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December 2, 2024

The General Assembly of Virginia
201 N. Ninth Street
The General Assembly Building
Richmond, VA 23219

Dear Senators and Delegates:

The Virginia Behavioral Health Docket Act (Virginia Code 18.2-254.3) directs the Office of the Executive Secretary of the Supreme Court of Virginia, with the assistance of the state behavioral health dockets advisory committee, to develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all local behavioral health dockets established in accordance with the Rules of the Supreme Court of Virginia. Please find attached the current annual report.

If you have any questions regarding this report, please do not hesitate to contact me.

With best wishes, I am

Very truly yours,

Karl R. Hade

Karl R. Hade

KRH:tec

Enclosure

cc: Division of Legislative Systems

2024

Virginia Behavioral Health Dockets Annual Report

REPORT OF THE
Office of the Executive Secretary
Supreme Court of Virginia

TO THE
General Assembly of Virginia

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PREFACE

Virginia Code § 18.2-254.3 (Appendix A) requires the Office of the Executive Secretary (OES) of the Supreme Court of Virginia, with assistance from the state Behavioral Health Docket Advisory Committee, to develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all behavioral health dockets.[1] The Behavioral Health Docket Act further directs OES to submit an annual report of these evaluations to the General Assembly by December 1 of each year. This report presents data from fiscal year 2024.

[1] Va. Code §18.2-254.2 directs OES to develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all local specialty dockets established in accordance with the Rules of Supreme Court of Virginia. The following behavioral health docket report also satisfies a component of that requirement.

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BEHAVIORAL HEALTH DOCKETS

Background

Behavioral health dockets, modeled after recovery courts, were developed to address the overrepresentation of individuals with behavioral health disorders in the criminal justice system. These programs aim to divert eligible defendants diagnosed with serious mental health disorders into judicially supervised, community-based treatment programs designed and implemented by a team of court staff and mental health professionals.

Behavioral health dockets are characterized by several distinctive elements: a problem-solving focus, a collaborative team approach to decision-making, integration of social services, judicial monitoring of the treatment process, direct interaction between defendants and the judge, community outreach, and an active, proactive role for the judge. Participation in these dockets is voluntary, with eligible defendants invited to take part after undergoing specialized screening and assessment.

Defendants who agree to the terms and conditions of community-based supervision work with a team of docket and treatment professionals to develop individualized service plans. This team also oversees the participants' progress. Research indicates that participants in behavioral health dockets demonstrate lower rates of criminal activity and stronger connections to treatment services compared to defendants with serious mental illnesses processed through the traditional court system.

By combining tailored resources with community supervision, behavioral health dockets significantly reduce the likelihood of criminal activity among participants relative to those in the traditional court system.[2]

Behavioral health dockets integrate treatment services with justice system case processing to promote public safety while upholding participants' due process rights. These dockets aim to slow the "revolving door" of criminal justice involvement by addressing the underlying issues contributing to criminal behavior. They seek to improve court outcomes not only for participants but also for victims, litigants, and the broader community.

Behavioral health dockets provide justice-involved individuals with access to substance use and mental health treatment as an alternative to traditional case processing. These programs often include alternatives to incarceration, case dismissal, charge reduction, and reduced supervision requirements.

Mental illness is a widespread issue, affecting millions of people annually. In Virginia alone, over 1,200,000 adults live with a mental health condition. According to a 2022 CDC report, one American dies by suicide every 11 minutes. In Virginia, the suicide rate for the general population in 2022 was 13.3 deaths per 100,000.[3]

[2] Steadman, 2005; Thomas, Osher, & Tomasini-Joshi, 2008; VADBHDS, 2016
[3] https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

According to the National Institute of Mental Health (NIMH) at the National Institutes of Health, substance use disorders are mental health conditions that affect a person's brain and behavior, leading to an inability to control the use of substances such as legal or illegal drugs, alcohol, or medications. Although substance use disorder is classified as a brain disease, it is also a mental health condition. These terms are synonymous, describing how excessive substance use can alter the brain and impact both thinking and behavior.

In Virginia Specialty Dockets (Veterans Treatment Dockets, Behavioral Health Dockets, and Recovery Courts), approximately 70–80% of participants have a co-occurring disorder. Individuals experiencing both mental illness and substance use disorders are disproportionately likely to encounter law enforcement, which often leads to their over-representation in the criminal justice system without corresponding access to appropriate care. Behavioral health dockets address this gap by incorporating evidence-based strategies within a public health framework to address offenders' specific needs. These dockets provide solutions not adequately addressed in traditional court settings, improving public safety by integrating the criminal justice system with treatment services and community resources.

Understanding behavioral health dockets involves recognizing the range of options available to enhance the court's response to defendants with behavioral health issues. In Virginia, these specialized dockets are designed to meet local needs using local resources. Any circuit, general district, or juvenile and domestic relations district court that seeks to establish one or more behavioral health dockets must petition the Supreme Court of Virginia for authorization before initiating operations.

Both the behavioral health docket application and standards incorporate the Essential Elements of a Mental Health Court,[4] which includes the following components:

1. Planning and Administration
2. Target Population
3. Timely Participant Identification and Linkage to Services
4. Terms of Participation
5. Informed Choice
6. Treatment Supports and Services
7. Confidentiality
8. Docket Team

[4]Essential Elements of Mental Health Courts were developed as part of a technical assistance program provided by the Council of State Governments (CSG) Justice Center through the Bureau of Justice Assistance (BJA) Mental Health Courts Program. The BJA Mental Health Courts Program, which was authorized by America's Law Enforcement and Mental Health Project (Public Law 106-515), provided grants to support the development of mental health courts in 23 jurisdictions in FY 2002 and 14 jurisdictions in FY 2003. The CSG Justice Center currently provides technical assistance to the grantees of BJA's Justice and Mental Health Collaboration Program, the successor to the Mental Health Courts Program.

9. Monitoring Adherence to Docket Requirements
10. Sustainability

In November 2017, the Council of State Governments (CSG) Justice Center convened the "50-State Summit on Public Safety" in Washington, D.C. to help teams from each state gain insights into criminal justice system trends and learn about the latest best practices in the field. Each state team included representatives from law enforcement, behavioral health, corrections, and the legislature. Virginia was represented by Senator Creigh Deeds (D-11th), Senator Charles Carrico, Harold Clarke, former director of Virginia Department of Corrections, and Michael Herring, former Commonwealth's Attorney for Richmond. The Virginia delegation expressed interest in adopting a Justice Reinvestment approach.

Behavioral Health Dockets in Virginia

Virginia Supreme Court Rule 1:25, Specialty Dockets, set forth the type of court proceedings appropriate for grouping in a specialty docket as "those which (i) require more than simply the adjudication of discrete legal issues, (ii) present a common dynamic underlying the legally cognizable behavior, (iii) require the coordination of services and treatment to address that underlying dynamic, and (iv) focus primarily on the remediation of the defendant in these dockets. The treatment, the services, and the disposition options are those which are otherwise available under law."[5]

The Virginia General Assembly enacted the Behavioral Health Docket Act in 2020. (See Appendix A). Administrative oversight of the implementation of behavioral health dockets lies with the Supreme Court of Virginia. Oversight responsibilities include the following: "(i) providing oversight of the distribution of funds for behavioral health dockets; (ii) providing technical assistance to behavioral health dockets; (iii) providing training to judges who preside over behavioral health dockets; (iv) providing training to the providers of administrative, case management, and treatment services to behavioral health dockets; and (v) monitoring the completion of evaluations of the effectiveness and efficiency of behavioral health dockets in the Commonwealth." Va. Code § 18.2-254.3(E).

The state Behavioral Health Docket Advisory Committee (see Appendix B) established by statute, reviews all applications for authorization in accordance with the approved Virginia Behavioral Health Docket Standards and National Best Practice Standards for Adult Treatment Court. The Committee has developed an application process (see Appendix C) and standards for behavioral health dockets in Virginia (see Appendix D) to evaluate requests from localities seeking permission to establish a behavioral health docket. All applications must be submitted to the state Behavioral Health Docket Advisory Committee.

Behavioral Health Docket Standards

The planning and administration of a behavioral health docket should reflect extensive collaboration among practitioners from various systems, as well as engagement with community members.

[5] The Supreme Court of Virginia Rule 1:25 was last amended by Order dated June 21, 2024, effective August 20, 2024, to reflect the 2024 legislation renaming the Drug Treatment Court Act as the Recovery Court Act.

Virginia's Standards for Behavioral Health Dockets provide guidance to ensure the highest levels of access, fairness, timeliness, accountability, and the use of evidence-based practices for criminal justice and behavioral health care providers.

Virginia's Standards for Behavioral Health Dockets have been developed to:

- Assist with planning and implementation of new behavioral health dockets;
- Guide training efforts for key team members and collaborators;
- Establish a framework to ensure accountability;
- Provide a structure that maintains continuity during transitions in judicial or administrative leadership;
- Demonstrate the effectiveness of dockets in meeting their stated goals;
- Offer a framework for internal monitoring, including performance measures; and
- Ensure adherence to a research-based model that incorporates evidence-based best practices.

The ten standards outlined in Virginia's Standards for Behavioral Health Dockets (see Appendix D) distill the best of research and practice into operational standards. These standards foster high-quality programming and accountability for behavioral health dockets.

Behavioral Health Dockets in Operation

This report reviews the operations and outcomes of Virginia's behavioral health dockets during FY 2024. The analyses are based on data for participants who were enrolled in a behavioral health docket at any point between July 1, 2023, and June 30, 2024. The report includes measures related to docket participants, such as demographics, entry offenses, length of participation, and completion rates. All data presented in this report were extracted from the Specialty Dockets Database, which is developed and maintained by the Office of the Executive Secretary (OES).

Behavioral health dockets utilize evidence-based practices to diagnose serious mental illness and provide appropriate treatment. Their goals include enhancing public safety, reducing recidivism, ensuring offender accountability, and promoting self-management of mental illness within the community.

During FY 2024, nineteen (19) behavioral health dockets were operating in Virginia during FY 2024. Of these, fifteen (15) were in general district courts, three (3) in circuit courts, and one (1) in a juvenile and domestic relations district court. While the Essex Behavioral Health Docket was approved for operation during this fiscal year, it has not yet become operational. See Figure 1 and Table 1 for additional details.

Figure 1. Approved Behavioral Health Dockets in Virginia, FY 2024

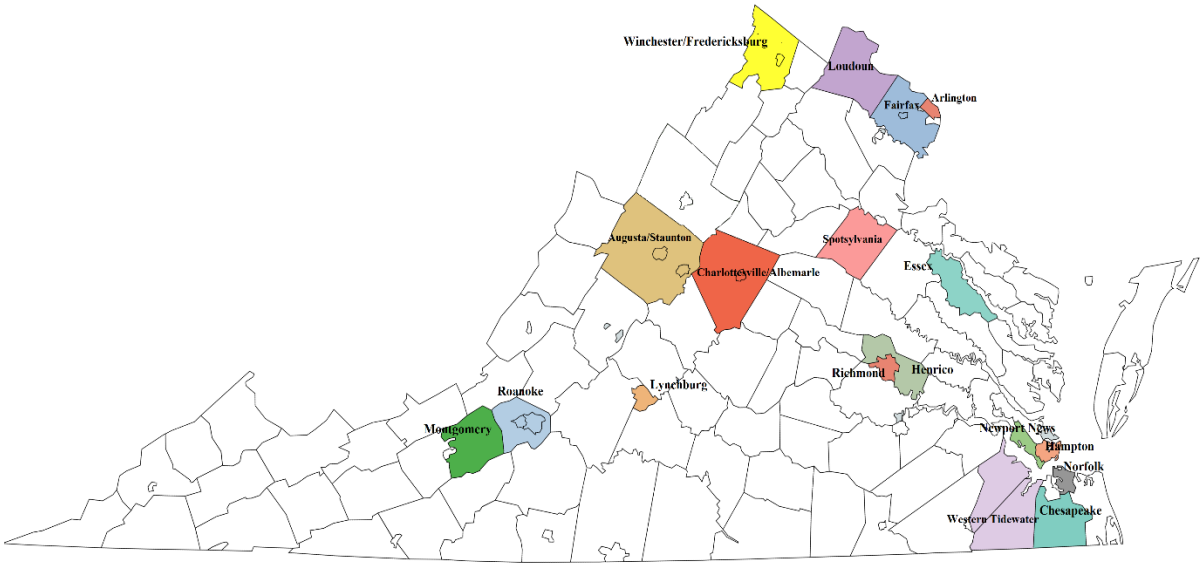


Table 1. Approved Behavioral Health Dockets in Virginia, FY 2024

Approved Behavioral Health Dockets in Virginia		
Arlington General District Court	Henrico General District	Richmond General District Court
Augusta General District Court (Augusta/Staunton)	Loudoun General District Court	Richmond Juvenile and Domestic Relations District Court
Albemarle General District Court (Charlottesville/Albemarle)	Lynchburg General District	Roanoke General District Court (Roanoke City, Roanoke County, and Salem)
Chesapeake General District Court	Montgomery General District Court	Spotsylvania Circuit Court
Essex General District Court	Newport News General District Court	Winchester/Fredericksburg General District Court (Winchester/Fredericksburg)
Fairfax County General District Court	Norfolk Circuit Court	Suffolk General District Court (Western Tidewater)
Hampton General District Court	Richmond Circuit Court	

Summary of Behavioral Health Docket Activity FY 2024

Active Participants: Behavioral health dockets reported 393 active participants in FY 2024, a 0.8% increase from 390 reported in FY 2023.

Referral and Admissions: There were 277 referrals to behavioral health dockets in FY 2024. Of these referrals, 123 were accepted resulting in a 44.4% acceptance rate.

Gender: The majority of the 393 active behavioral health docket participants in FY 2024 were male (232 or 59.0%); 161 (41.0%) were female.

Race: Most participants self-identified as White (202 or 51.4%) or Black/African American (165 or 42.0%).

Age: The largest set of active participants were between 18-29 years old (36.6%), followed by 30-39 years old (33.8%). The median age was 35 years.

Marital Status: A frequent response reported among active participants was being single (166 or 42.2%) at the time of referral. (See Table 3).

Employment: The most frequent response reported among active participants was being unemployed (132 or 33.6%) at the time of referral.

Education: The most frequent response reported among active participants was High School/GED education (125 or 31.8%).

Table 2. Demographics of Active Behavioral Health Docket Participants, FY 2024

Gender	#	%
Male	232	59.0%
Female	161	41.0%
Race		
White	202	51.4%
Black/African American	165	42.0%
Asian/Pacific Islander	12	3.1%
Other	13	3.3%
Native American	1	0.2%
Ethnicity		
Hispanic	20	5.1%
Non-Hispanic	373	94.9%
Age at Start of Program		
Below 18 years	1	0.3%
18-29 years-old	144	36.6%
30-39 years-old	133	33.8%
40-49 years-old	62	15.8%
50-59 years-old	33	8.4%
60 years and older	18	4.6%
Unknown	2	0.5%
Total	**393**	**100.0**

Note: Data reflect reported demographics at the time of referral

Table 3. Social Characteristics of Active Behavioral Health Docket Participants, FY 2024

Marital Status	#	%
Single	166	42.2%
Divorced	22	5.9%
Married	23	5.6%
Separated	12	3.1%
Cohabitating	1	0.3%
Widowed	4	1.0%
Other	1	0.3%
Unknown	164	41.6
Employment		
Unemployed	132	33.6%
Disabled	31	7.9%
32+ hours/week	32	8.1%
Less than 32+ hours/week	10	2.5%
Full-Time w/Benefits	17	4.3%
Seasonal Employment	3	0.8%
Unknown	168	42.8%
Education		
Less than High School	9	2.3.%
Some College	50	12.7%
High School/GED	125	31.8%
Bachelor's Degree	23	5.9%
Vocational Training	7	1.8%
Associate's degree	6	1.5%
Post-Bachelor's	5	1.3%
Unknown	168	42.7%
Total	**393**	**100.0**

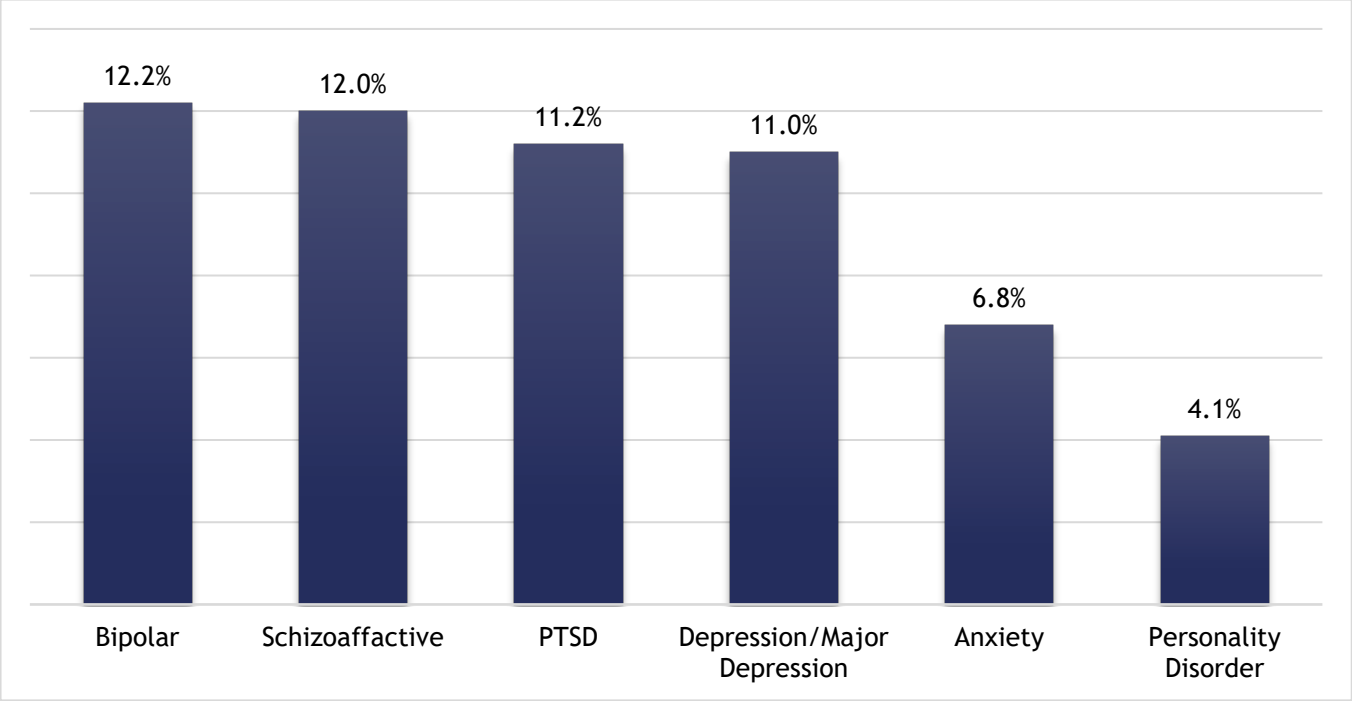
Note: Data reflect self-reported characteristics at the time of referral.

Mental and Behavioral Health Diagnosis Information

The six most common diagnoses amongst the behavioral health docket participants were:

- Bipolar disorder: 123 participants (12.2%)
- Schizoaffective disorder: 121 participants (12.0%)
- Post-traumatic stress disorder (PTSD): 113 participants (11.2%)
- Depression/major depressive disorder: 111 participants (11.0%)
- Anxiety disorders: 69 participants (6.8%)
- Personality disorders: 41 participants (4.1%)

Figure 2: Percent of Behavioral Health Participants with Major Diagnoses, FY 2024



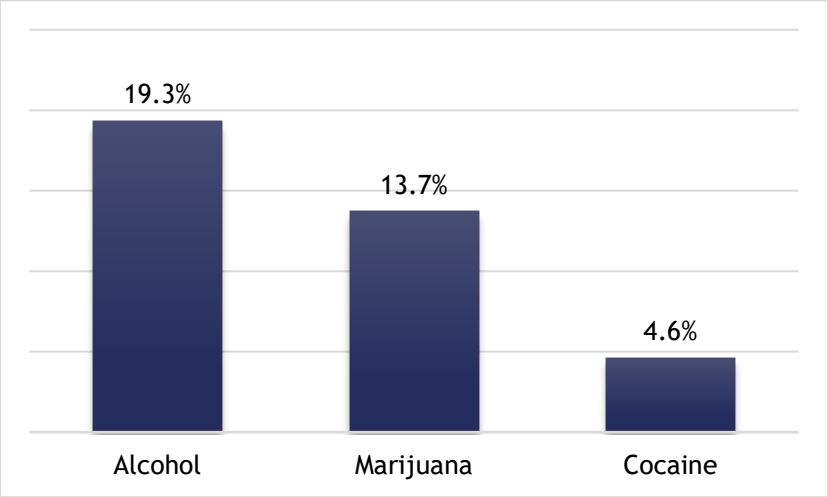
One-quarter of participants (257 individuals) had disorders related to the misuse of drugs and/or alcohol.

Drugs Of Choice and Drug Screens

Upon admission into a behavioral health docket, 19.3% of participants identified alcohol as their primary drug of choice, making it the most commonly reported substance. Marijuana was the second most reported substance at 13.7% (see Figure 3).

Figure 3. Primary Drug of Choice Most Frequently Used by Behavioral Health Docket Participants, FY 2024

Note: Figure 3 should be interpreted with caution. Data are based on self-reported drug use. Participants may report using more than one drug or may choose to not disclose previous drug use.



Program Drug Screenings: In behavioral health dockets, 1,985 drug screens were conducted, with data available for 1,107 participants. Of these, 1,574 screenings (79.3%) returned negative results (see Table 4).

Table 4. Behavioral Health Docket Drug Screens, FY 2024

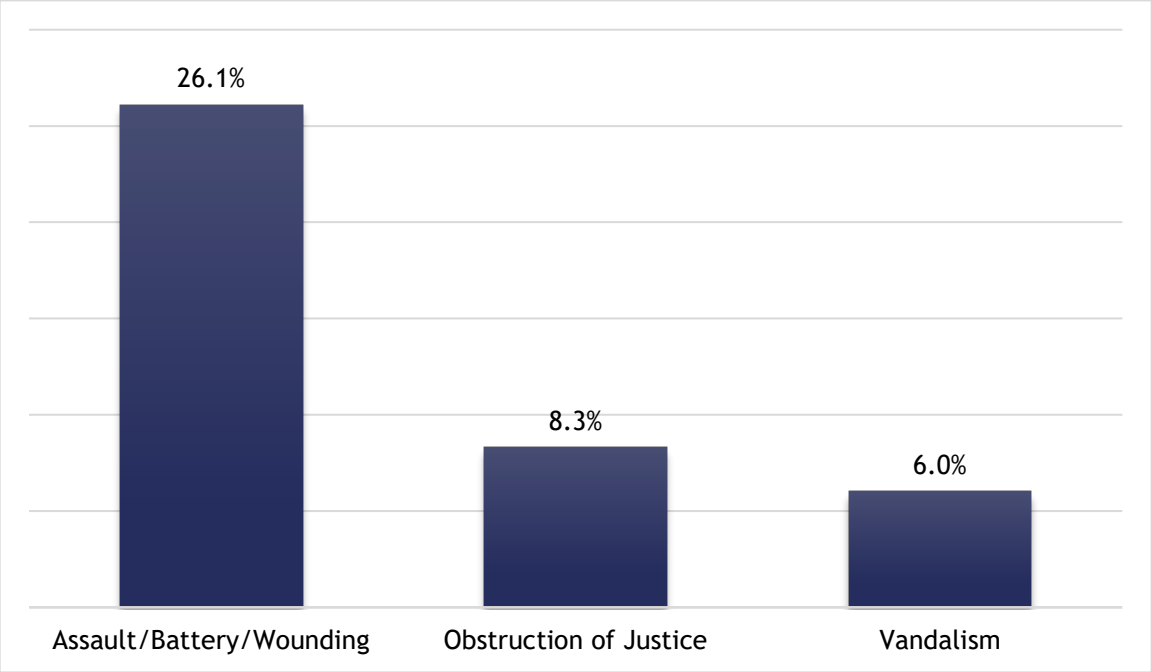
	#	%
Negative	1,574	79.3%
Positive	390	19.6%
Administrative Positive*	21	1.1%
Total Screens	**1,985**	**100.0%**

*An Administrative Positive screen is where a participant fails to appear for screening and is assumed to be positive.

Offenses

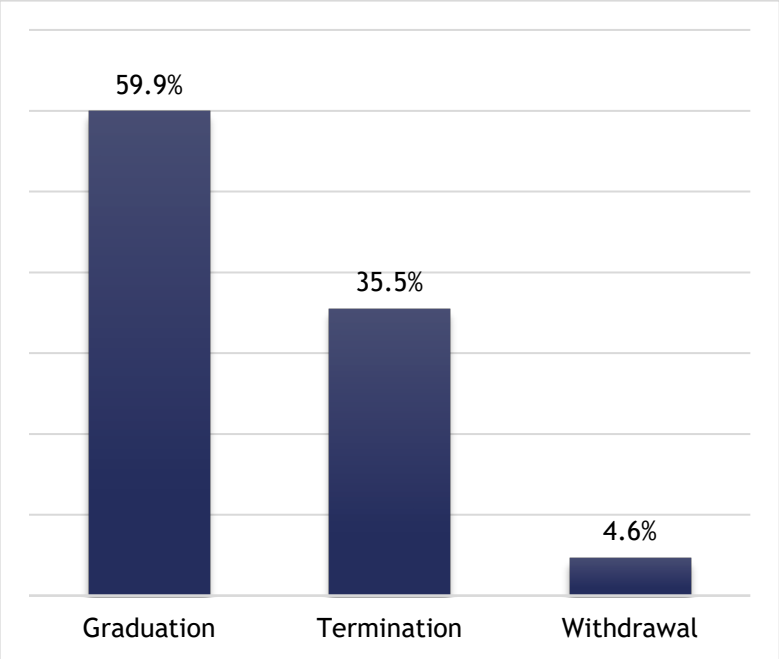
Offenses Leading to Behavioral Health Docket Referral: Analysis of offenses leading to referral for a behavioral health docket shows that the most common offense was assault, battery, or wounding, reported for 217 participants (26.1%) (see Figure 4). The next most common offenses were obstruction of justice (69 participants, 8.3%) and vandalism (50 participants, 6.0%).

Figure 4. Offense Types: Behavioral Health Docket Participants, FY 2024



Summary of Departures

Figure 5. Behavioral Health Docket Completions by Type, FY 2024



Graduation and Termination Rates: In FY 2024, 152 behavioral health docket participants exited the program through graduation, termination, or withdrawal. Of those, 59.9% (91 participants) graduated from the docket. The termination rate was 35.5% (54 participants), while a small percentage (4.6%, or 7 participants) voluntarily withdrew from the program (see Figure 5).

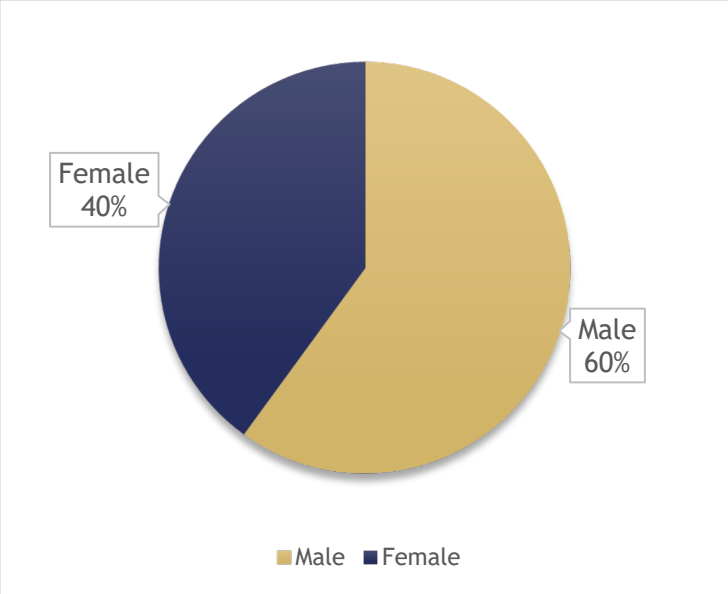
Table 5. Behavioral Health Docket Length of Stay, Departures, FY 2024

Length of Stay: The length of stay was calculated as the number of days from docket entry to departure (graduation, termination, or withdrawal). The average length of stay was 423 days for graduates, 305 days for those who were terminated, and 238 days for participants who voluntarily withdrew (see Table 5).

Mean Length of Stay (Days)	
Graduates	423
Terminations	305
Withdrawals	238

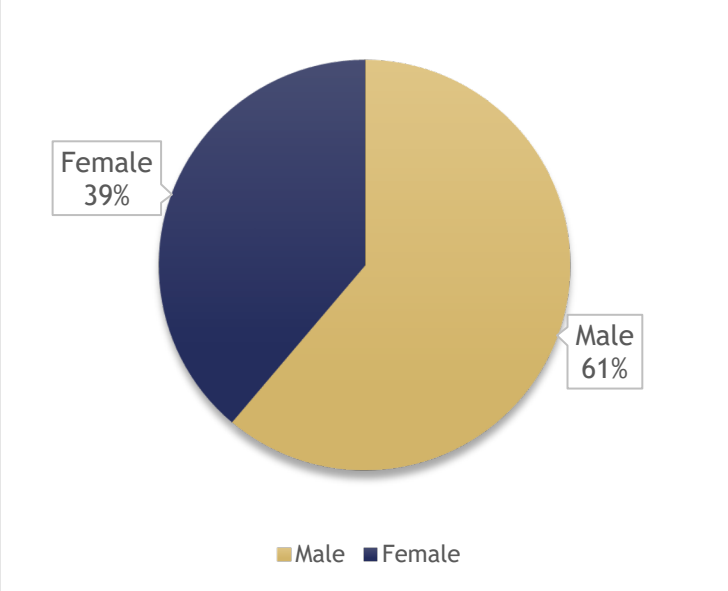
Departures by Gender

Figure 6. Behavioral Health Docket Graduates by Gender, FY 2024



Of the 91 graduates, 36 (40.0%) were female, while 55 (60.4%) were male (see Figure 6).

Figure 7. Behavioral Health Docket Terminations by Gender, FY 2024



Additionally, a total of 54 participants were terminated from the program during FY 2024. Males had a higher termination rate than females (see Figure 7).

Behavioral Health Docket Recidivism

Recidivism Analysis: Criminal history records obtained from the Virginia State Police for all behavioral health docket program departures in FY 2021 were used to calculate recidivism. Recidivism is defined as any rearrest or reconviction. Offenses classified as Good Behavior Violations, Probation Violations, and Contempt of Court were excluded from the analysis.

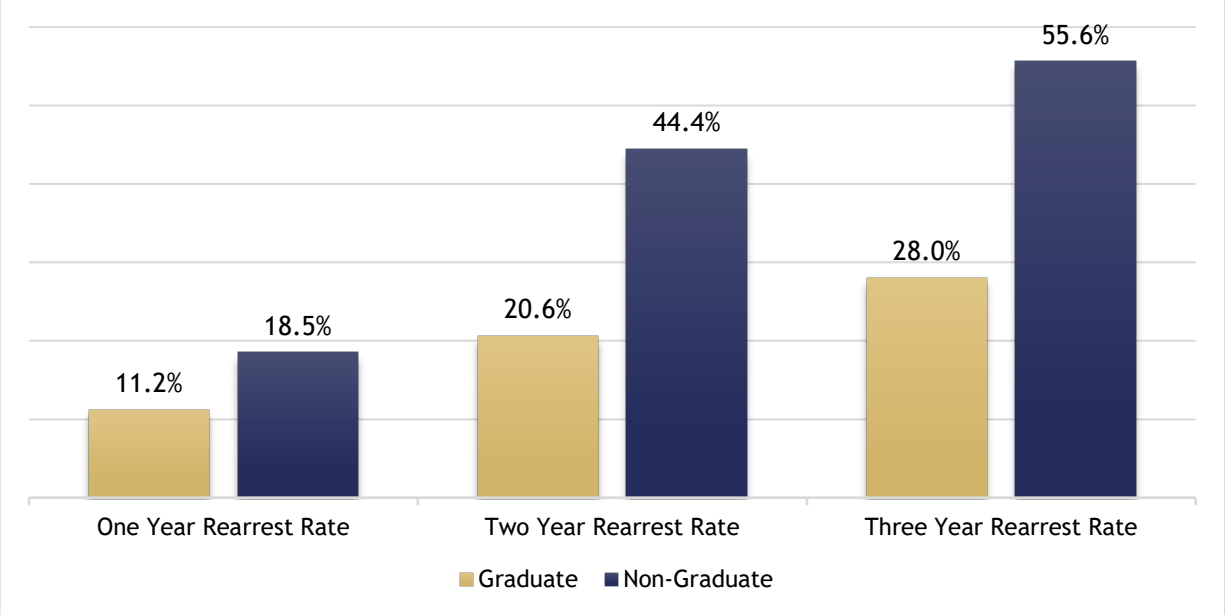
Per national standards, recidivism rates were calculated for one, two, and three-year periods. The one-year recidivism rate includes participants whose first rearrest occurred within 0–365 days of docket departure. The two-year rate includes those whose first rearrest occurred within 0–730 days, while the three-year rate accounts for first rearrests occurring within 0–1,095 days of departure.

Findings were compared between graduates and participants with unsuccessful departures to identify potential differences. It is important to exercise caution when comparing recidivism rates for behavioral health docket exits to those in other recidivism studies, as methodologies may vary.

FY 2021 Rearrest Rates

The overall rearrest rate for non-graduates was 1.9 times that of graduates (see Figure 8 and Table 6).[6]

Figure 8. Behavioral Health Docket Graduate and Non-Graduate Rearrest Rates, Post-Departure, Persons Exiting a Docket During FY 2021



[6] The one, two, and three-year rearrest rates are cumulative.

Table 6. Behavioral Health Docket Graduate and Non-Graduate Rearrest Rates, Post-Departure, Persons Exiting a Docket During FY 2021

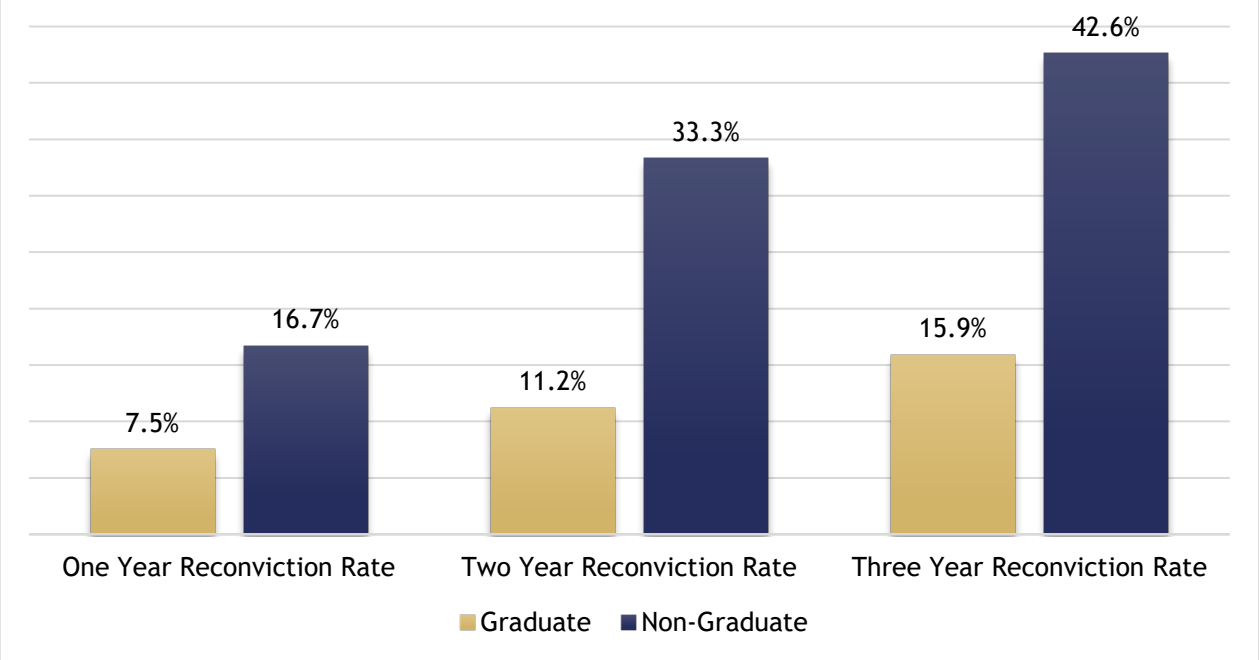
	Graduates	Non-Graduates	Total
One Year Count	12	10	22
One Year Rearrest Rate	11.2%	18.5%	13.7%
Two Year Count	22	24	46
Two Year Rearrest Rate	20.6%	44.4%	28.6%
Three Year Count	30	30	60
Three Year Rearrest Rate	28.0%	55.6%	37.3%
***Total Departures**	**107**	**54**	**161**

*Total departures include all the participants who exited in FY 2021. It is not the summary of those who were rearrested in years 1,2, and 3.

FY 2021 Reconviction Rates

The overall reconviction rate for unsuccessful completion was higher than that of graduates (see Table 7 and Figure 9).[7]

Figure 9. Behavioral Health Docket Graduate and Non-Graduate Reconviction Rates, Post-Departure, Persons Exiting a Docket During FY 2021



[7] The one, two, and three-year reconviction rates are cumulative.

Table 7. Behavioral Health Docket Graduate and Non-Graduate Reconviction Rates, Post-Departure, Persons Exiting a Docket During FY 2021

	Graduates	Non-Graduates	Total
One Year Count	8	9	17
One Year Reconviction Rate	7.5%	16.7%	10.6%
Two Year Count	12	18	30
Two Year Reconviction	11.2%	33.3%	18.6%
Three Year Count	17	23	40
Three Year Reconviction	15.9%	42.6%	24.8%
***Total Departures**	**107**	**54**	**161**

*Total departures include all the participants who exited in FY 2021. It is not the summary of those who were rearrested in years 1,2, and 3.

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APPENDICES

Appendix A: § 18.2-254.3. Behavioral Health Docket Act.

A. This section shall be known and may be cited as the "Behavioral Health Docket Act."

B. The General Assembly recognizes the critical need to promote public safety and reduce recidivism by addressing co-occurring behavioral health issues, such as mental illness and substance abuse, related to persons in the criminal justice system. It is the intention of the General Assembly to enhance public safety by facilitating the creation of behavioral health dockets to accomplish this purpose.

C. The goals of behavioral health dockets shall include (i) reducing recidivism; (ii) increasing personal, familial, and societal accountability among offenders through ongoing judicial intervention; (iii) addressing mental illness and substance abuse that contribute to criminal behavior and recidivism; and (iv) promoting effective planning and use of resources within the criminal justice system and community agencies. Behavioral health dockets promote outcomes that will benefit not only the offender but society as well.

D. Behavioral health dockets are specialized criminal court dockets within the existing structure of Virginia's court system that enable the judiciary to manage its workload more efficiently. Under the leadership and regular interaction of presiding judges, and through voluntary offender participation, behavioral health dockets shall address offenders with mental health conditions and drug addictions that contribute to criminal behavior. Behavioral health dockets shall employ evidence-based practices to diagnose behavioral health illness and provide treatment, enhance public safety, reduce recidivism, ensure offender accountability, and promote offender rehabilitation in the community. Local officials shall complete a planning process recognized by the state behavioral health docket advisory committee before establishing a behavioral health docket program.

E. Administrative oversight of implementation of the Behavioral Health Docket Act shall be conducted by the Supreme Court of Virginia. The Supreme Court of Virginia shall be responsible for (i) providing oversight of the distribution of funds for behavioral health dockets; (ii) providing technical assistance to behavioral health dockets; (iii) providing training to judges who preside over behavioral health dockets; (iv) providing training to the providers of administrative, case management, and treatment services to behavioral health dockets; and (v) monitoring the completion of evaluations of the effectiveness and efficiency of behavioral health dockets in the Commonwealth.

F. A state behavioral health docket advisory committee shall be established in the judicial branch. The committee shall be chaired by the Chief Justice of the Supreme Court of Virginia, who shall appoint a vice-chair to act in his absence. The membership of the committee shall include a behavioral health circuit court judge, a behavioral health general district court judge, a behavioral health juvenile and domestic relations district court judge, the Executive Secretary of the Supreme Court or his designee, the Governor or his designee, and a representative from each of the following entities: the Commonwealth's Attorneys' Services Council, the Virginia Court Clerks' Association, the Virginia Indigent Defense Commission, the Department of Behavioral Health and Developmental Services, the Virginia Organization of Consumers

Asserting Leadership, a community services board or behavioral health authority, and a local community-based probation and pretrial services agency.

G. Each jurisdiction or combination of jurisdictions that intend to establish a behavioral health docket or continue the operation of an existing behavioral health docket shall establish a local behavioral health docket advisory committee. Jurisdictions that establish separate adult and juvenile behavioral health dockets may establish an advisory committee for each such docket. Each local behavioral health docket advisory committee shall ensure quality, efficiency, and fairness in the planning, implementation, and operation of the behavioral health dockets that serve the jurisdiction or combination of jurisdictions. Advisory committee membership may include, but shall not be limited to, the following persons or their designees: (i) the behavioral health docket judge; (ii) the attorney for the Commonwealth or, where applicable, the city or county attorney who has responsibility for the prosecution of misdemeanor offenses; (iii) the public defender or a member of the local criminal defense bar in jurisdictions in which there is no public defender; (iv) the clerk of the court in which the behavioral health docket is located; (v) a representative of the Virginia Department of Corrections or the Department of Juvenile Justice, or both, from the local office that serves the jurisdiction or combination of jurisdictions; (vi) a representative of a local community-based probation and pretrial services agency; (vii) a local law-enforcement officer; (viii) a representative of the Department of Behavioral Health and Developmental Services or a representative of local treatment providers, or both; (ix) a representative of the local community services board or behavioral health authority; (x) the behavioral health docket administrator; (xi) a public health official; (xii) the county administrator or city manager; (xiii) a certified peer recovery specialist; and (xiv) any other persons selected by the local behavioral health docket advisory committee.

H. Each local behavioral health docket advisory committee shall establish criteria for the eligibility and participation of offenders who have been determined to have problems with drug addiction, mental illness, or related issues. The committee shall ensure the use of a comprehensive, valid, and reliable screening instrument to assess whether the individual is a candidate for a behavioral health docket. Once an individual is identified as a candidate appropriate for a behavioral health court docket, a full diagnosis and treatment plan shall be prepared by qualified professionals.

Subject to the provisions of this section, neither the establishment of a behavioral health docket nor anything in this section shall be construed as limiting the discretion of the attorney for the Commonwealth to prosecute any criminal case arising therein that he deems advisable to prosecute, except to the extent that the participating attorney for the Commonwealth agrees to do so.

I. Each local behavioral health docket advisory committee shall establish policies and procedures for the operation of the docket to attain the following goals: (i) effective integration of appropriate treatment services with criminal justice system case processing; (ii) enhanced public safety through intensive offender supervision and treatment; (iii) prompt identification and placement of eligible participants; (iv) efficient access to a continuum of related treatment and rehabilitation services; (v) verified participant abstinence through frequent alcohol and other drug testing and mental health status assessments, where applicable; (vi) prompt response

to participants' noncompliance with program requirements through a coordinated strategy; (vii) ongoing judicial interaction with each behavioral health docket participant; (viii) ongoing monitoring and evaluation of program effectiveness and efficiency; (ix) ongoing interdisciplinary education and training in support of program effectiveness and efficiency; and (x) ongoing collaboration among behavioral health dockets, public agencies, and community-based organizations to enhance program effectiveness and efficiency.

J. If there is cause for concern that a defendant was experiencing a crisis related to a mental health or substance abuse disorder then his case will be referred, if such referral is appropriate, to a behavioral health docket to determine eligibility for participation. Participation by an offender in a behavioral health docket shall be voluntary and made pursuant only to a written agreement entered into by and between the offender and the Commonwealth with the concurrence of the court. If an offender determined to be eligible to participate in a behavioral health docket resides in a locality other than that in which the behavioral health docket is located, or such offender desires to move to a locality other than that in which the behavioral health docket is located, and the court determines it is practicable and appropriate, the supervision of such offender may be transferred to a supervising agency in the new locality. If the receiving agency accepts the transfer, it shall confirm in writing that it can and will comply with all of the conditions of supervision of the behavioral health docket, including the frequency of in-person and other contact with the offender and updates from the offender's treatment providers. If the receiving agency cannot comply with the conditions of supervision, the agency shall deny the transfer in writing and the sending agency shall notify the court. Where supervision is transferred, the sending agency shall be responsible for providing reports on an offender's conduct, treatment, and compliance with the conditions of supervision to the court.

K. An offender may be required to contribute to the cost of the treatment he receives while participating in a behavioral health docket pursuant to guidelines developed by the local behavioral health docket advisory committee.

L. Nothing contained in this section shall confer a right or an expectation of a right to treatment for an offender or be construed as requiring a local behavioral health docket advisory committee to accept for participation every offender.

M. The Office of the Executive Secretary shall, with the assistance of the state behavioral health docket advisory committee, develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all behavioral health dockets. The Executive Secretary shall submit an annual report of these evaluations to the General Assembly by December 1 of each year. The annual report shall be submitted as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website. Each local behavioral health docket advisory committee shall submit evaluative reports, as provided by the Behavioral/Mental Health Docket Advisory Committee, to the Office of the Executive Secretary as requested.

2020, c. 1096; 2021, Sp. Sess. I, c. 191.

Appendix B: State Behavioral Health Docket Advisory Committee Membership Roster

Chair:

The Honorable S. Bernard Goodwyn
Chief Justice
Supreme Court of Virginia

Vice-Chairs:

The Honorable Jacqueline F. Ward Talevi
Judge
23rd Judicial District of Virginia
Roanoke County General District Court
&
The Hon. Philip Hairston
Judge
13th Judicial Circuit of Virginia
Richmond Circuit Court

Members:

The Hon. Llezelle Agustin Dugger
Clerk
Charlottesville Circuit Court
Virginia Circuit Court Clerks Association

The Hon. Erin Evans-Bedois
Judge
Chesapeake General District Court

Catherine French-Zagurskie
Chief Appellate Counsel
Virginia Indigent Defense Commission

Wendy Goodman
Administrator
Infrastructure Reentry and Programs Unit
Virginia Department of Corrections

The Hon. Marilynn Goss-Thornton
Judge
Richmond Juvenile & Domestic Relations District Court

The Hon. Nathan R. Green
Commonwealth's Attorney
Williamsburg, VA

Jennifer MacArthur
Manager
Division of Programs and Services
Adult Justice Programs

Sara Davis, MA
Forensic Operations Manager
Office of Forensic Services

J. Martin Marsh
Network Program Director
Virginia Organization of Consumers Asserting Leadership (VOCAL)

Leah Mills
Deputy Secretary
Office of Health & Human Resources

Heather Zelle, J.D., Ph.D.
Assistant Professor of Research
Department of Public Health Services
Associate Director of Mental Health Policy
Institute of Law, Psychiatry, Public Safety

Staff:
Paul DeLosh
Director
Department of Judicial Services
Office of the Executive Secretary

Anna T. Powers
Specialty Dockets Coordinator
Department of Judicial Services
Office of the Executive Secretary

Auriel Diggs
Specialty Dockets Grants Analyst
Department of Judicial Services
Office of the Executive Secretary

Celin Job
Specialty Dockets Analyst
Department of Judicial Services
Office of the Executive Secretary

Liane Hanna
Specialty Dockets Compliance Analyst
Department of Judicial Services
Office of the Executive Secretary

Olivia Terranova
Specialty Dockets Compliance Analyst
Department of Judicial Services
Office of the Executive Secretary

Renee Rosales
Specialty Dockets Budget Analyst
Department of Judicial Services
Office of the Executive Secretary

Taylor Crampton
Specialty Dockets Administrative Assistant
Department of Judicial Services
Office of the Executive Secretary

Appendix C: Application for Behavioral Health Docket

Application

for

Behavioral Health Docket

Submitted by:

_____ _____

Signature of Judge Signature of Coordinator

of

_____

Name of Court

_____

Date

APPLICATION GUIDELINES

The Supreme Court of Virginia has established a standardized review process to use in evaluating requests from any locality seeking permission to establish a behavioral health docket. The application should be completed by the local planning committee created to plan the docket. Applications should be submitted to the Supreme Court of Virginia. All application packages should be sent to:

Supreme Court of Virginia
Office of the Executive Secretary
100 North 9th Street
Richmond, Virginia 23219
Email: apowers@vacourts.gov

In order to evaluate the quality, efficiency and fairness of dockets requesting approval to establish a behavioral health docket the following information shall be submitted by the requesting local advisory committee.

Behavioral Health Docket Application

Jurisdiction Name: _____

Court: _____Circuit _____ District

Specialty Docket Model: _____ Veterans _____ Behavioral Health

Supervising Judge:

Name: _____ Telephone:

Address:_____ E-mail:

Docket Coordinator:

Name:_____ Telephone:

Address: _____ E-mail:

Target Population –(list all that apply):

Proposed Start Date: ____/____/

Approved Docket Planning Training:

_____ _____
Date Location

_____ _____
Date Location

_____ _____
Date Location

_____ _____
Date Location

Veterans Treatment Court Planning Initiative (VTCPI)

Developing **a Mental Health Court: An Interdisciplinary Curriculum (CSG)**

Other:_____

Other:_____

Application Contact Person:

Name:_____ Telephone:

Address: _____ E-mail:

Please submit your Operations Manual, all forms and the following information as attachments to this application. If any of the information described in an attachment is included in the docket's Operations Manual, please reference its location in the Operations Manual on the application form.

Attachment A: Project Abstract and the Ten Essential Elements of Behavioral Health Dockets

This attachment must include the project abstract and how it will implement and comply with the Ten Essential Elements of Behavioral Health Dockets as well as incorporate evidence-based practices into the daily operations of the behavioral health docket.

Attachment B: Statement of the Problem

Attachment C: Docket Goals and Objectives

This attachment must include a description of the behavioral health docket goals and objectives. Each docket goal should include measurable objectives and should reflect the docket's proposed operations.

Attachment D: Description of the Behavioral health docket

This attachment must include a case flow chart outlining a description of the docket's operational and administrative structure to include:

1. Screening and eligibility
2. Structure of the docket
3. Length of stay
4. Graduation requirements
5. Expulsion criteria

This attachment should include a detailed description of the legal eligibility for behavioral health docket participation as well as any other factors taken into consideration when determining eligibility.

Attachment E: Operations Manual

This attachment must include a current copy of the behavioral health docket Operations Manual.

The Operations Manual should incorporate the principles of problem-solving courts, the ten (10) essential elements of behavioral health dockets, and include information related to participant eligibility, the screening and referral process, docket services and requirements, graduation criteria, case management procedures, judicial interaction, team meetings and court session schedule, incentives and sanctions, compliance monitoring, confidentiality policies and termination procedures. It should also include all docket forms, such as the participation agreement, consent for release of confidential information, orientation information, and referral agreements.

Attachment F: Participant's Handbook

The local Behavioral Health Docket Advisory Committee shall also establish a Participant's Handbook to align with the Operations Manual. The Participant's Handbook should include all information the participants need to know about the program operations in an easy-to-read format. The Specialty Dockets Division can provide a sample Participant's Handbook upon request.

Attachment G: Estimated Budget

This attachment must include the estimated behavioral health docket budget including all projected income (user- fees, grants, county general funds) and expenses. All fees must be assessed and collected in compliance with financial management general principles.

Attachment H: Organizational Plan

This attachment must include an organizational chart and a description of the docket's operational and administrative structure to include:

Behavioral Health Docket Staff Requirements (For each staff position include the person's name, agency, address, telephone, and e-mail address.) This attachment must include documentation that the behavioral health docket coordinator, each case manager and any volunteer who performs one or more job functions for the docket is appropriately trained and credentialed.

Treatment Provider Information (Include name, agency, address, telephone a, and e-mail address for each treatment agency providing services to participants.)

Referring Courts/Dockets (names of other courts referring or transferring cases to the Behavioral Health Docket)

Monitoring and Evaluation

Ongoing Interdisciplinary Education and Training

Ongoing Collaboration/Sustainability

Attachment I: Memoranda of Understanding (MOU)

This attachment must include information on each partner and a copy of their MOU with the docket.

Attachment J: Certification and Assurances

Attachment K: Applicant Disclosure of Pending Grant Applications

Appendix D: Standards for Behavioral Health Dockets in Virginia

Standard 1: Goals. The goals of behavioral health dockets shall include (i) reducing recidivism; (ii) increasing personal, familial, and societal accountability among offenders through ongoing judicial intervention; (iii) addressing mental illness and substance abuse that contribute to criminal behavior and recidivism; and (iv) promoting effective planning and use of resources within the criminal justice system and community agencies. Behavioral health dockets promote outcomes that will benefit not only the offender but society as well.

Standard 2: Administration. A circuit or district court which intends to establish a behavioral health docket must petition the Supreme Court of Virginia for authorization before beginning operation of a specialty docket or, in the instance of an existing specialty docket, continuing its operation. A petitioning court must demonstrate sufficient local support for the establishment of this specialty docket, as well as adequate planning for its establishment and continuation. Each docket must have a policy and procedure manual that sets forth its goals and objectives, general administration, organization, personnel, and budget matters The policies and procedures for the operation of the docket shall attain the goals as listed in §18.2-254.3.I.

Standard 3: Local Behavioral Health Docket Advisory Committee. Each local behavioral health docket advisory committee shall ensure quality, efficiency, and fairness in the planning, implementation, and operation of the behavioral health dockets that serve the jurisdiction or combination of jurisdictions. Membership should include those as stated in §18.2-254.3.G. An offender may be required to contribute to the cost of treatment received while participating in a behavioral health docket pursuant to guidelines developed by the local advisory committee. An inability to pay shall not prohibit participation in the docket.

Standard 4: Docket Team. A behavioral health docket team should include, at a minimum, the judge, a representative from the local Behavioral Health Authority/Community Services Board, and a representative from community corrections. The Commonwealth's Attorney and the Defense Attorney are encouraged, but are not required, to participate as members of the court docket team.

Standard 5: Evidence-Based Practices. The docket should establish and adhere to practices that are evidence-based and outcome-driven and should be able to articulate the research basis for the practices it uses.

Standard 6: Voluntary and Informed Participation. All docket participants should be provided with a clear explanation of the docket process including sanctions and removal proceedings. Participation in the docket must be completely voluntary and made pursuant only to a written agreement entered into by and between the offender and the Commonwealth with concurrence of the court. Participants must have capacity to consent to participation in the docket.

Standard 7: Eligibility Criteria. Criteria regarding eligibility for participation in the docket must be well-defined and written and must address public safety and the locality's treatment capacity. The committee shall ensure the use of a comprehensive, valid, and reliable screening instrument to assess whether the individual is a candidate for a behavioral health docket. The criteria should focus on defendants whose mental illness is related to their current offenses.

Standard 8: Program Structure. A behavioral health docket program should be structured so that participants progress through phases which may include orientation, stabilization, community reintegration, maintenance, successful completion and transition out of the program.

Standard 9: Treatment and Support Services. Behavioral health dockets must provide prompt admission to continuous, comprehensive, evidence-based treatment and rehabilitation services to participants. Once an individual is identified as a candidate appropriate for a behavioral health court docket, a full diagnosis and treatment plan shall be prepared by qualified professionals. All treatment providers used by the docket should be appropriately licensed by the applicable state regulatory authority and trained to deliver the necessary services according to the standards of their profession.

Standard 10: Participant Compliance. Behavioral health dockets should have written procedures for incentives, rewards, sanctions, and therapeutic responses to participant behavior while under court supervision. These procedures must be provided to all team members and the participant at the start of a participant's participation in the program.

Standard 11: Confidentiality. Behavioral health docket programs must protect confidentiality and privacy rights of individuals and proactively inform them about those rights. Information gathered as part of a participant's court-ordered treatment program or services should be safeguarded in the event that the participant is returned to traditional court processing.

Standard 12: Evaluation and Monitoring. Behavioral health docket programs must establish case tracking and data collection practices as required by the Office of the Executive Secretary specialty dockets. At a minimum, data should be collected regarding 1) Characteristics of the Participants, 2) Clinical Outcomes, and 3) Legal Outcomes. All behavioral health docket programs are subject to annual fiscal and program monitoring and compliance review by the Office of the Executive Secretary.

Standard 13: Education. All team members, including the judge, should be knowledgeable about underlying medical or social-science research relevant to the docket. All team members should attend continuing education programs or training opportunities to stay current regarding the legal aspects of a behavioral health docket and the clinical aspects of mental illness and substance abuse.

VIRGINIA BEHAVIORAL HEALTH DOCKET STANDARDS

Table of Contents

INTRODUCTION

The goals of the Virginia Behavioral Health Dockets shall include (I) reducing recidivism; (II) increasing personal, familial, and societal accountability among offenders through ongoing judicial intervention; (III) addressing mental illness and substance use that contribute to criminal behavior and recidivism; and (IV) promoting effective planning and use of resources within the criminal justice system and community agencies. Behavioral Health Dockets promote outcomes that will benefit both the offender and society.

The Virginia Behavioral Health Docket standards have been revised to align with the All Rise National Best Practice Standards, the Bureau of Justice Assistance's Essential Elements, and DBHDS' Essential Elements. Elements from the newly released second edition of All Rise's Adult Treatment Court Best Practice Standards have also been included in this revised manual. It is important to recognize that the second edition incorporates research and best practice standards specific for behavioral health dockets.

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

STANDARD I
Administration

Behavioral Health Dockets depend upon a comprehensive and inclusive planning process.

1.1 The planning group has a written work plan addressing the program's needs for budget and resources, operations, information management, staffing, community-relations, and ongoing evaluation that have been collaboratively developed, reviewed, and agreed upon by the planning team. Policies and procedures for the operation of the docket shall attain the goals as listed in §18.2-254.3.I.

- **a.** Representatives of the court, community organizations, employers, law enforcement, corrections, prosecution, defense counsel, supervisory agencies, treatment and rehabilitation providers, educators, health and social service agencies, and the faith community have opportunity to contribute to the ongoing improvement of the Behavioral Health Docket.
- **b.** The work plan has specific descriptions of roles and responsibilities of each docket component. For example, eligibility criteria, screening, and assessment procedures are established in line with the Virginia's Adult Behavioral Health Docket Standards.
- **c.** Treatment requirements and expectations are understood and agreed upon by the planning group.

1.2 The Behavioral Health Docket has demonstrated participation in a planning process to ensure a coordinated, systemic, and multidisciplinary approach. New behavioral health dockets are required to request and attend a Behavioral Health Docket Training with the Office of the Executive Secretary's Specialty Dockets team prior to applying.

1.3 The planning committee should identify agency leaders and policy makers to serve on a local advisory committee; the planning committee and local advisory committee may have the same representatives.

1.4 The local advisory committee, as identified in 18.2-254.3.G., includes (i) the behavioral health docket judge; (ii) the attorney for the Commonwealth, or, where applicable, the city or county attorney who has responsibility for the prosecution of misdemeanor offenses; (iii) the public defender or a member of the local criminal defense bar in jurisdictions in which there is no public defender; (iv) the clerk of the court in which the behavioral health docket is located; (v) a representative of the Virginia Department of Corrections, or the Department of Juvenile Justice, or both, from the local office which serves the jurisdiction or combination of jurisdictions; (vi) a representative of a local community-based probation and pretrial services agency; (vii) a local law-enforcement officer; (viii) a representative of the Department of Behavioral Health and Developmental Services or a representative of local drug treatment providers; (ix) the behavioral health docket administrator; (x) a representative of the Department of Social Services; (xi) county administrator or city manager; (xii) mental health advocates, crime victims, consumers, family and community members, and any other people selected by the behavioral health docket advisory committee which has an interest in the success of the program.

1.5 The local advisory committee conducts quarterly meetings during the first three years of the docket being approved, and twice a year thereafter.

1.6 Mechanisms for sharing decision making and resolving conflicts among Behavioral Health Docket team members, such as multidisciplinary committees, are established, emphasizing professional integrity.

STANDARD II
Behavioral Health Docket Team

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the Behavioral Health Docket, which integrates mental health treatment services with adjudication of the case(s) before the court. The docket should establish and adhere to practices that are evidence-based and outcome-driven and should be able to articulate the research basis for the practices it uses.

2.1 The Behavioral Health Docket team includes, at a minimum, the judge, behavioral health docket coordinator, a representative from the local Behavioral Health Authority/Community Services Board or local treatment provider, a representative from local community corrections and/or state probation and parole, a representative from the Public Defender's Office or local defense bar, and a representative from the Commonwealth's Attorney.

2.2 All team members consistently attend pre-court staff meetings to review participant

progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court.

2.3 The court, supervision, and treatment providers maintain ongoing and consistent communication, including frequent exchanges of timely and accurate information about the individual participant's overall performance.

2.4 Participation in a Behavioral Health Docket is voluntary and made pursuant only to a written agreement entered into by and between the offender and the Commonwealth with the concurrence of the court.

2.5 The Behavioral Health Docket does not impose arbitrary restrictions on the number of participants it serves; census is predicated on local need, obtainable resources, and the docket's ability to apply best practices.

2.6 Staff of the Behavioral Health Docket engages in community outreach activities and proactive recruitment to build partnerships that will improve outcomes.

STANDARD III
Target Population, Eligibility Criteria, and Equity and Inclusion

Each Behavioral Health Docket will have published objective eligibility and exclusion criteria that have been collaboratively developed, reviewed, and agreed upon by members of the Behavioral Health Docket team, and the local advisory committee, and emphasize early identification and placement of eligible participants. The criteria should focus on defendants whose mental illness is related to their current offenses.

3.1 Dockets should target defendants of moderate to high risk of failing to appear and incurring new charges while on release. The "Risk-Need-Responsivity" (RNR) Model should be used as a guide to identify and prioritize defendants for participation in the docket, as well as the intensity of supervision and clinical interventions. This is to be determined by using validated risk-assessment and clinical assessment tools. Dockets should serve participants that are high-risk, high need.

3.2 Eligibility screening is based on established written objective criteria pursuant to Va. Code § 18.2-254.3. Criminal justice officials or others (e.g., pretrial services, probation, treatment providers) are designated to screen cases and identify potential Behavioral Health Docket participants using validated risk- and clinical-assessment tools. The Behavioral Health Docket team does not apply subjective criteria or personal impressions to determine participants' suitability for the program. Certified or licensed addictions/mental health professionals provide additional screening for substance use disorders and suitability for treatment.

3.3 The docket shall not prohibit acceptance or graduation of eligible participants who are on Medication Assisted Treatment (MAT).

3.4 Narcan training and distribution to all participants should be available onsite.

3.5 Members of all sociodemographic and sociocultural groups[8] receive the same opportunities as other individuals to participate and succeed in the docket.

[8] This is to encompass groups that have historically experienced discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status and others cultural disparities.

3.6 Eligibility criteria for the docket are nondiscriminatory in intent and impact. If an eligibility requirement has the unintended effect of differentially restricting access for members of a certain sociodemographic and sociocultural group, the requirement is adjusted to increase the representation of such persons unless doing so would jeopardize public safety or the effectiveness of the docket.

STANDARD IV
Mental Health Treatment

Behavioral Health Dockets are structured to integrate a comprehensive continuum of mental health treatment and rehabilitation services that are desirable and acceptable to participants and adequate to meet their validly assessed treatment needs.

4.1 An approved consent form is completed, to provide communication regarding participation and progress in treatment and compliance with 42 CFR, Part 2 (regulations governing confidentiality of treatment records) applicable state statutes, and HIPAA regulations. The Docket should make counsel available to advise participants about their decision to enter the docket.

4.2 Behavioral Health Dockets should be structured so participants progress through five phases which may include orientation, stabilization, community reintegration, maintenance, successful completion and transition out of the docket.

4.3 Once accepted for admission, the participant is enrolled immediately in evidence-based mental health treatment services based on their validly assessed treatment needs and placed under supervision so compliance can be monitored. Assessors are trained to administer screening and other assessment tools validly, reliably, and in a manner that does not retraumatize or shame participants. Participants collaborate with their treatment providers or clinical case managers in setting treatment plan goals and choosing from among the available treatment options and provider agencies.

4.4 Participants attend group counseling and meet individually with a clinical case manager or comparable treatment professional at least weekly during the first phase of the Docket. Counseling groups have no more than 12 participants and at least 2 facilitators. Persons with trauma histories are treated in same-sex groups or groups focused on their culturally related experiences, strengths, and stress reactions resulting from discrimination, harassment, or related harms.

4.5 Participants are assessed using a validated instrument for trauma history, trauma-related symptoms, posttraumatic stress disorder (PTSD). Participants with PTSD receive an evidence-based intervention that teaches them how to manage distress without resorting to substance use or other avoidance behaviors, desensitizes them gradually to symptoms of panic and anxiety, and encourages them to engage in productive actions that reduce the risk of re-traumatization. Participants with PTSD or severe trauma-related symptoms are evaluated for their suitability for group interventions and are treated on an individual basis or in small groups when necessary to manage panic, dissociation, or severe anxiety. Female participants receive trauma-related services in gender-specific groups. All Docket team members, including court personnel and other criminal justice professionals, may receive formal training on delivering trauma-informed services from

the Office of the Executive Secretary.

4.6 All mental health treatment and substance use disorder treatment services are provided by programs licensed by the Virginia Department of Behavioral Health and Developmental Services pursuant to Va. Code § 37.2-405, or persons licensed by the Virginia Department of Health Professions. The docket offers a continuum of care for mental health treatment including residential, day treatment, intensive outpatient, and outpatient services.

4.7 A participant may be required to contribute to the cost of the treatment they receive while participating in a behavioral health docket pursuant to guidelines developed by the local behavioral health docket advisory committee. The docket supervises such payments and considers the participant's financial ability to fulfill these obligations.

4.8 The inability to contribute to the cost of treatment will not prevent someone from phase progression, graduation, or result in a sanction.

4.9 The Behavioral Health Docket judge can impose continuing financial conditions that remain enforceable after program completion as persons attain employment or accrue other financial or social capital enabling them to meet their financial obligations and other responsibilities.

4.10 All prospective candidates for, and participants in, the Behavioral Health Docket are screened as soon as possible after arrest or upon entering custody for their potential overdose risk and other indications for Medication Assisted Treatment (MAT) and are referred, where indicated, to a qualified medical practitioner for a medical evaluation and possible initiation or maintenance of MAT. Assessors are trained to administer screening and other assessment tools validly and reliably and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation. Participants are rescreened if new symptoms develop or if their treatment needs or preferences change. Behavioral Health Docket staff rely exclusively on the judgment of medical practitioners in determining whether a participant needs MAT, the choice of medication, the dose and duration of the medication regimen, and whether to reduce or discontinue the regimen. Participants inform the prescribing medical practitioner that they are enrolled in the Behavioral Health Docket and execute a release of information enabling the prescriber to communicate with the docket team about their progress in treatment and response to the medication. All members of the docket team receive at least annual training on how to enhance program utilization of Medication Assisted Treatment (MAT) and ensure safe and effective medication practices.

4.11 Participants receive behavioral therapy and cognitive behavioral therapy (CBT) interventions that are documented in treatment manuals and proven to enhance outcomes for persons with substance use or mental health disorders who are involved in the criminal justice system. CBT interventions focus, sequentially, on addressing substance use, mental health, and/or trauma symptoms; teaching prosocial thinking and problem-solving skills; and developing life skills (e.g., time management, personal finance, parenting skills) needed to fulfill long-term adaptive roles like employment, household management, or education.

4.12 In the first phase of Behavioral Health Docket, participants receive services designed primarily to stabilize them, initiate abstinence if applicable, teach them effective prosocial problem-solving skills, and enhance their life skills (e.g., time management,

personal finance) needed to fulfill adaptive roles like employment. In the interim phases of Behavioral Health Docket, participants receive services designed to resolve criminogenic needs that co-occur frequently with mental health disorders and substance use, such as criminal-thinking patterns, delinquent peer interactions, and family conflict. In the later phases of the Behavioral Health Docket, participants receive services designed to maintain treatment gains by enhancing their long-term adaptive functioning, such as vocational or educational counseling.

4.13 Members of all sociodemographic and sociocultural groups receive the same levels of care and quality of treatment as other participants with comparable clinical needs. The Behavioral Health Docket administers evidence-based treatments that are effective for use with members of all sociodemographic and sociocultural groups who are represented in the Behavioral Health Docket population.

4.14 Participants are not detained in jail to achieve treatment or social service objectives.

STANDARD V
Complementary Services and Recovery Capital

Complementary services for conditions that co-occur with mental health disorders and are likely to interfere with their compliance in the docket, increase criminal recidivism, or diminish treatment gains will be available to each participant. Participants receive desired evidence-based services from qualified treatment, public health, social service, or rehabilitation professionals that safeguard their health and welfare, help them to achieve their chosen life goals, sustain indefinite recovery, and enhance their quality of life.

5.1 Trained evaluators assess participants' skills, resources, and other recovery capital, and work collaboratively with them in deciding what complementary services are needed to help them remain safe and healthy, reach their achievable goals, and optimize their long-term adaptive functioning.

5.2 Participants with unstable or insecure living arrangements receive housing assistance for as long as necessary to keep them safe and enable them to focus on their recovery and other critical responsibilities. Until participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, they are referred to assisted housing that follows a "housing first" philosophy and does not discharge residents for new instances of substance use. After participants are clinically and psychosocially stable, those with insecure housing may be referred to a recovery residence that focuses on maintaining abstinence and requires participants to contribute within their means to the functioning and leadership of the facility. Participants who are in acute crisis or are at imminent risk for drug overdose, hospitalization, or other serious health threats are referred, if available, to peer respite housing where they receive 24-hour support, monitoring, and advice from certified peer recovery support specialists or supervised peer mentors.

5.3 A trained and qualified assessor screens all participants for medical and dental care needs and refers those needing services to a medical or dental practitioner for evaluation and treatment. An experienced benefits navigator or other professional such as a social worker helps participants complete enrollment applications and meet other coverage

requirements to access third-party payment coverage or publicly subsidized or indigent healthcare.

5.4 Participants receive vocational, educational, or life skills counseling to help them succeed in chosen life roles such as employment, schooling, or household management. Qualified vocational, educational, or other rehabilitation professionals assess participants' needs for services that prepare them to function well in such a role and deliver desired evidence-based services proven to enhance outcomes in substance use, mental health, or criminal justice populations. Participants are not required to obtain a job or enroll in school until they are psychosocially stable, have achieved early remission of their substance use or mental health disorder, and can benefit from needed preparatory and supportive services. For participants who are already employed, enrolled in school, or managing a household, scheduling accommodations (e.g., after-hours counseling sessions) are made to ensure that these responsibilities do not interfere with their receipt of needed docket treatment services. Staff members engage in active outreach efforts to educate prospective employers about the benefits and safety of hiring treatment docket participants who are being closely monitored, receiving evidence-based services, and held safely accountable for their actions on the job.

5.5 Participants receive evidence-based family counseling with close family members or other significant persons in their life when it is acceptable to and safe for the participant and other persons. Qualified family therapists or other trained treatment professionals deliver family interventions based on an assessment of the participant's goals and preferences, current phase in the docket, and the needs and developmental levels of the participant and impacted family members. In the early phases of the docket, family interventions focus on reducing familial conflict and distress, educating family members or significant others about the recovery process, teaching them how to support the participant's recovery, and leveraging their influence, if it is safe and appropriate to do so, to motivate the participant's engagement in treatment. After participants have achieved psychosocial stability and early remission of their substance use or mental health disorder, family interventions focus more broadly on addressing dysfunctional interactions and improving communication and problem-solving skills. Family therapists carefully assess potential power imbalances or safety threats among family members or intimate partners and treat vulnerable persons separately or in individual sessions until the therapist is confident that any identified risks have been averted or can be managed safely. In cases involving domestic or intimate partner violence, family therapists deliver a manualized and evidence-based cognitive behavioral therapy curriculum that focuses on the mutually aggravating effects of substance-use or mental health symptoms and domestic violence, addresses maladaptive thoughts impacting these conditions, and teaches effective anger regulation and interpersonal problem-solving skills. Family therapists receive at least 3 days of pre-implementation training on family interventions, attend annual booster sessions, and receive at least monthly supervision from a clinical supervisor who is competently trained on the intervention.

5.6 Experienced staff members or community representatives inform participants about local community events and cultural or spiritual activities that can connect them with prosocial networks, provide safe and rewarding leisure opportunities, support their recovery efforts, and enhance their resiliency, self-esteem, and life satisfaction.

STANDARD VI
Participant Compliance

A coordinated multidisciplinary strategy governs incentives, sanctions, and service adjustments from the Behavioral Health Docket to each participant's performance and progress.

6.1 The docket team classifies participants' goals according to their difficulty level before considering what responses to deliver for achievements or infractions of these goals. Incentives and sanctions are delivered to enhance compliance with goals that participants can achieve in the short term and sustain for a reasonable period of time (proximal goals), whereas service adjustments are delivered to help participants achieve goals that are too difficult for them to accomplish currently (distal goals).Treatment providers, the judge, supervision staff and other docket staff maintain frequent, regular communication to provide timely reporting of participant performance to enable the court to respond immediately.

6.2 Graduated responses to the participant's compliance and noncompliance are defined clearly in the docket's operating documents and are appropriately consistent with the infraction or accomplishment.

6.3 The docket provides clear and understandable advance notice to participants about docket requirements, the responses for meeting or not meeting these requirements, and the process the team follows in deciding on appropriate individualized responses to participant behaviors. This information is documented clearly and understandably in the docket manual and in a participant handbook that is distributed to all participants, staff, and other interested stakeholders or referral sources, including defense attorneys.

6.4 Participants receive copious incentives for engaging in beneficial activities that take the place of harmful behaviors and contribute to long-term recovery and adaptive functioning, such as participating in treatment, recovery support activities, healthy recreation, or employment. Examples of effective low-cost incentives include verbal praise, symbolic tokens like achievement certificates, affordable prizes, fishbowl prize drawings, points or vouchers that can be accumulated to earn a prize, and reductions in required costs of treatment or community service hours. Incentives are delivered for all accomplishments, as reasonably possible, in the first two phases of the docket, including attendance at every appointment, truthfulness (especially concerning prior infractions), and participating productively in counseling sessions. Once goals have been achieved or managed, the frequency and magnitude of incentives for these goals may be reduced, but intermittent incentives continue to be delivered for the maintenance of important managed goals.

6.5 Service adjustments, not sanctions, are delivered when participants do not meet distal goals. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to treatment plans are based on the recommendations of duly trained treatment professionals. Supervision adjustments are carried out based on recommendations from trained community supervision officers predicated on a valid risk and need assessment and the participant's response to previous services. Supervision is increased when necessary to provide needed support, ensure that participants remain safe, monitor their recovery obstacles, and help them to develop better coping skills.

6.6 Jail sanctions should be imposed only after verbal warnings and several low-and moderate-magnitude sanctions have been unsuccessful in deterring repeated infractions of proximal goals or when participants engage in behavior that endangers public safety. Continued use of illicit substances is insufficient, by itself, to establish a risk to public safety or participant welfare requiring a jail sanction. Jail sanctions are not imposed for substance use before participants are psychosocially stable and in early remission from their substance use or mental health disorder, are usually no more than 3 to 6 days in length, and they are delivered in the least disruptive manner possible (e.g., on weekends or evenings) to avoid interfering with treatment, household responsibilities, employment, or other productive activities. Participants receive reasonable due process protections before a jail sanction is imposed. Jail detention is not used to achieve rehabilitative goals, such as to deliver in-custody treatment for continuing substance use or to prevent drug overdose or other threats to the person's health, because such practices increase the risk of overdose, overdose-related mortality, and treatment attrition. Before jail is used for any reason other than to avoid a serious and imminent public safety threat or to sanction a participant for repeated infractions of proximal goals, the judge finds by clear and convincing evidence that jail custody is necessary to protect the participant from imminent and serious harm and the team has exhausted or ruled out all other less restrictive means to keep the person safe. If no less restrictive alternative is available or likely to be adequate, then as soon as the crisis resolves or a safe alternative becomes available, the participant is released immediately from custody and connected with needed community services. Release should ordinarily occur within days, not weeks or longer. While participants are in custody, staff ensure that they receive uninterrupted access to Medication Assisted Treatment, psychiatric medication, medical monitoring and treatment, and other needed services, especially when they are in such a vulnerable state and highly stressful environment. Participants are given an opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and service adjustments. If a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge permits the participant's attorney to assist in providing such explanations. Participants receive a clear justification for why a particular consequence is or is not being imposed.

6.7 Sanctions are delivered for infractions of proximal goals, are delivered for concrete and observable behaviors (e.g., not for subjective attitudinal traits), and are delivered only when participants have received clear advance notice of the behaviors that are expected of them and those that are prohibited. Participants do not receive high-magnitude sanctions like home detention or jail detention unless verbal warnings and several low and moderate-magnitude sanctions have been unsuccessful in deterring repeated infractions of proximal goals. Sanctions are delivered without expressing anger or ridicule. Participants are not shamed or subjected to foul or abusive language. Treatment services or conditions are not used as incentives or sanctions.

6.8 The docket does not deny admission, advancement, impose sanctions, or discharge participants unsuccessfully for the prescribed use of prescription medications, including Medication Assisted Treatment (MAT), psychiatric medication, and medications for other diagnosed medical conditions such as pain or insomnia.

6.9 Staff deliver sanctions or service adjustments pursuant to best practices for the

nonmedical or "recreational" use of marijuana. In jurisdictions that have legalized marijuana for medical purposes, staff adhere to the provisions of the medical marijuana statute and case law interpreting those provisions. Participants using marijuana pursuant to a lawful medical recommendation inform the certifying medical practitioner that they are enrolled in the docket and execute a release of information enabling the practitioner to communicate with the docket team about the person's progress in treatment and response to marijuana. Staff deliver sanctions or service adjustments pursuant to best practices for the nonmedically recommended use of medically certified marijuana.

6.10 Participants facing possible unsuccessful discharge from the docket receive a due process hearing with comparable due process elements to those of a probation revocation hearing. Before discharging a participant unsatisfactorily, the judge finds by clear and convincing evidence that: the participant poses a serious and imminent risk to public safety that cannot be prevented by the docket's best efforts, the participant chooses to voluntarily withdraw from the docket despite staff members' best efforts to dissuade the person and encourage further efforts to succeed, or the participant is unwilling or has repeatedly refused or neglected to receive treatment or other services that are minimally required for the person to achieve rehabilitative goals and avoid recidivism. Before discharging a participant for refusing offered treatment services, treatment professionals make every effort to reach an acceptable agreement with the participant for a treatment regimen that has a reasonable chance of therapeutic success, poses the fewest necessary burdens on the participant, and is unlikely to jeopardize the participant's welfare or public safety. Defense counsel clarifies in advance in writing with the participant and other team members what consequences may result from voluntary withdrawal from the docket and ensures that the participant understands the potential ramifications of this decision.

STANDARD VII
Testing

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the Specialty Docket. [9]

7.1 Specialty Dockets have written policies and procedures for the frequency of drug screening, sample collection, chain of custody, sample analysis, and result reporting. At a minimum, dockets should be urine testing participants at least twice per week until participants are in the last phase of the program and preparing for graduation. During the first two phases, participants should be Ethyl Glucuronide (EtG), or Ethyl Sulphate (EtS) tested on a weekly basis. All drug and alcohol tests should be administered by a trained professional staff member assigned to or authorized by the Specialty Docket. Urine specimens are delivered no more than eight hours after being notified that a urine test has been scheduled. Testing should be random[10] and unpredictable, including weekends and

[9]Unauthorized substances include alcohol, illicit drugs, and addictive or intoxicating prescription medications that are taken without prior approval from the specialty docket and not during a medical emergency.

[10] lacking a definite plan, purpose, or pattern. Removal of human element, unknown beforehand, random system-purchased through a provider.

holidays.

7.2 The testing policies and procedures include a coordinated strategy for responding to noncompliance, including prompt responses to positive tests, missed tests, and fraudulent tests.

7.3 The testing policies and procedures address elements that contribute to the reliability and validity of a urinalysis testing process. The scope of testing is sufficiently broad to detect the participant's primary drug of choice as well as other potential drugs of abuse, including alcohol. Test specimens are examined routinely for evidence of dilution and adulteration. Each specialty docket has breathalyzer capability, dockets without a breathalyzer may pursue grant funds for this resource.

7.4 Upon entering the specialty docket, participants receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information is described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

7.5 Test results are communicated to the court and the participant within forty-eight hours of sample collection, recognizing that the specialty docket functions best when it can respond immediately.

STANDARD VIII
Role of the Judge

The Behavioral Health Docket judge stays abreast of current law and research on best practices in treatment dockets and carefully considers the professional observations and recommendations of other team members when developing and implementing docket policies and procedures. The judge develops a collaborative working alliance with participants to support their recovery while holding them accountable for abiding by docket conditions and attending treatment and other indicated services.

8.1 Regular status hearings are used to monitor participant performance:

- **a.** Participants appear in court for status hearings no less frequently than every two weeks during the first two phases of the docket or until they are clinically and psychosocially stable and reliably engaged in treatment. Some participants may require weekly status hearings in the beginning of the docket to provide for more enhanced structure and consistency, such as persons with co-occurring mental health and substance use disorders or those lacking stable social supports. Participants continue to attend status hearings on at least a monthly basis for the remainder of the docket or until they are in the last phase and are reliably engaged in recovery support activities that are sufficient to help them maintain recovery after docket discharge.
- **b.** A significant number of docket participants appear at each session. This gives the judge the opportunity to educate both the participant at the bench and those waiting[11] as to the benefits of docket compliance and consequences for noncompliance. The judge should average at least 3 minutes with each participant.

8.2 The judge attends pre-court staff meetings routinely and ensures that all team members

[11] Docket participants should stay for the duration of the docket.

contribute their observations about participant performance and provide recommendations for appropriate actions. The judge gives due consideration to each team member's professional expertise and strategizes with the team to intervene effectively with participants during status hearings.

8.3 The presiding judge should remain as consistent as possible; terms should be no less than 2 years in length with a required training from the Office of the Executive Secretary's Specialty Docket team prior to presiding over a behavioral health docket. If the judge must be absent temporarily because of illness, vacation, or similar reasons, the team briefs substitute judges carefully about participants' performance in the docket to avoid inconsistent messages, competing demands, or inadvertent interference with behavioral health docket policies or procedures. The team also briefs substitute judges on behavioral health docket best practices per their docket operations manual and the state standards.

8.4 The judge attends training conferences or seminars at least annually on judicial best practices in treatment dockets, including legal and constitutional standards governing docket operations, judicial ethics, achieving cultural equity, evidence-based behavior modification practices, and strategies for communicating effectively with participants and other professionals. The judge also receives sufficient training to understand how to incorporate specialized information provided by other team members into judicial decision making, including evidence-based principles of substance use and mental health treatment, complementary interventions and social services, community supervision practices, drug and alcohol testing, and docket performance monitoring.

8.5 The judge is the ultimate arbiter of factual disputes and makes the final decisions concerning the imposition of incentives, sanctions, or dispositions that affect a participant's legal status or liberty interests. The judge makes these decisions after carefully considering input from other docket team members and discussing the matter with the participant and their legal representative in court.

8.6 The judge relies on the expertise of qualified treatment professionals when setting court-ordered treatment conditions. The judge does not order, deny, or alter treatment conditions independently of expert clinical advice, because doing so may pose an undue risk to participant welfare, disillusion participants and credentialed providers, and waste treatment resources.

STANDARD IX
Evaluation and Monitoring

The Behavioral Health Docket has results that are measured, evaluated, and communicated to the public.

9.1 The goals of the Behavioral Health Docket are described concretely and in measurable terms. Minimum goals are:

a. Treating participant's mental health symptoms;
b. Reducing crime;
c. Improving public safety, including highway safety;
d. Reducing recidivism;
e. Reducing behavioral health-related court workloads;
f. Increasing personal, familial, and societal accountability among participants; and

g. *Promoting effective planning and use of resources among the criminal justice system and community agencies.*

9.2 The Behavioral Health Docket has an evaluation and monitoring protocol describing measurement of progress in meeting operational and administrative goals, effectiveness of treatment, and outcomes. An evaluator examines the docket's adherence to best practices and participant outcomes no less frequently than once every five years. The docket develops a remedial action plan and timetable to implement recommendations from the evaluator to improve the docket's adherence to best practices.

9.3 The docket monitors and evaluates its adherence to best practice standards on at least an annual basis, develops a remedial action plan and timetable to rectify deficiencies, and examines the success of the remedial actions. Outcome evaluations describe the effectiveness of the docket's adherence to best practices.

9.4 Information systems adhere to written policies consistent with state and federal guidelines that protect against unauthorized disclosure.

9.5 The docket must use and maintain current data in an information technology system as prescribed by the Office of the Executive Secretary.

9.6 The docket continually monitors participant outcomes during enrollment in the docket, including attendance at scheduled appointments, drug and alcohol test results, graduation rates, lengths of stay, and in- docket technical violations and new arrests.

9.7 Outcomes are examined for all eligible participants who entered the docket regardless of whether they graduated, withdrew, or were terminated from the docket.

9.8 Where such information is available, new arrests, new convictions, and new incarcerations are monitored for at least three years following each participant's entry into the docket. Offenses are categorized according to the level (felony, misdemeanor, or summary offense) and nature (e.g., person, property, drug, or traffic offense) of the crime involved.

9.9 The Behavioral Health Docket in addition to the local advisory committee regularly monitors whether members of all sociodemographic and sociocultural groups complete the docket at equivalent rates. If completion rates are significantly lower for certain sociodemographic and sociocultural groups, the docket team investigates the reasons for the disparity, develops a remedial action plan, and evaluates the success of the remedial actions.

STANDARD X
Education and Training

The Behavioral Health Docket team requires continued interdisciplinary education, training, and program assessment.

10.1 Key personnel have attained a specific level of basic education, as defined in staff training requirements and in the written operating procedures. The operating procedures define annual requirements for the continuing education of each docket staff member.

10.2 Equity and inclusion training is prioritized, and affirmative steps are taken to detect and correct inequities services and disparate outcomes among any sociodemographic or sociocultural groups.

10.3 All docket personnel attend continuing education programs. Regional and national

specialty docket training programs provide critical information on innovative developments across the nation. Sessions are most productive when specialty docket personnel attend as a group.

10.4 Interdisciplinary education is provided for every person involved in behavioral health dockets in order to develop a shared understanding of the values, goals, and operating procedures of both the treatment and justice system components. This includes participating in a How Being Trauma Informed Improves Criminal Justice System Responses training offered by the Office of the Executive Secretary Specialty Dockets team.

10.5 All members of the docket team receive at least annual training on trauma-informed practices and ways to avoid causing or exacerbating trauma and mental health symptoms in all facets of the docket, including courtroom procedures, community supervision practices, drug and alcohol testing, and the delivery of incentives, sanctions, and service adjustments.