Assessing the Impact and Effectiveness of Virginia's Crisis Intervention Team Programs FY2011 (§ 9.1-190)

Department of Criminal Justice Services and
Department of Behavioral Health and Developmental Services

November 15, 2011

Table of Contents

Legislative Directive 3
Introduction 3
Sequential Intercept Model 4
Crisis Intervention Team Program Description 6
Assessing the Development and Expansion of CIT 7
Cumulative Summary 2001 - 2011 8
CIT Initiatives Funding Summary 9
Key Elements of CIT Programs Status 9
Virginia CIT Coalition 15
Future Trends and Challenges for Virginia CIT 16
Prioritization of Programmatic Needs 177
Data Collection 18
Improving Access to Services 199
Conclusion 19
Additional References 20
Appendix 1: Executive Order 98, Establishing the Commonwealth Consortium for Mental Health/Criminal Justice Transformation 211
Appendix 2: Code of Virginia, 9.1-102, 9.1-187-190 233
Appendix 3: Virginia CIT Coalition Organizational Chart & Advisory Council Membership . 255
Appendix 4: Impact of CIT Program Training 266
Appendix 5: Impact of CIT Programs Community and Infrastructure Development 29
Appendix 6: VACIT Coalition Survey Results – Current Needs of Virginia CIT Programs 34
Appendix 7: VACIT Coalition Survey Results – Level of Importance to the Success of CIT Programs 35
Appendix 8: Summary of Currently Operating CIT Assessment Sites 365

Legislative Directive

Legislation passed in the 2009 General Assembly Session amended Sections 9.1-102, 9.1-187, 9.1-188, 9.1-189 and 9.1-190 of the *Code of Virginia* directing the Department of Criminal Justice Services (DCJS) and the Department of Behavioral Health and Developmental Services (DBHDS) to "…support the development and establishment of crisis intervention team programs in areas throughout the Commonwealth." The legislation also set forth criteria for the two departments to use in implementing its provisions, directed that an initial status report be submitted to the Joint Commission on Health Care (JCHC) in November 2009 and that the departments submit an annual report in 2009, 2010 and 2011, assessing the impact and effectiveness of crisis intervention team programs in meeting statutory program goals. Herein is the final assessment report in accordance with § 9.1-190.

Introduction

The Commonwealth of Virginia is making great strides in identifying and addressing the challenges encountered when individuals with behavioral health issues become entangled with the criminal justice system. Beginning with its Systems Transformation initiative in 2002, the Department of Behavioral Health and Developmental Services (DBHDS) focused significant attention on criminal justice issues within the behavioral health system through the work of its Forensic Special Populations Workgroup[1]. The Department of Criminal Justice Services (DCJS) developed a white paper on Mental Health Issues in Jails and Detention Centers[2] as part of its 'Blueprints for Change' series. Since 2007, the State Compensation Board has utilized an annual survey of Virginia's 68 local and regional jails as the basis for developing its Mental Illness in Jails Reports to the General Assembly, pursuant to Acts of Assembly, 2008 Session, Chapter 879, §53.1-83.1, §53.1-84 and §53.1-85, Code of Virginia[3], the latest of which is scheduled for publication on October 1, 2011.

In October, 2006, when the Supreme Court of Virginia established the Virginia Commission on Mental Health Law Reform, it specified the inclusion of a Criminal Justice Workgroup with broad criminal justice and behavioral health stakeholder participation to develop recommendations for improving the behavioral health and criminal justice (BHCJ) systems interface. In response to the Commission's initial recommendations published in 2007[4], the

---

[1] http://www.dbhds.virginia.gov/documents/omh-mhtsigapplication.pdf
[2] http://www.dcjs.virginia.gov/blueprints/mentalhealthissues.pdf
[3] Item 70, Paragraph L: "The Compensation Board shall provide an annual report on the number and diagnoses of inmates with mental illnesses in local and regional jails, the treatment services provided, and expenditures on mental health programs.
[4] A Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform, http://www.courts.state.va.us/programs/cmh/2007_0221_preliminary _report.pdf

Commonwealth Consortium for Mental Health and Criminal Justice Transformation[5] (Consortium) was created to bring together state agencies, as well as statewide advocacy and constituency organizations representing affected stakeholders, to develop and support policy and training to improve systems interoperability and identify training needs and options.
There was not a need to renew the Consortium's Executive Order mandate because so much progress was made in a short period of time, and it expired on June 30, 2011. However, the Consortium's legacy as the vehicle for identifying and supporting programmatic and training activity to enhance cross system collaboration and criminal justice response to individuals with mental illness will impact the Commonwealth for many years to come.

As a direct result of the Consortium's work, Virginia undertook a statewide initiative to provide localities with a means to understand and address local systems' interface, utilizing the Sequential Intercept Model. One effective means of accomplishing this has been by providing professionally facilitated Cross Systems Mapping Workshops to communities across the state. Utilization of the Sequential Intercept model as a framework for understanding, discussing and improving the behavioral health and criminal justice interface is now ubiquitous across the Commonwealth, from local and regional groups to statewide efforts like Governor McDonnell's Virginia Prisoner and Juvenile Reentry Council[6], and the Alternatives for Non-violent Offenders Task Force. The latter two include mental health and substance abuse issues workgroups.

In 2009, sections 9.1-102, 9.1-187, 9.1-188, 9.1-189 and 190 of the *Code of Virginia* were amended, directing the DCJS in conjunction with the DBHDS to "…support the establishment of crisis intervention team programs in areas throughout the Commonwealth." [7] Crisis Intervention Team (CIT) program development has coincided with and been enhanced by the improved understanding of the nexus between the criminal justice and behavioral health systems. The Consortium's work fully embraced the training, programmatic and collaborative systems changes engendered by the development of CIT programs across the state.

Sequential Intercept Model

The Sequential Intercept Model provides a framework for understanding the correlative processes of the behavioral health and criminal justice systems by identifying five discrete points of intersection between the systems. These five 'intercept points' represent the most effective stages in the criminal justice process for ***identification*** of individuals with behavioral health disorders, ***intervention*** through training and improved access to services in the least restrictive means consistent with the goals of public safety and ***impact*** on producing positive change for systems and individuals.

These five 'intercept points' are listed below and displayed in Figure 1:

1. Law Enforcement and Emergency Services (e.g., Crisis Intervention Teams)

---

[5] **See Executive Order 98, attached hereto as Appendix 1: Establishing the Commonwealth Consortium for Mental Health/Criminal Justice Transformation**
[6] http://www.governor.virginia.gov/PolicyOffice/ExecutiveOrders/pdf/EO_11.pdf
[7] **See Code sections, attached hereto as Appendix 2: Code of Virginia, 9.1-102, 9.1-187-190**

2. Initial Detention and Initial Court Hearings (e.g., Post Booking Jail Diversion)
3. Jails, Courts, Forensic Evaluations, and Forensic Commitments (e.g., Mental Health Courts)
4. Re-entry from Jails, State Prisons, and Forensic Hospitalization (e.g., Reentry Programs)
5. Community Corrections and Community Support Services (e.g., Probation/Mental Health Partnership Programs)

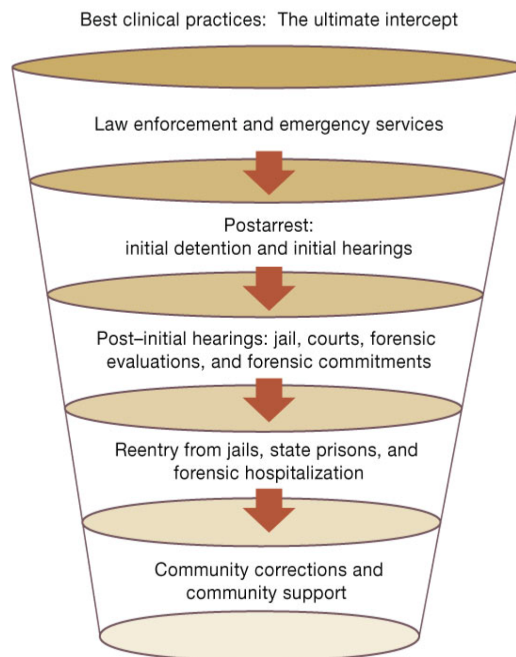


Figure 1: Sequential Intercept Model

The depiction in Figure 1 illustrates the five intercept points as a funnel or filter, identifying individuals with mental illness and diverting them before they reach the next filter. At the first intercept, CIT programs have the greatest opportunity to identify, intervene with and divert persons with behavioral health issues. Ideally, at each subsequent point, ever fewer people with mental illness remain in the system. Those that penetrate more deeply into the criminal justice system (where meeting their needs is more costly to both the criminal justice and behavioral health systems), are, ideally, only those most appropriate to remain in the system due to the serious nature of their crimes or other criminogenic risk factors. This process is accomplished by:

- Preventing, when appropriate, initial involvement in the criminal justice system;
- Decreasing unnecessary jail admissions;
- Engaging individuals in treatment as rapidly as possible;
- Reducing time spent going through the criminal justice system;
- Connecting individuals to community treatment and services following release from incarceration;
- Decreasing criminal recidivism rates; and
- Enhancing public safety.

Crisis Intervention Team Program Description

Crisis Intervention Team (CIT) Programs represent the premier first intercept, police based, mental health crisis response initiatives in the nation. They provide a community supported, enhanced local law enforcement based capability to respond to situations involving individuals with symptomatic behavioral health issues. CIT brings together local stakeholders, including law enforcement, emergency dispatchers, mental health treatment providers, consumers of mental health services and others (such as hospitals, emergency medical care facilities, non-law enforcement first responders, and family advocates), in order to improve and coordinate criminal justice and behavioral health system responses to persons experiencing behavioral health crises who come into contact with law enforcement Such individuals may come to the attention of law enforcement and other first responders or corrections and jail personnel because they are exhibiting symptoms or behaviors that are misinterpreted as criminal in nature, inappropriate, dangerous or violent. Additionally, law enforcement officers routinely interact with individuals with behavioral health disorders as a result of the statutory structure of Virginia's civil commitment process. In many of these situations, it is necessary to help such people access mental health treatment, or place them in custody and seek either mental health treatment referral or incarceration for criminal acts.

CIT programs are more than simply excellent mental health crisis response training, although that is a core component of successful CIT implementation. CIT programs additionally require enhanced community support and collaboration, the development of effective cross-systems infrastructure *and* effective law enforcement training to improve BHCJ systems' response to individuals with mental health issues. As a result of continuing demand for and growth of these comprehensive CIT programs in Virginia throughout the early 2000's, the 2009 General Assembly amended the *Code of Virginia* to direct DCJS in conjunction with DBHDS to "…support the establishment of crisis intervention team programs in areas throughout the Commonwealth."

The goals for CIT programs are included in the *Code of Virginia*, §9.1-187, and are generally oriented toward the reduction of both law enforcement official and civilian injuries, the reduction in arrests of persons in behavioral health crisis, improvements in access and linkage to appropriate community treatment and support, and the promotion of dignity and respect for individuals with behavioral health disorders. Additionally, in 2011, DBHDS and DCJS established a guidance document; *Essential Elements for the Commonwealth of Virginia's CIT Programs* (see further explanation, *infra*).

At its core, CIT provides 1) law enforcement-based crisis intervention training for assisting individuals with a mental illness; 2) a forum to promote effective systems change and problem solving regarding interaction between the criminal justice and mental health care systems; and, 3) improved community-based solutions to enhance access to services for individuals with mental illness. Successful CIT programs improve officer and consumer safety, and appropriately redirect individuals with mental illness from the criminal justice system to the health care system.

Assessing the Development and Expansion of CIT

Ten years ago, the first comprehensive CIT program in Virginia began in the New River Valley. This also marked the first rural multi-jurisdictional program in the nation based on the Memphis Model of CIT. This program continues to thrive and includes 14 law enforcement agencies within four counties and one city.

Twenty two other communities are working on CIT initiatives or have successfully developed CIT programs across 92 Virginia localities. In their initial report to the General Assembly, DCJS and DBHDS developed definitions for delineating program status. As of the end of FY11, the 23 known CIT initiatives were categorized by their development status as follows[8]:

> **Operational:** Programs that have a stakeholder taskforce which meets regularly and provides program oversight and educational outreach, has a CIT coordinator in place, has trained the number of CIT officers necessary to provide 24/7 CIT response capability, has an established therapeutic assessment location or protocol in place and has begun collecting data to assess the efficacy of the program. There are currently nine operational programs in the Commonwealth. Hampton-Newport News, New River Valley, Thomas Jefferson Area and Virginia Beach CIT programs are examples of operational programs.
>
> **Developing:** At the present time, there are seven developing programs. Examples of developing programs include the Chesapeake, Henrico, Rappahannock Area and City of Richmond CIT programs. These programs that have a well-established stakeholder taskforce and CIT coordinator in place or dedicated leadership, and a significant number of CIT-trained Officers and CIT faculty, who are working toward the implementation of a therapeutic assessment location or the establishment of protocols to enhance service linkage in lieu of incarceration.
>
> **Planning:** Programs that are working to establish a stakeholder taskforce are currently studying the CIT model and providing initial officer and mental health provider training, and developing partnerships to address options for implementing assessment locations or establishing protocols to enhance linkage to services. Seven communities are in the planning stage of program development. Colonial Area, District 19, Middle Peninsula-Northern Neck and Rockbridge CIT initiatives are examples of communities in the planning phase.

From November, 2010 through June, 2011, one program moved from planning status to developing status and one program moved from developing status to operational status.

[8] **See complete list of programs by status in Appendix 3**

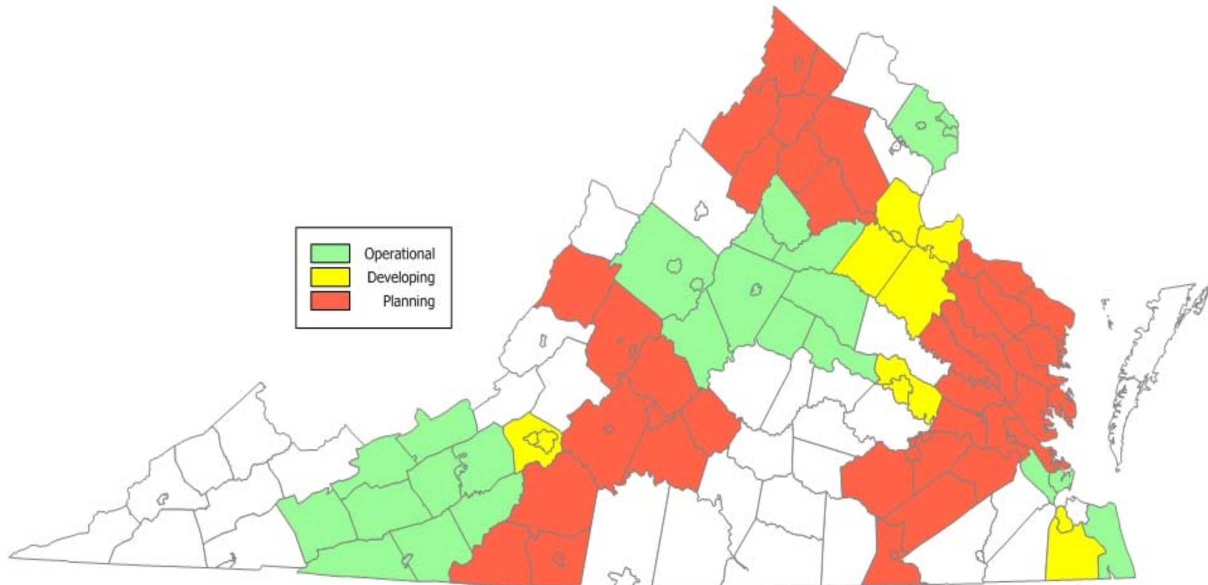


Figure 3: Geographical breakdown of Virginia's Crisis Intervention Team Initiatives by locality as of June 30, 2011

Since 2007, CIT continues expanding across the Commonwealth at a notably rapid pace. In that fiscal year, the New River Valley CIT (NRVCIT) program received an appropriation from the General Assembly to begin initial statewide expansion efforts. At the beginning of FY07, NRVCIT was the only program in the Commonwealth to meet the 'operational' definition. The program had conducted five 40-hour CIT trainings resulting in a total of 83 CIT-trained officers and deputies. CIT's growth since that time has been exponential, as illustrated by following cumulative outcomes as of June 30, 2011:

- 120 core 40-hour CIT trainings conducted across the Commonwealth
- 2,354 law enforcement officials completed 40 hour core CIT training
- 217 non-law enforcement first responders and corrections officers completed 40 hour core CIT training
- 165 mental health providers completed the 40 hour core CIT training
- 432 certified CIT trainers completed the 20-hour CIT Train the Trainer curriculum

Cumulative Summary 2001 - 2011	2001-2009	2010	2011	Total
40 hr Trainings Conducted	32	56	32	120
CIT Officers Trained	1,068	560	726	2,354

A table further detailing the statewide impact of CIT training through FY11, *Impact of Crisis Intervention Team Program Training*, is included in Appendix 4.

CIT Initiatives Funding Summary

Five programs – City of Richmond CIT, Henrico County CIT, Blue Ridge CIT, Alexandria CIT and Chesterfield CIT were awarded a third and final year of CIT start up funding made available through DBHDS jail diversion general funds and administered through DCJS. These five programs received annual funds of up to 50,000 for three years. Two programs, Arlington and District 19, received a second year of 75,000 in funding through DCJS Byrne JAG grant allocations. Hampton-Newport News CIT finished its final year of Byrne JAG grant funding in December, 2011. Virginia Beach CIT entered into its final year of Byrne JAG grant funding in FY12. Seven of the ten CSB site jail diversion 'cohort'[9] continue to utilize a portion of their funding to support CIT initiatives. These include: Arlington, Hampton-Newport News, Middle Peninsula-Northern Neck, New River Valley, Portsmouth, Rappahannock Area CSB and Virginia Beach.

Key Elements of CIT Programs Status

It is commonly said by one of CITs founders that "CIT is more than just training." This valuable point has not been lost in the development of Virginia's CIT initiatives. Over the past year, DCJS and DBHDS worked with the Virginia CIT Coalition Advisory Council to establish a limited number of uniform requirements, referred to as the "Essential Elements for the Commonwealth of Virginia's Crisis Intervention Teams," to assure that the basic structure of all CIT programs is consistent and effective throughout the state. A large portion of the writing, research and experiential data that led to the development of these uniform core elements was provided by the VACIT Coalition's working committees dedicated to various topical areas, which include Training, Community and Infrastructure, and Data and Evaluation. Feedback from Virginia CIT programs was also an important consideration for development of the uniform requirements. The "Essential Elements for the Commonwealth of Virginia's Crisis Intervention Teams" document received approval as the Commonwealth's guidance document for CIT programs in September, 2011.

The key areas of CIT program development and operation to which the uniform elements pertain are:

- Community stakeholder collaboration and oversight;
- CIT program coordination;
- 40-hour DCJS-certified core training for law enforcement personnel;
- Train-the-trainer classes for CIT program sustainability;
- Dispatcher training;
- Program policies and procedures;

[9] The 10 site jail diversion 'cohort' is a group of 10 CSBs awarded ongoing funding to support jail diversion programs, including CIT initiatives, beginning in 2009.

- Therapeutic assessment facility, or procedures, to streamline access to services in lieu of incarceration (when appropriate); and
- Collection of data to monitor statutory outcome measures.

These elements are central to the success of CIT programs and the achievement of CIT program goals in Virginia. Although each of the foregoing elements is required to be eligible for DCJS and DBHDS funding, and highly encouraged for all CIT programs operating statewide, at the same time the very essence of CIT model dictates that communities be afforded some flexibility in the development of their local programs as community needs and resources may require. To that end, in any case where a program desires to obtain a waiver of a specific essential element, it is able to do so by notifying the Virginia CIT Advisory Committee through its DCJS or DBHDS representatives, as indicated on the Virginia CIT website (http://www.vacitcoalition.org/), and submitting its request on the simple form. The Advisory Team then works with the program requesting the waiver to resolve the matter in a timely manner.

The discussion below includes a detailed description of these program elements, as well as progress across the state in implementing them. **Appendix 5, *Impact of Crisis Intervention Team Programs Community and Infrastructure Development*, summarizes the status of these three key elements of Virginia CIT programs.**

Community Collaboration and CIT Program Coordination

The existence of both the CIT coordinator and a community task force are critical to the achievement of program goals and objectives. CIT programs bring together professionals in a new and unique partnership - from mental health treatment and service providers, criminal justice and public safety, as well as consumers and community members. This requires close coordination, collaboration, problem-solving, and negotiation. Without one person tasked with facilitating this process and a local task force of the key stakeholders to work out details and reach consensus on the policies and procedures needed to reach those goals, the programs are significantly challenged.

An oversight committee of critical community partners is essential in order to guide the initial planning and implementation of a CIT program and provide ongoing oversight of the program's continued operation and sustainability, including critical incident review, funding, and community outreach and education. These committees have taken a variety of names, including oversight committee, advisory committee, task force, etc. At the conclusion of FY11, 16 Virginia CIT programs had such a committee in place that met regularly and of those committees 12 were providing program oversight and conducting community education and outreach in support of their programs.

Each CIT program requires a designated individual or individuals to serve as CIT Coordinator(s) in order to manage the various training and program elements, including day-to-day logistics of inter-departmental communication, data collection and management, scheduling trainings and working with the community oversight committee. The ideal candidate for the position of CIT Coordinator should possess a basic understanding of the issues confronting law enforcement and emergency services and should have pre-existing relationships and connections

to the law enforcement and mental health communities. At the conclusion of FY11, 16 Virginia CIT programs had a full- or part-time CIT coordinator.

Therapeutic Treatment Alternative

A 'therapeutic treatment alternative' is a catch all phrase describing a non-criminal justice location, mechanism or protocol that is created to more effectively divert appropriately identified individuals from incarceration into community care and treatment while also reducing officer involved time. It may consist of an actual physical location to which persons experiencing a mental health crisis may be taken for assessment, emergency treatment or stabilization, or it may consist of some other set of alternative means for handling people in this situation. Sometimes, it is a combination of the two.

The ideal for a CIT program is to have a physical location to which an officer can deliver a person in crisis that is *not* a jail or lock up and is always available. If the person is subject to an Emergency Custody Order (ECO) the officer could transfer custody to a willing program or site[10]. The person could also be brought to that site voluntarily. In either case, this kind of community alternative allows the officer to return to other duties while providing assessment and access to community based treatment options. Of course, a person for whom a therapeutic community based alternative is not appropriate due to the nature of a crime charged may well need mental health treatment and related care at the jail to which he is taken. Under those circumstances, effective CIT involvement is likely to reduce the difficulties which a jail might encounter with such a person who has been effectively identified as having a mental health issue or been involved in an appropriate CIT de-escalation.

Therapeutic treatment alternative sites are often the most challenging element for a CIT program to establish. The concept of a locally available, round the clock, secure facility for civil commitment assessment under an ECO is new to Virginia. They are not common in most localities, utilize different protocols where they do exist and are often challenged when it comes to providing the appropriate staffing levels, both from a security and a treatment resources aspect. At the conclusion of FY11, five CIT programs had developed an operational therapeutic alternative assessment site; one additional program, Arlington, brought their assessment site on line at the beginning of FY12, and information about that site is included in this report (**a summary of the six assessment sites is attached hereto as Appendix 8**). Six other programs are actively engaged in the development of such a site, and 10 have formal protocols in place to enhance access to services.

Data Collection

Data collection is essential for assessing the progress and impact of Virginia's CIT programs. The success of a CIT program is based upon the outcomes of its CIT Officers' response. Many incidents that, in the absence of CIT, typically lead to arrest and injuries may have resulted from contact with persons experiencing mental health crises for which the responding officers were not well trained or prepared to handle with alternatives to physical arrest. Identifying such incidents and alternative resolutions employed, is critical to measuring the success of a CIT program.

---

[10] See *Code of Virginia* § 37.2-808.E.

Initial efforts toward this end are focused on implementation of statewide data collection on four key statutory concerns regarding CIT interventions: 1) how CIT officers are linked to such calls; 2) how long a CIT officer remains involved in the call; 3) the number of injuries involved, if any; and, 4) the final disposition of the call. DCJS, DBHDS and Virginia CIT program stakeholders identified and agreed upon four key variables which all Virginia CIT programs are required to collect:

1. **Call Type:**
   - CIT officer dispatched to call for assistance with possible mental health involvement;
   - CIT officer dispatched to serve an ECO
   - CIT officer dispatched for wellness check; and
   - CIT officer self-initiated response on scene for any of the above.

2. **Time in Service for call:**
   - CIT officer spent less than 30 minutes;
   - CIT officer spent 30 minutes to 2 hours;
   - CIT officer spent 2 to 4 hours; and
   - CIT officer spent more than 4hours.

3. **On-scene Injuries:**
   - No injuries reported;
   - Injuries to officer(s);
   - Injuries to individual(s); and
   - Injuries to both officer(s) and individual(s).

4. **Call Disposition:**
   - Call cleared on scene with no additional action taken;
   - Individual transported to community treatment or services ;
   - Individual taken into civil custody by officer (ECO); and
   - Individual arrested.

These agreed upon variables represent outcomes measuring specific goals stated in the CIT legislation. They can be utilized to determine if CIT reduces the amount of time officers spend on mental health-related calls, if CIT decreases injuries to law enforcement and civilians, and if CIT reduces the inappropriate incarceration of persons in behavioral health crisis by linking them to necessary treatment and services in the community.

At the conclusion of FY11, ten CIT programs had established data collection processes, although only three programs had information compiled in time for this report. The data from these three programs (Arlington, New River Valley, and Rappahannock Area CIT programs) is presented below. The information is through FY11 and represents a total of 390 CIT calls from the three programs. A majority of the CIT calls (55%) are from the Arlington CIT program, 30% are from Rappahannock Area CIT, and the remaining 15% are from New River Valley CIT. The

information provided below provides a preliminary baseline for future assessment of program effectiveness.

Figure 4, below, represents data collected for the type of call to which CIT Officers and Deputies responded. A majority of CIT interventions (65%) were initiated through a dispatch request for law enforcement to serve an emergency custody order. Another 30% of interventions were initiated by a dispatched call for assistance with possible mental health involvement. 4% of documented CIT interventions were for dispatch requests for wellness checks on known or identified subjects, and 1% of interventions were self-initiated by CIT Officers or Deputies.

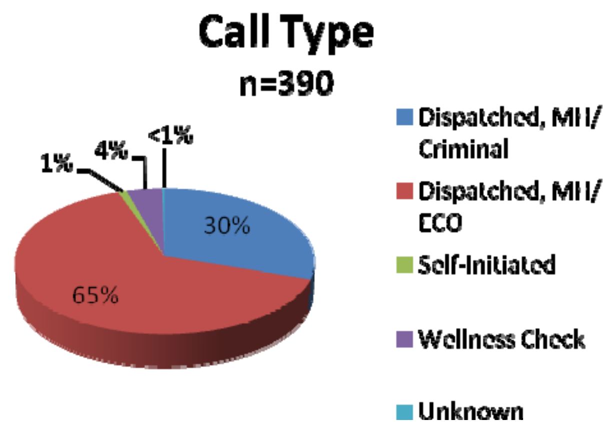


Figure 4: Preliminary Data, Type of CIT Call

Officer-involved time, or time in service, for CIT interventions is displayed in Figure 5, below. While 33% of CIT interventions are taking more than 4 hours, it is encouraging to note that 32% of reported interventions took 30 minutes to 2 hours. One of the objectives of the program is to reduce officer-involved time and as these programs develop the full capacity of therapeutic receiving facilities or enhance the efficiency of their alternative treatment protocols, the data should reflect continued reductions in the amount of time that CIT Officers are involved in CIT calls. 22% of reported CIT interventions took between 2 and 4 hours, and 9% lasted less than 30 minutes.

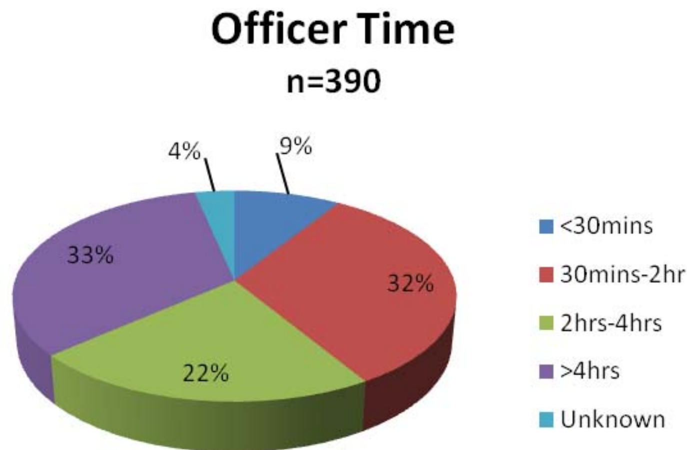


Figure 5: Preliminary Data, Officer-involved Time on CIT Intervention

On-scene injuries during a CIT intervention are reported, below, in Figure 6. It should be noted that on-scene injuries only refers to those which occur following the arrival of CIT Officers on-scene. At the present time, there is no unified metric for describing the nature of any injuries, so the extent of the reported injuries is not known. However, it is significant to note that all but 3 of the reported CIT interventions did not involve any Officer or civilian injuries. Of the 390 reported events, civilian subjects were injured in only 2 encounters; only 1 involved an injury to a CIT Officer, and 2 resulted in injuries to both an Officer and a civilian.

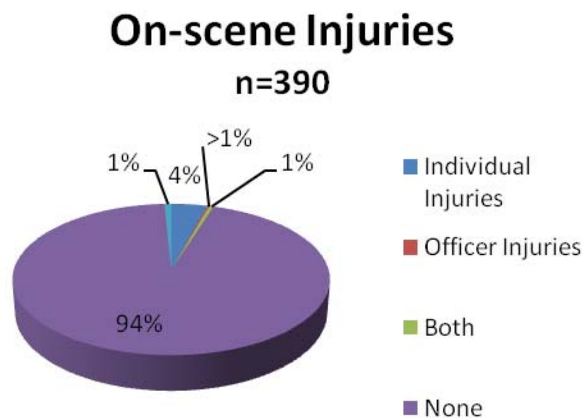


Figure 6: Preliminary Data, Officer and Civilian Injuries during CIT Interventions

The final disposition, or resolution, of CIT calls is documented below in Figure 7. 56% of CIT interventions resulted in an individual taken into civil custody with an ECO by an officer. Individuals were taken to community treatment facilities to receive services in 29% of CIT

interventions. 13% of CIT interventions were resolved on scene with no additional action taken by the responding officer, and only 1% of interventions resulted in arrest. Only three, or 1%, resulted in the arrest of an individual, which clearly points to the success of CIT in Virginia and the high quality of Virginia's CIT-trained Officers and Deputies.

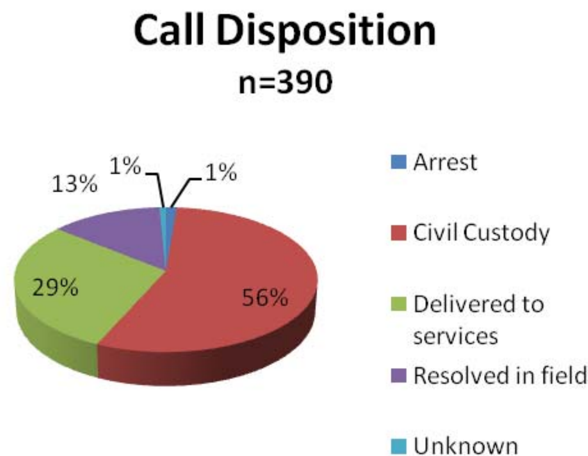


Figure 7: Preliminary Data, Disposition of CIT Call

Virginia CIT Coalition

DCJS and DBHDS began collaborating in advance of the July 1, 2009 effective date of the CIT legislation to develop a plan for organizing, assessing and reporting on the impact and effectiveness of CIT programs in meeting established goals. To support growth and development in all aspects of CIT programs, DCJS and DBHDS worked with Virginia's then existing CIT programs to create the Virginia CIT Coalition (VACIT). VACIT's mission is to promote and support the effective development and implementation of CIT programs in Virginia in order to improve the criminal justice and mental health systems and to help prevent the inappropriate incarceration of individuals with mental illness. Membership in VACIT is encouraged for all programs seeking state support and state-sponsored training and services and is open to all other interested stakeholders. VACIT was initially developed largely through the cooperation and leadership of three well established CIT programs – New River Valley, Thomas Jefferson Area, and Hampton-Newport News. CIT coordinators and stakeholders from these programs spent many hours working with DCJS and DBHDS to help identify needs and priorities for Virginia's CIT programs. The two departments later formalized this group through the creation of the VACIT Advisory Council. Council membership currently includes individuals from the Hampton-Newport News, Henrico, New River Valley, Thomas Jefferson Area, and Virginia Beach CIT programs. The Advisory Council meets quarterly to discuss strategic and emerging issues concerning the continued expansion of Virginia CIT programs and to plan for the meetings of the full VACIT Coalition. **Refer to Appendix 3 for the VACITs organizational structure and Advisory Council membership**.

Through these meetings and its website (www.vacitcoalition.org), VACIT provides a forum for the exchange of information, expertise and ideas benefitting all Virginia CIT programs. Specific needs and priorities for Virginia CIT programs identified by the Advisory Council include a variety of training and resource needs, assisting new programs in developing their community advisory task forces, and sharing policies, procedures, service and treatment access strategies, as well as data collection techniques. VACIT meetings have increased the capacity of planning and developing CIT initiatives with these needs through targeted breakout sessions with leadership from operational programs. The VACIT website also provides a lot of information and documents to assist programs. VACIT has brought nationally recognized speakers to talk to Coalition members, and conducted targeted trainings at the meetings, including a recent overview of traumatic brain injury for law enforcement officials and behavioral health workers to help enhance their knowledge and skills to identify and assist persons that may have such disorders.

Future Trends and Challenges for Virginia CIT

In September 2011, the City of Virginia Beach served as the site host for two interrelated CIT training conferences. With 221K in federal funding (Transformation Transfer Initiative competitive grant award to DBHDS through the National Association of State Mental Health Program Directors),DBHDS partnered with DCJS, the National Alliance on Mental Illness Virginia (NAMI VA), the City of Virginia Beach and the VACIT Coalition to provide a two-day, Virginia CIT-focused conference. In an innovative move, this state conference was planned with a focus on Virginia-specific CIT issues and other jail diversion strategies while also providing national training by overlapping with the 7th Annual Crisis Intervention Team International Conference (CIT I 2011). This model provided 335 Virginians, including NAMI-Virginia consumers and family members, existing Virginia CIT programs and those interested in starting CIT programs, the opportunity to participate together in a number of workshops aimed at Virginia-specific program development and information sharing. Two hundred Virginia CIT stakeholders received scholarships to attend one or both conferences through the federal allocation.

CIT I 2011 brought together nearly 1,200 participants to hear from Virginia and national experts on mental illness and violence, veterans' issues, CIT development and implementation, wellness/prevention for first responders, and to hear what works from those with lived experience.
Participants from 45 of the 50 states were in attendance. In addition to the 335 Virginia CIT stakeholders, other states well represented were North Carolina (75), Texas (47), Florida (46) and Utah (33). The conference also lived up to its international name, attracting a dozen Canadians, as well as Crisis Intervention Team leaders from Sweden, Australia, England and the Federated States of Micronesia.

The Commonwealth is already seeing benefits from hosting these conferences. First and foremost, Virginia CIT stakeholders were provided with additional training, technical assistance and examples of innovative and successful elements of CIT programs. Additionally, Virginia's profile as a national leader was substantially raised. However, even while deserving great credit for its work in developing CIT programs, the Commonwealth faces challenges in creating and

sustaining programs that can continue to meet statutory and programmatic goals. A discussion of some of the key challenges ahead follows.

Prioritization of Programmatic Needs

At the conclusion of FY11, VACIT surveyed local CIT program participants and other interested stakeholders to get their perspective on current program-specific needs and gauge their perception of the importance of specific program elements to the success of CIT programs generally. Of the 294 people receiving the survey, 169 responded, representing an impressive 57% response rate. Of these respondents, 50% self identified as law enforcement or criminal justice personnel, 24% as mental health professionals or administrators, and 17% as individuals with mental health conditions, family members of such individuals or advocates. An overwhelming majority of survey respondents were affiliated with operational CIT programs (60%), 22% were affiliated with developing programs, and CIT programs in the planning phase were represented by 18% of respondents. Interestingly, 34% of respondents were from communities that were not part of Virginia's 23 recognized CIT initiatives.

Survey respondents were asked to rate 10 program elements and supports in rank order for the survey's two primary questions. These program elements and supports were:

1. Community Collaboration and Program Oversight;
2. CIT Coordinator Position;
3. Training;
4. Policies and Procedures;
5. Therapeutic Receiving Facility;
6. Community-Based Services;
7. Data Collection;
8. Technical Assistance and Mentoring;
9. Grant Funding; and
10. Ongoing Funding.

The first question asked only of those involved in a CIT Program to rank the importance of these 10 elements to the current needs of their respective CIT program. Not surprisingly, the three most important needs were ongoing funding, grant funding, and a therapeutic receiving facility. By far, the biggest ongoing expense for a CIT program is the operation of a therapeutic receiving facility, which often presents obstacles for program development in many Virginia communities. The remaining elements and supports were fairly evenly rated. In descending order they were: training, community collaboration and program oversight, community-based services, CIT Coordinator position, policies and procedures, data collection, and technical assistance and mentoring.

The second question asked all respondents to rank each element in terms of its level of objective importance to the success of CIT programs overall, rather than subjectively identifying their own program needs. The results were similar to the previous question. Again, by far the highest ratings were given to ongoing and grant funding. However, community collaboration and oversight, training, and community-based services were rated of higher importance, while

therapeutic receiving facility was rated at lesser importance. The remaining elements were rated at, generally, the same level of importance.

Appendices 6 and 7 contain tables with the full breakout of survey responses noted above.

Data Collection

DCJS, DBHDS and VACIT recognize the importance of data collection to the measurement of program success and improvement. Despite the fact that Virginia CIT stakeholders agree with that the four data variables are appropriate and reasonable, getting consistent data from communities and law enforcement agencies across the state remains challenging.

Each Virginia law enforcement agency is locally autonomous in its operations and therefore each agency has discretion as to the type of communication system it utilizes to dispatch officers and the type of information system utilized to collect incident information. This has led to development of localized communications and management information systems that are not required to be uniform and consistent from one locality to the next, even in the same county. All Virginia law enforcement agencies collect significant operational data, but the fundamental problem with CIT program evaluation revolves around the acquisition of data sets for the purpose of efficiently compiling that information for comparison statewide. Some law enforcement agencies participate in regional dispatching operations, or share dispatching operations with one or more other agencies. In such cases, it can be problematic to acquire the specific type of data needed for the evaluation purposes of a CIT program. Establishing data collection guidelines and identifying necessary data elements is a priority for VACIT. This will result in better compilation and comparison of statewide data with which to evaluate the success of the many CIT programs in Virginia

The lack of a uniform statewide database or other information system in which to submit information, in addition to the insufficient financial and human resources to gather and report on data, pose challenges to statewide CIT program evaluation. The necessity for more local financial and human resources could potentially be minimized through the development and utilization of standardized reporting forms and formats supported by a local and statewide database that would receive, organize and extrapolate necessary CIT data.

To that end, DCJS awarded Byrne Justice Assistance Grant funds to support the Thomas Jefferson Area CIT program to develop a statewide CIT data collection and reporting system. The project has three primary objectives:

1) To provide all Virginia CIT programs with standardized forms and software to collect the necessary data elements;
2) To develop a web-based program for the submission of necessary data from all Virginia CIT programs; and
3) To provide the Commonwealth with access to and ownership of the forms, software, web-based program and data for Virginia CIT.

Improving Access to Services

The availability of therapeutic assessment sites and, through their utilization, access to an adequate array of community based services, is the greatest challenge to CIT program success. In addition to CIT training for criminal justice stakeholders and enhanced coordination between the criminal justice and behavioral health systems, a CIT program's success depends on a community's ability to provide effective alternatives to institutionalization – whether that institution is a jail or a hospital. This requires development of and access to a full continuum of community based options for people with mental illness.

Support for this continuum of care can be realized, in part, through more effective utilization of available resources. CIT has provided the opportunity for many communities to re-evaluate and re-direct their current resources to great impact. However, no community is currently capable of providing the CIT model's preferred 24/7 therapeutic assessment site. Several programs, however, are seeing successful outcomes utilizing assessment sites that are not fully available or fully operational. Valley CSB's Blue Ridge , Hampton-Newport News, Thomas Jefferson Area, Virginia Beach and the Rappahannock Area CIT programs have all developed assessment site capability which they utilize to the greatest extent their resources will allow. They continue struggling to support full 24/7 access for law enforcement and to provide the array of services that will continue to reduce incarceration and hospitalization.

Conclusion

In 2001, Virginia could boast only a handful of police departments with only a few CIT trained law enforcement first responders among them. In the past decade, Virginia has seen CIT grow from a single, experimental rural program in the New River Valley to the point where the state has become a nationally recognized leader in the field. The trajectory of this development can be traced from an initial allocation of expansion funds through the passage of precedent-setting legislation and the collaborative support of state, regional and local partners. As a result, initial findings are that law enforcement officers respond more effectively to calls involving mental health crisis; people with mental illness are more apt to be directed into the mental health system instead of the criminal justice system; and, communities, officers and individuals are reaping the benefits of improved systems response to people with mental illness.

Additional References

Blueprints for Change: Mental Health Issues in Jail and Detention Centers
http://www.dcjs.virginia.gov/blueprints/mentalhealthissues.pdf

Commission on Mental Health Law Reform: Criminal Justice Taskforce
http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/tf_criminal.pdf

Commission on Mental Health Law Reform: Preliminary Report
http://www.courts.state.va.us/programs/cmh/2007_0221_preliminary_report.pdf

Use of the Sequential Intercept Model as An Approach to Decriminalization of People with Mental Illness
http://psychservices.psychiatryonline.org/cgi/content/full/57/4/544

Virginia Prisoner and Juvenile Reentry Council
http://www.governor.virginia.gov/issues/ExecutiveOrders/2010/EO-11.cfm

2010 Report to the Joint Commission on Healthcare regarding Crisis Intervention Team Assessment
http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/1cf9d7d74e2382f1852576900071514f?OpenDocument

Appendix 1: Executive Order 98, Establishing the Commonwealth Consortium for Mental Health/Criminal Justice Transformation

National surveys have shown that 16% of all jail inmates have some form of mental illness. The 2005 Virginia Jail Survey yielded a similar prevalence in the Commonwealth of jail inmates with mental illness. These findings suggest that persons with mental illness are far too often subject to arrest and incarceration in Virginia for minor "nuisance" offenses related to their symptoms, and that many jail inmates with mental illness do not receive adequate mental health treatment in our jails, or when they return to the community. This lack of treatment access can lead to continuing acute illness or relapse, as well as engagement in criminal activity, including violent acts.

During the past decade, Virginia lawmakers and Executive Branch agencies have spearheaded efforts at identifying the needs of persons with mental illness who become involved with the criminal justice system. It is imperative that Virginia address the pressing public safety and treatment access challenges posed by the lack of adequate mental health treatment for persons with mental illness in the criminal justice system. Doing so will require that there be a coordinated effort across all branches of state government, as well as the active and direct development of community-based solutions to this serious social problem.

By virtue of the authority invested in me by Article V of the Constitution of Virginia and Section 2.2-134 of the Code of Virginia, I hereby direct the Office of the Secretary of Health and Human Resources and the Office of the Secretary of Public Safety to lead the Commonwealth Consortium for Mental Health/Criminal Justice Transformation, with the dual purpose of preventing unnecessary involvement of persons with mental illness in the Virginia criminal justice system, and promoting public safety by improving access to needed mental health treatment for persons with mental illness for whom arrest and incarceration cannot be prevented.

The Commonwealth Consortium shall be chaired by the Secretary of Health and Human Resources and the Secretary of Public Safety, or their designees. The Office of the Attorney General and the Secretary of Finance shall provide key leadership and guidance to the Consortium. The Virginia General Assembly and the Supreme Court of Virginia have been invited to participate as partners in the Consortium. Membership of the Consortium shall include Commissioners or Directors of the following state government agencies (or their designees) that have a current or potential central role in improving access to treatment for persons with mental disorders in the criminal justice system:

- Board for People with Disabilities
- Commonwealth Attorney's Services Council
- Department of Corrections
- Department of Correctional Education
- Department of Education
- Department of Health
- Department of Housing & Community
- Department of Juvenile Justice
- Department of Medical Assistance Services
- Department of Planning & Budget
- Department of Health Professions
- Department of Rehabilitation Services
- Department of Social Services
- Department of Veterans Services
- Governor's Office for Substance Abuse Prevention
- Office of the Comprehensive Services Act (CSA)
- Virginia Criminal Sentencing Commission

- Virginia Employment Commission
- Virginia Indigent Defense Commission
- Virginia Office of Protection and Advocacy (VOPA)
- Virginia State Crime Commission
- Virginia State Police

The following additional organizations shall be invited to serve as members of the Commonwealth Consortium:

- Mental Health America of Virginia (MHAV)
- NAMI Virginia and its state regional affiliates
- University of Virginia, Institute of Law, Psychiatry and Public Policy
- Virginia Association of Chiefs of Police
- Virginia Association of Community Services Boards (VACSB)
- Virginia Association of Counties
- Virginia Association of Regional Jails
- Virginia Bar Association
- Virginia Community Criminal Justice Association (VCCJA)
- Virginia Council on Juvenile Detention
- Virginia Municipal League
- Virginia Sheriffs' Association
- Virginia Hospital and Healthcare Association
- VOCAL Virginia

The Consortium shall have the following goals:

Goal I: Transformation planning:

The Consortium shall evaluate the viability of jail diversion models for persons with mental illness, and develop recommendations for improving access to mental health treatment for persons with mental illness who cannot be diverted from arrest and incarceration. Representatives from relevant stakeholder groups in each locality, including Community Criminal Justice Boards, Law Enforcement, Local and Regional Jails, Community Services Boards and Local Community Corrections, Mental Health Services Consumers, and other public and private organizations shall be invited to participate in comprehensive transformation planning for their regions.

Goal II: Establish a Criminal Justice/Mental Health Training Academy for the Commonwealth:

The Academy will provide an integrative locus for coordinating the training activities of currently disparate state and local, public and private organizations into a concerted program of cross-training for criminal justice and mental health personnel.

This Executive Order shall be effective upon its signing and shall remain in full force and effect until December 31, 2009, unless sooner amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 23rd day of January 2008.

/s/ Timothy M. Kaine, Governor

Appendix 2: *Code of Virginia*, 9.1-102, 9.1-187-190

§ 9.1-102. Powers and duties of the Board and the Department.

51. Assess and report, in accordance with § 9.1-190, the crisis intervention team programs established pursuant to § 9.1-187;

§ 9.1-187. Establishment of crisis intervention team programs.

A. By January 1, 2010, the Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services, utilizing such federal or state funding as may be available for this purpose, shall support the development and establishment of crisis intervention team programs in areas throughout the Commonwealth. Areas may be composed of any combination of one or more counties, cities, towns, or colleges or universities contained therein that may have law-enforcement officers as defined in § 9.1-101, or campus police officers appointed pursuant to the provisions of Chapter 17 (§ 23-232 et seq.) of Title 23. The crisis intervention teams shall assist law-enforcement officers in responding to crisis situations involving persons with mental illness, substance abuse problems, or both. The goals of the crisis intervention team programs shall be:

1. Providing immediate response by specially trained law-enforcement officers;

2. Reducing the amount of time officers spend out of service awaiting assessment and disposition;

3. Affording persons with mental illness, substance abuse problems, or both, a sense of dignity in crisis situations;

4. Reducing the likelihood of physical confrontation;

5. Decreasing arrests and use of force;

6. Identifying underserved populations with mental illness, substance abuse problems, or both, and linking them to appropriate care;

7. Providing support and assistance for mental health treatment professionals;

8. Decreasing the use of arrest and detention of persons experiencing mental health and/or substance abuse crises by providing better access to timely treatment;

9. Providing a therapeutic location or protocol for officers to bring individuals in crisis for assessment that is not a law-enforcement or jail facility;

10. Increasing public recognition and appreciation for the mental health needs of a community;

11. Decreasing injuries to law-enforcement officers during crisis events;

12. Reducing inappropriate arrests of individuals with mental illness in crisis situations; and

13. Decreasing the need for mental health treatment in jail.

B. The Department, in collaboration with the Department of Behavioral Health and Developmental Services, shall establish criteria for the development of crisis intervention teams that shall include assessment of the effectiveness of the area's plan for community involvement, training, and therapeutic response alternatives and a determination of whether law-enforcement officers have effective agreements with mental health care providers and all other community stakeholders.

C. By November 1, 2009, the Department, and the Department of Behavioral Health and Developmental Services, shall submit to the Joint Commission on Health Care a report outlining the status of the crisis intervention team programs, including copies of any requests for proposals and the criteria developed for such areas.

§ 9.1-188. Crisis intervention team training.

The Department, in consultation with the Department of Behavioral Health and Developmental Services and law-enforcement and mental health stakeholders, shall develop a training program for all persons involved in the crisis intervention team programs, and all team members shall receive this training. The curriculum shall be approved for Department-certified in-service training credits for law-enforcement officers from each crisis intervention team and shall include four hours of mandatory training in legal issues.

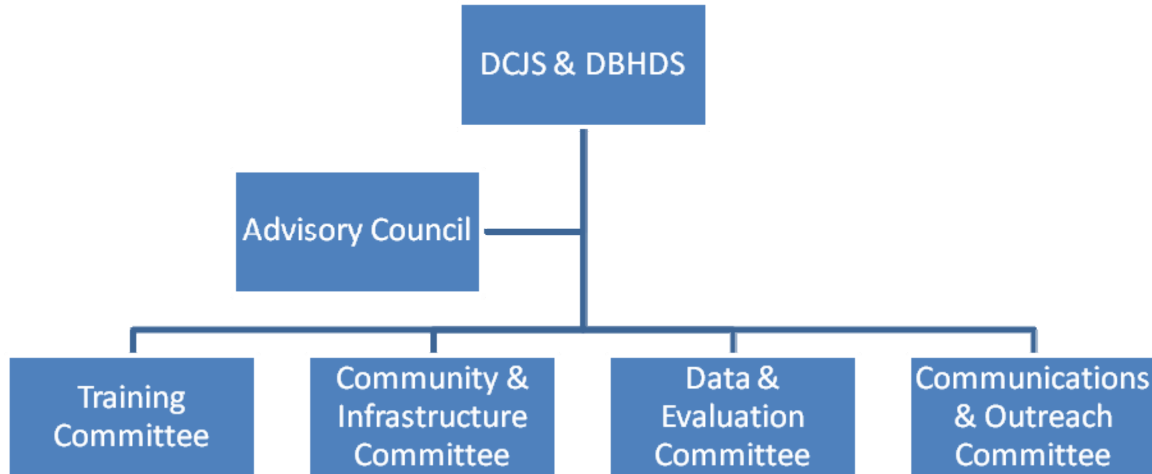
§ 9.1-189. Crisis intervention team protocol.

Each crisis intervention team shall develop a protocol that permits law-enforcement officers to release a person with mental illness, substance abuse problems, or both, whom they encounter in crisis situations from their custody when the crisis intervention team has determined the person is sufficiently stable and to refer him for emergency treatment services.

§ 9.1-190. Crisis intervention team program assessment.

The Department, and the Department of Behavioral Health and Developmental Services, shall assess and report on the impact and effectiveness of the crisis intervention team programs in meeting the program goals. The assessment shall include, but not be limited to, consideration of the number of incidents, injuries to the parties involved, successes and problems encountered, the overall operation of the crisis intervention team programs, and recommendations for improvement of the program. The Department, and the Department of Behavioral Health and Developmental Services, shall submit a report to the Joint Commission on Health Care by November 15, 2009, 2010, and 2011.

Appendix 3: Virginia CIT Coalition Organizational Chart & Advisory Council Membership



VACIT Advisory Council Members

Dean Barker, CIT/Jail Services Coordinator, Hampton-Newport News Community Services Board

Steve Clark, Coordinator, Office of Campus Policing & Security, DCJS

Victoria Cochran, State Coordinator for Criminal Justice and Behavioral Health Initiatives, DBHDS

William Dean, Police Captain, Virginia Beach Police Department

Patrick Halpern, Executive Director, Mental Health Association of the New River Valley

Thomas von Hemert, CIT Coordinator/Community Criminal Justice Planner, Offender Aid and Restoration of Charlottesville

Nicolette Moon, CIT Coordinator Henrico Area Mental Health & Developmental Services Board

Andy Warriner, Director, Hampton-Newport News Criminal Justice Agency

Mary Witwer, CIT Coordinator/Emergency Services Coordinator, Virginia Beach Department of Human Services

Cynthia Wood, Police Lieutenant, Henrico County Division of Police

Joseph Yost, Jail Diversion Coordinator, Mental Health Association of the New River Valley

Appendix 4: Impact of CIT Program Training

Program Affiliated CSB Program Name *Localities*	Program Status	40 Hour CIT Trainings Held	CIT Officers Trained	Other First Responders Trained	Non First Responders Trained	40 Hour Faculty Trained (TTT)
STATEWIDE TOTALS	7 Planning 7 Developing 9 Operational **23 Total**	120	2,354	217	165	432
Alexandria CSB **City of Alexandria CIT** *City of Alexandria*	Operational	4	75	5	2	8
Arlington County CSB **Arlington County Crisis Intervention Team** *Arlington*	Operational	5	112	13	6	18
Central Virginia CSB **Central Virginia CIT Initiative** *Amherst, Appomattox, Bedford, Campbell, and the Cities of Bedford and Lynchburg*	Planning[10]	0	0	0	0	0
Chesapeake CSB **Chesapeake CIT** *City of Chesapeake*	Developing[11]	7	145	0	4	18
Colonial CSB **Colonial Area CIT** *Charles City, James City, New Kent, York and the Cities of Poquoson and Williamsburg*	Planning[12]	0	0	0	0	0
District 19 CSB **District 19 CIT Initiative** *Dinwiddie, Greensville, Prince George, Surry, Sussex and the Cities of Colonial Heights, Emporia, Hopewell and Petersburg*	Planning	0	18	0	0	14

[11] Developing programs are those that have a well established stakeholder task force with a CIT coordinator in place, have a significant number of trained local CIT officers and CIT faculty and are working toward the implementation of a therapeutic assessment location or establishing protocols to enhance linkage to services in lieu of incarceration.
[2] Planning programs are those that are establishing a stakeholder task force, studying the CIT model, providing initial officer and mental health provider training and developing partnerships to address options for implementing assessment locations or establishing protocols to enhance linkage to services.

Program Affiliated CSB Program Name *Localities*	Program Status	40 Hour CIT Trainings Held	CIT Officers Trained	Other First Responders Trained	Non First Responders Trained	40 Hour Faculty Trained (TTT)
Fairfax-Falls Church CSB Fairfax Crisis Intervention Team *Fairfax and the Cities of Falls Church and Fairfax*	Operational	2	150	0	0	2
Hampton-Newport News CSB Hampton/Newport News CIT *Hampton, Newport News*	Operational[13]	12	261	44	18	80
Henrico Area Mental Health and Retardation Services Henrico CIT *Henrico County*	Developing	11	161	141	12	35
Middle Peninsula-Northern Neck CSB Middle Peninsula Northern Neck CIT *Essex, Gloucester, King & Queen, King William, Lancaster, Matthews, Middlesex, Northumberland, Richmond and Westmoreland*	Planning	0	0	0	0	6
Mount Rogers CSB Mount Rogers Community Services Board Crisis Intervention Team *Bland, Carroll, Grayson, Wythe, Smyth, City of Galax*	Operational	9	138	0	0	20
New River Valley Community Services New River Valley CIT *Floyd, Giles, Montgomery, Pulaski and City of Radford*	Operational	16	304	0	34	57
Northwestern Community Services Northwestern CIT *Clarke, Frederick, Page, Shenandoah, Warren and the City of Winchester*	Planning	4	60	4	16	14

[3] Operational programs have a stakeholder task force which meets regularly and provides program oversight and educational outreach, has a CIT coordinator in place, has trained the number of CIT officers necessary to provide 24/7 CIT response capability, has an established therapeutic assessment location or protocol in place and has begun collecting data to assess the efficacy of the program.

Program Affiliated CSB **<u>Program Name</u>** *Localities*	**Program Status**	**40 Hour CIT Trainings Held**	**CIT Officers Trained**	**Other First Responders Trained**	**Non First Responders Trained**	**40 Hour Faculty Trained (TTT)**
Piedmont Community Services **<u>Piedmont Area CIT Initiative</u>** *Franklin, Henry, Patrick and the City of Martinsville*	Planning	0	0	0	0	0
City of Portsmouth Dept. of Behavioral Healthcare Services **<u>Portsmouth CIT</u>** *Portsmouth*	Developing	2	24	3	0	4
Rappahannock Area CSB **<u>Rappahannock Area Crisis Intervention Team</u>** *Caroline, King George, Spotsylvania and Stafford Counties; City of Fredericksburg*	Developing	3	61	0	0	5
Rappahannock-Rapidan CSB **<u>Rappahannock-Rapidan CIT</u>** *Culpepper, Fauquier and Rappahannock*	Planning	0	0	0	0	0
Richmond Behavioral Health Authority **<u>City of Richmond Crisis Intervention Team</u>** City of Richmond	Developing	3	34	0	3	27
Blue Ridge Behavioral Health Care **<u>Roanoke Valley CIT</u>** *Roanoke and the Cities of Salem and Roanoke*	Developing	2	40	0	0	0
Rockbridge Area CSB **<u>Rockbridge Crisis Intervention Team</u>** *Bath, Rockbridge and the Cities of Lexington and Buena Vista*	Planning	0	0	0	0	0
Region 10 CSB **Thomas Jefferson Area CIT** *Albemarle, Fluvanna, Goochland, Greene, Louisa, Madison, Nelson, Orange, City of Charlottesville*	Operational	25	500	0	23	64

Program Affiliated CSB Program Name *Localities*	Program Status	40 Hour CIT Trainings Held	CIT Officers Trained	Other First Responders Trained	Non First Responders Trained	40 Hour Faculty Trained (TTT)
Valley CSB **Blue Ridge Crisis Intervention Team** *Augusta, Cities of Waynesboro and Staunton*	Operational	9	142	7	11	21
Virginia Beach Human Services **Virginia Beach CIT** *Virginia Beach*	Operational	6	129	0	25	39

Appendix 5: Impact of CIT Programs Community and Infrastructure Development

Program Affiliated CSB Program Name *Localities*	CIT Program Coordinator	Data Collection Process in Place	Therapeutic Assessment Site	Therapeutic Assessment Alternative Options	CIT Task Force
Alexandria CSB **City of Alexandria CIT** *City of Alexandria*	Yes	Yes	No	• Yes • Existing Memoranda Of Understandings (MOU) • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and community outreach
Arlington County CSB **Arlington County Crisis Intervention Team** *Arlington*	Yes	Yes	Yes (As of July, 2011)	• No • Planning underway for therapeutic assessment site • Enhanced access to services in place	• Meets monthly • All CJ/BH stakeholders represented • Program oversight and community outreach • Cross systems mapping completed
Chesapeake CSB **Chesapeake CIT** *City of Chesapeake*	Yes	No	No	No	• Meet bi-monthly • All CJ/MH stakeholders represented • Program oversight and public outreach • Cross Systems Mapping completed
Colonial CSB **Colonial Area CIT** *Charles City, James City, New Kent, York and the Cities of Poquoson and Williamsburg*	No	No	No	No	• CCJB involved in planning • Cross Systems Mapping completed

Program Affiliated CSB **Program Name** *Localities*	CIT Program Coordinator	Data Collection Process in Place	Therapeutic Assessment Site	Therapeutic Assessment Alternative Options	CIT Task Force
District 19 CSB **District 19 CIT Initiative** *Dinwiddie, Greensville, Prince George, Surry, Sussex and the Cities of Colonial Heights, Emporia, Hopewell and Petersburg*	Yes	No	No	No	• CCJB involved in planning • Cross Systems Mapping completed
Fairfax-Falls Church CSB **Fairfax Crisis Intervention Team** *Fairfax and the Cities of Falls Church and Fairfax*	Yes	No	No	• No • Enhanced access to services in place	No
Hampton-Newport News CSB **Hampton/Newport News CIT** *Hampton, Newport News*	Yes	Yes	Yes	• Yes • Therapeutic assessment site	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and community outreach • 2 cross systems mappings completed
Henrico Area Mental Health and Retardation Services **Henrico CIT** *Henrico County*	Yes	Yes	No	• No • Planning underway for therapeutic assessment site	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and public outreach
Middle Peninsula-Northern Neck CSB **Middle Peninsula Northern Neck CIT** *Essex, Gloucester, King & Queen, King William, Lancaster, Matthews, Middlesex, Northumberland, Richmond and Westmoreland*	Yes	No	No	No	No
Mount Rogers CSB **Mount Rogers Community Services Board Crisis Intervention Team** *Bland, Carroll, Grayson, Wythe, Smyth, City of Galax*	Yes	Yes	No	• Yes • Planning underway for therapeutic assessment site • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and community outreach

Program Affiliated CSB **Program Name** *Localities*	CIT Program Coordinator	Data Collection Process in Place	Therapeutic Assessment Site	Therapeutic Assessment Alternative Options	CIT Task Force
New River Valley Community Services **New River Valley CIT** *Floyd, Giles, Montgomery, Pulaski and City of Radford*	Yes	Yes	No	• Yes • Existing Memoranda of Understandings (MOU) • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and community outreach
Northwestern Community Services **Northwestern CIT** *Clarke, Frederick, Page, Shenandoah, Warren and the City of Winchester*	Yes	No	No	No	No
Piedmont Community Services **Piedmont Area CIT Initiative** *Franklin, Henry, Patrick and the City of Martinsville*	No	No	No	No	• Meet bi-monthly • All CJ/MH stakeholders represented • Cross Systems Mapping completed
City of Portsmouth Dept. of Behavioral Healthcare Services **Portsmouth CIT** *Portsmouth*	No	No	Status uncertain	• Yes • Therapeutic assessment site alternative • Enhanced access to services in place	• Meet bi-annually • All CJ/MH stakeholders represented • Community outreach
Rappahannock Area CSB **Rappahannock Area Crisis Intervention Team** *Caroline, King George, Spotsylvania and Stafford Counties; City of Fredericksburg*	Yes	Yes	Yes	• Yes • Therapeutic assessment site alternative under development • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and Community outreach • Cross systems mapping completed
Rappahannock-Rapidan CSB **Rappahannock-Rapidan CIT** *Culpepper, Fauquier and Rappahannock*	No	No	No	No	No

Program Affiliated CSB **Program Name** *Localities*	CIT Program Coordinator	Data Collection Process in Place	Therapeutic Assessment Site	Therapeutic Assessment Alternative Options	CIT Task Force
Richmond Behavioral Health Authority **City of Richmond Crisis Intervention Team** City of Richmond	Yes	Yes	No	• No • Therapeutic assessment site alternative under development • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and community outreach • Cross Systems Mapping completed
Blue Ridge Behavioral Health Care **Roanoke Valley CIT** *Roanoke and the Cities of Salem and Roanoke*	No	No	Status uncertain	• No • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Cross Systems Mapping completed
Rockbridge Area CSB **Rockbridge Crisis Intervention Team** *Bath, Rockbridge and the Cities of Lexington and Buena Vista*	No	No	No	• No • Planning underway for therapeutic assessment site and/or develop protocols to enhance access to services	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and communityoutreach
Region 10 CSB **Thomas Jefferson Area CIT** *Albemarle, Fluvanna, Goochland, Greene, Louisa, Madison, Nelson, Orange, City of Charlottesville*	Yes	Yes	Yes	• Yes • Therapeutic assessment site alternative • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Cross systems mapping completed
Valley CSB **Blue Ridge Crisis Intervention Team** *Augusta, Cities of Waynesboro and Staunton*	Yes	Yes	Yes	• Yes • Therapeutic assessment site alternative being developed • Memoranda Of Understandings (MOU) in place • Enhanced access to services in place	• Meet quarterly • All CJ/MH stakeholders represented • Program oversight and community outreach
Virginia Beach Human Services **Virginia Beach CIT** *Virginia Beach*	Yes	Yes	Yes	• Yes • Therapeutic assessment site alternative • Enhanced access to services in place	• Meet bi-monthly • All CJ/MH stakeholders represented • Program oversight and community outreach • Cross systems mapping completed

Appendix 6: VACIT Coalition Survey Results – Current Needs of Virginia CIT Programs

Program Element	Rank Order Importance									
	1	2	3	4	5	6	7	8	9	10
1. Ongoing Funding	54%	7%	4%	6%	7%	4%	3%	1%	2%	12%
2. Grant Funding	**45%**	7%	11%	3%	14%	1%	3%	2%	5%	8%
3. Therapeutic Assessment Center	**40%**	16%	10%	5%	4%	2%	3%	7%	7%	8%
4. Training	**29%**	15%	10%	3%	11%	0%	3%	12%	2%	16%
5. Community Collaboration & Program Oversight	**22%**	9%	12%	10%	13%	9%	2%	8%	4%	10%
6. Community-based Services	**21%**	10%	18%	10%	14%	10%	4%	3%	7%	6%
7. CIT Coordinator Position	20%	15%	8%	8%	9%	6%	1%	7%	8%	**21%**
8. Policies & Procedures	**20%**	9%	9%	11%	16%	3%	10%	5%	4%	13%
9. Data Collection	16%	11%	13%	10%	**19%**	6%	7%	7%	4%	8%
10. Technical Assistance & Mentorship	8%	12%	**17%**	9%	9%	9%	4%	10%	12%	8%

Appendix 7: VACIT Coalition Survey Results – Level of Importance to the Success of CIT Programs

Program Element	Rank Order Importance									
	1	2	3	4	5	6	7	8	9	10
1. Ongoing Funding	**52%**	10%	6%	1%	11%	4%	3%	2%	5%	6%
2. Grant Funding	**42%**	12%	8%	6%	10%	4%	3%	4%	4%	8%
3. Community Collaboration & Program Oversight	**42%**	13%	10%	5%	13%	3%	2%	7%	3%	4%
4. Training	**37%**	12%	16%	8%	10%	2%	3%	3%	4%	5%
5. Community-based Services	**30%**	14%	10%	8%	12%	6%	5%	5%	5%	5%
6. Therapeutic Assessment Center	**29%**	10%	12%	7%	15%	5%	7%	5%	5%	6%
7. CIT Coordinator Position	**28%**	20%	7%	11%	2%	5%	4%	7%	4%	5%
8. Policies & Procedures	**24%**	16%	10%	11%	11%	5%	15%	9%	5%	5%
9. Technical Assistance & Mentorship	12%	18%	11%	14%	**15%**	6%	8%	5%	5%	7%
10. Data Collection	**17%**	10%	15%	8%	16%	4%	6%	13%	6%	6%

Appendix 8: Summary of Currently Operating CIT Assessment Sites

I. Primary Agency or Entity: Arlington CSB

Name of Assessment Site:
Arlington Crisis Intervention Center

Description of Location:
Therapeutic drop off center for law enforcement; currently open from 6 a.m. - 10 p.m. Monday through Thursday; 7 a.m. - 10 p.m. Friday; 10 a.m. -8 p.m. Saturday. Staff is on call and responds back to the center on Sunday and after hours, as needed. Co-location of Emergency Services, Jail Diversion/Forensic Case Management, Discharge Planning, Entry services, Transitional Case management, and Homeless Outreach.

Name of Operational Partner Agencies/Facilities:
Currently partner with Arlington County Police Department as well as other law enforcement agencies that operate in Arlington County.

Operational Protocols/Utilization Requirements or Restrictions:
Protocols are being developed by the Police Department to prepare for transfer of custody to a security company. No other restrictions in place.

Additional Information:
Office-Based Crisis Stabilization is offered during all operating hours. Goal is to have this center open 24/7/365 once budget allows for enough FTEs as well as DCJS certified security.

II. Primary Agency or Entity: Hampton-Newport News CSB

Name of Assessment Site:
Hampton-Newport News CIT

Description of Location:
Crisis Stabilization Unit (10 beds), physically attached to a freestanding psychiatric hospital. Access and entry completely independent from attached facility. "Assessment area" separated from main treatment area to allow for heightened security and confidentiality with a separate entrance. 24/7 on site security coverage by CIT Deputy Sheriff.

Name of Operational Partner Agencies/Facilities:
Hampton-Newport News CSB

Operational Protocols/Utilization Requirements or Restrictions:
CIT Officer to contact CSB field emergency services worker to coordinate "drop off" assessment at CIT Receiving Facility. Sworn Deputy on site to provide for exchange of custody on ECOs as

well as heightening security of unit; the latter allowing for increased ability to treat persons with a more acute presentation. Facility can accept voluntary sub-acute persons but can act as "assessment site" to assess and hold individual until a TDO bed is located when necessary.

Additional Information:

III. Primary Agency or Entity: Rappahannock Area CSB

Name of Assessment Site:
The Sunshine Lady House for Mental Health Wellness and Recovery (SLH)

Description of Location:
SLH is a 12 bed crisis stabilization program open 24 hours per day. There is an emergency services office located in the building where we are able to complete assessments of individuals brought to the facility by law enforcement as well as individuals who present on their own after contacting our emergency services department. We have off duty Fredericksburg city officers working at SLH from 3pm – 11 pm daily, allowing for secure drop off and transfer of custody for ECOs. We are able to complete ECO evaluations outside of the 3pm – 11pm time period, but require the referring law enforcement personnel to stay with the individual being assessed.

Name of Operational Partner Agencies/Facilities:
Fredericksburg Police Department

Operational Protocols/Utilization Requirements or Restrictions:
Off duty officers will be available to accept transfer of custody from 3 pm to 11 pm daily. Law enforcement may utilize the drop off site for evaluations outside of this time frame, but will be required to remain with the individual being assessed until the evaluation is complete or until the off duty officer has arrived and custody has been transferred.

The Sunshine Lady House for Mental Health Wellness and Recovery (SLH) may not accept more than one transfer from all participating agencies at one time.

It is at the discretion of law enforcement and the RACSB whether to accept transfer of an individual into the SLH.

Established SLH Temporary Detention Order (TDO) policy, procedure and protocols are executed when an individual is transferred to the SLH under a TDO.

Persons must meet the *GUIDELINES FOR CRISIS CARE ADMISSION MEDICAL SCREENING* for drop off and be cleared medically before consideration for admission to SLH.

Additional Information:

1. Police notification of individuals being transported to the SLH will take place to RACSB Emergency Services prior to drop off. Transporting officer will provide relevant information concerning disposition of person served as part of notification. Emergency Services will divert persons served to the Mary Washington Hospital Emergency Room for screening if

deemed not appropriate for drop off at SLH. Persons not appropriate for drop off include individuals:
   - Needing medical attention
   - Violent to the point of needing restraints
2. Emergency Services will notify SLH staff of police drop off and SLH staff will contact on-call off duty Fredericksburg police officer for custody exchange. SLH staff will notify Crisis Stabilization Coordinator, Crisis Stabilization Assistant Coordinator or designee of impending drop off.
3. RACSB Emergency Services will prescreen person served for determination of continuum of care. Drug and alcohol screening may take place prior to prescreen being completed if the person served is suspected of being under the influence of alcohol and/or illicit or licit substances.
4. SLH admission will be determined through collaborative consultation of RACSB Emergency Services, SLH Coordinator or designee, and if detainment criteria is met, the Medical Director. If Crisis Stabilization admission is not appropriate, Emergency Services staff will coordinate appropriate level of care and transportation as needed.
5. Officers on duty will be first responders to any display of physical aggression that might occur during transfer and assessment of person served.

IV. Primary Agency or Entity: Thomas Jefferson Area Community Criminal Justice Program

Name of Assessment Site:
Thomas Jefferson Area CIT (Regional CIT Custody Exchange Program)

Description of Location:
University of Virginia Hospital Emergency Room

Name of Operational Partner Agencies/Facilities:
University of Virginia Police/Security Officers

Operational Protocols/Utilization Requirements or Restrictions:
Participating agencies have entered into an MOU with the Thomas Jefferson Area CIT Program and established protocols for providing ECO assessment at the UVA ED. At the ED, there are two rooms where persons under ECO can be held. Custody is transferred to UVA security from local law enforcement. The site is open 24/7, however, UVA security has the final determination for accepting an individual into the Custody Exchange Program.

Additional Information:
The MOU draft is attached hereto an further details the process summarized above.

V. Primary Agency or Entity: Valley CSB

Name of Assessment Site:
Augusta Health’s Emergency Department

Description of Location:
Community Hospital Emergency Room
There are two designated "secure" rooms near the ambulance entrance. These rooms are separated from the rest of the patient care rooms and have a small common area with a non-locking restroom separating them from the main hallway. The Charge nurse makes the decision to use one of the secure rooms or one of the standard treatment rooms depending on their staffing and other factors.

Name of Operational Partner Agencies/Facilities:
Augusta Health and G4S Secure Solutions Custom Security (Contracted provider of "Registered Armed Security Officers")
Law enforcement agencies which are party to the transfer agreement are:
Augusta County Sheriff's Office
Staunton Police Department
Waynesboro Police Department
Staunton Regional Office of the Virginia State Police
Highland County Sheriff's Office (agreed but not yet signed)

Operational Protocols/Utilization Requirements or Restrictions:
For individuals requiring an ECO in the community:
Law Enforcement Officer takes the individual into custody on either a Magistrate issued ECO or Officer initiated "paperless" ECO. Officer contacts the security office at Augusta Health and informs them of the ECO and their expected time of arrival to the emergency room. The Security Officer informs the ED Charge RN and Valley CSB Emergency Services about the ECO. When the Law Enforcement Officer arrives with the Individual, The Charge Nurse directs them to a room and the Security Officer in charge of the shift meets with the Law Enforcement Officer and the individual.
The Security Officer in charge considers the overall situation at the hospital, the Law Enforcement Officers report and the current behavior of the individual, and makes a determination whether they can accept a transfer of custody for that individual. If the Security Officer in charge decides they cannot safely complete the transfer, the Law Enforcement Officer must stay to maintain the individual's custody. If the Security Officer in charge decides they can safely complete the transfer, the Law Enforcement Officer fills out a Transfer of Custody form (attached) which is used to track the event, time ECO expires, recommendation for disposition etc.

For individuals requiring an ECO within the facility at Augusta Health:
If a patient inside the hospital facility appears to require an ECO, hospital staff contacts the Office of the Magistrate to present the situation and request an ECO. Once a "papered" ECO has been issued for an individual currently located at Augusta Health, a copy of the paperwork is sent to the Security Office and to the appropriate jurisdiction for their residence (Augusta County if the person resides in a jurisdiction not party to the agreement). The Security Officer in charge makes the same safety assessment noted above, and makes the determination whether law enforcement assistance will be required to maintain custody. If a transfer of custody is not completed, the appropriate law enforcement agency is required to send an officer to execute the ECO and maintain their custody.

If a transfer of custody is appropriate, the security officer executes the ECO and maintains custody, documenting it on a transfer of custody form. See the agreement for discussion of the statutory basis for this part and for security officers executing TDO paperwork noted in disposition process below.

Disposition process:
If the individual is released, or agrees to a voluntary admission, it is documented on the transfer of custody form, and ECO paperwork, if any. The security officer ends custody, and faxes the completed paperwork to the appropriate law enforcement department.
IF, AT ANY TIME, the individual escalates, or another situation in the hospital indicates a need for Law Enforcement Officers to return, the security officer contacts the appropriate department to dispatch an Officer to take over their custody. The Security Officer is required to remain with the individual under custody until relieved by the responding Law Enforcement Officer. If a TDO is petitioned and granted indicating an admission to the Psychiatric unit at Augusta Health, Security Officers receive the TDO paperwork by fax from the Office of the Magistrate, serve the paperwork on the individual, and when ready, escort them to the unit. The security officer faxes the completed paperwork back to the appropriate law enforcement department. If a TDO is petitioned and granted indicating admission to a Psychiatric hospital or unit other than Augusta Health, the appropriate law enforcement department is notified to send an officer to execute the paperwork and transport the individual to the facility indicated.

TDO is issued without a preceding ECO:
When a TDO is issued without a preceding ECO for an individual located within the hospital facility and indicating admission to the psychiatric unit at Augusta Health, the Security Officer in charge reviews the situation as above and either executes the paperwork and escorts them to the unit, or requests the appropriate law enforcement department to dispatch an officer to execute the paperwork as noted above.

Additional Information:
Note regarding the Security Officer in charge's option to decline a transfer of custody:
The protocols indicate the Security Officer in charge has the right to decline any transfer of custody or to require law enforcement to return. This protocol is necessary for safety and logistical reasons, however, in practice there has been less than a 1% refusal rate.

The admission and evaluation process for individuals brought in by Police has been streamlined by implementation of this agreement and current statistics show an average of 2 and a half hours between initial transfer and final disposition. For individuals who enter the ED seeking psychiatric admission on a voluntary basis through the standard triage process, this average is 6 and a half hours.

Agreement signed September 14th 2009.
Assessment site has been in full operation 24/7 since the first transfer of custody occurred on September 16th 2009.
In FY 2011, July 2010 – June 2011, 502 transfers were completed, saving Law Enforcement 1413 hours and 20 minutes of duty time.

VI. Primary Agency or Entity: Virginia Beach Department of Human Services (CSB)

Name of Assessment Site:
Virginia Beach CIT Assessment Center

Description of Location:
Virginia Beach Psychiatric Center, 1100 First Colonial Road, Virginia Beach, Virginia

The CIT Assessment Center is located within Virginia Beach Psychiatric Center (VBPC) and has an office, a comfort room and an assessment/conference room. The suite is located within locked doors. The comfort room has a sofa, table and chairs, 2 loungers, a flat screen TV, and gender specific bathrooms. The office has two work stations, Emergency Services computers, telephones and MFP. The conference/assessment room has a work station, sofa and conference table with chairs. There is discreet drive up parking behind the building for police, and a private exterior door at the rear for consumers to be escorted by police instead of through the hospital's public lobby. Family and others access the facility from the front door and hospital reception greets them. When needed, consumers are provided meals, snacks or drinks from the hospital's cafeteria.

Name of Operational Partner Agencies/Facilities:
The City of Virginia Beach- Department of Human Services (DHS)- Mental Health Substance Abuse Division operates the CIT Assessment Center under lease from VBPC. The MOU is signed by DHS, Virginia Beach Police Department and VBPC. DHS Emergency Services (ES) clinicians are on site 24/7. VBPC and DHS share the cost of the security officers from United American Security, LLC who are also on site 24/7, even during Hurricane Irene. VBPC is a private-for-profit free-standing psychiatric hospital. VB CIT Assessment Center is separate from the hospital. In other words, consumers are not considered to be the responsibility of VBPC when receiving services from VB Emergency Services at the Assessment Center.

Operational Protocols/Utilization Requirements or Restrictions:
The CIT Assessment Center provides 24 hour-a-day crisis intervention services for voluntary or involuntary consumers. Any Virginia Beach Police Officer may bring a consumer in crisis to be assessed by a Virginia Certified Prescreener at VB CIT Assessment Center. VBPD policy requires officers to contact VB ES for consult prior to arriving. VBPD does a background check and VB ES checks their electronic medical record to determine if there is any reason police need to remain with the consumer.

Current policy provides for only Virginia Beach **CIT Officers** to transfer custody to the security officer and only when the ES clinician and police officer agree that a safe transfer can occur. Some officers choose to remain after transfer to assure safety. Upon admission to the Assessment Center, consumers are searched for dangerous items in the presence of police. Family or significant others are wanded prior to entering. The security officers have been provided eight hour training by CIT Instructors. They learn about CIT, people with mental illnesses, de-escalation, policy and procedures and participate in role plays. They are DCJS Certified to be armed, but are not armed with weapons at VB CIT AC. They have handcuffs and are allowed to restrain a consumer. If a consumer requires restraint police may be contacted to return if necessary. The CIT Assessment Center has a police radio for direct contact with law

enforcement. Currently, only one consumer under an Emergency Custody Order (ECO) may be transferred to the security officer at any one time. Sometimes a CIT Officer may need to wait until the security officer is free. Voluntary consumers are not considered to be in the custody of the security officers. However, the security officer is vigilant about safety in the center. The ES pre-screener provides a preliminary medical assessment, but if consumer under an Emergency Custody Order requires medical clearance, police must return to transport to VB General Hospital ED. There are times police are instructed to take a consumer directly to VBGH ED because of apparent medical, substance use, or the knowledge that TDO facilities available will require the medical clearance prior to accepting. Our goal is to be able to develop an MOA with VBGH ED to provide ECO transfer of custody to expedite the separation of law enforcement from a consumer at that setting also.

Additional Information:
Data collection is done utilizing a form called the PD 175, which is on a shared City IT drive that police can access (in the field) and that ES pre-screeners also complete.