



Forensic Services and the Sequential Intercept Model: Opportunities for Collaboration

**Angela Torres, Ph.D., ABPP (Forensic) and
Kristen A. Hudacek, Psy.D., LCP**

Department of Behavioral Health and Developmental Services

Office of Forensic Services

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Virginia Association of Community Services Boards



- Most persons in our state hospitals are non-convicted, pretrial defendants and from Virginia jails
- Number of inpatient orders for competency restoration has skyrocketed, causing a public health crisis nationally and in Virginia
- A significant portion of people in our state hospitals are there for misdemeanor offenses, and at a significant cost to the state
- Because we have so many beds occupied by the pretrial population, those is crisis in our communities have less access to state hospital beds, contributing to longer waits in the ED, with significant burdens placed on law enforcement
- National experts and research tells us this group in particular benefit from diversion out of the criminal justice system at earlier stages (Murrie, et.al 2023, Callanan & Pinals, 2020), but we continue to struggle in Virginia to make an impact
- Building out community resources at earlier Intercepts 0,1,2 (and 3 in some cases) will have the most impact
- Both criminal justice and behavioral health stakeholders are needed to consider solutions and recommendations for improvement...but we have a good foundation....



How can we understand gaps and target change:

The Sequential Intercept Model (SIM) Griffin, P. & Munetz, M.

The SIM is a conceptual tool to inform community-based response to justice-involved people with mental illness and substance use disorders

- Assess available resources, determine gaps in services, and plan for community change
- Best accomplished by a team of stakeholders that cross over multiple systems (SA, MH, law enforcement, pretrial services courts, jails, community corrections, housing, etc.)
- The model is then used to create a comprehensive picture of how persons with behavioral health disorders flow through the criminal justice system, along each specific intercept

Key Assumptions:

- Well-intentioned systems contribute to criminalizing behaviors associated with MI/SUD
- When individuals with MI/SUD become involved in the criminal justice system, they pass through a series of “intercepts” in predictable ways
- *The deeper one gets pulled into the criminal justice system, the more difficult it is to disentangle/divert them to more appropriate care*

Key principles:

- Prompt access to treatment
- Opportunities for diversion
- Timely movement through the criminal justice system
- Linkage to community resources

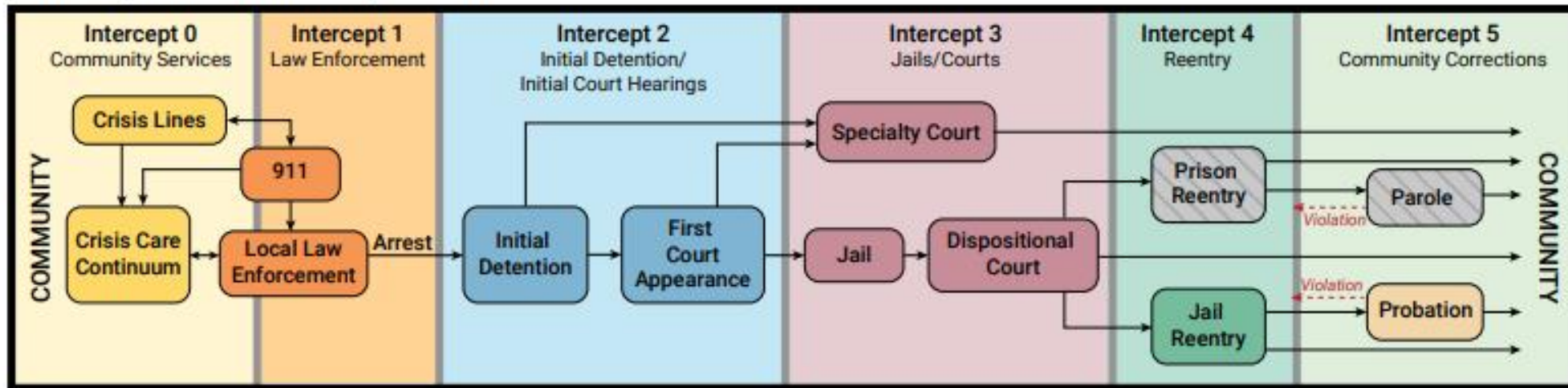


THE SEQUENTIAL INTERCEPT MODEL

Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders



The Sequential Intercept Model



- In 2008, then Governor Tim Kaine issued an Executive Order establishing the Commonwealth Consortium for Mental Health and Criminal Justice Transformation.
- Policy Research Associates (PRA) developed a 1.5 day Cross Systems Mapping workshop
 - Across two trainings in August 2008 & December 2010 a total of 40 community criminal justice and behavioral health leaders completed a “Train the Trainer” program to become certified Cross Systems Mapping workshop facilitators.
 - Trainers led 40 workshops covering 98 of 134 (73%) of localities.
 - Approximately 1,400 community behavioral health and criminal justice stakeholders attended the workshops.
 - Thirty-three out of 40 Community Service Boards (CSB’s) participated in a Cross Systems Mapping.
- From 2014 to 2016, the Office of Forensic Services began offering one-day "re-mappings" to communities that were interested in setting new priorities and action plans. Ten localities participated in the re-mapping efforts.
- Attrition, changes in administration, funding, and loss of expertise led to the dismantling of this initiative.

DBHDS Office of Forensic Services published a report summarizing this work [Cross Systems Mapping Statewide Initiative \(2008-2013\)](http://www.virginia.gov) ([virginia.gov](http://www.virginia.gov))



- **Intercept 0:** Community Services
 - Ex: *STEP-VA, Crisis Now Model, Psychiatric ER's*
- **Intercept 1:** Law enforcement/Emergency Services Response
 - Ex: *Marcus Alert & CIT Coalition (CSUs, CRCs, CITACs)*
- **Intercept 2:** Booking/Initial Court Hearings
 - Ex: *Screening for MI/SUD; **MAT**, Diversion First-Fairfax*
- **Intercept 3:** Jails & Courts
 - Ex: *Specialty dockets (MH, Drug, Veteran); Jail-based-restoration programming & health care services, Region-4 Jail Team, FDP's,*
 - **Chesterfield Court-based Clinician**
- **Intercept 4:** Re-entry from Jails/Prisons
 - Ex: *Transition planning, medication access upon release, warm hand-off to community providers, SOAR, **Peer Support Specialists (RBHA)***
- **Intercept 5:** Community corrections/Community Support
 - Ex: *Local Reentry Councils, VADOC most have specialty caseloads across Virginia*





**RIGHT HELP.
RIGHT NOW.**

Transforming Behavioral Health Care for Virginians

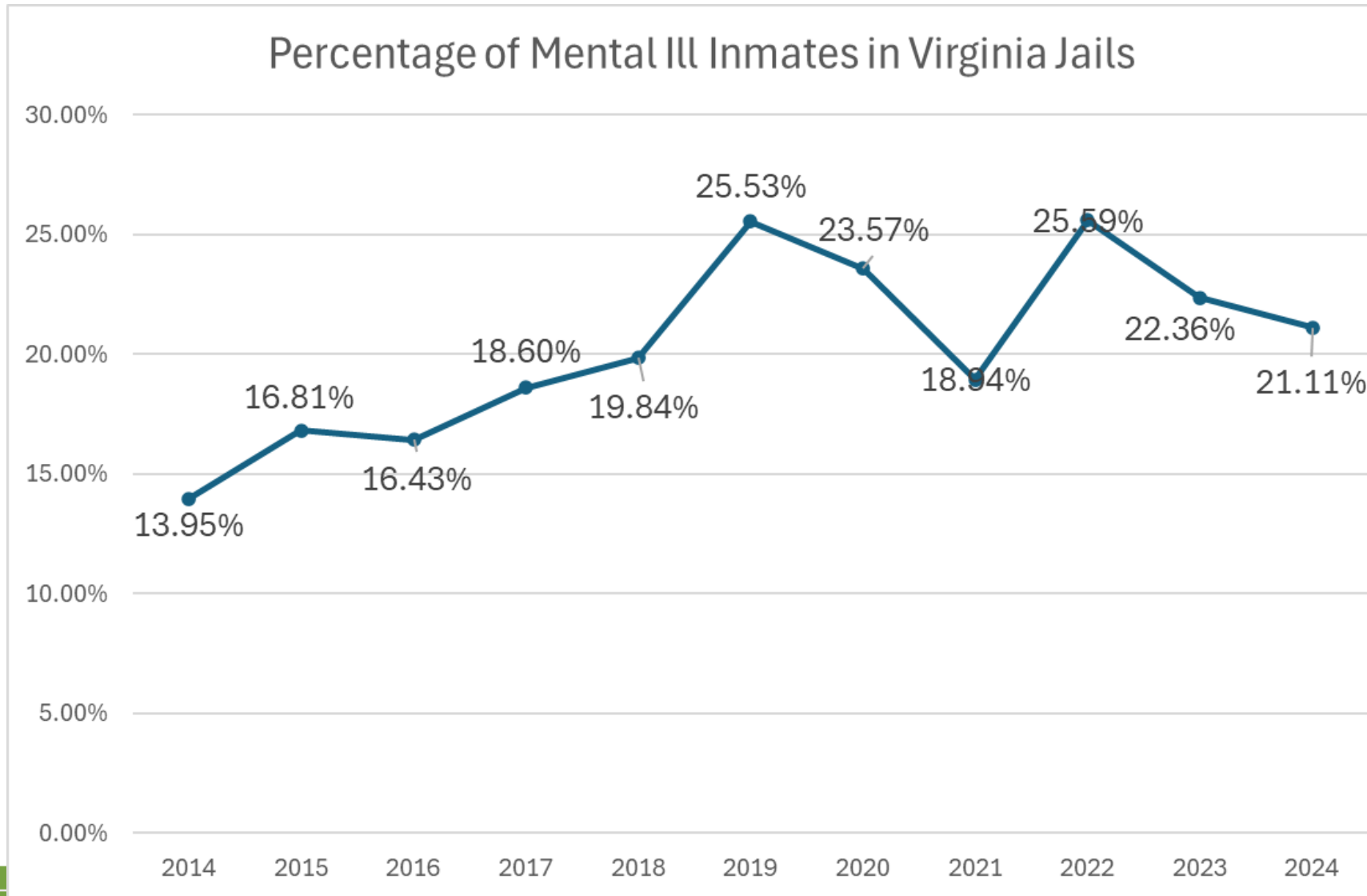
1. Ensure same-day care for individuals experiencing behavioral health crises
2. **Relieve law enforcement's burden and reduce the criminalization of mental health**
3. Develop more capacity throughout the system, going beyond hospitals, especially community-based services
4. Provide targeted support for substance use disorder and efforts to prevent overdose
5. Make the behavioral health workforce a priority, particularly in underserved communities
6. Identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps





Serious Mental Illness (SMI) in Jails





51.33%
increase in
one decade

- According to the 2024 Mental Illness in Jails Report by the State Compensation Board, the average daily inmate population was 18,542.
- 56% were pretrial
- 2022 was the first time in the report's history that pretrial inmates > post-conviction, and this year is the same.

Mental Illness in
Jails Report
Compensation Board

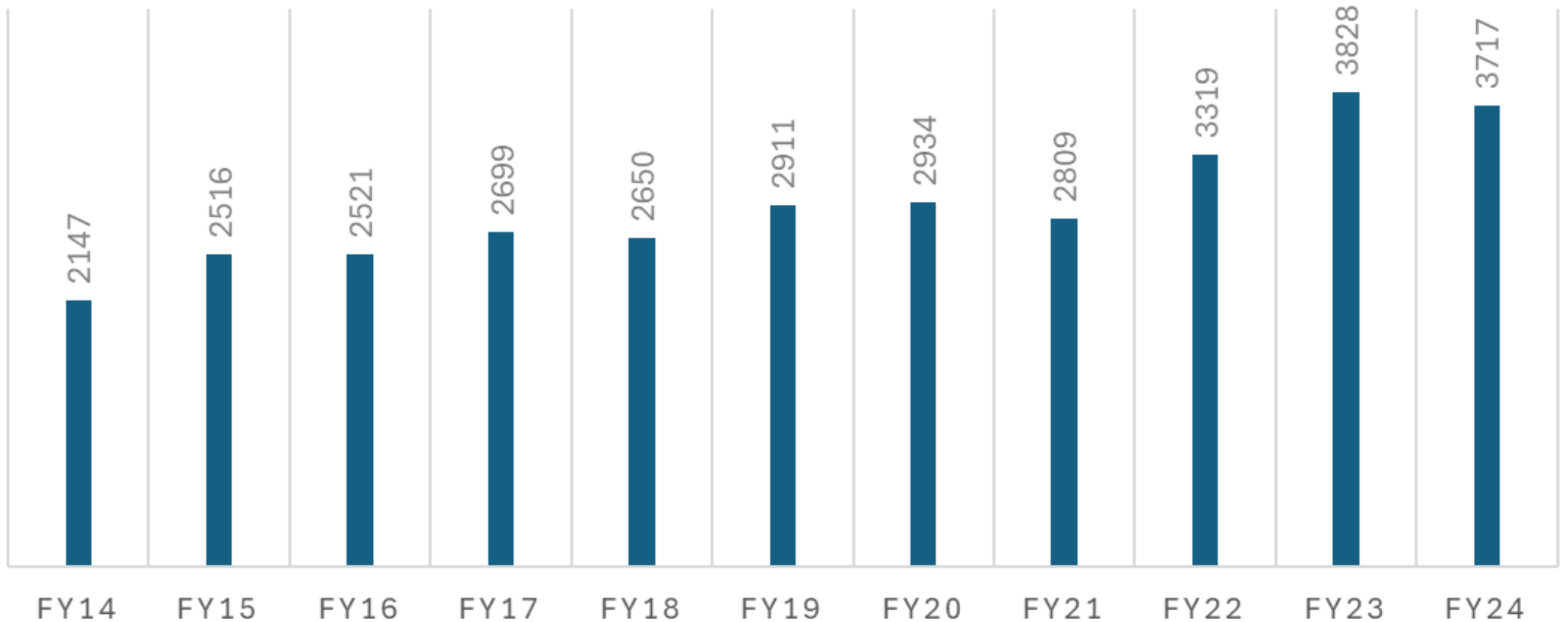
2024

November 1,
2024

Note: The average daily population was 19,734, but they excluded federal and out of state inmates in jail custody for the purpose of the study. 50 out of 57 jails responded.

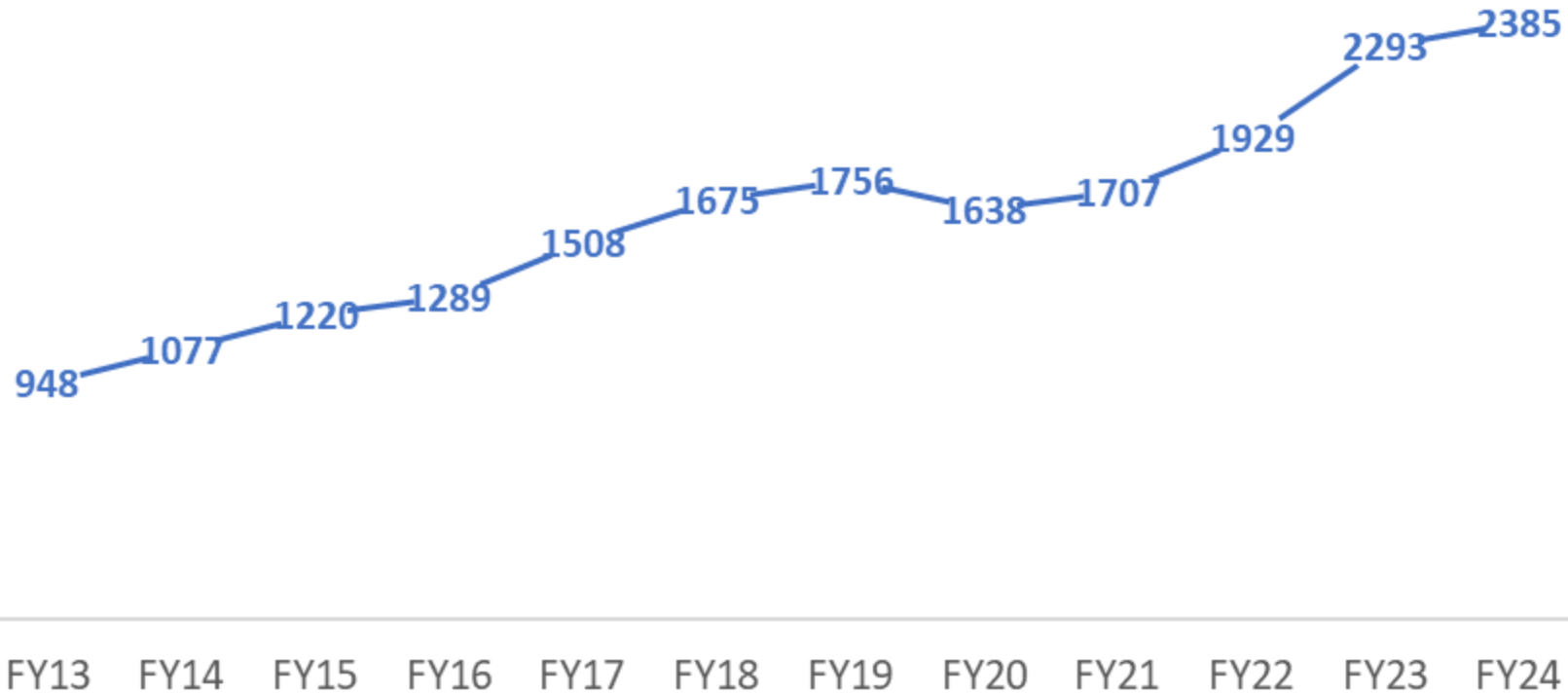
73.13%
increase
over 10
years

OUTPATIENT ADULT CST EVALUATION ORDERS



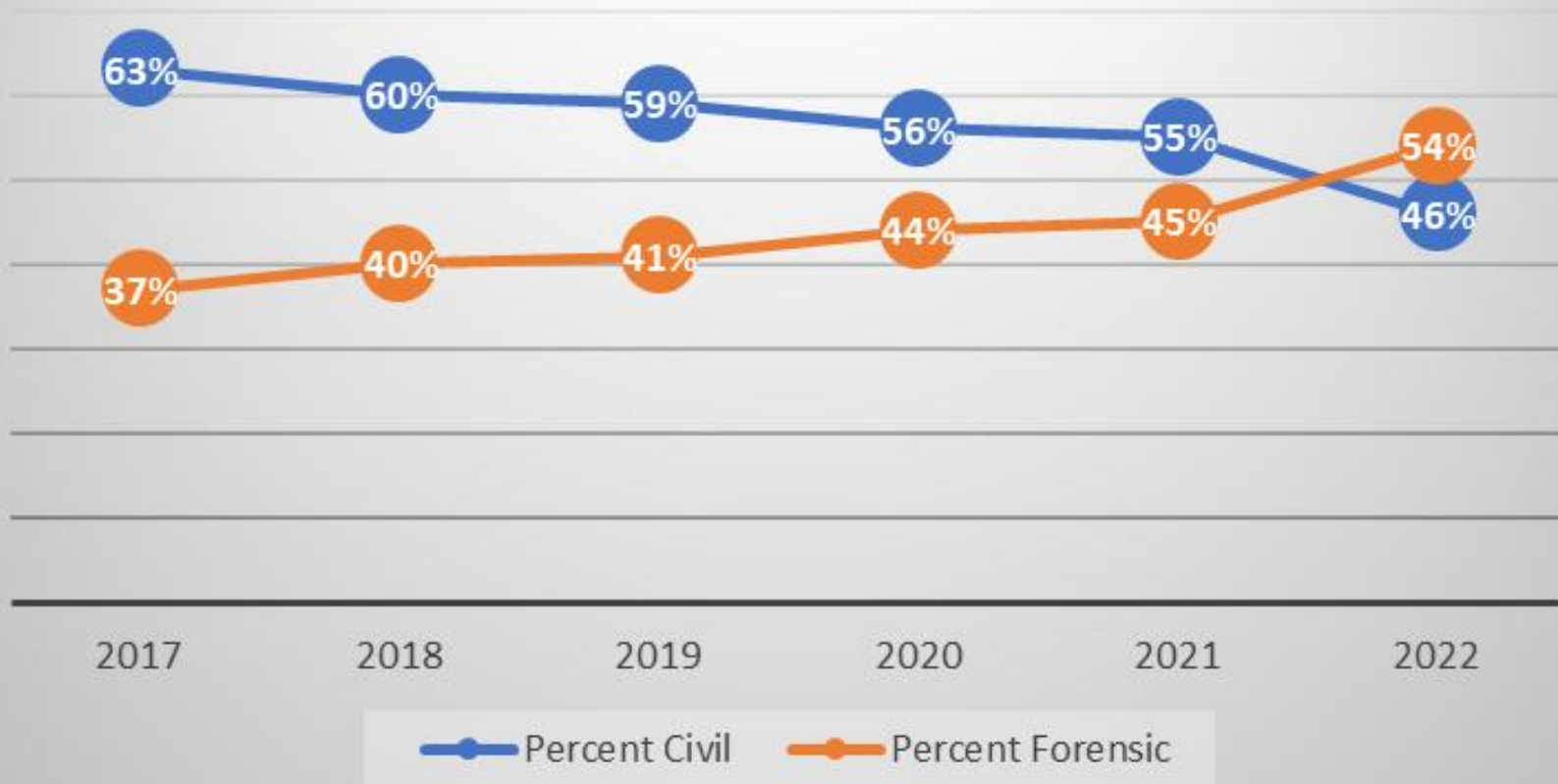
Data provided by the Office of the Executive
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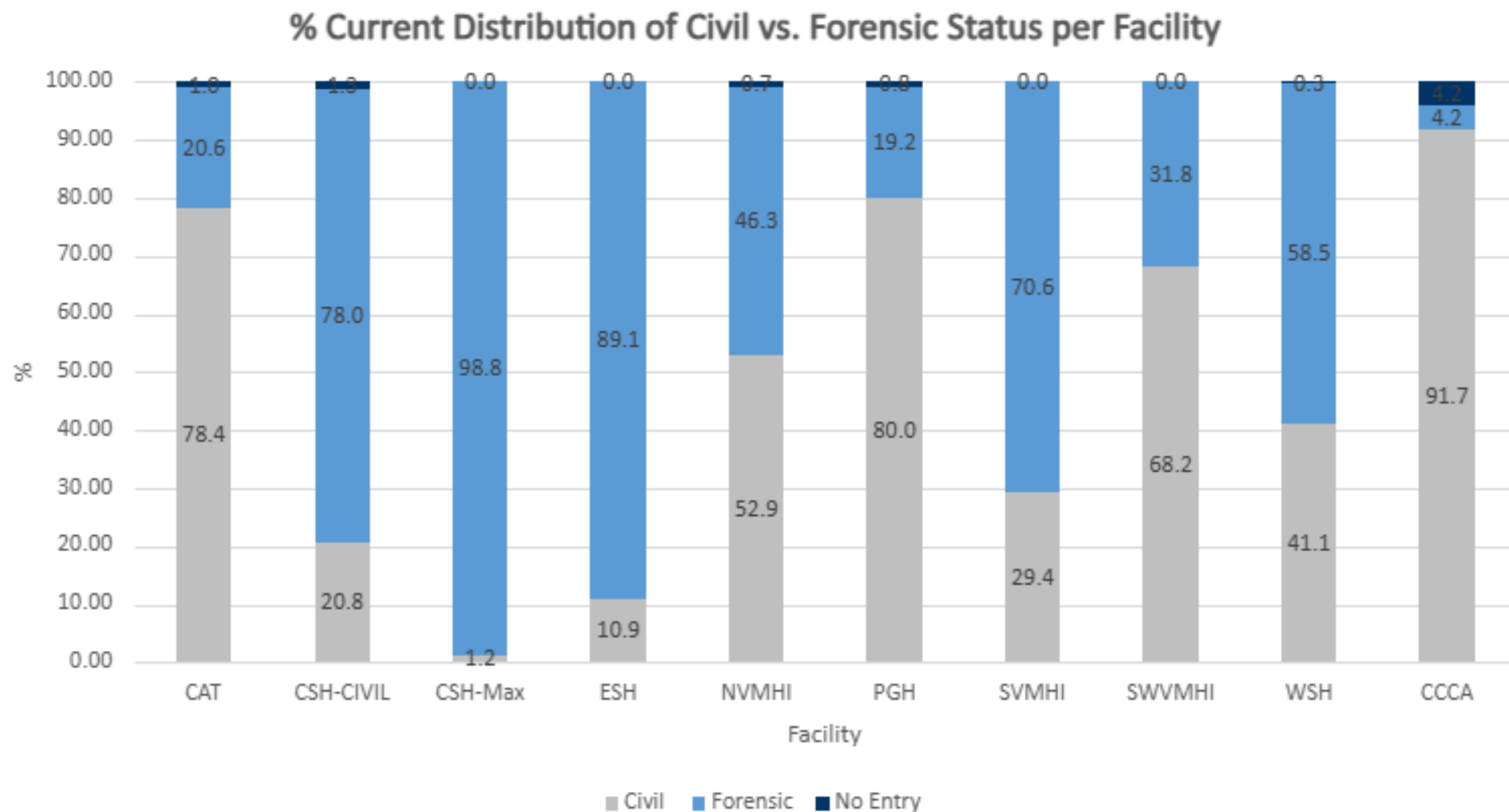
ADULT/GERIATRIC FORENSIC ADMISSIONS



151.58%
increase
over 10
years

Civil vs. Forensic Census







Early Diversion in Virginia



Someone to Call



Crisis Call Centers

When someone calls **988**, a trained crisis worker will provide support such as safety planning, referrals, and a listening ear. If needed, crisis workers can connect to the full continuum of services. Through Virginia's co-responder initiative (Marcus Alert) appropriate calls to 911 can be routed to the 988 call centers.

Someone to Respond



Mobile Crisis

Mobile Crisis Response teams are deployed in real-time, 24 hours a day, to the location of the individual experiencing a behavioral health crisis. These rapid responders provide on-scene evaluation, intervention, and connection to follow-up resources.

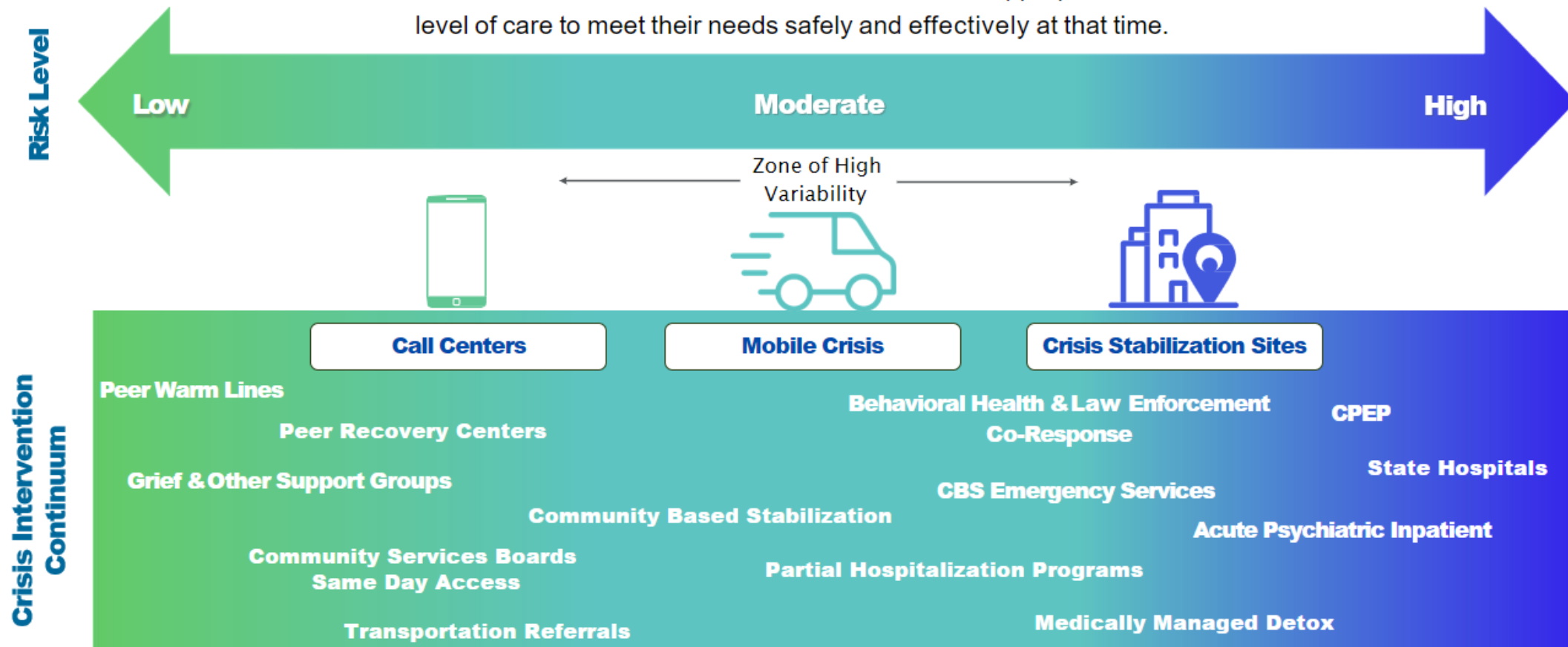
Somewhere to Go

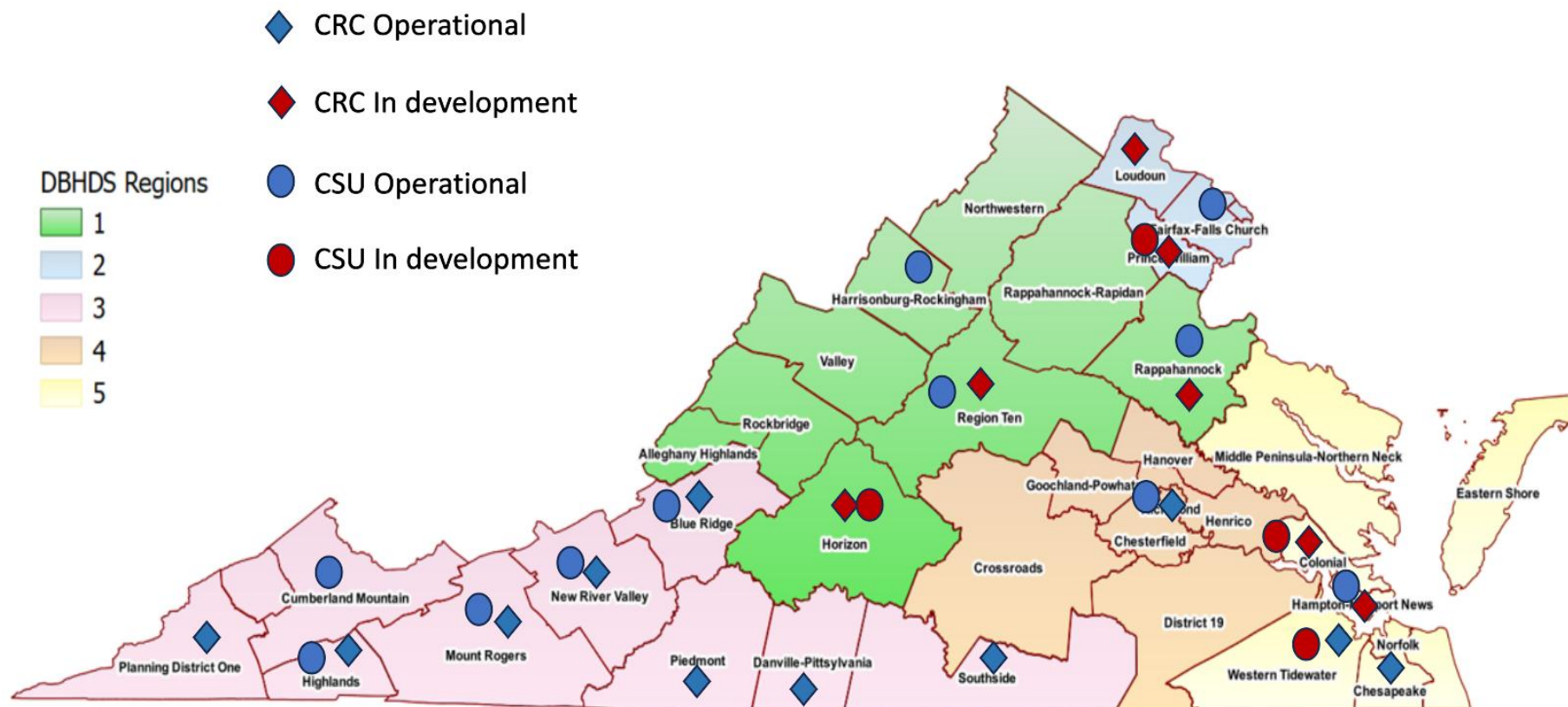


Crisis Stabilization Sites

23-hour Crisis Receiving Centers and short-term residential Crisis Stabilization Units provide a safe, secure community-based environment for assessment, resources, and emergent crisis treatment.

Individuals in crisis should be matched with the appropriate level of care to meet their needs safely and effectively at that time.

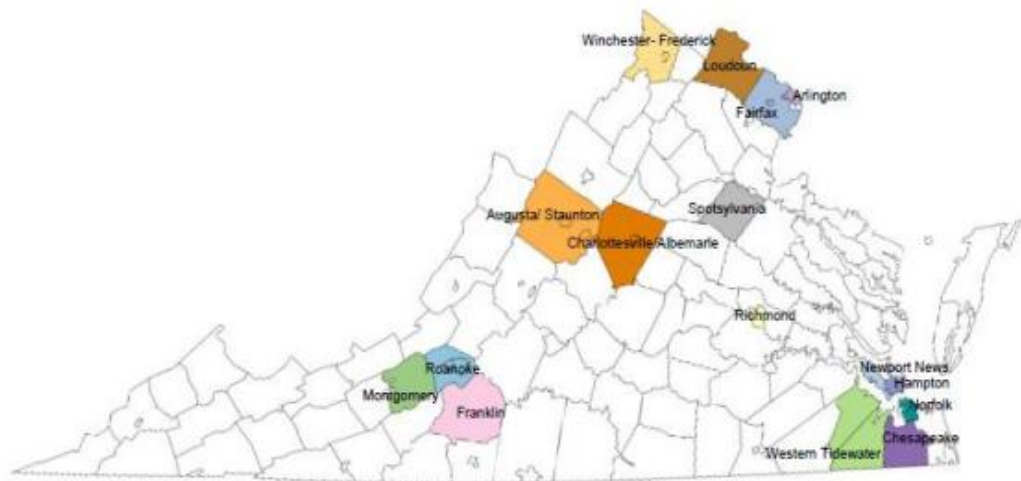




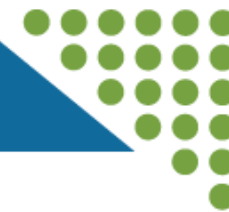


- Best Practice
- Reducing time in custody
- Reducing recidivism
- Connection to appropriate levels of care and evidence-based treatment >> Improved Outcomes
- Connection to meaningful services and supports in the community
- Integration of comprehensive and whole-person approaches to behavioral health treatment
- Reducing Stigma
- Cost-Savings
- Reducing collateral consequences
- Possible avoidance of criminal record



**Table 1. Approved Behavioral Health Dockets in Virginia, FY 2023**

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



SEPTEMBER 2024

A Resource Guide on Court Navigator Programs: Providing Connections and Support Across the Legal and Behavioral Health Systems

Policy Research Associates, Inc.



DBHDS Information Exchange Code Sections



§ 53.1-133.03. Exchange of medical and mental health information and records.

§ 32.1-127.1:03. Health records privacy.

- Basic information can be shared for continuity of care of the defendant between jail, and local CSB, forensic evaluator, without an ROI
- You will need a ROI for the release of records*





Competency Restoration

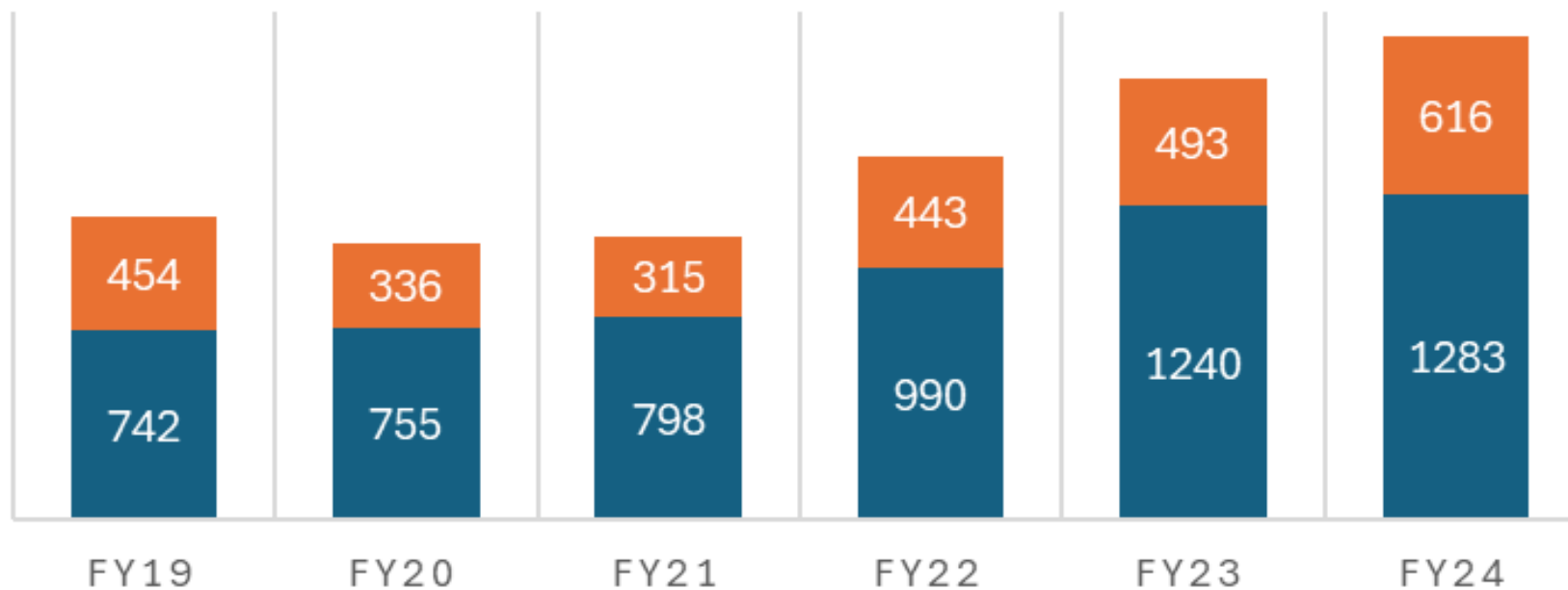


Adult Restoration Admissions to DBHDS



INPATIENT VS. OUTPATIENT RESTORATION

■ Inpatient ■ Outpatient



Reasons Behind the Competency Crisis

Lack of adequate
community
resources

Persons who lack
capacity to
consent to
treatment are
ending up in the
CST system

Greater
demand by
courts

More persons
with MI are
remaining in
jail

Steady
increase in
misdemeanor
inpt. orders

Gaps in data
collection among
CJ & BH
stakeholders

Poor
communication,
collaboration





Impact of Persons with SMI charged with Misdemeanor Offenses



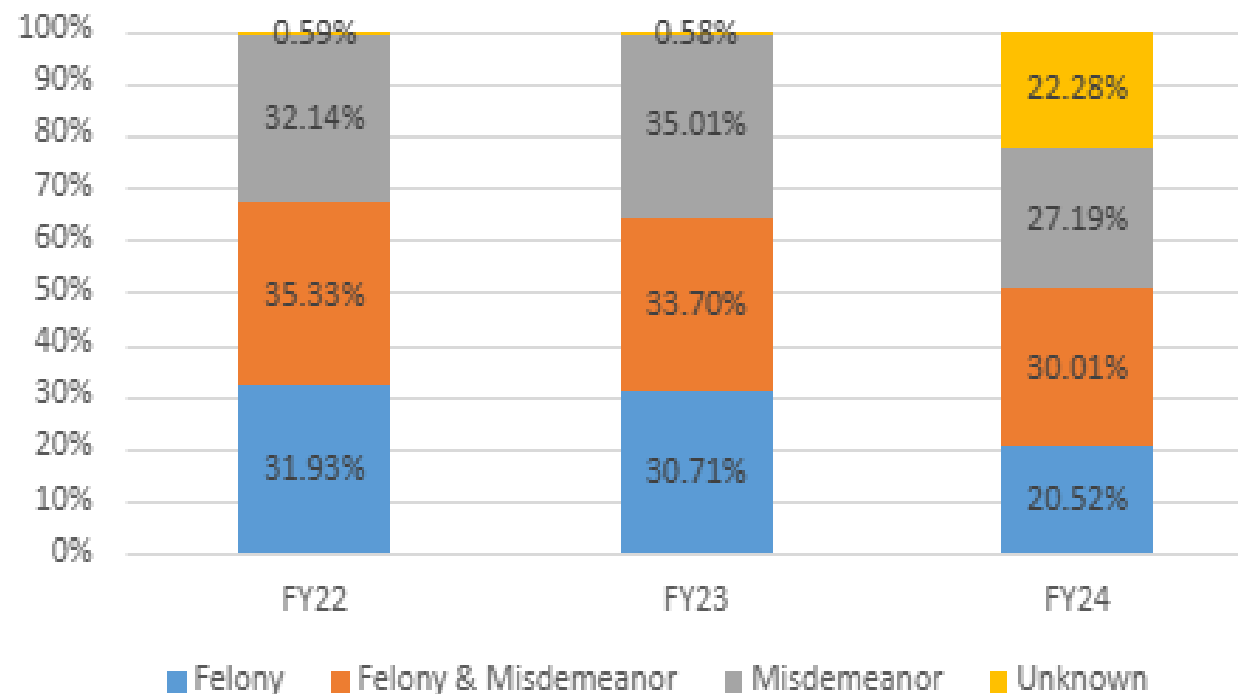
Those with SMI are more likely to be:

- Arrested and confined in jail
- Not granted bail or not able to pay cash bail
- Confined in jail or a hospital longer than misdemeanor offenders without SMI
- Incarceration and involuntary admission can be traumatizing

Impact on DBHDS:

- Over **30%** of restoration admissions are for misdemeanors
- Take enormous amount of resources and cost to face very minor charges and get timed served
- Longer LOS than civil patients; fewer civil beds available

FY22-24 Percent of Patients per Charge Level and Fiscal Year

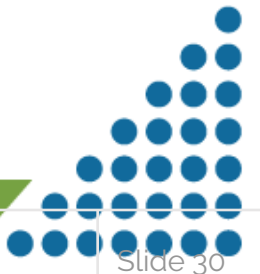




- The average cost of a DBHDS bed, per day, is approximately \$1,205.73
- Average length of stay for restoration: 106 days
 - Trespassing, Disorderly Conduct, Petty Larceny are limited to 45 days

Someone charged with a misdemeanor (not a 45-day), may be in DBHDS custody for approximately 106 days. Using the formula $(106 * \$1,205.73)$, the average cost of restoring a defendant (even one charged with a misdemeanor) is =

\$127,807.38

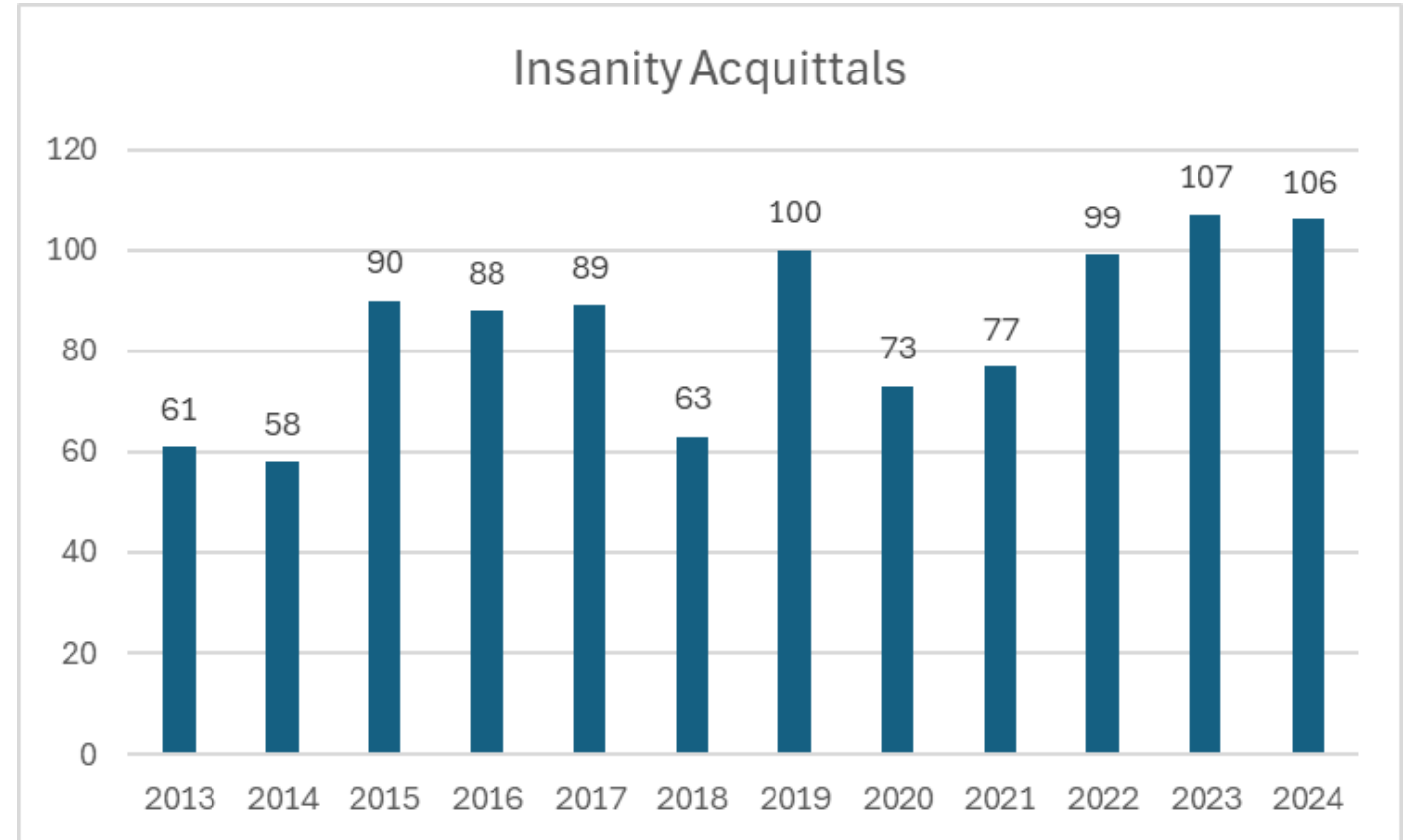




- *Callahan & Pinals (2020)* recommend expanding diversion options and provide a pathway for mental health treatment not contingent on a CST-finding, or access to the right care at the right level
- Increase opportunities for cross-collaboration
- Systemic data is needed to understand disruptions in care across systems (e.g. community, jails, state hospitals) and its impact on the individual (e.g. loss of housing, employment, etc.)
- Low level offenders are ordered to state hospitals, perhaps with little or no assessment of criminal risk, and whether remaining in custody is necessary
- Murrie, Gowensmith, Kois & Packer (2023)
 - Demand for inpatient restoration has amounted to a “competency crisis”
 - Settings for restoration should be diversified (e.g. community outpatient, Jail-based)
 - States should ensure evaluations meet minimum standards
 - Triaging strategies may be necessary (States with lengthy waitlists)
 - Re-evaluations may be needed to redirect unnecessary hospitalization (California)
 - Research on competency restoration is need



- Mental state at the time of the crime
- Due to a severe mental illness
 - Didn't know nature, character, or consequences of their actions; *or*
 - Didn't understand the wrongfulness of their actions; *or*
 - The behavior was the result of irresistible impulse

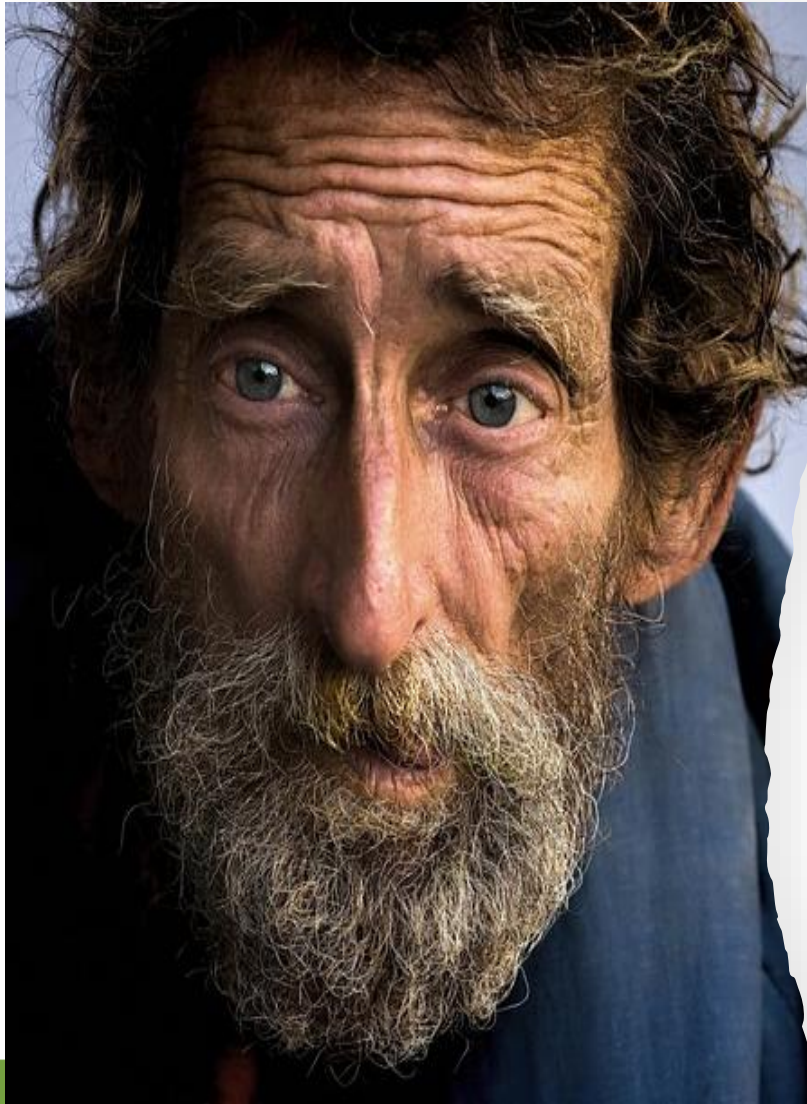


- Approximately 23,145 under VADOC supervision have mental health needs
- In Community Corrections, all Probation and Parole Districts and CCAP facilities are staffed with District Mental Health Clinicians (DMHCs) who facilitate the mental health continuum of care for inmates transitioning from incarceration to the community.
- Frequent collaboration between the DMHCs, CSBs, and Jails ensure the continuum of care for individuals with mental health needs, ultimately enhancing public safety and reducing recidivism.
 - Primary role is facilitating the “warm handoff” from incarceration to the community for returning citizens with mental health challenges. They also provide consultation to all probation/parole offices, assess mental health needs while in jail/prison, provide recommendations for care, and assist with follow-up in the community.
- For more information, contact Dr. Parham at Patricia.Parham@vadoc.virginia.gov



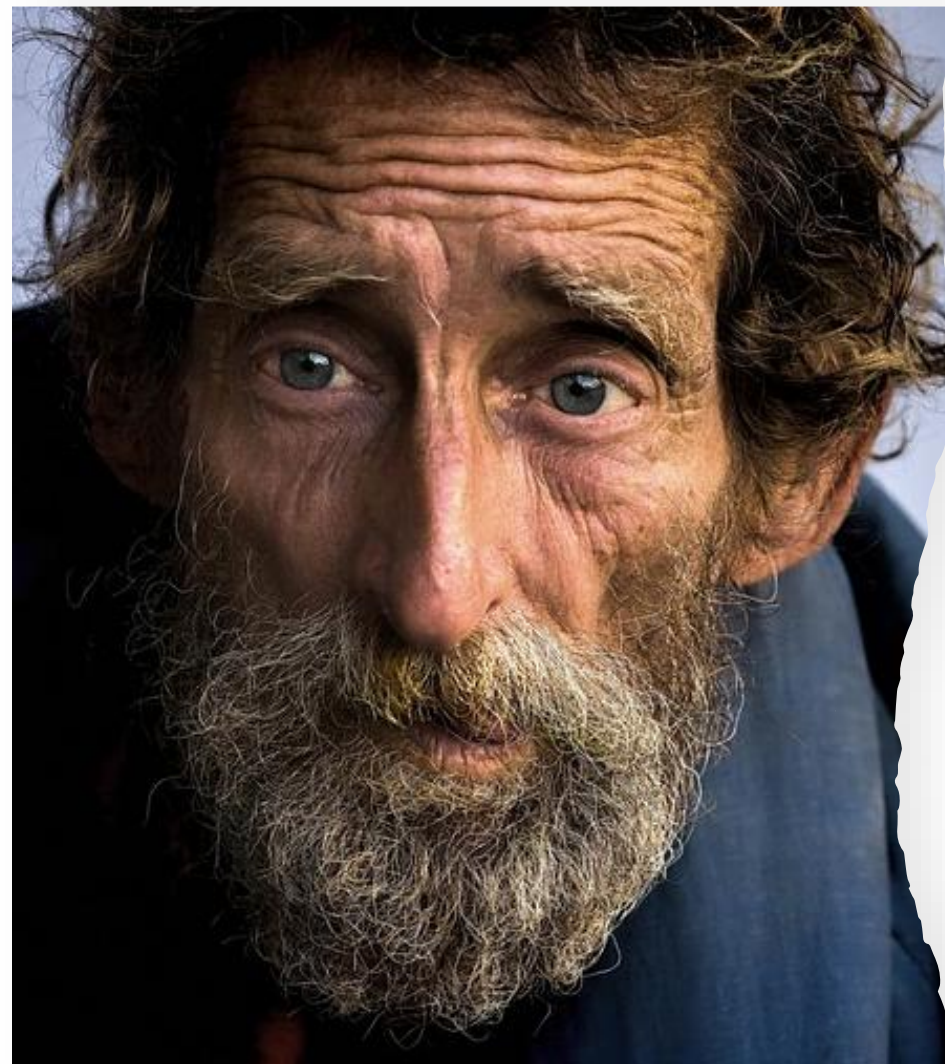
Case Illustration: “Rodney”





- 4/17/22: Police dispatched to 7-11. He is agitated, cursing, and obviously psychotic. He is told to leave and is cited for Trespassing and Profane Language over Airways. Informed that he has court on 4/24/22.
- 4/24/22: Misses court. Summons issued to take Rodney into custody.
- 4/25/22: Rodney is arrested and placed in jail.
- 4/26/22: Rodney arraigned. Determined that he should not be released on bond because he does not have stable housing and had previous failures to appear.
- 4/28/22: Defense has concerns about Rodney's ability to understand court due to what may be mental illness.
- 5/4/22: A motion for a CST evaluation is completed and order issued.

- 6/4/22: Evaluator recommends that Rodney be found incompetent to stand trial.
- 6/5/22: Order received by DBHDS
- 6/15/22: Rodney is admitted to DBHDS for restoration.
- 10/9/22: Rodney is opined competent to stand trial and returned to jail.
- 10/28/22: Rodney has a status hearing. At some point becomes partially non-adherent with medications.
- 11/7/22: Rodney has court, accepts a plea bargain, has time served.
- Jail mental health staff did not know he was going to court, so there was no means to connect him with aftercare before he was discharged by the jail. He is discharged immediately with no placement or connection with BH care.
- Two weeks later, Rodney is arrested again for Trespassing





Rodney Discussion

What were some "gaps" in Rodney's story that allowed him to penetrate deeper into the criminal justice system?

What were some potential points to intercept him out of the criminal justice system and connect him with community behavioral health care?

What could have been done differently in Rodney's case?



DBHDS»» What could have been done differently for Rodney?



- Intercept 0: FACT services or other intensive community treatment; housing
- Intercept 1: CIT trained officer at the scene, taken to CITAC or CSU instead of given a charge, taken to jail
- Intercept 2: Identification at the point of first appearance as requiring mental illness treatment; coordination between magistrate, court, pretrial services, and CSB for plan for discharge; post-booking assessment and transfer to care; MH Bond
- Intercept 3: Early identification in the jail and referrals to CSB for potential bond hearings; forensic discharge planners; holding charges in abeyance to allow for treatment through a behavioral health docket (if he was still competent to make that decision to participate)
- If Rodney continues to be arrested, and/or hospitalized, examine MOT as an option





"Familiar Faces"/Super-utilizers



- Defined as 3 or more admissions to a state facility (either a pretrial criminal or a civil commitment) within a two-year period.
- Many readmitted/known to the Behavioral Health Dockets
- Cycle in/out of jails and the state facilities (and private facilities)
 - 25% CST rearrested/restoration ordered again within 3 years 7% within 1 year
- Focus for Office of Forensic Services
- Names are provided to:
 - CSB's
 - State Hospitals
 - Early identification ideal for intervention, diversion from jail, out of CJ
- Persons often have high service needs
 - Housing
 - Health disparities
 - Lack of engagement
 - Co-occurring disorder
 - Criminogenic needs
 - Peers
 - RNR Model approach needed



Examples of Criminal Justice and Behavioral Health Collaboration



- Virginia was chosen among few other states to participate in this “policy academy”
- Facilitated by [SAMHSA’s GAINS Center](#) (operated by Policy Research Associates [PRA])
- Anchored in best practices in Competence to Stand Trial (CST) and Competence Restoration (CR), the Policy Academy focused on people with criminal legal system involvement within the trial process who exhibit signs or symptoms of conditions that can impair the ability to competently proceed with their trial
- Key leaders attended and now consist of a multistakeholder group from DBHDS, BHC, Pretrial Services, local jails, Commonwealth Attorney’s, Public Defender’s, local CSBs, GDC Judge



RECOMMENDATIONS TO REDUCE FREQUENT JAIL CONTACT

Policy Brief

Prepared by: Sarah L. Desmarais, Brandon Morrissey, Lisa Callahan, Samantha A. Zottola, Jen Elder, Kristin Lupfer, Elan C. Hope, & Richard A. Van Dorn

MAY 2023

1. Create a Data Sharing Ecosystem
2. Establish Formal, Jurisdiction-Specific Definitions
3. Use Validated Behavioral Health Screening Tools
4. Implement Psychiatric Advanced Directives

5. Facilitate Jail In-Reach Programs
6. Increase Peer Support Programs
7. Increase Access to Housing
8. Increase Utilization of Community-Based Services
9. Center and Evaluate Efforts for Racial Equity

Challenge/PRA

Safety + Justice

Possible Solutions in Virginia

Expand programs that address complex needs of person with MI accessing care through the CJ system (e.g. PSH, FACT Teams, MOT, Peers, Boundary Spanners)

Data and Information sharing among CSB's, courts, evaluators, DBHDS to reduce recidivism and re-evaluation

Expand Intercept 2 diversion (e.g. EDCOT, expand JD, Magistrate or prosecutor led diversion, MOT, etc.)

Limit inpt.
Restoration



- Early Diversion, address barriers to exiting JD programming
- More Boundary Spanners
- Expand Assertive Community Treatment
- Trauma-informed approaches
- Integration of peer services into CJ spaces
- Housing, transportation, employment
- Others?
- Focus on Superutilizers/Familiar Faces in the CST System (e.g. MOT)
- Integrated health services and healthcare reform
- Improve Information Sharing/MOU's among VACSB, Jails, Forensic Evaluators, Forensic Coordinators
- Expand state-level planning between OFS/DBHDS and VACSB to better service person with SMI, justice involved



- **Sarah Davis, M.A.**, Forensic Operations Manager
Sarah.Davis@dbhds.virginia.gov
804-814-3993
- **Jessica Peay, LPC**, Court Based Diversion Coordinator & Forensic MH Consultant
Jessica.Peay@dbhds.virginia.gov
804-318-7387
- **Ashley Anderson, LCSW**, Behavioral Health/Criminal Justice Consultant
Ashley.Anderson@dbhds.virginia.gov
804-944-6918
- **Betsy Hunt, Ph.D.**, ABPP, Forensic Evaluation Oversight Manager
Elizabeth.Hunt@dbhds.virginia.gov
804-402-4052
- **Jeff Aaron, Ph.D.**, Juvenile Justice & Behavioral Health Program Manager
Jeff.Aaron@dbhds.virginia.gov
804-937-7588
- **Ben Skowysz, LCSW**, Office of Juvenile Competency Services Program Manager
Ben.Skowysz@dbhds.virginia.gov
804-840-0280





Thank you!

Angela Torres, Ph.D., ABPP (Forensic)

Chief Forensics Officer

Department of Forensic Services

Virginia Department of Behavioral Health
and Developmental Services

Phone: 804-655-4431

Angela.torres@dbhds.virginia.gov

Kristen A. Hudacek, Psy.D., LCP

Behavioral Health & Justice Initiatives, Manager

Department of Forensic Services

Virginia Department of Behavioral Health and
Developmental Services

757.707. 5192 (Mobile)

Kristen.Hudacek@dbhds.virginia.gov

