989 to the world wide program it is today, and DBHDS strives to continue to strengthen the bonds that support our success in behavioral health diversion efforts.