Report on Intellectual and Developmental Disabilities in the Criminal Justice System

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EXECUTIVE SUMMARY

The Connecticut Sentencing Commission presents this Report in response to the Connecticut General Assembly's (CGA) request under Public Act (P.A) 23-137 §15 to conduct a research study, and report on its findings and recommendations as to the viability of a potential criminal justice diversionary program in Connecticut (CT) to help adult individuals diagnosed with intellectual and/or developmental disabilities (I/DD) to avoid incarceration. This research study and report mark the first time the Assembly has requested this type of analysis pertaining to individuals with I/DD and their interactions with the Connecticut criminal justice system.

Due to a lack of expertise and staff capacity, the Commission chose to contract with Disability Rights Connecticut (DRCT). DRCT is a non-profit organization designated as the Protection and Advocacy System under Connecticut state law, providing services and resources such as advocacy assistance to individuals with disabilities, including those individuals with I/DD who are institutionalized and/or may interact with the criminal justice system. In May 2024, DRCT presented to the Commission about the risks that individuals with I/DD face in the criminal justice system. Following this presentation, the Commission asked DRCT to collaborate on the research study and report requested by the CGA, a proposal which DRCT agreed to.

This Report is designed to support evidence-based decision making and permit stakeholders to evaluate the viability of a potential I/DD diversionary program. It highlights decisions to be made and additional questions related to evaluating the performance of a future I/DD diversionary program in Connecticut. This Report begins with an introductory section followed by six (6) additional sections: (1) Introduction; (2) Methodology; (3) I/DD Defined; (4) the Prevalence of Individuals with I/DD in Connecticut; (5) Screening Tools and Assessments; and (6) Conclusions/Findings. Commission recommendations on this topic can be found in a separate document on our website (ctsentencingcommission.org).

The Commission's determinations of report findings, in collaboration with DRCT, are based upon a variety of resources and interviews conducted to compile this Report. This Report includes a review and evaluation of scholarly articles, state and national prevalence data, reports published by CT state agencies and councils on numbers and needs of individuals with I/DD; training materials utilized in educating individuals with I/DD; and information about 21 I/DD diversionary programs in 16 states. Additionally, DRCT conducted several interviews with professionals in the criminal justice and I/DD fields including educators, social workers, prosecutors, criminal defense attorneys, probate attorneys and judges, individuals with I/DD both in the community and who have been incarcerated; and parents/caregivers of individuals with I/DD. Lastly, DRCT conferred with state agency personnel including at the Department of Developmental Services (DDS), Council on Developmental Disabilities, Department of Social Services (DSS), Department of Mental Health and Addiction Services, Department of Children and Families, Judicial Branch, Court Support Services Division (JB-CSSD), Office of the Chief Public Defender (OCPD); and Office of Policy and Management.

This Report includes the following key findings:

- CT collects limited data on its I/DD population, relying upon data for qualified state service recipients collected by DDS and DSS. According to the Connecticut Department of Correction, as of September 2025, 68 individuals with intellectual disability, 43 individuals with ASD, and four individuals with both ASD and ID were incarcerated in a Correctional facility.

- State agencies who interact with individuals impacted by the criminal justice system often lack training on how to identify I/DD characteristics and interact with individuals with I/DD. This includes agencies, such as police departments, the Judicial Branch, the Division of Criminal Justice (DCJ), and OCPD.

- There is limited communication between criminal justice related agencies about individuals with I/DD,

and this could impede the success of an I/DD diversionary program.

- There is a lack of standardized practice on collecting data on crimes charged for individuals with I/DD.

- The CT statutory definition of ID under CGS §1-1g does not account for individuals with IQs over 69 who may interact with the criminal justice system.

- Due at least partly to a lack of appropriate diversionary options for defendants with I/DD, there are instances where individuals with I/DD are ordered to Whiting Forensic Hospital for competency evaluation and restoration, a facility that may be ill-equipped to meet the needs of this population.

- CT lacks a statutory definition of developmental disability.

- Research supports the need for separate screening tools for individuals with intellectual disability (ID) and autism spectrum disorder (ASD).

- An analysis of other state I/DD programs supports that most state I/DD programs:

    - Combine I/DD programs with an existing program, usually a mental health program;
    - Designate a single entity to administer the program such as a state agency or non-profit organization;
    - Do not automatically exclude a program applicant solely because of criminal history or the type of crime(s) charged, but rather consider them as factors in part of an overall eligibility determination;
    - Utilize individualized support plans with both attainable goals and incentives for each participant.
    - Recognize the need for after program supports for each participant given that individuals with I/DD have lifelong disabilities;
    - Establish a board or council to evaluate the program success compromised of different professionals connected to the criminal justice system.

The Commission notes that a couple of findings resulted in the acknowledgement that select information remains unknown of an I/DD diversionary program. Two main areas of inquiry remain unknown: (1) data on the types of crimes with which individuals with I/DD in Connecticut are charged; (2) further detail on how states with I/DD diversionary programs administer and evaluate their programs. The Commission may wish to consider these areas for future study.

Finally, in connection with this report and its ongoing work, the Commission advanced proposals during the 2024 and 2025 legislative sessions to expand the state's pre-existing mental health diversionary program, the Pretrial Supervised Diversionary Program (SDP), to include individuals with intellectual disabilities and defendants with autism spectrum disorder. While in both sessions, the proposals were raised by the Judiciary Committee; neither were enacted by the General Assembly. The Commission intends to use this report to inform any future legislative proposals addressing this population.

INTRODUCTION

This Report is provided in response to the Connecticut General Assembly's request under Public Act (P.A.) 23-137 for the Sentencing Commission to conduct a research study, and report on its findings and recommendations as to the viability of a potential criminal justice diversionary program in Connecticut to help adult individuals diagnosed with intellectual and/or developmental disabilities (I/DD) avoid incarceration.[1] This request is based upon guidance provided by the Connecticut General Assembly under P.A. 23-137, which outlines the parameters of the General Assembly's request for more information regarding this potential program.

Specifically, P.A. 23-137 §15 outlines that the Sentencing Commission

> shall study the experience of persons with an intellectual disability or other developmental disabilities, including, but not limited to, autism spectrum disorder, who are involved in the criminal justice system. Such study shall include, but need not be limited to, (1) rates of incarceration of such persons compared to the overall population of such persons in the state, (2) the advisability of behavioral assessments of such persons before sentencing and costs of such assessments, and (3) best practices of other states concerning such persons. . . The report shall include the commission's recommendations for sentencing considerations for such persons.[2]

This Report serves to address each of the requests outlined by the General Assembly, including what information is known as of the date of this Report, and what information and/or questions still need to be answered.

This Report is divided into six main components. The first section describes the methodology, including written materials, meetings, and interviews conducted to compile research conducted for this Report. The second section provides an overview of how I/DD is defined and characteristically recognized, including autism spectrum disorder (ASD), and how those characteristics overlap with the criminal justice system. The third section provides an in-depth description of what and how prevalence and census data on adult individuals in Connecticut with I/DD are collected. This discussion includes data collected on adult I/DD individuals both in the community and those who are incarcerated. The fourth section discusses different behavioral screening and assessment tools used in various I/DD diagnoses, including those which may be self-administered or administered by non-clinical professionals. The fifth section provides a comparison analysis of 21 similar programs which exist in 16 states, highlighting both separate diversionary programs specifically designed for I/DD populations as well as other state examples which incorporate an I/DD diversionary program component as an add-on to an existing diversionary program. The sixth section provides a summation of conclusions drawn from all previous sections. Recommendations can be found on the Commission's website in a separate document (ctsentencingcommission.org).

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[1] Currently, Connecticut has one jail diversionary program for individuals with disabilities known as the Supervised Diversionary Program (SDP), a program for individuals with psychiatric disabilities including veterans with mental health conditions pursuant to C.G.S §54-56*l*. Of relevance to this Report, the SDP includes both screening and evaluation requirements to be accepted into the program, with the latter requirement necessitating either verification by a professional of an existing psychiatric disability or evaluation completed by a professional. More information about this program is available here: https://www.jud.ct.gov/Publications/CR137E.pdf.

[2] An Act Concerning Resources and Support Services for Persons with an Intellectual or Developmental Disability. P.A. 23-137 §15 (2023).

Problem Analysis

P.A. 23-137 recognizes the need for a variety of Connecticut state agencies to review and report on the existence and sufficiency of programs and services available to Connecticut residents with I/DD. One request within P.A. 23-137 calls upon the Connecticut Sentencing Commission to research and report on the current state of resources available to individuals with I/DD which arises out of several reported concerns this Report aims to address. Currently, there are limited options available to individuals with I/DD diagnoses who are charged with crimes in Connecticut. Interviews conducted for this Report confirm that individuals with I/DD and their attorneys face barriers when utilizing I/DD diagnoses as mitigating factors to avoid convictions or institutionalization for their clients. Attorneys report several recurring challenges including, but not limited to:

1. Many defendants have symptoms akin to one or more I/DD diagnoses, but have never been evaluated;
2. Defendants often lack adequate financial resources to obtain an evaluation from a psychologist, psychiatrist, or other clinician;
3. Lack of assistance from guardians or the Department of Developmental Services (DDS) for DDS eligible clients despite requests being made;
4. The only alternative option to incarceration is the Accelerated Rehabilitation (AR)[3] or the Supervised Diversionary Program; however, these options do not adequately address a defendant's individual I/DD needs. Nevertheless, if the defendant is eligible, these programs are better options than incarceration;
5. Difficulties requesting competency evaluations when clients are ineligible for existing diversionary programs pursuant to C.G.S. §54-56d, which gives the court discretion to order either inpatient or outpatient evaluations. However, in these instances many individuals interviewed stated that courts tend to send individuals with I/DD diagnoses (or those likely to have I/DD but lacking a formal diagnosis) to Whiting Forensic Hospital, an inpatient psychiatric hospital ill-equipped to address the needs of individuals with I/DD[4];
6. Persuading prosecutors and judges to view I/DD diagnoses as a mitigating factor particularly for individuals who were never diagnosed or misdiagnosed; and
7. Ethical concerns when advising defendants with I/DD to accept plea agreements, subjecting these defendants to jail time, knowing that the Department of Correction (DOC) does not provide evaluations, treatment plans, or supports and services to address their individualized needs.

Interviews with individuals with lived experience confirmed other concerning themes including:

1. Being charged with crimes stemming from behavior associated with I/DD without having been evaluated for I/DD;

[3] Accelerated Rehabilitation allows a defendant to avoid a conviction if the individual has not used the program in the last ten years and has been charged with crimes eligible under the program. The individual must adhere to condition set forth by the Court and supervised by the Court Support Services Division for up to two (2) years. Accelerated Rehabilitation (n,d,) https://www.jud.ct.gov/Publications/CR137D.pdf.

[4] Specifically, *Mihalcik v. Lensink*, 732 F. Supp. 299, 304 (D. Conn. 1990) highlights the Constitutional rights of individuals with I/DD "to minimally adequate habilitation ... which will tend to render unnecessary the use of chemical restraint, shackles, solitary confinement, locked wards, or prolonged isolation from one's normal community." Placing individuals with I/DD at Whiting Forensic Hospital for competency evaluations contradicts this federal court decision.

2. Being misdiagnosed to find out later in life they had an I/DD, after already being charged and/or convicted;
3. Following evaluation, being told that judges do not believe that they have I/DD diagnoses or that the diagnoses were not severe enough to be a mitigating factor;
4. Lacking resources while incarcerated to address support needs; and
5. Lacking I/DD specific resources and job training (e.g., Customized Employment or Supported Employment) to help with the transition out of incarceration and to minimize recidivism.

Although not an exhaustive list, these themes shed light on current common and repetitive concerns that persist in Connecticut's criminal justice system. The creation of an I/DD diversionary program could help to address and lessen the barriers individuals with I/DD face in our criminal justice system.

METHODOLOGY

The research conducted is a culmination of the review of primary and secondary data including interviews with experts and non-experts detailed below and cited, as appropriate, throughout this Report. DRCT relied upon the following information in the creation of the Report:

- Review of scholarly work;
- Prevalence statistics and state administrative data from agencies and councils who serve I/DD populations;
- More than ten reports published by state agencies and councils on the numbers and needs of individuals in Connecticut with I/DD;
- Training materials used to educate others about I/DD;
- Twenty interviews with[5]
    - Expert professionals in the field of I/DD;
    - Educators;
    - Social workers;
    - Prosecutors;
    - Criminal defense attorneys who practice in state and federal court;
    - Probate attorneys and judges;
    - Individuals with I/DD lived experience in the community;
    - Incarcerated individuals with I/DD lived experience; and
    - Parents and caregivers of individuals with I/DD lived experience;
- Eight meetings with Connecticut state agencies:
    - Department of Developmental Services;
    - Council on Developmental Disabilities;
    - Department of Social Services;
    - Department of Mental Health and Addiction Services;
    - Department of Children and Families;
    - Court Support Services Division;
    - Office of the Chief Public Defender; and

[5] This Report respectfully maintains the anonymity of individuals' identity in any discussion in this Report regarding information obtained from interviews. Anonymity does not include information or recommendations from publicly known expert professionals in the I/DD field.

    - Office of Policy and Management.
- Email correspondence with the Department of Correction;
- Review of scholarly work, statutes and articles of 21 I/DD related diversionary programs outside of Connecticut among 16 states.

Research Limitations

This Report covers many crucial topics necessary for the Legislature to evaluate in establishing an I/DD diversionary program in Connecticut; however, it does not cover all topics relevant to the creation, implementation, and monitoring of such a program. This Report is the first step in addressing the topics of interest in P.A. 23-137, provides a solid preliminary foundation of the characteristics of the potential I/DD eligible population, and highlights best practices in the country. Additional research and policy analysis is needed to help inform priorities and the type of decisions that must be made.

Should the Legislature seek to expand this scope of work into relevant areas for an I/DD diversionary program in Connecticut, the following topics are recommended for consideration.

- Literature review;
- Legal review;
- Additional stakeholder interviews (e.g., government officials, legislators, judges);
- Special considerations for youth ages 18-21;
- Risk factors and other special considerations for incarcerated persons with I/DD and their interaction with the criminal justice system;
- The possible deleterious effects of incarceration;
- Service and support gaps of people with I/DD for youth and adults at risk who live in the community;
- Identification of service gaps and areas for potential collaboration between state and local service systems who are responsible for serving people with co-occurring IDD and ASD.
- Stigma and misconceptions of people with I/DD;
- Reasonable accommodation concerns for individuals with I/DD utilizing the court system; and
- The overlap between the criminal justice and probate court systems for individuals under guardianship or conservatorship.

I/DD Defined

This Report addresses both intellectual and developmental disabilities, each of which has different definitions and characteristics associated with them.

Intellectual Disability

Statutory Definition in Connecticut

Intellectual disability impacts an individual's lifelong ability to think, learn and perform daily tasks.[6] In Connecticut, intellectual disability is defined as "a significant limitation in intellectual functioning existing concurrently with deficits in adaptive behavior that originated during the developmental period before eighteen years of age."[7] A significant limitation is defined as "an intelligence quotient more than two standard deviations below the mean as measured by tests of general intellectual functioning that are individualized, standardized and clinically and culturally appropriate to the individual."[8] The Connecticut Department of Developmental Services (DDS) uses an IQ quotient of 69 as being more than two standard deviations below the mean to determine an individual's eligibility for DDS services. Adaptive behavior refers to the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for the individual's age and cultural group as measured by tests that are individualized, standardized, and clinically and culturally appropriate to the individual.[9]

American Association of Intellectual and Developmental Disabilities Definition

The American Association of Intellectual and Developmental Disabilities (AAIDD) also provides helpful guidance on the definition of ID. Like the Connecticut statutory definition, AAIDD recognizes that ID originates in an individual's developmental period before the age of 22. Intellectual disability is characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, social, and practical adaptive skills. Additionally, the AAIDD highlights five characteristics included in its ID definition, which provide further detail lacking in the Connecticut definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture;
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors;
3. Within an individual, limitations often coexist with strengths;
4. An important purpose of describing limitations is to develop a profile of needed supports; and
5. With appropriate personalized supports over a sustained period, the life functioning of the person with ID generally will improve. [10]

DSM V Definition & the Role of Social Interactions

In the widely recognized and accepted Diagnostic and Statistical Manual of Mental Disorders (DSM) V, the American Psychological Association (APA) provides additional detail as to the level of severity of the ID diagnosis. Severity levels help to provide understanding about the nature of the ID diagnosis

[6] CT Gen Stat § 1-1g.
[7] CT Gen Stat § 1-1g(a).
[8] CT Gen Stat § 1-1g(b).
[9] CT Gen Stat § 1-1g(b).
[10] Schalock, R.L., Luckasson, R., and Tasse, M.J. (2021). An Overview of Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Support. *American Journal on Intellectual and Developmental Disabilities.* (12 e). 1-7. definition-diagnosis-classification-and-systems-of-supports-(12e).pdf

and guidance as to the needs of the individual.[11] According to the DSM V, an intellectual disability arises during the developmental period of a person, and includes both intellectual and functioning deficits in conceptual, social, and practical aspects of a person's life.[12] Intellectual disability is classified based on severity in four categories: mild, moderate, severe, and profound.[13] These severity categories provide context for the needs of individuals with ID interacting with the criminal justice system. Individuals with severe or profound ID are less likely to interact with the criminal justice system. According to the Bureau of Justice Assistance, U.S. Department of Justice, and The Arc National Center for Criminal Justice and Disability, 85% of individuals with ID fall into lower supports needs categories (mild or moderate ID).[14]

For mild ID, adults may experience difficulty with conceptualizing information with abstract thinking and/or executive functioning.[15] Executive functioning, in this case, refers to an individual's difficulty with multitasking and organizing efficiently.[16] This could include tasks such as planning, strategizing, priority setting, and cognitive flexibility.[17] The person may also struggle with short-term memory loss and academic skills. In social situations, a person with mild ID may be incapable of accurately perceiving social cues and regulating emotions and behaviors in an age-appropriate manner.[18] These difficulties may be exhibited in one's communication, conversations, and language choices. When faced with practical life decisions such as employment, health care/legal decisions, or raising a family, individuals with mild ID may require support. [19]

For an individual with moderate ID, comprehension, social skills, and practical skills require increased support. Academically, individuals with moderate ID experience an elementary level of comprehension, with support often required for academic, vocational, and daily living skills. Although an individual with moderate ID can learn to be independent, reminders may be needed. Areas where the individual may need assistance include eating, dressing, and personal hygiene. Assistance may

[11] This term is sometimes referred to as "adaptive functioning" as well – the conceptual, social, and practical skills to function in society. What is Adaptive Behavior. (n.d.) American Association on Intellectual and Developmental Disabilities. https://www.aaidd.org/intellectual-disability/definition/adaptive-behavior

[12] American Psychiatric Association. (2013). Intellectual Disabilities. In *Diagnostic and Statistical Manual of Mental Disorders*. (5th Ed.), at 33.

[13] *Id.*

The individual must have the following attributes:

1. Deficits in intellectual functions such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience.
2. Deficits in adaptive functioning which result in a failure to meet developmental and sociocultural standards for personal independence and social responsibility. Adaptive functioning limits a person's ability to engage in one or more activities of daily living (ADLs) without support. ADLs may include communication, social participation, and difficulties in home, school, work and/or community environments.
3. The onset of the intellectual and adaptive deficits occur during the developmental period.

[14] Sims, A., Hamann, K., *et al.* (June 24, 2019). "Victims, Witnesses, and Defendants with Intellectual and Developmental Disabilities: Key Information for Prosecutors." https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/Victims_Witnesses_and_Defendants_with_Intellectual_and_Developmental_Disabilities_Key_Information_for_Prosecutors.pdf

[15] American Psychiatric Association. (2013). Intellectual Disabilities. In *Diagnostic and Statistical Manual of Mental Disorders*. (5th Ed.), at 34.

[16] Volkmar, F., Loftin, R. *et al.,* (2021). *Handbook of Autism Spectrum Disorder and the Law.* (p. 4). Springer.

[17] American Psychiatric Association. (2013). Intellectual Disabilities. In *Diagnostic and Statistical Manual of Mental Disorders*. (5th Ed.), at 34.

[18] American Psychiatric Association. (2013).

[19] American Psychiatric Association. (2013).

include the incorporation of assistive technology aids to accommodate executive functioning.[20] An individual with moderate ID will also struggle with social skills, such as informed decision making, understanding social cues, and communicating in social situations. To succeed with employment, the individual requires support. This may involve enhanced training and support from co-workers and supervisors to help manage social expectations, job complexities, and ancillary responsibilities such as scheduling, transportation, money management, and healthcare decisions.[21] For those qualifying for Home and Community Based Services, direct support staff assist with everyday occupations and individuals benefit from Customized Employment or Supported Employment solutions, two evidenced-based practices for people with I/DD to attain Competitive Integrated Employment.

An individual with severe ID often requires significant support to complete everyday tasks (e.g., eating, bathing, accessing the community). Such individuals have significant challenges with comprehension and communication; may have behavioral challenges; may benefit from Assistive Technology to express their needs and wants; and often rely on those closest to them to communicate and interpret their needs. Individuals with severe ID often require assistance with many aspects of their life to ensure health, safety, and wellbeing. An individual with profound ID often requires direct support from professionals and/or family members for basic needs on a 24/7 basis.

Support needs vary by person and no one definition of ID applies to everyone. Individual screens and testing are required to identify intellectual, functional, and behavioral considerations of each person.

Developmental Disability

Definition

Developmental disabilities are broadly defined as a variety of disabilities impacting intellectual, physical, or both aspects of a person's life, which can include intellectual disabilities.[22] Connecticut does not specifically define the term "developmental disability" by statute but rather relies upon the definition defined under federal law. Under federal law, "developmental disability" is defined as "a severe, chronic disability of an individual that—

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(ii) is manifested before the individual attains age 22;
(iii) is likely to continue indefinitely;
(iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:

(I) Self-care.
(II) Receptive and expressive language.
(III) Learning.

[20] Assistive technology aids are products, equipment and/or systems which enhance the daily life activities of individuals with disabilities such as at work, school, or around the home. What is AT? (n.d.). Assistive Technology Industry Association. https://www.atia.org/home/at-resources/what-is-at/
[21] Volkmar, F., at 34.
[22] National Institute of Health. (n.d.) "About Intellectual and Developmental Disabilities." https://www.nichd.nih.gov/health/topics/idds/conditioninfo

(IV) Mobility.
(V) Self-direction.
(VI) Capacity for independent living.
(VII) Economic self-sufficiency; and

(v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.[23]

Developmental disabilities characteristically impact both a person's quality of life and the interactions they have with others. Common examples of developmental disabilities include ASD, attention deficit hyperactivity disorder, cerebral palsy, and blindness. For a more detailed list, please refer to Attachment A at the end of this Report. The list includes many common diagnoses but is not exhaustive.

Autism Spectrum Disorder

This Report highlights a specific developmental disability known as autism spectrum disorder (ASD) in response to increased interest and impact on individuals diagnosed with the disorder within the State of Connecticut.[24] Connecticut law does not define ASD, but, rather, recognizes the definition of autism spectrum disorder defined in the DSM V.[25] The DSM V defines ASD as persistent deficits in social communication and interaction across multiple contexts within a person's life.[26] Although deficits must be present during the early developmental stages of a person's life, it is common for the deficits to manifest and become noticeable or identified later in life.[27] An ASD diagnosis includes the following deficits:

1. Deficits in a person's ability to reciprocate specific social and/or emotional responses such as conversational exchanges; shared interests, emotions or affect; and the inability to initiate or respond to social interactions.

2. Deficits in the use of nonverbal communication such as poorly integrated verbal/nonverbal communication; abnormalities in eye contact or body language; difficulty in understanding or using gestures; and lack of facial expression or nonverbal communication. Communication difficulties can also include challenges with executive functioning.

[23] Connecticut Council on Developmental Disabilities, Definition and demographics of developmental disabilities. (n.d.) https://portal.ct.gov/ctcdd/common-elements/v4-template/definition .(citing Havercamp, S.M., Krahn, G., Larson, S., Weeks, J.D., and the National Health Surveillance for IDD Workgroup (2019). Working Through the IDD Data Conundrum: Identifying people with Intellectual Disability and Developmental Disabilities in National population Surveys. Washington, D.C.: Administration on Intellectual and Developmental Disabilities.
[24] The increased focus on ASD is supported by Connecticut's Autism Waiver Program administered by the Department of Developmental Services since 2007. Additionally, the State funds a specific position to address the specific needs of individuals with autism known as a lead planning analyst, currently held Tara Viens at the Office of Policy Management.
[25] CT Gen Stat § 17a-215f.
[26] American Psychiatric Association. (2013). Intellectual Disabilities. In *Diagnostic and Statistical Manual of Mental Disorders*. (5th Ed.).
[27] American Psychiatric Association. (2013).

3. Deficits in developing, maintaining, and understanding relationships including difficulty in adjusting behavior to suit various social contexts; difficulty in engaging in imaginative play; difficulty making friends; and the absence of interest in peers.[28]

Additionally, an ASD diagnosis requires that the individual exhibit restricted and repetitive patterns of behavior, interests, and/or activities in two of four following areas: 1) stereotyped or repetitive movements, use of objects, or speech;[29] 2) insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal/nonverbal behavior;[30] 3) highly restricted, fixated interests that are abnormal in intensity or focus;[31] and 4) hyper or hypoactivity with sensory input or unusual interest in sensory aspects of the environment.[32]

These challenges could include misunderstanding the cues of others, sensory processing difficulties, and engaging in repetitive behaviors.[33]

Common I/DD Characteristics Relevant to the Criminal Justice System

Individuals with I/DD exhibit common patterns of behavior which have been systemically identified within criminal justice literature and studies. An individual with I/DD will likely exhibit a limited understanding of the risks he/she may face in a given situation, which can result in the individual being easily led by others to engage in criminal activity.[34] The person may give into impulse and lack the ability to use logical reasoning.[35] The individual may struggle to understand why a decision he/she made – whether pressured or not – is a mistake.[36]

An individual with I/DD often thrives in familiar situations; when placed in the unfamiliarity of the criminal justice system, he/she will struggle to adapt to the new situation.[37] Individuals with I/DD often rely upon rules they know, engaging in repetitive behaviors consistent with that familiarity.[38] The individual will likely find enjoyment in familiar familial relationships which create a sense of routine.[39] When this familiarity is taken away, the individual may struggle to adapt to change which could result in maladaptive behavior.[40] Familiarity may become unavailable for a person with ID who is charged with a crime, particularly crimes where a court issues a protective order involving a family

[28] *Id.*
[29] E.g., use of idiosyncratic phrases.
[30] E.g., extreme distress over small changes, difficulty with transitions, rigid thinking patterns, greeting rituals, the need to eat the same food daily.
[31] E.g., strong attachment to or preoccupation with unusual objects, perseverative interests.
[32] E.g., apparent indifference to pain/temperature, adverse responses to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement.
[33] Sims, 2019.
[34] King, C., & Murphy, G. H. (2014). A systematic review of people with autism spectrum disorder and the criminal justice system. *Journal of Autism and Developmental Disorders, 44*(11), 2717–2733. https://doi.org/10.1007/s10803-014-2046-5
[35] Wood, M. Ph.D,, Lawson, K., B.A. *et al.* (November 2019). "Reasonable Accommodations for Meeting the Unique Needs of Defendants with Intellectual Disability." American Academy of Psychiatry and the Law. 47: 1-11.
[36] *Id.*
[37] Hannah, T., & Hurley, M. J. (2025). Judging offenders with learning disabilities: A systematic review of qualitative literature. *British Journal of Learning Disabilities, 53* (1), 37-48.
[38] Volkmar, 2021, at 190.
[39] American Association on Intellectual and Developmental Disabilities. (n.d.) "Criminal Justice System." https://www.aaidd.org/news-policy/policy/position-statements/criminal-justice
[40] *Id.*

member.[41] For example, the individual with I/DD may struggle to understand a protective order because he/she does not know how to adapt or relies solely upon the family member that a court now deems a victim even if the individual tells the court he/she understands the order and will comply.[42]

An individual's gullibility and inability to understand consequences of a decision can lead to a higher level of criminal behavior and victimization for individuals with I/DD.[43] Individuals with I/DD are likely to engage in criminal behavior not because they want or intend to break the law, but rather, they do not understand that their actions violate the law and/or they are more vulnerable to the suggestions of others compared to individuals without I/DD.[44] Individuals may also engage in behaviors that interest them in connection with crimes without awareness of the consequences of engaging in these actions (e.g., interest in weapons because they enjoy video games that contain weapons).[45] These individuals are likely to be victimized by others and charged for crimes relating to violence, financial and sexual exploitation, cybercrimes, and human trafficking.[46] Individuals with I/DD are also highly susceptible to be charged with vandalism, theft, and other property crimes due to impulsivity.[47]

These charges could be exacerbated by the person's willingness to answer questions from the police without understanding the consequences of doing so, and for the police to misinterpret the person's gestures, words, and/or lack of emotion.[48] As a result of these types of charges, individuals are likely to waive their *Miranda* rights unknowingly; give incriminating statements without understanding the consequences of giving such statements; provide false confessions; receive inaccurate or inappropriate competency evaluations; and be forced into institutions to evaluate their competency to stand trial, environments which do not meet their individualized needs.[49]

Interviews with attorneys, social workers, and anecdotal evidence from individuals with I/DD who have a history of interactions with the Connecticut criminal justice system confirm crime patterns similar to the broad trends mentioned above. The attorneys and social workers interviewed work directly with clients charged with crimes in Connecticut (including in the federal system) who have I/DD diagnoses. Anecdotal evidence of individuals with I/DD are experiences voluntarily shared for this Report involving their interactions with the criminal justice system, including incarceration. All of these interviews suggest that individuals with I/DD in Connecticut often commit crimes in four main categories – arson; sex crimes (primarily accessing pornography); theft crimes; and domestic violence (often where the victim is a family member or longtime trusted adult).

[41] King, 2014.
[42] *Id.*
[43] Volkmar, 2021, at 233.
[44] Cooper, S.-A., Ali, A., Collacott, R., Branford, D., & Sonthalia, S. (2022). A systematic review of autism and the criminal justice system. *BJPsych Open, 8*(1), e25. https://pubmed.ncbi.nlm.nih.gov/35068170/
[45] Volkmar, 2021, at 190.
[46] Holland, K., Clare, I. C., & Mukhopadhyay, T. (2002). Prevalence of unlawfully at large behaviour in people with mild intellectual disabilities. *Journal of Intellectual Disability Research, 46*(1), 39
47. https://pubmed.ncbi.nlm.nih.gov/12061335/
[47]Holland, 2002.
[48] Allely, C. S. (2015). Autism spectrum disorders in the criminal justice system: Police interviewing, the courtroom and the prison environment. *Medicine, Science and the Law, 55*(1), 49–
57. https://www.researchgate.net/publication/290396155_Autism_Spectrum_Disorders_in_the_Criminal_Justice_System_Police_Interviewing_the_Courtroom_and_the_Prison_Environment
[49] *Id.*

PREVALENCE OF INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Connecticut collects limited data on individuals with I/DD both in the community and in correctional facilities. The prevalence data for both populations is discussed in this section and compared to prevalence data analyses conducted outside of Connecticut. Studies for both populations suggest that the prevalence data collected in Connecticut is significantly lower relative to estimates of the actual numbers of individuals with I/DD that likely reside in the state. This section also highlights the important concern that what and how the prevalence data currently collected in Connecticut does not accurately reflect its actual I/DD population. Interviews conducted for this Report have provided important insights into CT's data limitations; how and what Connecticut collects for I/DD prevalence; and how these deficits can be corrected. If this identified barrier is addressed, Connecticut will be able to collect more accurate prevalence data to use in a diversionary program for individuals with I/DD.

Prevalence of Intellectual and Developmental Disabilities in Connecticut

Current Data Collection

In order to consider the fiscal impact of a diversionary program for people with I/DD in Connecticut, it is important to have a picture of the estimated size of the overall I/DD population in the state. According to the United States Administration for Community Living (ACL), it is estimated that there are approximately **43,000 +/- 14,000**[50] people with "developmental disabilities" in Connecticut.[51] This estimate is based upon the definition of "developmental disabilities" as defined by the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), which is broader than the definition of "intellectual disability" in Connecticut's statutory law, as previously discussed in this Report. This estimate from ACL recognizes that there are individuals with I/DD which are not known to the state for a variety of reasons including lack of records and/or individuals with I/DD who did not apply for or are deemed ineligible for state services.[52]

Although there is not a precise number for all people with I/DD in Connecticut, there is reported data regarding the total number of individuals with I/DD who are eligible for state services from the Department of Developmental Services (DDS).[53] As of September 2025, DDS reported a total of **17,636** individuals with intellectual disabilities who were receiving DDS services.[54] This number includes 1,831 juveniles (18 years and younger) and **15,805** adults (18 years and older).[55]

The eligible Connecticut DDS population is significantly less than people who fall into the broader

[50] Connecticut's Developmental Disability Council estimates based on ACL's reasonable statistical belief that there is fluctuation in the I/DD population of 14,000.
[51] Definitions and Demographics of Developmental Disabilities. https://portal.ct.gov/ctcdd/common-elements/v4-template/definition
[52] Havercamp, 2019.
[53] To be eligible for services from Connecticut's Department of Developmental Services (DDS) an individual must be a resident of Connecticut, and have an intellectual disability as defined under CT Gen Stat § 1-1g or have a medical diagnosis of Prader-Willi Syndrome diagnosed by a physician. Connecticut Department of Developmental Services "Eligibility (n.d.) https://portal.ct.gov/dds/searchable-archive/selfadvocacyselfdetermination/self-determination-fact-sheets/eligibility-fact-sheet?language=en_US
[54] Department of Developmental Services, Management Information Report - September 2025 at 2. mir_September_2025_with_attachment.pdf
[55] Management Information Report - September 2025 at 7.

category of developmental disabilities, which includes ASD and people with IQ scores greater than 69. The aforementioned data does not include individuals with ASD who are referred by DDS to the Department of Social Services (DSS) for community-based services. DSS is the state agency responsible for administering services for eligible residents diagnosed with ASD under the ASD Waiver for Home and Community-Based Services.[56] Based upon DSS' most recent report, there are 262 residents ages 22 and older who are either participating in the ASD Waiver or are actively enrolling in it.[57] Additionally, the report documents that 846 adults ages 22 and older are on an ASD Waiver waitlist.[58]

Nationally, ASD data sources differ in their approach as to how the number of individuals with ASD should be calculated. According to a 2022 study conducted by the National Center on Birth Defects and Developmental Disabilities at the Center for Disease Control, approximately 5.4 million adults, or 1 in 45 adults ages 18-84, have ASD nationally.[59] In other words, approximately 2.21% of the population has an ASD diagnosis.[60]

Considerations in Data Collection Inaccuracies in Connecticut

Based on the data analyzed, there are concerns regarding the inaccuracy of the prevalence data available on individuals with I/DD in Connecticut. There is consensus among I/DD experts interviewed for this Report that the data collected in Connecticut fails to adequately reflect all individuals who have one or more I/DD diagnoses.[61] The two main reasons cited were that 1) the definition of an ID under C.G.S. §1-1 g excludes individuals who have ID but are not included in data because they are deemed ineligible for or have not applied for DDS services; and 2) Connecticut does not collect data on adult individuals with ASD except for those documented for ASD Waiver eligibility.

First, the definition of ID under Connecticut's statute does not recognize that there are adult individuals with I/DD diagnoses that have IQs above 69. Connecticut's limited definition eliminates individuals in Connecticut who could be eligible for an I/DD diversionary program, yet we do not know that they exist because data on their disability is not collected. In response to P.A. 23-137, the University of Connecticut conducted a study analyzing criteria other states use to determine when

[56] For more information on the ASD Waiver please visit https://portal.ct.gov/dss/health-and-home-care/autism-spectrum-disorder---asd/autism-spectrum-disorder---asd/eligibility?language=en_US

[57] The data provided by DDS separates out age categories between 11-21, with the next category listed as 22-30. Because the data provided does not break down how many individuals for ages 18-19 are either enrolling or have enrolled in the ASD Waiver, this age range is excluded from the calculation. Barton Reeves, Andrea, J.D., *Report to the Joint Committees of the General Assembly on Human Services and Public Health: Public Act 24-134 Home and Community Supports Waiver for Persons with Autism.* April 2025. https://portal.ct.gov/dss/-/media/dss/legislative-reports/2025/autism-waiver-waitlist-report-2025.pdf?rev=8a852acdf8784f338bb3504a14b6dd2f&hash=15391B3382A9BF777BC07FDBE5AB83B8

[58] Barton Reeves, 2025.

[59] Dietz, P., Rose, C. *et al*., *National and State Estimates of Adults with Autism Spectrum Disorder*., J Autism Dev Disord. 2020 Dec;50(12) (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC9128411/

[60] Dietz, 2020.

[61]The following experts were consulted for this Report: Michael Powers, Psy.D, Executive Director at The Center for Children with Special Needs and Associate Clinical Professor at The Yale Child Study Center; Fred Volkmar, M.D., Center Director, Goodwin Endowed Chair Special Education at Southern CT University and Irving B. Harris Professor of Child Psychiatry, Pediatrics at the Yale Child Study Center; Dr. Inge-Marie Eigsti, Professor of Psychological Sciences at the University of Connecticut; Kathleen Collins, clinical psychologist at the Massachusetts Department of Developmental Services; Andrea Spence, Ph.D., Director of Online Masters for Teachers at the University of Saint Joseph; and Laurie Charlot Ph.D, Assistant Professor, Department of Psychiatry, UMass Medical School. Interviews were also conducted with additional clinical staff at The Yale Child Study Center.

I/DD individuals are eligible for similar DDS services.[62] This study, which reviews programs in all 50 states as well as the District of Columbia (D.C.), noted that there was a significant discrepancy between how states apply IQs in evaluating individuals for their respective services.[63] Approximately half of the states, including D.C., provide services to individuals with ID that are non-IQ dependent. Nationally, only seven states, including Connecticut, have a strict IQ cutoff to access state services.[64] Currently, because Connecticut has a strict IQ cutoff to qualify for services, this restriction limits the data collected on individuals who may have a slightly higher IQ but are excluded from Connecticut population statistics. If data on individuals with ID who have an IQ higher than 69 was collected, this prevalence data would help in understanding how many individuals with ID may potentially qualify for an I/DD diversionary program in Connecticut.[65]

Second, Connecticut does not currently and systemically collect prevalence data on individuals with ASD. In August 2025, the Lead Planning Analyst for Autism Services, Tara Viens, shared that Connecticut was awarded a grant permitting the state to create and implement a statewide autism assessment to help identify individuals with ASD throughout the state. This assessment tool (likely a survey), which has not yet been created or distributed, would be shared with other entities that provide services or other assistance to individuals with ASD. These include provider organizations, and other nonprofits. Currently, the Office of Policy and Management (OPM) plans to create an assessment tool which mimics that of the Pennsylvania Autism Needs Assessment.[66] OPM estimates that it will take approximately two years to create and disseminate the assessment, receive the data, and analyze it. This assessment, if successful, is likely to identify higher rates of ASD, including those diagnosed later in life who are currently excluded from the ASD Waiver program.

Prevalence of Individuals with Developmental Disabilities involved in the Criminal Justice System

Another important consideration with respect to understanding the fiscal and programmatic impact of the proposed legislation for a diversionary program is to try to understand, based on available data, the number of people with intellectual disabilities and/or ASD who are in Connecticut's criminal justice system.

Prevalence of Individuals with I/DD in Connecticut's Criminal Justice System

The overall prison population in Connecticut as of December 2025 was 11,053 (3,591 pretrial and 7,242 sentenced).[67] Department of Correction (DOC) data on individuals with I/DD relies upon the data it receives from DDS, which results in missing individuals not known to DDS. As of September

[62] *IQ Eligibility Criterion for Disability Services and Programs.* University of Connecticut, Center for Excellence in Developmental Disabilities, Education, Research, and Services. (n.d.) https://uconnucedd.org/iq-as-eligibility-criterion-for-disability-services-and-programs/

[63] *Id.*

[64] The other states with strict IQ cutoffs are: Alabama, Arkansas, Florida, Iowa, Maine, and Washington.

[65] It should be noted that in the recent U.S. Supreme Court ruling in *Hamm v. Smith*, 604 U.S. 1, (2024), the Court reviewed concerns when an individual receives more than one (1) IQ score as a result of more than one (1) evaluation. The Court noted an IQ should not be viewed in isolation, but, rather, recognized that IQ scores can be complex. Although a ruling requiring further guidance and clarity, it importantly notes the complexity of relying upon a single IQ score cutoff.

[66] For additional information, please visit https://needs.paautism.org/

[67] CT Department of Correction Monthly Statistics – December 1, 2025. https://portal.ct.gov/-/media/doc/pdf/monthlystat/stat12012025.pdf?rev=7ea506a679d24e7c9bf7fa07c0d366c7&hash=9EAE1A9B72A84769E6B06E4545D9F446

2025, the DOC shared that it has 68 individuals with intellectual disability, 43 individuals with ASD, and four individuals with both ASD and ID. The DOC clarified that it does not maintain its own numbers separately from DDS as to which individuals in its custody have I/DD.

Other informative data includes data set forth in the Sentencing Commission's 2023 study of the mental health disorders of individuals incarcerated in Connecticut's correctional facilities. In that study, researchers found that based on 2022 DOC data, there were 90 people with intellectual disabilities and 39 with ASD located in DOC facilities.[68]

National Prevalence Rates

There is limited data on the prevalence of people with disabilities in jails and prisons throughout the United States, including Connecticut. This is largely because most criminal justice systems do not screen for developmental disabilities, and relatedly, individuals with developmental disabilities often have not been diagnosed.[69] However, there is some data that is instructive and can help inform the number of people in Connecticut with I/DD, which would aid in determining the cost of an I/DD diversionary program. This data includes both national and limited state data. For example, a well-regarded study from 2000 by Joan Petrisilla found that people with I/DD represent between 4-10% of the prison population nationally.[70] This number includes individuals who have DD but not ID.[71]

A more recent, and often cited, national study issued in 2016 by the Bureau of Justice Statistics (BJS) addressing the number of people with disabilities, including cognitive disabilities in state and federal jails and prisons, found that the percentage of people with a "cognitive disability" to be approximately **24%** —which was the highest proportion of any disability in jails and prisons nationally.[72] This figure represented an increase from 19.5% in an earlier similar study by BJS in 2011-12, which defined "cognitive disability" as a disability that "describes a variety of medical conditions affecting different mental tasks, such as problem-solving, reading comprehension, attention, and remembering.[73] A cognitive disability is not the same as a mental disorder."[74] This definition is much broader than the definition of "intellectual disability" in Connecticut and the DD Act's definition of "developmental disability."

Considerations in Data Collection Inaccuracies in Connecticut's Prisons and Jails

[68] Tsarkov, A. J.D., Kapoor, R. M.D., *et al*. (2023). Mental Health Disorders in Connecticut's Incarcerated Population. Connecticut Sentencing Commission https://ctsentencingcommission.org/wp-content/uploads/2025/04/Mental-Health-Disorders-in-Connecticuts-Incarcerated-Population-2.pdf

[69] Walton, M. *Barriers to Justice: Inaccessibility of New York's Criminal Justice System for Individuals with Intellectual and Developmental Disabilities*, (2020). 14 ALBANY GOVT L. REV. 72. https://www.coursehero.com/file/243824984/32421-barriers-to-justice-inaccessibility-of-new-york-s-criminal-justice-system-for-individuals-with/

[70] Petrisilla, J. (2000). Doing Justice? The Criminal Justice System and Offenders with Developmental Disabilities at 4. California Policy Research Center. https://www.ojp.gov/ncjrs/virtual-library/abstracts/doing-justice-criminal-offenders-developmental-disabilities-0

[71] Petrisilla, J. (2000).

[72] Maruschak, L., Bronson, J. Ph.D., and Alper, M. Ph.D, Survey of Prison Inmates (2016). Disabilities Reported by Prisoners, United States Dep't of Justice Bureau of Justice Statistics at pp. 1 (Figure 1), 3(Table 2), https://bjs.ojp.gov/content/pub/pdf/drpspi16st.pdf

[73] Maruschak, L (2016) at 6 (Table 6).

[74] Maruschak, L. (2016) at 1 fn. 2.

There is a clear discrepancy between the data which the Connecticut DOC collects and the estimated national prevalence rates of incarcerated individuals with I/DD regarding the accurate number of incarcerated individuals with I/DD. According to DOC data from September 2025, **111** incarcerated individuals have I/DD, which represents around 1% of the total prison and jail population in Connecticut.[75] By contrast, in the aforementioned study by Petrisilla, the estimated number of incarcerated individuals in Connecticut with I/DD would be between **442-1,105** individuals. Using the study conducted by BJS, those estimates could be as much as **2,653**. Using national prevalence estimates as a guide, the rate of incarcerated individuals with I/DD in Connecticut's prisons and jails is likely higher. Additionally, because the Connecticut DOC does not conduct its own screening and assessments of individuals with I/DD, the DOC's prevalence data may not accurately measure the number of incarcerated individuals with I/DD. It would be beneficial for the DOC to independently assess I/DD reliably to better understand prevalence rates for this population, and potential impacts on a proposed diversionary program.

SCREENING TOOLS AND ASSESSMENTS

Overview

This Report looks at a variety of screening tools and assessments for identifying both ID and ASD. In conversations with I/DD experts[76], there was consensus that screening tools for ID and ASD can be administered by the individual, by a family member or educator familiar with the individual, or with assistance from non-clinical staff such as those at JB-CSSD, although JB-CSSD's administration of these tools would be dependent on available resources. These tools are best suited for those individuals who were misdiagnosed or never diagnosed with I/DD. For those individuals who were previously diagnosed by a qualified professional (e.g., doctor or clinician), a letter from the provider verifying the diagnosis should take the place of the screening tools and assessments discussed below.

In criminal justice settings, it is important to utilize evidence-based and reliable screening tools and assessments. In particular, if screening is not universally administered, there is a high likelihood that individuals with I/DD will be overlooked, placing them at significantly increased risk of exploitation, increased punitive measures, and other negative outcomes.[77] It is important that screening tools and assessments are reliable; that is, the screen should "flag" most people who would be diagnosed with I/DD using gold-standard expert assessment tools (this is called "sensitivity") and avoid flagging individuals without I/DD (this is called "specificity").[78] Sensitivity and specificity rates refer to the metrics used to evaluate the validity and reliability of the screening tool or assessment, helping to

[75] This number does not account for individuals who are on probation, parole or reside in halfway houses under DOC supervision as prevalence data on this population is unknown.

[76] Michael Powers, Psy.D, Executive Director at The Center for Children with Special Needs and Associate Clinical Professor at The Yale Child Study Center; Fred Volkmar, M.D., Center Director, Goodwin Endowed Chair Special Education at Southern CT University and Irving B. Harris Professor of Child Psychiatry, Pediatrics at the Yale Child Study Center; and Kathleen Collins, clinical psychologist at the Massachusetts Department of Developmental Services

[77] Apshaga, M. (2016). You Can't Just "Tell": Why Washington Jails Must Screen for Mental Illness and Cognitive Disabilities. Disability Rights Washington. https://disabilityrightswa.org/reports/cant-just-tell/

[78] McKenzie, K., Metcalfe, D., & Murray, A. L. (2023). Screening for intellectual disability in autistic people: A brief report. *Research in Autism Spectrum Disorders*. https://doi.org/https://doi.org/10.1016/j.rasd.2022.102076

determine the likelihood a person does or not have a condition or disability.[79] Accepted thresholds are 70% and over for sensitivity, and 80% and over for specificity.[80]

Screening tools and assessments for ID and ASD are discussed in detail below, including recommendations for which screens are best suited for either self-administration or for rating by non-clinical professionals.[81] The discussion includes cost analysis of purchasing screening tools and assessments when available. Additionally, for individuals who were not previously diagnosed, screening tools are an initial suggestive, not conclusionary step, toward determining an individual's diagnosis. A qualified professional (e.g., psychologist or psychiatrist) should make the ultimate diagnosis.

Lastly, in communications with the DOC about screening tools and assessments it provides to individuals with I/DD, the DOC confirmed that it does not have a standard practice of utilizing screening tools or assessments.[82] When asked about policies and procedures the DOC uses in screening and assessing individuals with I/DD, the DOC provided several policies and procedures. None of the policies and procedures provided mentioned screening tools and/or assessment for I/DD or other disabilities aside from mental illness.[83]

Within the criminal justice context, issues around psychological and risk assessments should not be part of the screening process but rather be addressed by a qualified professional (e.g., psychologist, psychiatrist) after the screening tools are utilized.

ID Screening Tools and Assessments

Research on ID screening tools and assessments focused on seven instruments, of which two stand out as the most accurate tools.[84] An important aspect of the most effective screening tools and assessments is their emphasis on adaptive behavior - the knowledge, behavior and skills necessary to be personally independent and socially responsible. These skills comprise of conceptual knowledge (e.g., verbal and written communication, understanding time), social knowledge (interpersonal skills and perspective taking), and practical life skills (personal care, health care, community use). These challenges translate directly to challenges in the criminal justice setting, such as comprehending complex legal language,

[79] Diagnostic Sensitivity and Specificity for Clinical Laboratory Testing. (n.d.). One Lab Reach. https://reach.cdc.gov/sites/default/files/job-aids-resources/Sensitivity_and_Specificity.pdf
[80] McKenzie, 2023.
[81] This Report includes only samples of recommended screening tools and assessments that can be accessed without paying a fee.
[82] This Report characterizes DOC use as not part of its "standard practice" in acknowledgement of the fact that qualified professionals at the DOC may use screening tools and assessments on a case-by-case basis.
[83] This conclusion was drawn following a review of the policies and procedures provided by the DOC in response to information for screening and assessment completed for individuals with I/DD. These policies procedures are: Administrative Directives 8.1 (Scope of Health Services Care) and 8.5 (Mental Health Services), Health Service Unit policies E 2.01 "Intake Health Screening", E 3.01 "Inmate Transfer Health Care Review", E 5.01 "Requests and Referrals for Mental Health Assessments and/or Services", E 13.01 "Medical/Mental Health Discharge Planning", and E 13.01a "Inmate Release to Residential Program."
[84] The discussion does not include an analysis of a common knowledge assessment, the Montreal Cognitive Assessment (MoCA) as research shows that the MoCA is not recommended to be administered by non-clinicians.

instructions, and forms, comprehending rules of behavior, and learning (often unspoken or implicit) social norms in a novel setting such as a prison.[85]

Based upon the review of seven ID tools and their corresponding scholarly literature, it is advisable to utilize either Hayes Ability Screening Index (HASI) or the Learning Disability Screening Questionnaire (LDSQ). This recommendation is further supported by discussions with Dr. Inge-Marie Eigsti, Professor of Psychological Sciences at the University of Connecticut[86], and Kathleen Collins, Clinical Psychologist at the Massachusetts Department of Developmental Services.

Learning Disability Screening Questionnaire

The Learning Disability Screening Questionnaire (LDSQ)[87] is a highly accurate, cost-effective screening tool to assess an individual for ID. The LDSQ is a 7-item questionnaire which takes approximately 5-10 minutes to complete. The questions require a yes or no response. The questionnaire covers topics including literacy, writing, telling time, employment, living situation, previous support in school, and contact with ID services. It can be self-administered by the individual age 16 or older or by someone who knows the individual well.[88]

Questions are scored dichotomously and used to calculate a total percentage score. The scorer of the LDSQ assigns each of the 7-item questionnaire a yes/no response (e.g., a "0" or "1") which is converted into a total percentage score.[89]

Accuracy percentages vary slightly depending on whether those being tested reside in the community or in a forensic setting.[90] The LDSQ has a sensitivity rate of 91.2% and 82.3% for community and forensic settings, respectively. It has a specificity rate of 87% and 87.5% for community and forensic settings, respectively. All estimated percentages are weighted higher than the minimal recommended accuracy rate to rule out individuals who do not have ID.[91]

Studies on the use of the LDSQ demonstrate that it is both effective and versatile. One study utilized the LDSQ in multiple different settings, including forensic settings and the community. In particular, the study noted that the use of the LDSQ to screen incarcerated individuals when little is known of the individual's history was a quick, easy, and relatively accurate measure as an ID diagnostic.[92]

The cost of the LDSQ is approximately $120 for a packet of 100 forms with the possibility of a price

[85] Ross, G. E., Hocken, K., & Auty, J. M. (2020). The reliability and validity of the Adaptive Functioning Assessment Tool in UK custodial settings. *Journal of Intellectual Disability*, *24*(1), 35-49. https://journals.sagepub.com/doi/10.1177/1744629518762885

[86] Additional information on Dr. Eigsti's background and research can be accessed here: https://psychology.uconn.edu/person/inge-marie-eigsti/

[87] The term "learning disability" is used in the United Kingdom in lieu of the phrase "intellectual disability."

[88] McKenzie, K., Michie, A., Murray, A, & Hales, C. (2012). Screening for Offenders with Intellectual Disability: The Validity of the Learning Disability Screening Questionnaire. 33(3), 791-795. https://www.sciencedirect.com/science/article/abs/pii/S0891422211004379

[89] The study notes that the LDSQ will reveal a reliable result if at least five (5) of the questions on the questionnaire are completed. McKenzie, K., Sharples, P., & Murray, A.L. (2015) Validating the Learning Disability Screening Questionnaire against the WAIS IV. Intellectual and Developmental Disabilities, 53(4), 301-307. https://researchportal.northumbria.ac.uk/ws/portalfiles/portal/2982059/WAISIV_LDSQ%20_author%20copy.pdf

[90] Because the creation of the LDSQ originated in the United Kingdom, the term "forensic settings" includes hospitals, and prisons/jails.

[91] McKenzie (2015).

[92] McKenzie (2012).

reduction for bulk orders.[93]

Hayes Ability Screening Index

The Hayes Ability Screening Index (HASI) is a second option with good accuracy and relatively low cost. The HASI is a screening tool for ID consisting of four background questions and test items covering activities such spelling backwards, puzzles, picture matching, and clock drawing. The screening tool can be utilized by individuals aged 13 or older and takes approximately five minutes to complete.[94]

Upon completion, the test is scored based upon a numeric score between 38-99. Scores lower than 85 suggest a high likelihood that the individual has ID.[95]

The HASI are within normal reliability accuracy ranges, but slightly below the reliability of the LDSQ. The HASI has a sensitivity rate of 82%, and a specificity rate of 76%. Studies noted that although the HASI may overidentify individuals with psychiatric disabilities or those with limited English proficiency, it does effectively distinguish between those with ID and those without cognitive impairments.[96]

The cost of the HASI is approximately $150 for a packet of 25 forms with the possibility of a price reduction for bulk orders. [97]

Other Screening Tools and Assessments

Five additional screening tools and assessments were reviewed for this Report but are not optimal. Although each tool discussed below has unique characteristics, these tools are either inaccurate or lack reliability or validity in their accuracy to detect or rule out individuals with ID, and therefore, are provided for context but not recommended for use as screens for individuals with ID in the criminal justice setting.

The Learning Disabilities in Probation Services (LIPS) assessment asks several questions covering a variety of skills commonly tested in individuals with ID, but it has not been widely researched, and its reliability is unknown. The LIPS, a screening tool applied in probationary settings in the United Kingdom, asks questions that test verbal cognition using a word-picture association task, and non-verbal cognition with a clock drawing task. Additionally, the test asks six questions regarding social functioning, and five covering education, mental health, and demographics. While literature indicates that when the screening tool was used, it correctly identified ID in individuals 87% of the time, information on specificity rates is unknown. Cost information about this tool is also unknown.[98]

The Adaptive Functioning Assessment Tool (AFAT) provides an informal ID diagnosis but has been shown to result in false positive ID diagnoses. The test, which is lengthier than other screening options,

[93] This information was confirmed in conversations with Dr. Eigsti.
[94] Braatveit, K. J., Assmus, J., & Hove, O. (2022). Exploring the predictive properties of the Hayes Ability Screening Index subtest background information in identifying individuals with MBID among in-patients with SUD. *Front Psychiatry*, *13*, 1051946. https://doi.org/10.3389/fpsyt.2022.1051946
[95] Braatveit (2022).
[96] Braatveit (2022).
[97] This information was confirmed in conversations with Dr. Eigsti.
[98] Murphy G, Mason J. (2007). People with intellectual disabilities who are at risk of offending. *Psychiatric and Behavioural Disorders in Intellectual and Developmental Disabilities*. Cambridge University Press,173-201.

contains 46 questions that can be completed by the individual or a person who knows him/her well. The questions cover four main areas – communication, socialization, independence, and functioning in employment, school, and day program environments. Research on the AFAT supports a sensitivity rate of 71%, and a specificity rate of 83%. Responses require "yes," "no," or "don't know." Scoring is calculated by adding the completed responses, excluding any "don't know" answers, and dividing the remaining number by the number of yes/no responses completed. Studies of the effectiveness of the AFAT show that false positives are common, negatively impacting the AFAT's reliability. It should also be noted that this screening tool was only tested on incarcerated individuals, not those in the community. This screening tool can be obtained at no charge from its creator.[99]

The Thirteen Question Battery covers questions on similar topics impacting individuals with ID. Examples of questions include "do you need help now with handling money?" and "did you ever need extra help with reading?" The screening tool requires that the individual answer "yes" to at least two questions as evidence that further assessment of ID is necessary. There is no information on sensitivity or specificity rates. The tool is free to use.[100]

The Proverbs, Fund of Knowledge, and Similarities (PROFOKS) scale is a 10-item questionnaire which tests an individual's knowledge of commonly known facts. Questions include "Who is the president of the United States" and "what do people mean when they say, 'don't cry over spilled milk'"? The subject is scored from 0-16 points; the higher the score, the more likely the subject has ID. Scores on the PROFOKS indicated only moderate correlations to ID diagnoses with a sensitivity rate of 65.3% and no data on a specificity rate. There is no data on the cost of the screening tool.[101]

The Disability Assessment Schedule is a self-administered screening tool consisting of 44 questions. The questions include scenarios related to physical and developmental disabilities as well as behaviors suggestive of I/DD. Information on pricing, sensitivity/specificity rates, and how to score the screening tool is not available.[102]

ASD Screening Tools and Assessments

There are four main screening tools and assessments to evaluate individuals who may have an ASD diagnosis by a non-clinician or via self-administration. These four options are: (1) the Comprehensive Autistic Trait Inventory (CATI); (2) the Ritvo Autism Asperger Diagnostic Scale Revised (RAADS-R); (3) the Adult Repetitive Behaviours Questionnaire (ARBQ); and (4) the Camouflaging Autistic Traits Questionnaire (CATQ).[103]

The CATI and the RAADS-R are considered reliable tools to initially evaluate the likelihood that a

[99] Ross (2020).
[100] Catalano, G., Mason, J., Brolan, C. E., Loughnan, S., & Harley, D. (2020). Diagnosing cognitive impairment in prisoners—A literature review. *Journal of Intellectual Disabilities and Offending Behaviour*, *11*(4), 221–232. https://doi.org/10.1108/JIDOB-01-2020-0002
[101] Donohue, A., Samuels, J., Thompson, R., Watson, C., & Gallucci, G. (2014). Use of a Brief Screening Tool to Assess Intellectual Functioning in a Forensic Population. *Journal of Intellectual Disability - Diagnosis and Treatment*, *2*, 54-58. https://www.lifescienceglobal.com/media/zj_fileseller/files/JIDDTV2N1A7-Donohue.pdf
[102]Holmes, N., Shah, A., & Wing, L. (1982). The Disability Assessment Schedule: a brief screening device for use with the mentally retarded. *Psychol Med*, *12*(4), 879-890. https://doi.org/10.1017/s0033291700049175
[103] Although some research articles in the United Kingdom reference a fifth assessment called the Glasgow Sensory Assessment, this tool is used to assess children with ASD and, therefore, not considered in this report. Smees, R. Rinaldi, L.J., Simmons, D.R., and Simner, J. (2013). Measuring Sensory Sensitivities in Children: The Parent-completed Glasgow Sensory Questionnaire. https://misophonia-hub.org/downloads/Smees_etal2021.pdf

person has or does not have ASD. Of these two options, there is some disagreement as to whether the RAADS-R should be used by non-clinicians or for self-administration. Two other assessment tools known as the Social Responsiveness Scale and the Autism Diagnostic Interview were reviewed as well; however, these tools are not suitable for non-clinicians or for self-administration. For these reasons, it is recommended that the CATI be utilized to screen individuals for ASD.[104]

Comprehensive Autistic Trait Inventory[105]

The Comprehensive Autistic Trait Inventory (CATI) is a 42-question, self-administered screening tool which takes approximately seven minutes to complete.[106] The tool is comprised of six subsections covering the following topics: social interaction; communication; social camouflage; self-regulatory behaviors; cognitive flexibility; and sensory sensitivity.[107] Studies emphasize that the CATI's strength is its accuracy and ability to ask questions that are non-stigmatizing.[108] Studies highlighted that the CATI correctly identified autism in a majority of cases for both individuals who had been previously diagnosed and those who reported having ASD but had not been professionally diagnosed.[109] The CATI has also been successfully shown to distinguish between those with ASD, and those without.[110]

Each question on the CATI is assigned a numerical value of 1-5 for each of the 42 questions. Each numerical value of 1-5 corresponds to a statement of "definitely disagree" (1) to "definitely agree" (5). The CATI is scored by adding a numerical value for all questions answered and then converting that numerical value into a percentage. The higher the percentage, the more likely the individual has an ASD diagnosis.[111]

The CATI has a sensitivity rate of 77.2%, and a specificity rate of 87.4%. In three studies comprised of 2,600 participants (1,322 autistic, and 1,279 non-autistic individuals), the CATI outperformed all other ASD assessments referenced in this Report. The CATI is free of charge.[112]

Ritvo Autism Asperger Diagnostic Scale Revised

The Ritvo Autism Asperger Diagnostic Scale Revised (RAADS-R) is an 80-question screening tool to ascertain autistic traits for undiagnosed ASD individuals. The tool includes questions about language, social relatedness, sensory skills, motor skills, interests, and repetitive behaviors. It is scored with a numerical value ranging from 0-240, with a score of 65 or higher indicating that the subject is likely to

[104] Constantino, J.N., Davis, S.A., Todd, R.D. *et al.* (2003). Validation of a Brief Quantitative Measure of Autistic Traits: Comparison of the Social Responsiveness Scale with the Autism Diagnostic Interview-Revised. *J Autism Dev Disord* 33, 427–433. https://doi.org/10.1023/A:1025014929212
[105] Samples of both the CATI screening tool and scoring key are located in Attachments B and C at the end of this Report.
[106] English, M.C.W., Gignac, G.E., Visser, T.A.W. *et al.* (2021). The Comprehensive Autistic Trait Inventory (CATI): development and validation of a new measure of autistic traits in the general population. *Molecular Autism* 12, 37. https://doi.org/10.1186/s13229-021-00445-7
[107] English, 2021.
[108] Hechler, F.C., Tuomainen, O., Weber, N. *et al.* (2025). "What does 'often' even mean?" Revising and validating the Comprehensive Autistic Trait Inventory in partnership with autistic people. *Molecular Autism* 16, 7. https://doi.org/10.1186/s13229-025-00643-7
[109] Hechler, 2025.
[110] Hechler, 2025.
[111] Comprehensive Autistic Trait Inventory. (n.d.) NovoPsych. https://novopsych.com/assessments/diagnosis/comprehensive-autistic-trait-inventory-cati/
[112] Hechler, 2025.

have autism. It takes approximately 20-30 minutes to complete.[113]

Although the RAADS-R has been shown to be accurate, it is not an ideal choice to be self-administered or administered by a non-clinician. Studies show that the RAADS-R has a sensitivity rate of 97% and a specificity rate of 100%.[114] However, the tool is noticeably much longer and detailed for use as an initial screening tool. Therefore, the RAADS-R is better suited for administration by clinicians as an evaluation tool.[115] Additionally, in a separate more recent study in 2025, it was noted that, unlike the CATI, the RAADS-R falls short in its ability to accurately assess sensory sensitivities in people with ASD and focuses questions on social rather than both social and non-social aspects of a person's life.[116] The cost of the RAADS-R is unknown.

Other ASD Screening Tools

The Autism Spectrum Quotient (AQ) is a 50-item self-administered screening tool. The tool covers topics including social skills; attention to detail; attention switching; communication; and imagination. The tool asks a variety of questions assessing the presence of autistic traits which asks the test taker to score his/her response based on a five-point scale (0-4) from "definitely disagree" (0) to "definitely agree" (4). The tool takes approximately 10-15 minutes to complete. [117]

There are a few aspects of the AQ that make it a less reliable screening tool than the CATI. An analysis of the tool in 2024 stated that although the AQ has good sensitivity, there is a concern that there is a higher sensitivity for male participants than female participants.[118] The AQ's inability to apply universally to both genders may, therefore, create difficulty in its administration. Another study from 2025 concluded that the AQ did not address sensory sensitivities in its tool and does not include questions on non-social aspects of a person's life.[119] The cost of the AQ is unknown.

The Adult Repetitive Behaviours Questionnaire (ARBQ) is a 20-question self-administered questionnaire which asks questions about repetitive and restricted behaviors as well as a person's interests. The tool is scored on a 3 or 4-point scale, with a higher score indicating a greater likelihood of an ASD diagnosis. A study of the ARBQ indicated that the test is reliable but noted some concerns. One study noted that because the ARBQ asks only six questions about sensory behaviors, a more detailed list of questions on this topic would be helpful to more accurately assess individuals with ASD. The same study also concluded that, since the age range of the individuals tested was limited to ages 18-50, no conclusions could be drawn as to the effectives of the ARBQ on older populations. It takes approximately 5-7 minutes to complete.[120] The cost of the ARBQ is unknown.

[113] Mastering the RAADS-R. (2024). B Above Autism Services. https://www.baboveservices.org/resources/raads-r-test
[114] Ritvo, R.A., Ritvo, E.R., Guthrie, D. *et al.* (2011). The Ritvo Autism Asperger Diagnostic Scale-Revised (RAADS-R): A Scale to Assist the Diagnosis of Autism Spectrum Disorder in Adults: An International Validation Study. *J Autism Dev Disord* 41, 1076–1089. https://doi.org/10.1007/s10803-010-1133-5
[115] Ritvo 2011.
[116] Hechler, 2025.
[117] Stevenson JL, Hart KR. (2017). Psychometric properties of the Autism-Spectrum Quotient for assessing low and high levels of autistic traits in college students. J Autism Dev Disord. 47(6):1838 53. https://doi.org/10.1007/s10803-017-3109-1
[118] Buchanan, B., Hegarty, D., Baker, S., Smyth, C., and Bartholomew, E. (2024). A Review of the Clinical Utility and Psychometric Properties of the Autism Spectrum Quotient; Gender-Specific Norms, Percentile Rankings, and Qualitative Descriptors. https://novopsych.com/wp-content/uploads/2025/02/Autism-Spectrum-Quotient-AQ-NovoPsych-Review-Paper.pdf
[119] Heckler, 2025.
[120] Barrett SL, Uljarević M, Baker EK, Richdale AL, Jones CRG, Leekam SR. (2015). The Adult Repetitive Behaviours Questionnaire-2 (RBQ-2A): a self-report measure of restricted and repetitive behaviours. J Autism Dev Disord. ;45(11):3680–92. https://doi.org/10.1007/s10803-015-2514-6.

The Camouflaging Autistic Traits Questionnaire (CAT-Q) is a 25-question self-administered screening tool focusing on behaviors often camouflaged in autistic adults compared to non-autistic adults including social interactions, communication, masking behaviors, and assimilation. Questions are scored on a scale of 1-7, with 1 indicating "strongly disagree," and 7 indicating "strongly agree." Higher combined scores indicate a greater likelihood of camouflaged behaviors in an individual with ASD. It takes approximately 10-15 minutes to complete.[121]

One study suggests that the CAT-Q may not be ideal. The CAT-Q only focuses on one characteristic common with individuals with ASD – camouflage – and, therefore, lacks the skill versatility of other ASD screening tools.[122] There is no cost to use the CAT-Q.[123]

Screening tools and Assessments for Comorbid Diagnoses

In conducting research for this Report, it is important to briefly address individuals who may have comorbidities. Comorbidities refer to diagnoses that an individual may have in addition to an I/DD diagnosis, such as mental illness. In speaking to I/DD experts for this Report[124], there is consensus that psychiatric diagnoses are the most common comorbidities for an individual with I/DD. There is also agreement that, because there are more complex and varied needs of individuals with I/DD, assessment and placement in a potential I/DD-focused jail diversionary program should be prioritized over a program to address the psychiatric diagnosis. However, a dual diagnosis of an I/DD and mental illness should be individually assessed and appropriately treated in a plan of care.

Evaluations and Care Planning

Although this Report does not focus on the evaluation and case management portions of a potential I/DD diversionary program, it is helpful to mention their relevance to this Report. As referenced previously, unless the individual being considered for the program has been previously diagnosed, an evaluation by a qualified professional (e.g., psychologist or psychiatrist) should follow a positive screening result to verify the diagnosis. It should be noted that for individuals who were never diagnosed or misdiagnosed, an individual's insurance (Medicaid/Medicare or private) likely covers the cost of an evaluation. In order to be covered by insurance, the evaluation must be based on the individual's request to be diagnosed after applying for the I/DD diversionary program without reference to the criminal justice system.[125]

Additionally, and notably different that the current SDP for individuals with psychiatric disabilities, the needs of an individual with I/DD will likely require some form of support which may impact multiple aspects of the individual's rehabilitation, such as education, employment, finances, and

[121] Lundin Remnélius, K., Bölte, S. Camouflaging in Autism: Age Effects and Cross-Cultural Validation of the Camouflaging Autistic Traits Questionnaire (CAT-Q). *J Autism Dev Disord* 54, 1749–1764 (2024). https://doi.org/10.1007/s10803-023-05909-8
[122] Lundin Remnélius, K (2024).
[123] The Camouflaging Autistic Traits Questionnaire (CAT-Q). (n.d.) https://novopsych.com/assessments/formulation/camouflaging-autistic-traits-questionnaire-cat-q/
[124] Concerns about comorbidity were discussed specifically with Dr. Kathleen Collins; Dr. Michael Powers; and Dr. Fred Volkmar.
[125] Although initial research has been conducted on insurance coverage to evaluate for an I/DD diagnosis, it is unknown if every private insurance carrier covers this cost. It is advisable that each individual requesting an evaluation through his/her insurance should consult the individual carrier.

counseling. This support should include both a psychological and risk assessment as well as an evaluation of needs to minimize regression of the skills being supported. It is common for individuals with I/DD to regress when they lack ongoing support.

Moreover, if assessed and positively screened, it is important to ensure that supports and services necessary to address the I/DD and/or psychiatric disability are provided. The state could utilize an assessment tool known as the Support Intensity Scale Index for Adults (SIS-A) as a standardized practice for lay professionals trained in the SIS administration and scoring procedures responsible for justifying and providing individualized support plans following the initial screening of individuals with I/DD. The SIS-A, in use since 2004 and created by AAIDD, measures the pattern of intensity of supports based upon type of support, frequency of support, and daily support time an individual needs. The information compiled from the SIS-A can help to

1. Provide a summary of the supports and services an individual needs;
2. Predict service needs to aid in the planning of obtaining needed supports;
3. Determine necessary services and staffing for those supports; and
4. Measure and compare support needs across and among adults who receive intellectual and developmental services.[126]

BEST PRACTICES IN STATES WITH I/DD DIVERSIONARY PROGRAMS

Overview

This Report includes a review of the best practices from other states that have some form of I/DD diversion program. A total of 16 states have diversionary programs. Twenty-one I/DD programs exist in these states and have similarities and differences in program characteristics as discussed below.[127] A detailed comparison table of identified best practice models is located in the appendices (see Attachment D). The best practice analysis focuses on the following factors: structure of the I/DD diversionary program(s); eligibility requirements; individualized support plans; program fees; program length; repetitive use of the program; and outcome measures of success. Some states have diversionary programs for specific counties rather than the entire state. These distinctions are noted in the appendices as well as the sources cited in the reference list that follows. Additionally, Attachment E lists the states which do not have adult I/DD diversionary programs.[128] Lastly, Attachments F and G provide examples of a participation handbook (Oklahoma – Delaware County) and the annual report for an I/DD diversionary program (Virginia – Fairfax County).

[126] Supports Intensity Scale – Adult Version (n.d.). American Association for Individuals with Intellectual and Developmental Disabilities. https://www.aaidd.org/sis/sis-a

[127] The best practices looks at the following counties and states: Arizona (Maricopa County); California; Florida (Broward, Alachua, and Polk Counties + 19th Judicial district); Illinois (Kane county); Indiana (Monroe County); Nebraska (Sarpy County); Michigan; Nevada (Washoe County); New York (Rockland County); New Jersey; Oklahoma (Tulsa, Cleveland/Oklahoma Counties); Ohio (Cuyahoga and Delaware Counties); Oregon (Washington County); Pennsylvania (Philadelphia County); Virginia (Fairfax County); and Washington (Spokane County).

[128] Although some states including Colorado and North Carolina provide diversion for individuals for I/DD, these programs are excluded from the analysis in this Report as they apply to only juveniles. Additionally, we acknowledge that North Dakota has issued a report on recommendations regarding jail diversion, but, because the report only discusses the possibility of a diversionary program, North Dakota is also not included.

Program Structure

Combined or standalone

I/DD diversionary programs are either classified as a separate standalone program, or as an add-on to an existing diversionary program. Most I/DD programs reviewed – 18 of 21 – were added to an existing mental health diversionary program by state statute. Within the programs that combine I/DD diversion programs with other programs, most of these programs are established at the county level. Of the 18 programs which add I/DD diversionary programs to existing program structures, 16 states created county-specific programs, revealing that many states only fund I/DD diversionary programs in select counties. By contrast, four states – California, Iowa, Michigan, and New Jersey – provide statewide programs.[129] Three programs in Arizona, California, and New York, established independent diversionary programs which apply to only individuals with I/DD diagnoses. New Jersey created a unique structure for program implementation, utilizing the resources and expertise of a disability-focused, self-funded non-profit, The Arc of New Jersey, rather than relying upon state resources.[130]

Additionally, there is a consistent best practice for a multi-agency partnership approach for most I/DD diversionary programs reviewed. Programs include the need to collaborate with multiple state agencies and/or non-profits to ensure the success of their respective programs. These collaborations require close coordination among courts, prosecutors, defense counsel, state agencies, and service providers. The programs require that referrals to their diversionary programs are directed at a single entity to begin the assessment process, although there are some differences in what entity each state uses. Many states rely upon their prosecutor's office as the first point of contact for the initial referral. Other states assign this responsibility to either the court or pretrial services. Three programs – Indiana, Oklahoma (Tulsa County) and New Jersey – represent outlier examples. Both Indiana and Oklahoma (Tulsa County) rely upon a separate state board or council which makes decisions about each applicant; this structure includes members of interested state agencies, police, and I/DD professionals. As the only state that does not rely upon coordination from state agencies, New Jersey sends referrals to The Arc of New Jersey, a nonprofit organization.[131]

Pre- or post-conviction

Most I/DD diversionary programs recognize that the diagnosis of I/DD occurs pre-conviction and prior to acceptance into the program, but a few programs that acknowledge exceptions to this rule. Eighteen of the programs permit applicants to enter their program at the resolution of their cases during the pretrial stage. New Jersey, Indiana, and two Florida courts (Broward and Alachua counties) permit post-conviction entry into their programs. Florida specifically permits admission of applicants for violation of probation with court approval.

[129] Iowa has an I/DD diversionary program; however the program was temporarily halted in November 2025 due to government restructuring and, thus, the outcome of a new program is unknown as of the release of this Report.
[130] Criminal Justice Advocacy Program. (n.d.) https://www.arcnj.org/programs/criminal-justice-advocacy-program/criminal-justice-advocacy.html
[131] Criminal Justice Advocacy Program. (n.d.)

Eligibility Requirements and Crime Exclusions

Requirement – I/DD diagnosis

All state programs require that participants provide proof of an I/DD diagnosis.[132] All states permit individuals aged 18 or above to be considered except New Jersey which reviews applicants aged 21 and above.[133] Some states specifically mention in their statutes that a diagnosis can be provided from documentation by a physician, psychiatrist, or psychologist (e.g., educational records). Most states allow for initial screening/assessments of individuals before the individual is accepted into the program and evaluated for a support plan.

Most states do not specifically reference the scenario of an individual who is believed to have an I/DD but was misdiagnosed or never diagnosed; however, none of the states prohibit these individuals from applying to their programs. Of note, there are no defined time limits that restrict the length of admissions from the time of a positive screen to program eligibility determination required for the court. This may suggest flexibility is needed to allow time for a thorough assessment by a qualified professional (e.g., psychologist or psychiatrist), or when no misdiagnosis is at issue, for both verifying an I/DD diagnosis and presenting a treatment plan.

Although not explicitly stated for all states, no program precludes consideration of an individual with co-occurring conditions.

Requirement – limits on criminal activity

Multiple state programs exclude individuals from program eligibility who engaged in past criminal activity considered too severe, violent, or that placed their community at higher risk. Other states consider an individual's criminal history as a factor for eligibility consideration, not an automatic preclusion to program entry. A third group of states recognizes that individuals with I/DD may be at a greater risk if convicted and incarcerated in lieu of considering them for placement in a diversionary program with the necessary supports.

Four programs in Florida (Broward County), Illinois (Kane County), Nebraska (Sarpy County) and Indiana (Monroe County) place strict limits on past criminal activity. Illinois and Nebraska place the strictest limits on criminal activity, requiring that applicants must not have any prior violent criminal offenses.[134] Additionally, Nebraska requires no criminal history within the last 15 years.[135] Broward County, Florida requires that the applicant cannot have more than three non-violent felony offenses to enter into its program.[136] Indiana, as the only state which provides both pre- and post-conviction

[132] Viriginia's program in Fairfax County is the only state which adds an additional requirement to the I/DD diagnosis which mandates that there must be a "court finding by clear and convincing evidence that criminal conduct caused by direct and substantial relationship to disability." Diversion First. (n.d.) Fairfax County Virginia. https://www.fairfaxcounty.gov/topics/diversion-first

[133] Criminal Justice Advocacy Program. (n.d.)

[134] Kane County Treatment Alternative Court Participant Handbook. (2020). http://courtservices.countyofkane.org/Documents/TAC%20Participant%20Handbook%202020.pdf ; Ramm, E. (2021, May 20). Mental Health Diversion serves as an alternative to incarceration. (n.d.) Sarpy County, NE. https://www.sarpy.gov/CivicAlerts.aspx?AID=59

[135] Mental Health Diversion serves as an alternative to incarceration. (n.d.)

[136] Diversion Programs. (n.d.). Office of Broward State Attorney Harold F. Pryor. https://browardsao.com/diversion-programs/

admissions into its program, mandates no violent offenses within 10 years (pre-conviction), and no drug dealing offenses (post-conviction).[137] Illinois adds a separate requirement that applicants are ineligible if they have any active warrants.[138]

Four other programs mandate that applicants must enter a guilty plea to be accepted into their programs, including programs in Indiana (Monroe County); Michigan; Nevada (Washoe County); and New York (Rockland County). Of those states, Michigan's requirement permits either a guilty or no contest[139] plea.[140] Nevada (Washoe County) will accept a guilty plea, or suspended sentence with probation.[141]

All other remaining programs – 13 in total – either consider an applicant's criminal history as a non-preclusive factor, or do not statutorily consider it in their eligibility assessments.

Crime Exclusions

As previously discussed in this Report, common charges for individuals with I/DD include sex and domestic violence offenses. Several state programs recognize that violent offenses should not automatically prohibit program admission and consider these charges on a case-by-case basis. Several programs prohibit applicants charged with violent felonies excluding some sex and/or domestic violence charges depending on how these crimes are classified in each state. The following programs make these exclusions: Florida (19th Judicial District); Illinois (Kane County); Indiana; Michigan; Nebraska (Sarpy County); Nevada (Washoe County); New York (Rockland County); Oklahoma (all counties); Ohio (Delaware County); Virginia (Fairfax County); and Washington (Spokane County). Some of these programs permit exceptions to violent felony charges with court permission and victim consent. For example, in Michigan, the courts are given broad discretion to permit applicants charged with violent felonies.[142]

In other examples, more than half of the programs permit applicant approval of candidates with violent felonies with more flexible conditions. For example, in Ohio (Cuyahoga County), where felonies are divided into five degrees of severity from 1st degree (i.e., murder) to 5th degree (i.e., crimes punishable by 6-12 months incarceration), applicants charged with 3rd degree sex offenses are program eligible.[143] Additionally, 2nd degree felonies such as home invasion and felonious assaults are program eligible offenses on a case-by-case basis.[144] Both in Oklahoma (all counties) and Florida (Broward, Alachua Counties), the court, at its discretion, may approve sex offenses to be program eligible. Although some states classify severity of felony-level sex offenses differently, Nevada (Washoe County), Arizona (Maricopa County), California, Pennsylvania (Philadelphia County), and New Jersey permit some low-level felony sex offenses. Specifically, California permits non-rape or charges that do not involve

[137] Community. (2020, August 10). About. Community Corrections. https://www.in.gov/idoc/community-corrections/about/
[138] Kane County Treatment Alternative Court Increases Capacity. (n.d.).
[139] A no contest plea permits an individual to plea to a charge or charges without admitting or denying guilt. No contest. (2020). Legal Information Institute. https://www.law.cornell.edu/wex/no_contest#
[140] Developing and Implementing a Mental Health Court in Michigan. (2016). State Court Administrative Office. https://www.courts.michigan.gov/siteassets/publications/manuals/psc/mhc-manual.pdf
[141] Mental Health Court Handbook, Reno Nevada. (n.d.) https://studylib.net/doc/7620955/mental-health-court---washoecourts.com
[142] Developing and Implementing a Mental Health Court in Michigan. (2016).
[143] Mental Health and Developmental Disability Court. (n.d.) Common Pleas Court General Division Cuyahoga County. https://cp.cuyahogacounty.gov/court-resources/specialty-courtsprograms/mental-health-and-developmental-disabilities-court/
[144] Mental Health and Developmental Disability Court. (n.d.).

a minor victim.[145] Pennsylvania (Philadelphia County) permits sex offenses with court and prosecutorial discretion.[146] New Jersey permits sex offenses and evaluates them on an individual basis.[147]

Program examples of domestic violence show that individuals convicted of these crimes can be program eligible in multiple states. Oklahoma (both counties), Florida (Broward, Alachua Counties), California, Ohio (both counties), Pennsylvania (Philadelphia County), and New Jersey all permit individuals charged with domestic violence to be considered for diversionary programs. Florida (Broward, Alachua Counties) specifically limits domestic violence charges involving victims who are the parent, child, or sibling of the individual charged. Oklahoma, California, and Pennsylvania require victim consent and court approval prior to the individual being accepted into a diversionary program.

Other programs offer considerable leniency regarding crimes charged, while one program has stringent charge-based restrictions; however, these state programs appear to be outliers. Pennsylvania (Philadelphia County) does not exclude any specific crimes as long as there is both court and prosecutorial approval.[148] New Jersey offers the most lenient program, without placing any explicit restrictions on criminal charge exclusions.[149] At the other end of the spectrum, Oregon (Washington County) prohibits individuals who commit felonies from its program, providing a list of twelve specific types of misdemeanors which are program eligible; other misdemeanors outside the scope of this list are considered at the prosecutor's discretion.[150]

Individualized Support Plans

All programs reviewed require professionals to develop individual support plan recommendations for the person accepted into the program. State programs either permit state agencies who provide I/DD or mental health services (i.e., DDS or DMHAS equivalents) or non-state agency entities to evaluate individuals and propose individualized support plans. Support plans are then reviewed by prosecutors, defense counsel, and the court after the professional presents his/her proposed support plan. Plans focus on wraparound services that address each individual's needs. These services may include, but are not limited to:

- Supervision;
- Support including therapy and medication management[151];
- Life skills training;
- Housing assistance;
- Benefits assistance;

[145] Regional Center Diversion Q&A. (2025). Disability Rights California. https://www.disabilityrightsca.org/latest-news/regional-center-diversion-qa
[146] Adult Diversion and Alternatives to Incarceration Initiatives. (n.d.) Philadelphia District Attorney's Office. https://phillyda.org/adult-diversion-and-alternatives-to-incarceration-initiatives/#mental-health-court-municipal-court
[147] Criminal Justice Advocacy Program. (n.d.)
[148] Adult Diversion and Alternatives to Incarceration Initiatives. (n.d.)
[149] Criminal Justice Advocacy Program. (n.d.)
[150] Mental Health Court. (n.d.) Washington County, Oregon, District Attorney. https://washingtoncountyda.org/da/mental-health-court
[151] This includes treatment for individuals charged with sex offenses.

- Education;
- Vocational training; and
- Training in positive social behaviors.

All state programs require that each applicant must be capable of following the rules within their respective diversionary programs with the necessary supports and services identified in the support plan and other conditions otherwise required by the court. Two programs – Florida (Broward County) and Ohio (Delaware County) – go a step further by statutorily requiring that the individual is competent. However, this requirement does not appear to be standard for all states.

Additionally, a few state programs offer support plans and assistance to participants in stages depending on the individual's level of need and progress. In Illinois (Kane County), the diversionary program utilizes its support plans based on "three steps of stabilization" – stabilization, building life skills, and reintegration.[152] In Ohio (Delaware County), support plans are based on Phases I, II and III – orientation, stabilization, and community integration.[153] More details on this program are available in Attachment F at the end of this Report. New Jersey utilizes micro (working with the individual), macro (working with organization to provide training and education), and mezzo (engaging in systemic change to help the community) levels of interventions in the support it provides and the recommendations that get provided to the court.[154]

Lastly, although all programs utilize disincentives (e.g., sanctions) to encourage success in their programs, there is an outlier, the state of Indiana (Monroe County), which permits institutionalization as an optional requirement determined by Indiana's Department of Mental Health and Addiction.[155]

Caution must be taken such that the setting is the least restrictive environment. Incorporating incarceration or other institutionalization into support plans should be avoided whenever possible for I/DD populations.[156]

Applicant fees

While fees for several I/DD diversionary programs are unknown, known fees represent a combination of caps on the restitution permitted and flat fee structures charged to the individual for utilizing the program. The following states utilize flat fees payable by the individual: California, Nebraska (Sarpy County), and Oklahoma (all counties). California requires both a flat fee and administrative fee capped at $800. Nebraska's fees range between $225-700 depending on the crime charged. All three of the Oklahoma counties rely on a unique fee structure which requires both monthly supervision and administrative fees of $40 and $20, respectively. Both of these fees can be waived due to indigency. By contrast, Arizona's fee is based upon restitution capped at $2,000. Information on the remaining programs reviewed is unknown.

[152] Kane County Treatment Alternative Court Participant Handbook. (2020).
[153] Mental Health Docket Participant Handbook. (February 2025). Delaware County Court of Common Pleas. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fcommonpleas.co.delaware.oh.us%2Fwp-content%2Fuploads%2Fsites%2F30%2F2021%2F07%2FMHD-Participant-Handbook.docx&wdOrigin=BROWSELINK
[154] Criminal Justice Advocacy Program. (n.d.).
[155] IN Code § 11-12-3.7-11 (2024).
[156] *See Mihalcik* at 304 (referencing the harmful effects of institutionalization on individuals with I/DD).

Program length

Although I/DD diversionary program length varies by state and by the crimes charged, data on these programs show that courts generally recognize that the integration of individualized support plans and subsequent success in executing the plans takes time and requires patience to meet each person's needs. Of the programs where time frames were provided, there are either minimum time frames or time frames limited by the maximum sentence allowed based on the crime(s) charged. Of the programs which rely upon specific time limits, program lengths averaged between 12-15 months. Programs in Oklahoma and Indiana could last up to three years; however, the three-year limit applied to only Indiana's post-conviction diversionary program. For four states, Nebraska, New Jersey, Pennsylvania, and Virginia, program length is determined by the needs of the individual. In Nevada, program length is based on the maximum allowable sentence for the crime(s) charged, with a minimum program length of one year. Other state program lengths are unknown.

Measures of program success

All state programs assessed rates of recidivism and individual program completions in their annual reports. Several other programs look at other factors aside from recidivism which include aftercare services,[157] participant incentives,[158] and data on increased safety to participants and the public as a result of program participation.[159] Four states – Indiana, Oklahoma, Ohio, and Michigan - use a court team or board/committee structure to monitor program success through oversight of those programs. These programs bring different criminal justice professionals together to analyze information, draw conclusions, and make recommendations about success including experts in the I/DD and substance use recovery fields, law enforcement, court support professionals, a judge, a prosecutor, a public defender and/or private criminal defense counsel, and psychologists/psychiatrists.

Of note, measures of success for individuals with I/DD should be viewed differently than diversionary programs for individuals with different disabilities. Many programs reviewed referenced recidivism statistics, which included combined data on individuals with both I/DD and other disabilities, primarily mental illness. Because recidivism rates cannot be distinguished from rates for other disabilities, these rates are not program standards of effectiveness. There is a dearth of evidence independently evaluating the programs.

As previously discussed in this Report, individuals with I/DD need continuing supports before, during, and after their interactions with the criminal justice system. States that discuss "aftercare services" or recognize a step-down approach with ongoing assistance, such as Illinois (Kane County) and New Jersey, reflect a more realistic approach to addressing individual needs of participants with I/DD on an ongoing basis.

Repeated use

Given that individuals with I/DD have diagnoses with lifelong impact, it is relevant to consider whether other state diversionary programs permit participants to utilize the programs more than once.

[157] Arizona, Nevada (Washoe County), and Ohio (Delaware County).
[158] Oklahoma (Tulsa County), New York (Rockland County), Pennsylvania (Philadelphia County).
[159] Illinois (Kane County), Virginia (Fairfax County).

Data is limited from the states reviewed. Most state programs do not preclude repeated program use outright. Arizona and California have the added requirement that an individual may return to the program within five years and two years, respectively. Oregon maintains a strict limitation, requiring that an individual cannot reuse the program at all.

CONCLUSION

A. Prevalence concerns and improvements

In order to execute a successful I/DD diversionary program, Connecticut needs to make improvements to its knowledge of population prevalence, as well as better understand its options for structuring an effective program. Research for this Report shows that a multi-agency, collaborative process with state and community-based organizations led by a single coordinating entity holds promise for implementing a successful I/DD diversionary program.

Currently, criminal justice agencies, as well as agencies who assist individuals with I/DD, lack enough data about individuals with I/DD who enter the criminal justice system. Our Report illustrates that Connecticut does not adequately collect prevalence statistics for individuals with I/DD. The current data, including data from the DOC on incarcerated populations, only tallies individuals with ID or ASD that are service eligible through DDS or DSS. The data DDS collects represents a small sub-group of individuals who may have the diagnosis of I/DD, may be at risk for committing crimes, and would possibly qualify for a diversionary program. DDS's eligible population does not account for individuals who have ID with an IQ above 69 and/or who may have other developmental, functional, or adaptive behavioral considerations. Since the DOC relies upon DDS data to verify I/DD status, the agency does not collect its own prevalence data for I/DD.

Criminal justice agencies in Connecticut lack adequate regulatory and administrative procedures to identify individuals with I/DD, as well as adequate training, particularly in court and correction settings, on how to interact with people with I/DD. Agencies in the criminal justice system (e.g., police departments, JB-CSSD, DOC, Office of the Chief State's Attorney, Office of the Chief Public Defender) need sensitivity training to better understand the individual, cultural, and legal accommodations (e.g., ADA) that are required to serve this population. Expanded professional development could improve how justice professionals interact with individuals with I/DD and increase knowledge of the reasonable accommodations they may need.

B. Individuals served by an I/DD diversionary program

An I/DD diversionary program necessitates the recognition that there are three separate categories of individuals that may benefit from the program. The three categories are:

Category #1: Individuals with I/DD who have been previously diagnosed and whose diagnoses can be verified (e.g., through medical/educational records, DDS or DSS involvement, letter from a physician or clinician);

Category #2: Individuals suspected of having an I/DD who have not been previously diagnosed, or

have been misdiagnosed, but may be identified by low-cost screens, later verified by a qualified professional after a positive screen; and

Category #3: Individuals with comorbidities, most likely an I/DD and psychiatric disability.

The experience for individuals across these categories will be different. The creation of an I/DD diversionary program must allow for these differences. It should also be noted that given known characteristics of individuals with I/DD, accommodations such as scribing or reading the screen aloud, and other accommodations should be afforded to reduce misunderstandings as to the self- reporting process.

Category #1: Individuals with I/DD previously diagnosed. This population is the most immediate cost and time efficient to act upon option and relies upon DDS, the individual, guardian, or other trusted adult to provide documentation of a verified I/DD diagnosis. This is followed by a second step of being evaluated for an appropriate support plan by a psychologist and psychiatrist addressing the individual's needs, including risks or other concerns connected to the crime(s) charged.

Category #2: Individuals suspected of having an I/DD disability. This population requires more time for screening, costs for testing, and potentially additional services for individuals who extend beyond the current IQ threshold of 69. An individual never diagnosed or misdiagnosed may need to complete a screening tool for ID, ASD, and/or DD, all of which take little time to screen for and are not costly. Unlike population #1 where individuals are previously identified following an independent, positive screen, the alleged and previously undiagnosed individual will need to go through a two-step process: 1) complete a clinical evaluation to verify whether the individual is assessed as positive for I/DD, and then 2) verify in an evaluation by a qualified professional to then determine rehabilitation and therapeutic remedies an individualized support plan that would best suit the individual.

Category #3: Individuals with Co-morbidities. This population necessitates distinguishing between multiple disabilities and may incur considerable time and cost. Some cost/time may be saved if the individual has records documenting previous diagnoses (e.g., educational or medical records). Individuals in population #3 will go through the same process as population #1 if they have a previously verified I/DD diagnosis, or alternatively, population #2 if they have an unknown but suspected I/DD.

It is recommended that Connecticut universally utilize the SIS-A if the individual has a verified I/DD diagnosis for all three scenarios listed above. The SIS-A indicates the type of supports the individual needs to live in the community. The integration of the SIS-A coupled with other tools and knowledge used by the psychologist or psychiatrist based on his/her professional knowledge, experience, and judgment should form the basis for the individualized support plan that can be shared with the court, defense counsel, and prosecution for review before the individual is accepted into the I/DD diversionary program.

C. Screening tools and assessments

The creation of an I/DD diversionary program requires the adoption of screening tools or assessments for people suspected of having an I/DD but who are not previously diagnosed. This need arises due to the low threshold of how DDS defines I/DD (e.g., IQ score less than or equal to 69) despite the

evidence suggesting that many with I/DD do not fit this criterion. This narrow definition limits access to services and supports and provides a barrier to effective crime prevention among youth and adults with I/DD; and until changed, a diversion program in Connecticut is unlikely to implement strategies capable of diverting crime and addressing the social vulnerabilities of individuals with diagnoses and an IQ score of 69 or higher.

This Report identifies multiple reliable screens that are designed to be completed by lay professionals and/or familiar contacts (e.g., family, educators, trusted allies) that know the individual well and can adequately assess them according to the identified scale. Because the characteristics of ID and ASD are different, unique screening tools and assessments should be utilized. The HASI and LDSQ are the most reliable tools for screening ID, while CATI is most reliable for screening individuals with ASD. For instances where Category #2 applies, two screening tools and assessments should be used (e.g., HASI or LDSQ and the CATI). For individuals who may have co-morbidities in Category #3, screening tools for both ID and ASD can be used. Each of the identified screening tools can be self-administered or administered with the assistance of a familiar and trusted adult. JB-CSSD could also oversee the administration of these screening tools and assessments.

Both positive screens and proposed support plans for individuals with I/DD and/or co-morbidities must be evaluated or reviewed by a qualified psychologist or psychiatrist for medical disability determination in the Medicaid program. Individuals who fit these criteria will fall under Category #2 as described above.

D. Best practice trends in other I/DD diversionary programs

A comparison of 21 programs in 16 states provides a helpful overview of what Connecticut I/DD diversionary program could look like and highlights several legislative and administrative decisions that needed to create a model demonstration diversionary program. Such decisions cover the following program aspects:

- Program structure;
- Eligibility and individualized support plans if deemed eligible;
- Crime exclusions;
- Fees charged to the defendant;
- Length of the program;
- Metrics of program success;
- Whether a defendant can apply to the program more than once.

The overall structure of a Connecticut I/DD diversionary program could be combined with the existing SDP program so long as clear distinctions in staff training and evaluation processes are made. An I/DD diversionary program cannot be treated identically to the SDP program; however, the majority of state programs have executed programs for both psychiatric disabilities and I/DD. Like other state programs, Connecticut should rely upon the expertise of psychologists and psychiatrists with I/DD expertise. Other outside experts with subject matter expertise in diversionary programs for people with I/DD are recommended for providing technical assistance to assessors.

Program eligibility and individualized support plans should be based upon the individual's I/DD diagnosis before the charged crime(s) are considered. Whether an individual has an I/DD diagnosis based on assessments completed must be the primary factor in determining program eligibility. The specific crime(s) for which the individual has been charged should not automatically exclude the individual, but rather, should be evaluated as a factor in determining eligibility. Clinical recommendations should assess whether the individual's behaviors which led to crime(s) charged can or cannot be addressed through an individualized support plan. These recommendations should include risks the individual poses to society and any recidivism concerns. Final eligibility should be determined once an I/DD diagnosis is verified, as should whether concrete supports and services can be provided to implement the treatment plan. Should the individual with a suspected I/DD diagnosis not have a diagnosis after being evaluated, the individual should be deemed ineligible for the program and considered for an alternative resolution of his or her case.

More needs to be learned about the cost effectiveness of programs that are in place nationwide and the lessons available to inform a possible diversionary program in CT. Furthermore, more information is needed to understand whether a fee structure should be implemented for such a program and if so, at what amount. It is both consistent with Connecticut's AR program and several other state I/DD diversionary programs that a fee is charged, usually a flat fee and, therefore, could also be appropriate for an I/DD diversionary program in Connecticut. Because Connecticut has waived fees due to indigency for other programs, the same should apply for an I/DD diversionary program. However, a definitive conclusion as to the amount cannot be drawn until further research into costs associated with running an I/DD diversionary program is completed.

Additional information is also needed to draw a conclusion about the length of an I/DD diversionary program and the metrics to measure its success. Comparisons to other state programs demonstrate a varied spectrum of program length that is subjectively influenced by factors such as the level of support that an individual needs and severity of crime(s). In some instances, state programs incorporate a step-down style program with decreased monitoring over time if the individual is improving in the program. While limits to program length are ill advised, it may be beneficial to set such limits on an individualized, case-by-case basis, with periodic progress reports and court monitoring. However, Connecticut needs to both improve its data collection practices to understand who could be served by a diversionary program, as well as to learn the types of crimes individuals with I/DD commit within the state, before proposing limits on program length.

Measuring the success of an I/DD diversionary program should not be based on one factor (recidivism), but rather, through reviews of an individual's progress in the program as set forth in the individualized support program. Because each individual's support plan will be different, an individual's response to the support plan will vary, and therefore, time must be allocated to evaluate the success of an I/DD diversionary program beyond just a recidivism rate. Because I/DD diagnoses are lifelong conditions in need of ongoing support, the likelihood of re-offense is possible because of the individual's disability, especially if supports and services are inadequate. The re-offense is often not because the individual intends to engage in criminal activity or understands the consequences of his or her actions.

For this reason, several state programs have adopted a collaborative approach which helps with the multifaceted needs of individuals with I/DD, relying upon other agency knowledge or resources to

support program success. In addition, the diversionary program, whether a pilot or permanent program, must be independently evaluated to determine program impact and inform improvement.

Lastly, individuals with I/DD should be permitted to apply to an I/DD diversionary program more than once. Because I/DD is a lifelong disability, and many individuals with I/DD have service gaps that currently fail to mitigate risks, individuals should not be automatically excluded due to prior program use. Additionally, one of the reasons for the creation of a diversionary program further supports its repetitive use in the form of diverting people with I/DD from institutionalization to instead receive services in the community that are less costly and more effective in generating socially positive outcomes. Whether the individual applicant meets the program criteria for acceptance must be assessed on an individual basis.

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ATTACHMENT A: DEVELOPMENTAL DISABILITIES

- Attention Deficit/Hyperactivity Disorder
- Autism Spectrum Disorder
- Blindness
- Cerebral Palsy
- Communication Disorders (e.g., stuttering, apraxia)
- Down Syndrome
- Epilepsy
- Fetal Alcohol Spectrum Disorder
- Fragile X Syndrome
- Motor Disorders (e.g., dyspraxia)
- Muscular Dystrophy
- Spina Bifida
- Prader-Willi Syndrome
- Speech Learning Disorders (e.g., dyslexia)
- Tourette Syndrome
- Williams Syndrome

ATTACHMENT B: CATI SCREENING TOOL

CATI Date: Name/ID:

INSTRUCTIONS

Below is a list of statements relating to various personality traits, behaviours, and characteristics. Using the five response options select the option that best describes you. For items of a social nature, think about situations that do not involve very close friends or family members. Try not to spend too much time thinking about each choice.

		Definitely Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Definitely Agree
1	I often find myself fiddling or playing repetitively with objects (e.g. clicking pens)					
2	I like to stick to certain routines for every-day tasks					
3	I expend a lot of mental energy trying to fit in with others					
4	I am very sensitive to bright lighting					
5	There are certain activities that I always choose to do the same way, every time					
6	Sometimes I watch people interacting and try to copy them when I need to socialise					
7	I often rock when sitting in a chair					
8	I generally enjoy social events					
9	I look for strategies and ways to appear more sociable					
10	In social situations, I try to avoid interactions with other people					
11	There are times when I feel that my senses are overloaded					
12	There are certain objects that I fiddle or play with that can help me calm down or collect my thoughts					
13	Reading non-verbal cues (e.g. facial expressions, body language) is difficult for me					
14	I like my belongings to be sorted in certain ways and will spend time making sure they are that way					
15	Social interaction is easy for me					
16	When interacting with other people, I spend a lot of effort monitoring how I am coming across					
17	I find social interactions stressful					
18	I am very sensitive to touch					
19	I can tell how people feel from their facial expressions					
		Definitely Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Definitely Agree

CATI v1.1

ATTACHMENT C: CATI SCORING KEY

CATI SCORING KEY

All items are scored 1 to 5 ('Definitely Disagree' to 'Definitely Agree') except items 8, 15, 19, 23, and 28 (highlighted below), which are reversed. Total scale score ranges from 42 – 210, whilst subscales range 7 – 35.

The six subscales are each made up of seven items. The subscale for each item is listed in the second column.

SOC = Social Interactions **COM** = Communication **CAM** = Social Camouflage		**RIG** = Cognitive (In)Flexibility **REG** = Self-regulatory Behaviours **SEN** = Sensory Sensitivity	Definitely Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Definitely Agree
1	REG	I often find myself fiddling or playing repetitively with objects (e.g. clicking pens)	1	2	3	4	5
2	FLX	I like to stick to certain routines for every-day tasks	1	2	3	4	5
3	CAM	I expend a lot of mental energy trying to fit in with others	1	2	3	4	5
4	SEN	I am very sensitive to bright lighting	1	2	3	4	5
5	FLX	There are certain activities that I always choose to do the same way, every time	1	2	3	4	5
6	CAM	Sometimes I watch people interacting and try to copy them when I need to socialise	1	2	3	4	5
7	REG	I often rock when sitting in a chair	1	2	3	4	5
8	SOC	I generally enjoy social events	5	4	3	2	1
9	CAM	I look for strategies and ways to appear more sociable	1	2	3	4	5
10	SOC	In social situations, I try to avoid interactions with other people	1	2	3	4	5
11	SEN	There are times when I feel that my senses are overloaded	1	2	3	4	5
12	REG	There are certain objects that I fiddle or play with that can help me calm down or collect my thoughts	1	2	3	4	5
13	COM	Reading non-verbal cues (e.g. facial expressions, body language) is difficult for me	1	2	3	4	5
14	FLX	I like my belongings to be sorted in certain ways and will spend time making sure they are that way	1	2	3	4	5
15	SOC	Social interaction is easy for me	5	4	3	2	1
16	CAM	When interacting with other people, I spend a lot of effort monitoring how I am coming across	1	2	3	4	5
17	SOC	I find social interactions stressful	1	2	3	4	5
18	SEN	I am very sensitive to touch	1	2	3	4	5
19	COM	I can tell how people feel from their facial expressions	5	4	3	2	1
			Definitely Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Definitely Agree

CATI v1.1 Scoring Key

			Definitely Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Definitely Agree
20	REG	I have a tendency to pace or move around in a repetitive path	1	2	3	4	5
21	FLX	I feel discomfort when prevented from completing a particular routine	1	2	3	4	5
22	CAM	I rely on a set of scripts when I talk with people	1	2	3	4	5
23	COM	I find it easy to sense what someone else is feeling	5	4	3	2	1
24	SEN	I am very sensitive to particular tastes (e.g. salty, sour, spicy, or sweet)	1	2	3	4	5
25	REG	I engage in certain repetitive actions when I feel stressed	1	2	3	4	5
26	COM	I rarely use non-verbal cues in my interactions with others	1	2	3	4	5
27	FLX	I often insist on doing things in a certain way, or re-doing things until they are 'just right'	1	2	3	4	5
28	SOC	I feel confident or capable when meeting new people	5	4	3	2	1
29	CAM	Before engaging in a social situation, I will create a script to follow where possible	1	2	3	4	5
30	SOC	Social occasions are often challenging for me	1	2	3	4	5
31	SEN	Sometimes the presence of a smell makes it hard for me to focus on anything else	1	2	3	4	5
32	REG	There are certain repetitive actions that others consider to be 'characteristic' of me (e.g. stroking my hair)	1	2	3	4	5
33	COM	Metaphors or 'figures of speech' often confuse me	1	2	3	4	5
34	FLX	It annoys me when plans I have made are changed	1	2	3	4	5
35	SOC	I find it difficult to make new friends	1	2	3	4	5
36	SEN	I react strongly to unexpected loud noises	1	2	3	4	5
37	COM	I have difficulty understanding someone else's point-of-view	1	2	3	4	5
38	FLX	I like to arrange items in rows or patterns	1	2	3	4	5
39	CAM	I try to follow certain 'rules' in order to get by in social situations	1	2	3	4	5
40	SEN	I am sensitive to flickering lights	1	2	3	4	5
41	REG	I have certain habits that I find difficult to stop (e.g. biting/tearing nails, pulling strands of hair)	1	2	3	4	5
42	COM	I have difficulty understanding the 'unspoken rules' of social situations	1	2	3	4	5
			Definitely Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Definitely Agree

ATTACHMENT D: STATES WITH ADULT I/DD DIVERSION PROGRAM COMPARISON (APPENDED AT END)

ATTACHMENT E: STATES WITHOUT ADULT I/DD DIVERSION

- Alabama
- Alaska
- Arkansas
- Delaware
- District of Columbia
- Georgia
- Hawaii
- Idaho
- Iowa[160]
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Minnesota
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Mexico
- North Carolina
- New York
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- West Virginia
- Wisconsin
- Wyoming

[160] Although Iowa had a diversion program for which individuals with developmental disabilities could be eligible, this program was terminated on November 30, 2025, due to reorganization within the Iowa Government. Kruse, A. (2025, May 14). State reorganization prompts end of Southeast Iowa mental health region. Southeast Iowa Union. https://www.southeastiowaunion.com/se-iowa-union-mount-pleasant/state-reorganization-prompts-end-of-southeast-iowa-mental-health-region/.

ATTACHMENT F: PARTICIPATION HANDBOOK DELAWARE COUNTY, OHIO (APPENDED AT END)

ATTACHMENT G: DIVERSION FIRST 2024 ANNUAL REPORT FAIRFAX COUNTY, VIRGINIA (APPENDED AT END)

ATTACHMENT H: RECOMMENDATIONS (FORTHCOMING)

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
Arizona – Maricopa County MCAO-DD-FDP-Diversion-Program-Handout---Public	Stand-alone program – Developmental Disabilities – Felony Diversion Program	Previous diagnosis or evaluation by professional + not on pretrial release or probation + has not used program in 5 years	Misdemeanors and low-level felonies excluding robbery; arson; sex offenses; cases involving firearms or infliction of injury; domestic violence.	Managed by District County Attorney; services through SW Behavioral and Health Services Individualized support plans addressing all aspects of life skills needed	No more than 2 years depending on assessed risk level	No more than $2,000 in restitution	Recidivism, aftercare
California - Cognitive Disability Diversion | Penal Code 1001.20 PC	Cognitive Disability Diversion – Either single or dual agency diversion depending on the amount of assistance needed.	Developmental Disability[1] + eligible for state services + have not used program within last two years	Misdemeanors and felonies excluding murder; rape**;** lewd or lascivious act on child under age 14; continuous sex abuse of child; assault with intent to commit rape, sodomy, or oral copulation	Regional Center if single agency or with Probation if dual agency Individualized support plans addressing all aspects of life skills needed	No more than 2 years	No more than a program fee of $500 + no more than $300 admin fee	Unknown

[1] California defines developmental disability broadly as intellectual disability, autism or "[d]isabling conditions found to be closely related to intellectual disability or autism, or that require support similar to that required for individuals with intellectual disability or autism, and that would qualify an individual for services provided under the Lanterman Developmental Disabilities Services Act." CA Penal Code § 1001.20(a).

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
Florida-Broward County IN THE CIRCUIT COURT OF THE	Felony Mental Health Court	Developmental disability[2] diagnosis+ no more than three (3) prior non-violent felony offenses + competent	Second and third felonies permitted[3]; excludes burglary and firearm charges; Can consider sex offenses, domestic violence with parents, children or siblings; violations of probation with court approval.	Assessed by pretrial services or contracted medical provider; services through Broward Behavioral Health Coalition	12-18 months	Unknown	Proposed indicators of recidivism, retention, sobriety and unities of service
Florida-Alachua County Court Services	Alachua County Mental Health Court	Developmental disability diagnosis	Misdemeanor and traffic offenses permitted. Simple batter permitted if victim consent. Can consider sex offenses, domestic violence with parents, children or siblings; violations of probation with court approval.	Referrals can be made by any agency including "interested parties." Support through outside providers.	9-12 months	Costs covered by Board of County Commiss-ioners; other costs unknown	In 2020, the MH Court reported a 20% recidivism rate
Florida – Polk County BHCBrochure.pdf Florida – Polk County	Behavioral Health Court (BHC)	Developmental disability diagnosis	Misdemeanor or third degree felony	Referrals can be made by any agency including "interested parties." Evaluation	Up to 1 year	Unknown	A FY 23-24 report indicated an 11% recidivism rate

[2] "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely. Fla. Stat. §393.063(12).

[3] Crimes with maximum sentences of 15 and five (5) years respectively. Fla. Stat. §775.082(3)(a)(6)(d)-(e).

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
(Cont'd)				completed by BHC coordinator.			
Florida - 19th Judicial Circuit district Problem Solving Courts - Circuit19	Mental Health Court	Developmental disability diagnosis	Misdemeanor, non-violent felonies, or if deemed incompetent	Referrals can be made by any agency including "interested parties." Support through outside providers.	15 months or more	Unknown – substantial grant funding	Unknown
Illinois - Kane County ELIGIBILITY	Kane Court – Treatment Alternative Court	Developmental disability diagnosis or co-occurring + high level of need and/or risk + no prior adjudications for violent offenses + no active warrants + must have housing	Non-violent probation eligible offenses	Referrals to State's Attorney or Court Services. Support through Ecker Center for Mental Health and the Association for Individual Development	24 months	Unknown; includes grants to provide "baskets of necessities" to participants	increased safety of the public and program participants, increased quality of life of the program's participants, increased engagement with support , and lowered recidivism rates
Indiana – Monroe County IDOC: Community Corrections: About	Community Corrections Division – community-based supervision	Pre-conviction: I/DD or comorbidities + no violent offense conviction in the past 10 years	No violent offenses. There are more than 25 violent offenses excluded including select sex assault offenses, arson, and domestic battery.	Monroe County Community Corrections Advisory Board oversees the program with support through providers certified by the	Pre-conviction up to 2 years. Post-conviction – up to 2	Unknown	Participation outcomes and recidivism

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
(Indiana Cont'd)		Postconviction – pre-conviction requirements + must enter guilty plea + no drug dealing offenses		Division of Mental Health and Addiction	years if misdemeanor or 3 years if felony.		
Nebraska – Sarpy County https://www.sarpy.gov/CivicAlerts.aspx?AID=59	Mental Health Diversion	Must provide disability verification or obtain evaluation + criminal history 15 years old or less + no violent offense history + cannot owe more than $5,000 in restitution	Low level non-violent offenses	Managed by district county attorney and Diversion Office after screening from County Jail. Support provided by outside providers	Depends on needs of the individual	$225-700 depending on the crime charged	Recidivism rates
Michigan msc_psc_fy_2023_proof5.pdf	Mental health treatment courts – 35 total statewide	Screening + evaluation for developmental disability or co-occurring disorder + plea guilty or no	First degree murder, criminal sexual misconduct, sexual abuse of a child excluded. No violent offenses unless consent	Overseen by Judicial Branch and MI State Administration Office; treatment by contracted providers	Differs based on district with average length of 15 months	State and federal funding	Recidivism rates

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
		contest + waive right to speedy trial	by judge, prosecutor and victim.				
Nevada – Washoe County https://studylib.net/doc/7620955/mental-health-court---washoecourts.com	Mental Health Court	Intellectual disability[4] + clinical assessment + guilty plea, suspended sentence or probation	Class A felonies and sex offenses classified as class B felonies excluded	Assessments done by Washoe County Court. Evaluating physician or counselor makes recommendation to the court	Length based on maximum sentence of crime; minimum 1 year	Unknown	Recidivism is estimated at 8% or 92% success rate; aftercare
New York – Rockland County aea0d1d7-b1f0-4d0b-9519-2a4159c656f4	Intellectual and Developmental Disabilities Alternatives to Incarceration (IDDATI)	IQ of 70, DD, autism diagnosis or low Adaptive Behavior Assessment System score + Rockland resident + guilty plea	Non-violent offenses permitted	Assessment completed by IDDATI case manager	12 months for a misdemeanors; 18 months for felonies	Unknown	95% success rate; incentives use to encourage success from participants
New Jersey Criminal Justice Advocacy Program : Criminal Justice	Criminal Justice Advocacy Program[5]	Age 21 and over + eligible for DD services + pending charges, or	No exclusions	Refers to CJAP – services and support from outside providers	Depends on needs of the individual; If on probation	Unknown	Unknown

[4] "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. NRS 433.099.

[5] The Criminal Justice Advocacy Program is non-profit that assists with the evaluation and creation of individualized justice plans for program participants.

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
Advocacy Program : Programs : The Arc of New Jersey		probation or parole			or parole – length of term		
Oklahoma – Tulsa County Tulsa County Community Sentencing	Community Sentencing	Individual with DD[6] or co-occurring convicted of or who entered a plea other than not guilty to a non-violent felony offense and who scored in the moderate range of the Level of Services Inventory (LSI) assessment instrument	Non-violent offenses including domestic violence and some property crimes are permitted	Tulsa County Criminal Justice Planning & Policy Council oversees program; services overseen by Department of Mental Health and Substance Abuse Services	3 years or less depending on individual needs	Supervision fee $40/mo Admin fee $20/mo Both can be waived due to indigency by statute	Graduations at end of program completion, success stories provided in annual reporting.
Oklahoma – Oklahoma and	Mental Health Court	Broad discretion based on	Drug trafficking, firearm charges, cases involving a victim	Coordination between The Court Team	3 years or less depending	Supervisi	General MH Court statistics indicated reduced recidivism,

[6] Oklahoma defines a developmental disability substantially the same as Connecticut. Its statute distinguishes ID from DD and requires that an individual's IQ for an ID diagnosis must be below 70. 10 OK Stat. §1408 (2024).

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
Cleveland Counties COCMHC Oklahoma – Oklahoma and Cleveland Counties (cont'd)		factors for pre and post plea: current charges and criminal history; history of violent behavior; existence of DD or co-occurring; capacity and willingness to comply with the program	where victim does not consent are excluded	comprised of Judges, Assistant District Attorneys, Attorneys from the Oklahoma Indigent Defense Services, Licensed Behavioral Health Professionals, Psychiatrists, Case Managers, Recovery Support Specialists, and Law Enforcement personnel	on individual needs	on fee $40/mo Admin fee $20/mo Both can be waived due to indigency by statute	decreased in unemployment, and decrease in days in inpatient facilities. However, these trends apply to the MH Court as a whole, not specifically I/DD.
Ohio – Cuyahoga County Mental Health and Developmental Disabilities Court | CCCCP	Mental Health Courts	DD with IQ > 75 or adaptive skills deficit + Plea + repetitive violent behavior reviewed on case by case basis	Third, fourth, fifth degree felonies permitted. Second degree felonies case-by-case basis. Murder and manslaughter excluded.	Overseen by Court with services provided by Cuyahoga County Board of Developmental Disabilities	Unknown	Unknown	Recidivism

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
Ohio – Delaware County Program Types - Adult Court Services	Mental Health Court	Diagnosis in the DSM V + program participation + competent + cannot pose risk to judge, staff or support team	Non-violent fourth or fifth degree felony. Sex offenses excluded.	Assessment and support overseen by the MH Court Docket team – judge, docket coordinator, probation officer, and other support professionals	18 months or more	Unknown	Some incentives, aftercare
Oregon – Washington County Mental Health Diversion Pilot Program | Washington County, OR	Mental Health Diversion Pilot Program[7]	Diagnosis of I/DD evaluated on case by case basis + no prior participation	Eligible crimes: Criminal Mischief 2 and 3; Criminal Trespass 1 and 2; Disorderly Conduct 1 and 2; Interfering with Public Transportation; Theft 2 and 3 and Theft of Services; Improper Use of 911; Interfering with a Peace Officer; Other misdemeanor crimes as approved by DA's Office	Supervision by probation unless other joint agreement by court and district attorney; support provided by outside providers	Unknown	Unknown	Unknown
Pennsylvania-Philadelphia County	MHC of Common Pleas add on	Documented I/DD + evaluation by	Exclusions – referrals from SPCA, Dept of Agri, Vehicle Fraud	Managed by First Judicial District	No time limit – at court's	Unknown	Incentives given for compliance.

[7] Because Oregon's only I/DD diversionary program is in the pilot stages, information is limited.

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
Adult Diversion and Alternatives to Incarceration Initiatives - Office of the District Attorney : City of Philadelphia	Requires plea	Department of Behavioral Health	Investigations, Dept of Revenue. Misdemeanors and felonies accepted at discretion of DAO and Court	Multidisciplinary collaborative approach – services from behavioral health dept	discretion when certain conditions met or limits set by statute		
Virigina – Fairfax County Diversion First | Topics	Diversion First	ID diagnosis or ASD diagnosis from psychiatrist or clinical psychologist + court finding by clear and convincing evidence that criminal conduct caused by direct and substantial relationship to disability	Exclusions – aggravated murder; violence defined by statute; crimes for which a deferred disposition is already provided.	Collaborative oversight – including the police department, Community Services Board, court, other county agencies as appropriate	Depends on the individual and crime charged	Unknown	Number of diverted arrests, decreased number of jailed individuals, crisis response data
Washington - Spokane County Spokane County 5177 Mental Health	Spokane County Mental Health Prosecutorial Diversion Program	I/DD diagnosis or co-occurring	Exclusions: Murder; manslaughter; first and second degree assault of a child; first degree extortion; sex crimes; first and second	Overseen by the prosecutor's office; services from Department of Health and Social Services	6-12 months	Unknown	Report of 72% program completion rate and 89% of participants did not reoffend within 12 months. However,

State	Diversion Structure	Eligibility	Crimes included/exclude	Who is responsible/ Services Provided	Length	Program Fees	Measures of success
Prosecutorial Diversion Program | Spokane County, WA			degree kidnapping; leading organized crimes; first and second degree robbery; theft of a motor vehicle	and Office of Forensic Mental Health Services			these trends apply to the MH Court as a whole, not specifically I/DD.

Delaware County Court of Common Pleas

MENTAL HEALTH DOCKET PARTICIPANT HANDBOOK

MARIANNE T. HEMMETER, JUDGE
117 NORTH UNION STREET
5TH FLOOR
DELAWARE, OHIO 43015
(740) 833-2530

February 2025 Edition

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WELCOME TO THE DELAWARE COUNTY COMMON PLEAS COURT MENTAL HEALTH DOCKET!

This handbook is designed to answer questions, address concerns, and provide information about the mental health docket. As a participant in the mental health docket, you will be required to follow instructions given by the Judge. This handbook will explain what will be expected of you.

WHAT IS A MENTAL HEALTH DOCKET?

The Mental Health Docket (MHD) is a part of the Delaware County Common Pleas Court. It is a court-supervised program primarily for Delaware County residents who face criminal charges and have a mental illness. It is a program that includes regular court appearances before a Judge.

The length of the program is 18 months, at a minimum. The program is divided into an orientation phase and three treatment phases. The phases are a way for the Court to monitor your progress, your motivation, and your performance. Your progress through the phases is based on your compliance with the directions of the Court, docket coordinator and of a probation officer, as well as your active participation in a mental-health treatment plan. Each participant will progress differently. Phases are not based solely on preset timelines. They are designed to build upon the skills acquired in the previous stage, allowing you to effectively manage your mental illness (and substance use disorder, if applicable) and fostering stable and independent living. Each participant will have a Court Services Plan that the probation officer and the participant will sign after the participant has completed specific requirements for each phase.

This book details your rights and responsibilities in the Mental Health Docket as well as specific information about eligibility requirements, rules, guidelines, probation requirements, and treatment information.

ELIGIBILITY REQUIREMENTS

To be eligible to for the Mental Health Docket, you must meet certain criteria:

Clinical:

- Have a primary diagnosis DSM-IVTR, DSMV, Axis I, severe mental health disorder.
- Be receptive to behavioral health treatment.
- Agree to comply with medication and treatment plans.
- Agree to actively participate and cooperate with the Mental Health Docket Team.

Legal:

- Be charged with a non-violent fourth- or fifth-degree felony.
- Understand and appreciate the consequences of the legal proceedings and the agreement that you are making with the Court.
- Cannot be charged with or convicted of a sexually-oriented offense.
- May not pose a risk of harm to the Judge, court staff, or the treatment team.

Written legal and clinical eligibility criteria alone do not create a right to participate in the specialized docket. Your ability to pay any court costs, fines, restitution, or supervision fees will not be taken into account when the Court determines your eligibility for the Mental Health Docket. The Mental Health Docket Judge has the discretion to decide who participates in the program in accordance with the eligibility criteria for this specialized docket.

REFERRAL PROCESS

Referrals to the Mental Health Docket are made by law enforcement, jail personnel, your attorney, the prosecutor, a community mental health provider, a judge, or a probation officer. Referrals may be made at any time during the legal process.

SCREENING/ASSESSMENT PROCESS

Within three days of receiving a referral, the Mental Health Docket Coordinator will make contact with those referred to the Mental Health Docket. Applicants are screened for eligibility and information is collected, including criminal history, residency, education, employment, family, medical and mental health history. Upon completion of the screening, the Mental Health Docket Coordinator provides a written recommendation to the Mental Health Docket team and the Court. The Mental Health Docket Judge makes the final determination regarding admittance into the program in accordance with the written eligibility criteria.

ADMITTANCE TO DOCKET

If accepted into the program, the Mental Health Docket coordinator will schedule the program admission orientation session. You will receive and review the participant handbook, obtain the Mental Health Docket calendar, and sign additional disclosure forms, if necessary. You will then be scheduled to observe the next Mental Health Docket status review hearing at which time with counsel, you will review and sign an Acknowledgement of Requirements of the Mental Health Docket. After the observation of a Mental Health Docket status review hearing is attended and the Acknowledgement of Requirements of the Mental Health Docket is signed, you will then be scheduled into the next Mental Health Docket status review hearing for participation in the program.

THE MENTAL HEALTH DOCKET TEAM & THEIR ROLES

The Mental Health Docket team consists of the Mental Health Docket Judge, docket coordinator, probation officer, and other treatment and service providers who are involved in your case. The team is in place to develop an appropriate court-services plan, assist you in obtaining program services and resources, and ensure that you fully participate in your treatment. The team does this by evaluating clinical information and probation concerns, as well as other sources of information during treatment-team meetings. This information is presented to the Judge during treatment-team meetings with recommendations that include but are not limited to rewards,

sanctions, changes in treatment levels of care, reductions in a variety of meetings, graduation, or possible termination from the program.

The role of the Judge is to lead the Mental Health Docket team and make final decisions concerning incentives, sanctions, advancement to the next phase, and successful completion of or termination from the program. The Mental Health Docket Coordinator conducts eligibility screenings, links participants to treatment providers, gathers treatment reports from providers, monitors your Court Services plan and your progress throughout the program, makes home visits, and provides feedback to the treatment team and Judge regarding your progress in meeting goals and objectives. The probation officer monitors compliance with your Court Services Plan, conducts drug and alcohol screens, makes home visits, and provides feedback to the treatment team and Judge regarding your progress in meeting goals and objectives. The treatment provider conducts assessments, develops individualized treatment plans, and makes recommendations to the treatment team regarding your specific treatment needs. MH Docket team meetings are held 60 minutes prior to docket status review hearings. You have the right to request attendance of defense counsel during the portion of the treatment team meeting that applies to you.

WHAT'S IN IT FOR YOU

Successful completion and graduation from the MHD program may result in shortening the time you are on probation.

This program offers you the chance to move forward in your life with the new skills you have learned that will enable you to function in the community more fully. The MHD program will help you take control of your life in many ways. Even more important than the things you will learn not to do – such as abusing drugs and alcohol and committing more crimes – are the things that you will learn how to do, such as eating right, reducing stress, becoming employed, rebuilding family relationships, and becoming a productive member of the community.

On the following pages you will find the steps involved in the MHD program. Remember that there are many people who make up the MHD program and they want to see you succeed. If you take advantage of their help, you will discover many ways to make a better life for yourself. Nobody said it would be easy. We are here to help!

RULES OF THE PROGRAM

To remain in the Mental Health Docket, you are required to follow rules:

- You must participate in regular status-review hearings. In other words, you must show up at Mental Health Docket court sessions on time.
- You must show up on time for meetings with your docket coordinator and probation officer.
- You must attend all scheduled treatment and provider appointments.
- You must complete required paperwork and homework assignments.

- You must successfully complete all four phases of the program.

Ask your docket coordinator and probation officer to explain to you anything in this handbook that you do not understand!

PARTICIPANT MONITORING

You will be required to appear in front of the Mental Health Docket Judge on a regular basis at the status-review hearings. Your attendance at the status-review hearing will diminish over time as you progress through the phases. During the Phase I (Orientation) and Phase II, each participant will appear twice each month. During Phase III each participant will appear once per month, and during Phase IV each participant will appear once every six weeks.

The Judge will be given progress reports regarding your drug tests, attendance at your treatment-provider appointments and other required programs, and make sure that you are compliant with your Court Services Plan. These reports will come from the docket coordinator, your probation officer, your treatment and/or mental health counselor(s), and any other members of support programs with whom you are working. The Judge will ask you about your progress and discuss any problems you may be having.

You must come to court every scheduled session. As you make progress, you will come less often. If you are doing well, you will be encouraged to continue working towards the goal of graduating from MHD.

You are required to arrive on time and stay until court is finished unless the Judge dismisses you earlier.

REGULAR TREATMENT PROVIDER ATTENDANCE

In the program, you are required to attend all of your scheduled treatment sessions and other provider appointments. You must be on time for all sessions. If you are late, you may not be allowed to attend and may be considered absent. Your treatment schedule will vary according to your progress, and it is your responsibility to schedule all needed appointments.

REQUIRED PAPERWORK: RELEASES OF INFORMATION

Members of the Mental Health Docket team and providers must be able to communicate about your eligibility and progress in the program. You must sign release-of-information forms to allow this to happen. You must also sign additional releases as needed to arrange additional treatment, counseling, or support-service referrals. Any failure by you to sign releases will be treated as a refusal to participate in the program and will be grounds for your dismissal.

COMPLETION OF PROGRAM PHASES

The Mental Health Docket is divided into an orientation phase and three treatment phases, and completion of the docket takes at least 18 months. How long it takes is based on you and your progress. Each phase consists of specific treatment goals, activities, and requirements that you must meet before moving to the next phase. The phases are explained in detail on the following pages.

Remember: While there are certain things you must complete, your ability to move along in the program and graduate will depend on your own actions. If you miss appointments, ignore requirements, or fail to stay away from non-prescribed drugs and alcohol, your time in the MHD program will be longer, and you may be dismissed from the program.

Throughout the time you are involved in the Mental Health Docket, it is your responsibility to review your Court Services Plan with your docket coordinator or probation officer and follow it carefully.

THE COURT SERVICES PLAN

A Court Services Plan begins with an assessment conducted by a licensed Mental Health agency or provider to create your behavioral-health treatment plan. The Court Services Plan will include this treatment plan as well as recovery goals developed by you, the docket coordinator, and your probation officer. Your docket coordinator will review and update your Court Services Plan with you on a regular basis.

This plan may require some or all of the following:

- Outpatient treatment
- Counseling (individual and group)
- Taking medication as prescribed
- Inpatient treatment/Residential treatment
- Regular and random drug/alcohol testing
- Alcohol and drug counseling
- Educational/vocational/employment programs
- Participation in self-help groups
- Community service
- Employment

Your docket coordinator or probation officer will also help you with other areas of your life according to your individual needs. This may include referrals for:

- Educational assessments
- School or other educational services
- Job training and job placement services
- Family counseling

- Life skills classes
- Public Assistance/Medicaid
- Recreational activities

THE PHASES OF THE MENTAL HEALTH DOCKET PROGRAM

Orientation - Phase I

The Orientation phase is the first six weeks of the program. The requirements are minimal, allowing time for you to acclimate to the program. You will be provided the Mental Health Docket calendar and Participant Handbook if you have not already received them.

Tasks to be considered for orientation phase include the following:

- Meeting with the coordinator to review the Participant Handbook, signing a confirmation that you have received the Handbook, and signing additional release-of-information forms
- Meeting with the docket coordinator and probation officer to review the Court Services Plan and community-control paperwork
- Attending all status-review hearings
- Addressing any issues with transportation
- Engaging in an individualized treatment plan.

Stabilization - Phase II

Stabilization is the beginning of your program. This phase focuses on stabilizing symptoms and obtaining compliance with the program requirements. Successful completion of this phase will be based upon your performance, your compliance with the program, and the recommendations of the Mental Health Docket Team. Your docket coordinator will prepare a case plan outlining specific goals and objectives for you to complete during Phase II.

Tasks to be considered for the stabilization phase include the following:

- Setting reasonable timeframes for any financial obligations to be met, such as developing payment schedules for fines, court costs, and victim-restitution payments if needed. The Court will take into account the participant's ability to pay those obligations.
- Assigning appropriate community service or serving mandatory jail time if applicable.
- Determining frequency of random drug and alcohol testing
- Identifying prescribed medications and determining frequency for medication-compliance monitoring.
- Completing all other assessments and inventories determined necessary by the mental health docket team, including housing, education, vocational, employment, and life skills.

Conditions to be monitored are as follows:

- Attending all Mental Health Docket status-review hearings two times per month

- Understanding the Mental Health Docket program expectations and handbook
- Complying with all rules of the Mental Health Docket program
- Completing necessary release-of-information forms
- Completing behavioral-health screenings and evaluations in a timely manner
- Understanding and complying Court Services Plan
- Attending medical, mental-health-treatment, and/or case management appointments
- Complying with all medication and treatment requirements
- Complying with the terms of probation
- Attending weekly meetings with the docket coordinator and/or probation officer
- Submitting to drug and alcohol testing
- Complying with instructions given by the Judge, docket coordinator, or probation officer
- Attending substance-abuse-treatment sessions and activities (if applicable)
- Attending support activities as directed by treatment provider, docket coordinator, probation officer, or Judge.

The following requirements must be met in order for the participant to move to the next phase:

- Participating in the Mental Health Docket for a minimum of 24 weeks
- Obtaining recommendation from treatment provider
- Receiving recommendation from Mental Health Docket team
- Providing negative drug screens for 60 days
- Avoiding new sanctions for the last four weeks
- Avoiding new convictions in the last 90 days
- Attending quarterly specialized docket event
- Completing satisfactory home visits with the probation officer
- Completing all homework assignments
- Submitting phase application.

Community Integration - Phase III

Phase III of the Mental Health Docket will focus on community reintegration. After you have remained stable for a designated period of time, other non-psychiatric needs can begin to be addressed. During this period, other service needs can be assessed and addressed, including health, dental, optical, clothing, housing, and vocational-training needs, as well as any other concerns identified by the Mental Health Docket team. Successful completion of this phase will depend on your performance and a recommendation from the Mental Health Docket team. Your docket coordinator will prepare a Court Services Plan outlining specific goals and objectives for you to complete during Phase III.

Tasks to be considered for the Community Integration Phase include the following:

- Ensuring court obligations are met, such as compliance with payment schedules for fines, court costs, victim-restitution payments, and with community-service requirements
- Continuing random drug and alcohol testing at a frequency determined by the Mental Health Docket team
- Continuing medication-compliance monitoring
- Continuing linkages with housing, educational, vocational, and employment opportunities.

Participant requirements to consider for the community reintegration phase include the following:

- Attending all Mental Health Docket status review hearings one time per month
- Complying with all rules of the Mental Health Docket program
- Complying with Court Services Plan
- Attending medical, mental-health-treatment, and/or case manager appointments
- Complying with all medication and treatment requirements
- Attending bi-weekly meetings with the docket coordinator and/or probation officer
- Complying with the terms of probation
- Complying with instructions from the Judge, docket coordinator, or probation officer
- Attending substance-abuse-treatment sessions and activities (if applicable)
- Submitting to all drug and alcohol testing
- Attending support activities as directed by your provider, docket coordinator, probation officer, or Judge
- Engaging in some meaningful activity as defined by the treatment team
- Performing all required community service
- Following through with all housing, educational, vocational, and employment referrals

The following requirements must have been met in order for the participant to move to the next phase:

- Participating in the Mental Health Docket for a minimum of 24 weeks
- Obtaining a recommendation from treatment provider
- Receiving recommendation from Mental Health Docket team
- Providing negative drug screens for 90 days
- Avoiding new sanctions for the last eight weeks
- Avoiding new convictions in the last 90 days
- Attending quarterly specialized docket event
- Completing satisfactory home visits with the probation officer
- Completing all homework assignments

- Submitting phase application.

Maintenance – Phase IV

Phase IV is focused on adhering to and sustaining the structure and discipline developed in earlier phases. By the time you graduate to this phase, you have successfully followed your psychiatric-treatment requirements, including medication compliance, and you will have successfully obtained and maintained housing, employment, volunteer activities, educational or vocational plans, developed a functional support system, abstained from use of non-prescribed drugs and alcohol; and avoided additional involvement with the criminal-justice system. The amount of case management will lessen as you build your capacity to work with service providers on your own. The Mental Health Docket team will act in a support role, monitoring your maintenance. With any regression, the docket team will act swiftly to guide you back on track. The length of this phase varies, depending on your needs and your progress. Your docket coordinator will prepare a case plan outlining specific goals and objectives for you to complete during Phase IV. Requirements include:

- Attending Mental Health Docket status review hearings once every 6 weeks
- Complying with the rules of the Mental Health Docket program
- Complying with Court Services Plan
- Attending all appointments with medical, mental-health or substance use treatment providers, and/or case managers
- Complying with all medication and treatment requirements
- Attending monthly meetings with the docket coordinator and/or probation officer
- Submitting to all drug and alcohol testing
- Complying with instructions from the Judge, docket coordinator, or probation officer
- Complying with terms of probation
- Attending support activities as directed by your treatment provider, Judge, docket coordinator, or probation officer
- Engaging in some meaningful activity as defined by the treatment team
- Performing all required community service
- Active participation in a structured daily activity
- Maintaining stable housing
- Following through with all housing, educational, vocational, and employment referrals and obtaining educational, vocational, or employment opportunities

The following requirements must be met in order for the participant to be considered for graduation:

- Participating in the Mental Health Docket for a minimum of 24 weeks
- Obtaining recommendation from a treatment provider
- Receiving the recommendation of the Mental Health Docket team
- Providing negative drug screens for 90 days
- Avoiding new sanctions for the last four weeks
- Avoiding new convictions in the last 90 days

- Completing satisfactory home visits with the probation officer
- Attending quarterly specialized docket event
- Completing all homework assignments
- Complete and turn in graduation packet at least one week prior to graduation
- Complete exit survey

Participants must also be drug or alcohol free for a period of 12 months or some other reasonable period of time as determined by the Judge and the treatment team to be considered for successful termination.

The frequency of case management will lessen as you build your capacity to engage with service providers on your own. At the discretion of the docket team, appearances at Mental Health Docket hearings are reduced even further. The Mental Health Docket team will act in a support role, monitoring your maintenance.

REQUIREMENTS FOR GRADUATION

The final decision about your readiness to graduate will be made by the Mental Health Docket Judge. Your probation officer will let you know when the judge has decided that you are eligible for graduation. Your family and other loved ones will be invited to attend the ceremony where the judge will commend you on successfully completing the program. Successful completion of the Mental Health Docket program may result in reduction or dismissal of the charges and reduction in fines. This is at the discretion of the Mental Health Docket judge and the rest of the Mental Health Docket treatment team and your sentencing judge (when applicable).

WHAT CAN HAPPEN IF YOU DO FOLLOW THE RULES (POSSIBLE INCENTIVES)

As you progress through the MHD program, you will be given rewards for your efforts. Incentives for progress in the Mental Health Docket may include:

- Increased or expanded community-control privileges
- Less frequent urine testing
- Judicial praise and encouragement at status-review hearings
- A decrease in attendance at MHD court sessions
- Certificates of completion of phases and graduation
- Graduation
- Living a life of recovery

WHAT CAN HAPPEN IF YOU DON'T FOLLOW THE RULES (POSSIBLE RESPONSES)

Sanctions, service responses, and therapeutic responses will be graduated and individualized. They will be used at times when you are not complying with court orders, treatment, docket requirements, and probation requirements. Sanctions, service responses,

and therapeutic responses are used to help your behavior conform to program requirements. It should be noted that treatment will not be used as a sanction. Inappropriate behavior that may result in a sanction, service response, or therapeutic response may include but are not limited to:

- Failure to appear for a Mental Health Docket status-review hearing without being excused
- Not following court orders
- Not following treatment recommendations
- Missing or being late for scheduled treatment or docket/probation appointments
- Missed payments
- Failure to complete docket assignments
- Failure to provide a drug test or providing dilute urine screens
- Testing positive for illicit drugs or alcohol
- New charges or convictions

Sanctions for noncompliance are graduated and may include the following:

- Additional community service
- House arrest
- Curfew imposition or modification
- Incarceration
- Dismissal from the Mental Health Docket.

Service responses for noncompliance are graduated and may include the following:

- Verbal warning
- Assignments
- Increased alcohol and drug testing
- Increased attendance to status review hearings
- Increased probation appointments
- Courtroom observation sessions
- Daily reporting/ “day jail” sessions

Therapeutic responses for noncompliance are graduated and may include the following:

- Skill development
- Homework/practice
- Referral for medication evaluation
- Increased level of treatment

Noncompliance may result in unsuccessful termination from the program. The judge makes the final determination regarding termination. The judge has the discretion to decide termination in accordance with the written eligibility criteria for this specialized docket. The Mental Health Docked will not unsuccessfully terminate you without first offering you an opportunity for a probation-violation hearing where you can be represented by an attorney. After consulting with an attorney, if you decide that you don’t want a hearing, you may waive your right to a hearing

as long as you do so knowingly, intelligently, and voluntarily. Unsuccessful termination may result in further legal action, including revocation of Intervention In Lieu of Conviction, filing of a probation violation, loss of eligibility for other specialized dockets, and jail or prison time. A jail or prison sanction will not be imposed unless you have first been given notice, a hearing, and the opportunity to be represented by an attorney. After talking to an attorney, you may waive the right to this hearing as long as you do so knowingly, intelligently, and voluntarily.

SUBSTANCE USE MONITORING

One of the Mental Health Docket goals is to help you remain abstinent from alcohol and all non-prescribed drugs. You will submit a urine sample at intake and be tested regularly throughout the program. Drug testing must occur throughout the duration of your time on the Mental Health Docket if you have been diagnosed with a substance-use disorder. Participants who do not have a history of substance use must still undergo random and observed drug testing, although a frequency of less than twice each week will be considered.

All drug and alcohol testing plans are individualized. Tests will be random, frequent, and always observed. Urine samples will be analyzed for temperature, specific gravity, Creatinine and other chemical markers to ensure a valid urine specimen. Drug screens may be conducted during your court appearance, during your home visits, or at any other time**.** Failing to submit to testing, refusing to submit to testing, submitting an adulterated sample, submitting the sample of another individual, or diluting a sample will be treated as positive tests that can result in an immediate sanction. A positive test or admission of alcohol or other drug use will not automatically disqualify you from the docket but will result in an immediate sanction or an increase or change in your current level of treatment.

Understand that test results will be shared at the treatment-team meetings, the judge will have access to all drug results including failures or refusals to test, and the judge or your probation officer may order a drug test at any time. The Judge will be notified immediately of any violations of the above rules.

All participants are responsible for calling in (740-836-6011) nightly after 6 p.m. and before 7 a.m. to find out if you are to report for testing. You are required to report between 8 a.m. and 9 a.m. OR between 3 p.m. and 4 p.m. on the day of the test. All participants are required to provide a sample in the above time frames. If you are unable to report at those times, you are to make prior arraignments with the probation officer.

Urine Specimen Procedures

While all participants will be required to submit a urine sample during the first probation-office visit, they do not have to be observed the first time. Your probation officer or other same-sex probation officer or monitor will personally watch you produce the urine sample.

All participants must wash their hands prior to submitting a sample.

If participants are unable to provide a urine specimen immediately, they will be told to remain until they are able to provide a urine specimen. Participants who are unable to provide a urine specimen with two hours of being ordered to do so or signing in will be considered to have refused to submit the specimen and will be viewed as having tested positive for illegal drugs. If the participant comes to the office to submit a urine sample shortly before the office is scheduled to close for the day, he or she will be given only two brief opportunities that day to provide a valid sample.

In the event a participant is physically or mentally unable to provide a urine sample due to a medical condition, he or she will be required to pay for the testing procedure. Testing that the probation office can consider includes blood tests or DNA testing of hair. The participant will be required to provide those results if they are in the participant's possession. If saliva tests are available, the officer may utilize those too.

Positive tests

Participants will be apprised of any positive test results and will be asked for an explanation or admission of use. If the participant admits to using, the sample will not be sent to the lab, and appropriate sanctions may be imposed. (See the "Sanctions" section).

If the participant denies using and the lab reports a positive result, the participant must pay the costs of the lab test. The participant who denies using illegal drugs must complete the admission-request form by checking the box indicating drug-use denial, and then the probation office will send the sample to a lab.

Positive drug tests will be addressed through the treatment provider to verify if the use is a continued use or a relapse. The participant will be reassessed and be placed in the appropriate level of care to address the positive screen and to re-engage or re-stabilize the participant. The treatment provider as well as the Mental Health Docket team will be notified of the positive urine screen. Sanctions for the relapse may include increased status-review hearings, homework assignments pertaining to relapse and drug use, increased office visits, and jail.

The Mental Health Docket team participates in determining the incentives and sanctions, and the Mental Health Docket Judge will enforce and reinforce them. All sanctions and rewards will be documented in the participant's file and reviewed at the status-review hearings.

Breathalyzer:

In the State of Ohio, person who that register a concentration of .08 gram or more by weight of alcohol per 210 liters of breath are considered to be under the influence for driving purposes only. A decision to arrest, refer to a detox center, or send home a participant with a breath-test reading of .08 or more will be made with reference to the participant's current behavior, whether the participant will be operating a motor vehicle, and other normal arrest criteria.

Under normal circumstances, all participants who test at or above the .08 threshold on a breath-alcohol test will be arrested and transported to the Delaware County jail for their safety.

Testing by Outside Treatment Agency

Testing on participants will occur through the treatment agency where they are being treated. A staff member from that agency will notify the Mental Health Docket probation officer about the outcome of any test results as they are conducted.

Notification/Documentation

The results of all drug tests are immediately shared with the Mental Health Docket Team and the participant's treatment provider. In addition, information will be shared if a participant failed to report, failed to provide a sample, adulterated a sample, provided a sample of another individual, and or tampered with a sample.

Sanctions Pertaining to Substance Use/Testing

- If a participant is late for a test or misses a test, that action will be considered a presumptive positive test for drugs or alcohol.

- If a participant refuses to submit a urine sample, that refusal is considered a presumptive positive test.
- The participant must provide a urine sample that is clean for all drugs and alcohol.

- If the participants fail to produce a urine specimen within two hours or if the sample provided is not of sufficient quantity, that action will be considered a presumptive positive test for drugs or alcohol.

- If the participant produces a diluted urine sample, that action will be considered a presumptive positive test for drugs or alcohol.

- If a participant substitutes or adulterates his or her specimen for the purposes of changing the drug-testing results, that participant will be considered to have tested positive test for drugs or alcohol and will receive a sanction, which might include removal from the Mental Health Docket. Positive urines at intake will be considered a baseline drug test and will be documented. The treatment provider will be immediately notified as will the Mental Health Docket team.

Relapses

Relapses will be addressed through the treatment provider to verify whether the use is a continued use or a relapse. The participant will be reassessed and placed in the appropriate level of care to address the positive screen and to re-engage or re-stabilize the participant. The treatment provider as well as the Mental Health Docket team will be notified of the positive urine screen. Sanctions for the relapse may include more frequent status-review hearings, homework assignments about relapse and drug use, more frequent office visits, and jail.

The Mental Health Docket team participates in determining the incentives and sanctions, and the Mental Health Docket Judge will enforce and reinforce them. All sanctions and rewards will be documented in the participant's file and reviewed at the status-review hearings.

Relapse Triggers and Relapse Prevention

The individual or group sessions focus on designing a plan to address your relapse prevention. Your probation officer and treatment counselors will help you identify your triggers and will discuss ways to avoid bad situations and to work through them when they cannot be avoided.

Relapse triggers can include:

- Spending time with people who are drinking and using illicit drugs
- Going to places that cause you to use drugs or alcohol or make you upset
- Denial of past problems
- Using defense mechanisms that caused problems in the past
- Not working on your recovery plan
- Isolation
- Arguing or fighting with loved ones
- Bad luck and disappointments
- Good luck, celebration events, holidays

Prescribed Medication Usage

Participants are responsible for informing all treating physicians of their past and current struggles with drug and alcohol use before participants are given any addictive medication. If a doctor believes that a docket participant should use a particular controlled substance that will yield a positive urine screen, the physician must submit a letter to the Mental Health Docket Probation Officer stating that the doctor is aware of the participant's status as a person in recovery and that the need for the medication outweighs the risks. The participant **MUST** secure that kind of letter **PRIOR** to taking any medication that will cause a positive screen. If the participant tests positive and does not have a letter from his or her doctor, the participant will face immediate sanctions.

If a participant receives emergency-room care, he or she must provide verification of all emergency-room orders and discharge information to the Mental Health Docket Probation Officer no later than seven days after the participant is released from the hospital. Any prescriptions must be cleared by a primary-care physician in order for the participant to continue taking the medication without sanctions. A pattern of visits to the emergency room for ailments that require opiate treatment may be brought back before the Court at the discretion of the Mental Health Docket team.

WHAT ELSE IS EXPECTED OF YOU

As you can see, you are expected to follow a set of basic rules. Some other expectations focus on your actions in court and the things that you must do as part of your Court Services Plan.

The rules require that everyone in Mental Health Docket:

- Treat others with respect;
- Follow a dress code;
- Refrain from possession, sale, or use of non-prescribed drugs and alcohol;
- Stay out of bars;
- Follow doctors' orders for taking prescribed medication;
- Submit to urine testing and alcohol breath testing;
- Provide current contact information; and
- Refrain from breaking the law again.

MHD expectations will also cover areas of housing, healthcare, employment, and education. The expectations are described below.

Treatment of Others

You should respect the opinions and feelings of other people in MHD. Verbal or physical threats to anyone in the program or any member of the team will not be tolerated. Do not bring items that might be used to hurt another person accidentally or on purpose. Any such behavior will immediately be reported to the Judge and may result in a severe sanction or your termination from the program.

You will not be asked to be an informant in this program. You will not be expected or encouraged to discuss any information concerning anyone's behavior or progress except your own.

Dress Code

You will be required to dress appropriately for your court sessions and treatment appointments. Clothing bearing drug and alcohol themes or advertising alcohol or drug use is inappropriate. Other inappropriate themes include sex, foul language, racial or ethnic slurs, self-hatred or defiance. Tank tops, hats/head coverings (unless for cultural or religious purposes), cropped tops, "muscle shirts," and shorts are not allowed in court. You cannot wear sunglasses in court unless a doctor has prescribed their indoor use for you. Pagers and cell phones are not permitted during court sessions or during meetings with the treatment team.

Refrain from Possession or Use of Drugs

You will not possess, sell, or use alcohol or illegal drugs.
You will be required to report all drug or alcohol usage to the Judge at each court appearance.

- Repeated use will result in an alcohol and drug assessment.
- Failure to report drug or alcohol use will result in a severe sanction.
- Any drugs that a doctor prescribes for you must be reported to your probation officer immediately.

Stay Out of Bars

As a Mental Health Docket participant, you are not permitted to frequent bars. A bar is any establishment whose primary income is derived from the sale of alcohol in any form.

Provide Current Contact Information

You agree to provide the Mental Health Docket team and other treatment providers and court staff current information about your residence address, mailing address, telephone number, and place of employment or schooling. You must report any changes that occur while you are in the program.

Refrain from Violations of the Law

You are required to refrain from further violations of the law. Additional offenses may result in your being terminated from the Mental Health Docket program.

Housing

Stable housing is necessary for recovery. Before you make a change in your living situation, you must discuss it with your probation officer and obtain that officer's permission.

Healthcare

You are expected to seek medical attention when needed. You are also expected to follow through on medical advice. You may be asked to provide evidence to the court of medical conditions or appointments. Healthcare appointments are not to be scheduled at times when you are to be in court. Any prescribed drugs must be reported to your probation officer immediately.

Employment and Education

If you are able, you agree to obtain and maintain verifiable employment, or enroll in an educational program. Employment must be consistent and legitimate.

FOLLOW UP

The Mental Health Docket Coordinator is required to follow up with you after you leave the program. This follow-up is not intended to identify you individually or to sanction you. Its purpose is to see how people who participate in the Mental Health Docket do after they leave the program and to determine what impact the program has had on your life. Your feedback is important in evaluating the overall effectiveness of the program and identifying opportunities for improvement. You are always invited to return to the Mental Health Docket as a visitor to share your success with us and the existing participants. Your success can be a motivating factor for the participants currently in the program!

IMPORTANT NAMES AND NUMBERS

My Mental Health Docket Judge:	***The Honorable Marianne T. Hemmeter*** 117 N. Union St., 5th Floor, Delaware, OH 43015 Phone: (740) 833-2530
My Mental Health Docket Probation Officer:	***Jeremiah Mowery*** 117 N. Union St., 3rd Floor, Delaware, OH 43015 Phone: (740) 833-2972 Fax: (740) 203-1524 Email: Jmowery@co.delaware.oh.us
My Mental Health Docket Coordinator:	**Holly Graham, LPCC, LSW** 117 N. Union St., 5th Floor, Delaware, OH 43015 Phone: (740) 833-2526 Fax: (740) 833-2529 Email: Hgraham@co.delaware.oh.us
My Treatment Providers:	Case Manager(s): _____ Therapist: _____ Psychiatrist: _____ Therapy Group: _____
Weather Emergencies:	(740) 833.2974 Message will note closure or delay of MHD OR you will receive a text message
Other:	

MENTAL HEALTH DOCKET
PARTICIPANT HANDBOOK CONFIRMATION STATEMENT

I acknowledge that I have received, have read, and understand the Mental Health Docket Participant Handbook. I have had the opportunity to ask questions regarding these issues, and they have been explained to me.

I have read and agree to abide by the guidelines as outlined in the Mental Health Docket Participant Handbook.

I understand what I can expect from this program and what this program expects of me.

Name: _____
Print

Name: _____ _____
Signature **Date**

Witness: _____ _____
Signature **Date**

DIVERSION FIRST

2024 Annual Report

Fairfax County, Virginia

Letter from Diversion First Leadership

Diversion First completed its ninth full year in 2024 and continues to have a positive impact throughout Fairfax County. In this report, you will read about diversion services that span across behavioral health, public safety and the courts, to include crisis and post crisis services, jail-based services, specialty dockets and community-based diversion services.

In addition to program information, you will read about the profound effect these services have had on individuals, families and the community. Success stories and quotes from individuals who have received services illustrate the transformation that is possible with support and hope for the future.

Fairfax County uses the nationally recognized Sequential Intercept Model (SIM) as a framework to inform strategies and community-based responses related to the involvement of people with behavioral health issues involved in the criminal justice system. The SIM identifies six distinct intercept points, each with possibilities for intervention. Since its inception, Diversion First has been intentional about developing services at each intercept point, recognizing that a comprehensive system would improve the lives of individuals and families. Diversion First now includes a continuum of services that provide a pathway to treatment and recovery.

Diversion First is a philosophy and approach that has been integrated across the county. Our efforts would not be possible without cross-system collaboration; it takes stakeholder involvement and the investment and commitment of multiple partners all working toward common goals and a collective vision. Aligning our efforts has led to more coordinated services, efficient use of resources, more responsive strategies and better outcomes for the individuals and communities we serve.

Diversion First continues to offer individuals with mental illness, substance use disorders and/or developmental disabilities the treatment and support they need to create and maintain a life in recovery and avoid further involvement in the criminal justice system. With sustained commitment and sense of purpose to divert those with behavioral health issues, comprehensive diversion programs are transformative and strengthen our community.

Sincerely,

Kevin Davis, Chief of Police, Fairfax County
Stacey A. Kincaid, Sheriff, Fairfax County
Daryl Washington, Executive Director, Fairfax-Falls Church Community Services Board

What Is Diversion First?

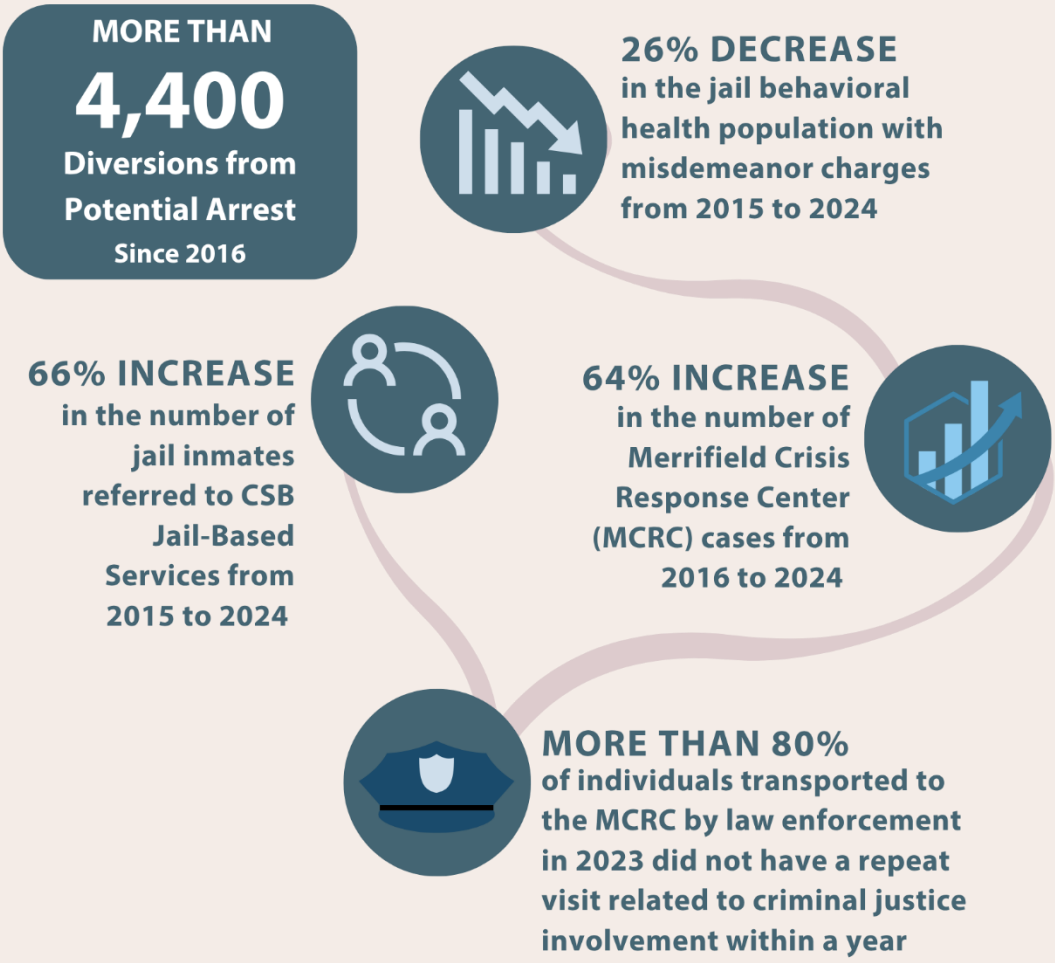
Diversion First offers alternatives to incarceration for people with mental illness, developmental disabilites and co-occurring substance use disorders who come into contact with the criminal justice system for low-level offenses.

The program aims to prevent repeat encounters with the criminal justice system, improve public safety, promote a healthier community, efficiently utilize resources and — most importantly — help people who are in crisis recover and take control of their lives.

Diversion First was implemented because:

- Too many people are in jail due to mental health issues. Jail is not the appropriate place to provide mental health treatment.
- There is a need to prevent the incarceration of people with intellectual/developmental disabilities.
- Intervening and de-escalating situations at the earliest point possible helps to avoid arrest and incarceration.
- It is the right thing to do to offer treatment to people who need it, instead of jail being the default solution.
- It is less costly for people to receive treatment instead of spending time in jail.
- Treatment offers hope by helping people recover and take control of their lives.
- 1 in 5 Americans has a mental illness. Having a mental illness is not a crime.

DIVERSION FIRST BY THE NUMBERS



Behavioral Health Crisis Response and the Marcus Alert

The behavioral health crisis response system, spanning Sequential Intercept Model (SIM) Intercept 0-1, is an integral part of diversion efforts. This system involves significant collaboration and coordination between the Fairfax-Falls Church Community Services Board (CSB), Fairfax County Police Department (FCPD), Fire and Rescue Department (FRD), Department of Public Safety Communications (DPSC), Fairfax County Sheriff's Office, regional partners and public safety entities within the county (i.e., police and fire and rescue departments and public safety answering points in the towns, cities and institutions of higher learning).

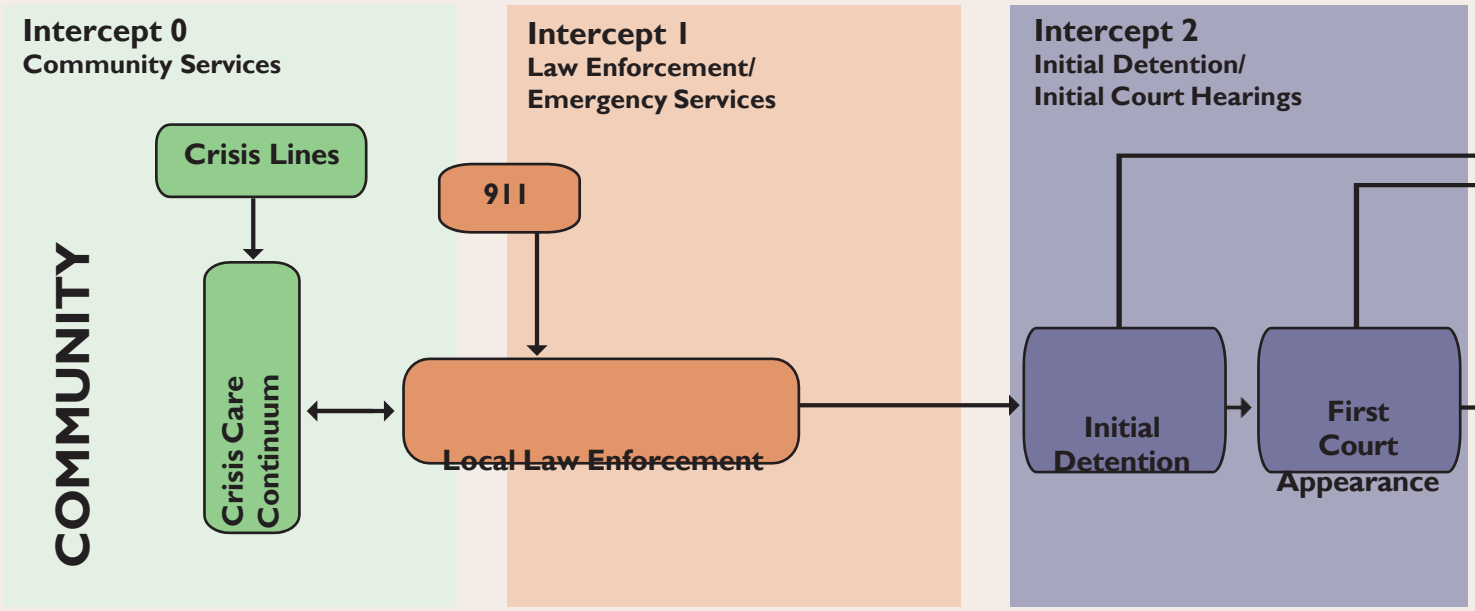
The past year marked the first full year of local implementation for the Marcus-David Peters Act (Marcus Alert). Marcus Alert requires public safety and behavioral health entities to provide a behavioral health response to behavioral health situations whenever feasible. It also involves coordination between Public Safety Answering Points (911) and Regional Crisis Call Centers (RCCC). RCCCs also serve as 988 answering points, providing 24/7 support and resources for behavioral health. Individuals who contact 988 have access to services in Spanish and translation services for 240 other languages and the Veterans Crisis Line.

The crisis response system provides services to individuals and families experiencing a behavioral health crisis and increases awareness of available services and linkages to care. Fairfax County's crisis response system is a commitment to providing "right care, right time, right place" interventions throughout the community.

Merrifield Crisis Response Center

Since the establishment of the Merrifield Crisis Response Center (MCRC) at the Sharon Bulova Center for Community Health in 2016, the Crisis Intervention Team (CIT) has been at the forefront of reshaping how the community responds to individuals experiencing behavioral health crises. The program's continued success in 2024 is a testament to the dedication and collaboration of the FCPD officers, the Sheriff's Office deputies assigned to the CIT and their co-location and relationship with the CSB. These agencies have worked hand in hand over the years to create a compassionate, community-based model that diverts individuals in crisis from the criminal justice system, connecting them instead to the treatment and services they need.

The Sequential Intercept Model



The MCRC is a CIT assessment site where law enforcement officers can bring people for services in lieu of arrest. On-site law enforcement officers can also accept custody if an individual is under an emergency custody order (danger to self or others or lacks capacity to provide for their basic needs). Community members can also be transported to the MCRC when a law enforcement officer recognizes that an individual needs services.

This innovative approach exemplifies how collaboration between law enforcement, behavioral health professionals and community organizations leads to better outcomes for individuals and the community. As we reflect on the progress made, it's clear that this is more than just collaboration — it's a movement that continues to thrive, reducing arrests, increasing access to behavioral health services and providing the support necessary for long-term recovery.

"Since transferring to MCRC, I have been able to utilize my training to listen, assist and give hope to our community in need and their families."
- PFC Carlos Guevara

Enhancing Response: Crisis Intervention Team Training

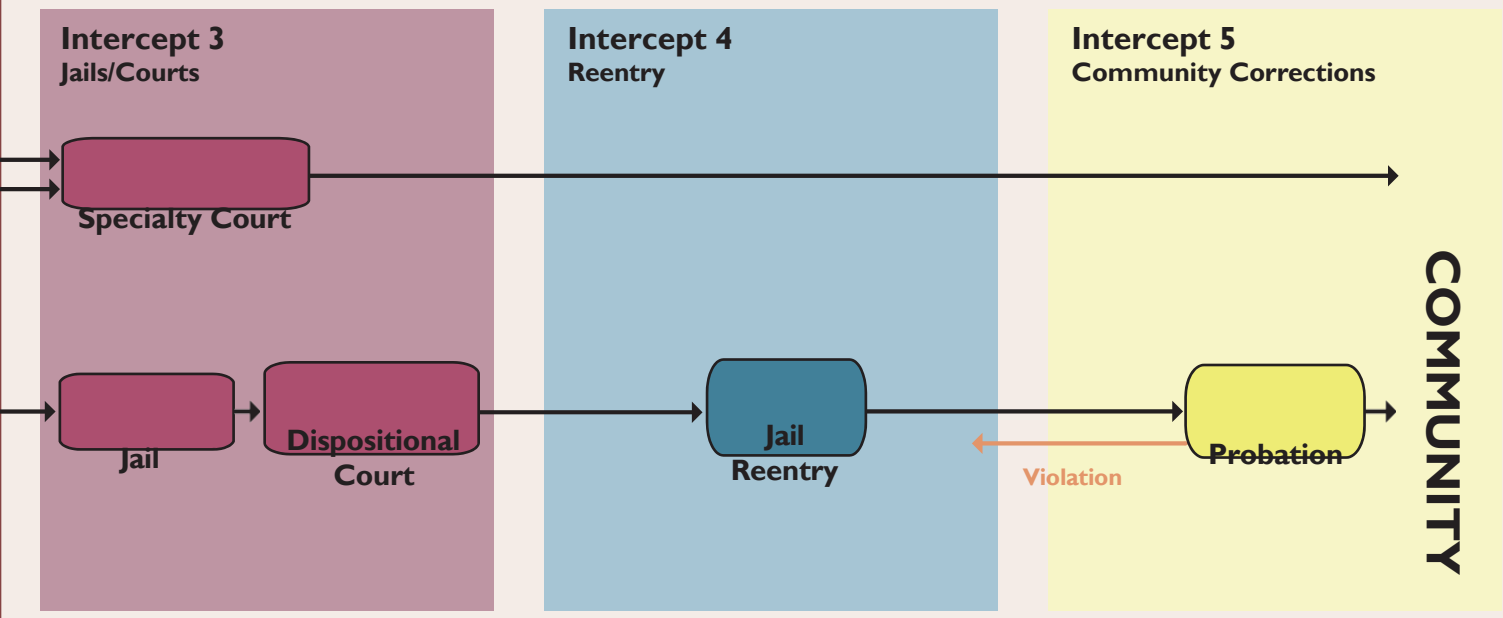
Law enforcement officers assigned to the MCRC serve as their agency's subject matter experts in the field and provide continuing education to public safety professionals. These law enforcement officers play a key role in the crisis intervention 40-hour class, advanced CIT class and train-the-trainer class, as well as countless station-level training refreshers.

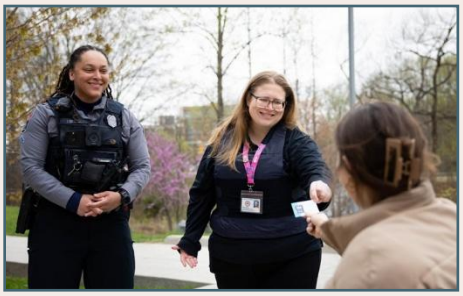
Co-Responder Program

The Co-Responder Program pairs a CIT-trained police officer with a CSB crisis intervention specialist to respond to public safety calls related to behavioral health issues. Co-Responder teams serve adults and youth who are experiencing emotional distress potentially related to mental illness, substance use, developmental disability and/or other related concerns.

The primary goals of the Co-Responder Program are to provide timely on-scene assessments and crisis de-escalation. These teams respond to 911 dispatched calls for service related to behavioral health to ensure individuals receive the appropriate level of care and resources based on the intensity of the crisis they are experiencing.

The Co-Responder team works closely with the CSB Mobile Crisis Unit, Community Response Teams, the





Post Response Team and various community-based programs to provide a seamless, coordinated response. Collaborating across these services ensures individuals receive the ongoing care and support needed to maintain stability and avoid future crises.

"I have been an officer for the FCPD for 11 years and during my career, mental health calls for service have significantly increased. Having this resource of a CIT-trained officer, as well as a clinician from the CSB, helps with providing multiple resources outside of just hospitalization for consumers in the field. I have always had a soft spot for helping others and being on this unit allows me to remain in the field and interact with those in need."

- PFC Indya Cottrell

"Being able to provide rapid-response support to individuals during some of their hardest and/or most vulnerable periods is a true privilege, which is why I chose to join the co-responder team - to make an impact and offer help when it's needed the most."

- Clinician David Klein

Community Response Team (CRT)

The CRT pairs a Community Services Board clinician and a technician from FRD to provide outreach, assessment and care coordination services to community members who have unmet behavioral health and/or medical needs and frequent interactions with the public safety system. The team also works closely with a peer recovery specialist, who has an important role in engaging community members.

In 2024, CRT continued its strong collaboration with public safety, healthcare and social services agencies. The program continues assisting community members with finding and accessing the help they need while providing services that allow for effective utilization of public safety resources.

Following the expansion to two teams in 2023, CRT served more than 430 individuals in 2024. CRT provides invaluable services to vulnerable community members and frequently has multiple encounters with individuals to assist with stability, resources and linkages to ongoing services. During the past year, the CRT also focused on strengthening partnerships with other teams involved in the Fairfax County Behavioral Health Crisis System, including the Co-Responder Teams.

The CRT does not respond directly to 911 calls related to behavioral health. The team provides engagement and linkages to services and aims to reduce 911 call volume for frequent utilizers of public safety services who do not need a public safety response. For individuals who received a CRT intervention in FY23 or FY24, there was a 51% reduction in their use of Fairfax County public safety calls for service.

CRT Success

Mary, a woman in her 80s with dementia, was aging in place in her single-family home. CRT received a referral from FRD personnel who had responded to her home on multiple occasions following numerous 911 calls. In addition to cognitive impairment, Mary had mobility problems and medical issues that were unaddressed.

CRT visited Mary and explained the scope of the program to Mary and her family. CRT made several recommendations, including the Home Repairs for the Elderly program, increasing home health care/in-home visits and seeking a referral to physical and occupational therapy.

Mary and her family appreciated that Fairfax County had a team that would help connect their family to these resources and expressed that it can be overwhelming for families to understand resources available and how to access them. The family explained that when Mary needed assistance, they did not know who to contact for help, so 911 was their default plan. Mary's family accessed the resources provided and were able to address safety concerns in the house while helping Mary address other issues. CRT noted a dramatic decrease in 911 calls and on the final outreach visit, a nurse practitioner was completing an in-home appointment as the team arrived. The nurse practitioner thanked the team for assisting Mary to obtain more home-based care and reported that the client had significantly improved.

The Sensory Box

Sensory Boxes, carried by all Co-Responder units and available at all district stations, contain clinically approved items designed to comfort and help focus individuals with autism and those with developmental disabilities. These items can soothe and calm individuals, provide sensory stimulation, redirect focus and promote emotional regulation, helping to improve interactions.

Post Response Team (PRT)

Launched on September 5, 2023, the PRT is part of the Merrifield Crisis Response Center's Mobile Services Teams. PRT provides follow-up support to individuals assessed by Emergency Services (ES), Co-Responder Teams (CoR) or the Mobile Crisis Unit (MCU). It focuses on individuals who do not require inpatient care but need ongoing assistance to access community-based behavioral health services.

PRT receives referrals from ES, CoR or MCU for individuals who are stable but need further support. The team schedules engagement sessions and connects individuals to services such as mental health support,

Co-Responder Team's Compassionate Approach Leads to Safe Outcome on Railroad Bridge

In September 2024, a train operator reported a man walking along the railroad tracks. The situation quickly escalated when a second train operator observed the man standing in the middle of a high railroad bridge, visibly distressed and expressing thoughts of self-harm.

The Co-Responder team was dispatched and while en route to the scene, the team coordinated additional support from the Fairfax County Police Marine Patrol Unit, which quickly deployed a boat beneath the bridge to monitor the evolving situation and provide safety coverage from below.

Upon arrival, the Co-Responder team quickly learned the man was experiencing overwhelming emotional distress following a recent incident in which his child suffered a serious injury. The team gathered critical background information from the man's father, who was also present, and the officer initiated a calm, empathetic dialogue that, together with the clinician's steady support, laid the foundation for trust.

What truly distinguished this response was the officer's decision to share a deeply personal story, one that mirrored the man's emotional struggle and created an immediate sense of connection. This moment of vulnerability created a breakthrough, allowing the man to feel understood and less alone. The power of that human connection, combined with the steady, supportive presence of the clinician, helped the man gradually step away from the edge.

In an emotional moment, the man approached his father and embraced him in the middle of the bridge.

Though the encounter briefly turned tense, officers acted quickly and compassionately, placing the man under an emergency custody order to ensure his safety, and he received immediate mental health care.

This incident exemplifies the profound impact of Fairfax County's Co-Responder Model for responding to individuals in crisis. The team's compassion and human-centered approach during this crisis were critical to achieving a safe and successful resolution.

housing and substance use treatment. Depending on an individual's needs, the PRT may meet with individuals and their families on multiple occasions to ensure continued support and reduce the need for more costly crisis services.

The PRT consists of a peer recovery specialist and a behavioral health specialist. This combination of professional expertise and lived experience helps build trust, encouraging clients to take steps toward long-term recovery. PRT has made a significant impact by connecting individuals to resources that reduce reliance on emergency services.

The PRT is integral to the MCRC's holistic crisis intervention approach, helping individuals transition from crisis to stability. By fostering genuine connections and offering ongoing support, PRT empowers individuals to overcome challenges and thrive within the community.

Post Response Team Successes

Mia was referred to PRT for emotional outbursts. Initially hesitant, she engaged in peer support and group activities, building confidence and self-awareness. She is now in college, studying science and economics with no further emergency service involvement.

Oliver was struggling with depression and substance use. Through peer support, he began attending Narcotics Anonymous meetings and became an active member of the recovery community. He now supports others in their recovery journey and contributes to a professional journal.

Behavioral Health Liaisons (BHL)

Since 2023, DPSC and the CSB have collaborated to support the Behavioral Health Liaisons program.

The program aligns with Virginia's Marcus Act to provide a behavioral health response where appropriate. BHLs are clinicians who are co-located within DPSC's 911 Operations Center and provide an array of resources to Fairfax County community members, Monday through Saturday from 11 a.m. to 9 p.m. by:

- Monitoring calls for service received by DPSC and conferring with staff in real time to offer support for callers that may be experiencing a behavioral health crisis.
- Consulting with law enforcement, Fire and Rescue and Co-Responder Units in the field.
- Following up with callers to limit dispatching public safety resources while providing support and services.
- Researching high users of the 911 system and referring them to appropriate behavioral health resources as needed.

In 2024, BHLs reviewed more than 1,120 public safety events and provided assistance as appropriate. For example, a BHL assisted in intervening with an 83-year-old woman who was experiencing increased paranoia and isolation and frequently called the 911 system in distress. The BHL contacted the caller, and with encouragement and compassion, assisted in reducing her stress by helping them identify supports within her community. This intervention aided the caller to be de-escalated without requiring law enforcement intervention. The BHL was also able to ensure that appropriate community resources were provided for follow-up. These multiple interventions for the individual resulted in a reduction of 911 calls.

Diversion Engagement

The Diversion Engagement Team is designed to serve individuals who are in a cycle of repeated incarcerations or psychiatric crises. Current criteria include three or more contacts with the CSB's Emergency Services (ES) within one month or four+ forensic behavioral health intakes in the Adult Detention Center (ADC) within six months. Individuals who meet criteria for this service have been diagnosed with serious mental illness and/or substance use disorder and struggle to engage in treatment services for a variety of reasons. These individuals will instead continue to utilize county services, often engaging through several various entry points to the system. Many of these individuals are homeless and without a phone, making robust outreach and engagement efforts both difficult and essential.

The Diversion Engagement Team has worked to streamline the admissions process by providing support and partnering with individuals to prioritize their needs and goals. The team works to eliminate barriers and often attends assessment appointments with individuals. After an assessment is completed, Diversion Engagement clinicians continue to provide care coordination through full engagement into ongoing CSB treatment services.

Diversion Engagement also provides Outpatient Competency Restoration services for individuals who were deemed incompetent to stand trial and are court-ordered to restoration services either in the community or the ADC. The purpose of this service is to provide education on legal rights, available pleas and potential consequences, individual charges, appropriate courtroom behavior and how to assist an attorney in one's own defense. While court-ordered to restoration services, an individual's trial process is on hold to allow time to better understand the charges against them and what to expect during the trial process. Many of the individuals served are unfamiliar with the legal system and processes. The team has created visuals in several different languages to include session guides, flash cards, interactive diagrams, puzzles/games and videos. Once deemed competent to stand trial, the client's legal process restarts and they are able to be adjudicated on alleged charges.

The Diversion Engagement Team can often be found in the community including local hospitals, crisis stabilization units, homeless shelters, Fairfax and Fairfax City courthouses, Fairfax County Adult Detention Center, drop in centers, food banks, CSB locations and essentially wherever the client can be located within the county. This flexibility allows the team to truly meet the clients where they are.

STAR Program

Established by Sheriff Stacey Kincaid in 2018, the Striving to Achieve Recovery (STAR) program was created to offer individuals an opportunity to begin their recovery journey while still incarcerated, providing them with the tools, skills and support needed to maintain sobriety and build a healthy, productive life upon release. Living in a recovery focused housing unit allows participants to practice new and healthy behaviors so that when they are released, they can confidently handle situations that once had them turning to substances.

Recovery is not a one-size-fits-all process and the STAR program embraces this by creating an environment that is peer-led, recovery-oriented and centered on hope and empowerment. Participants are not only encouraged to work on their personal recovery, but also to develop skills that allow them to support others on similar journeys, setting a strong foundation for success in the community.

One example of the STAR program teaching participants the benefit of helping others is the 72-hour Peer Recovery Specialist (PRS) training that is brought to the ADC by one of STAR's program partners, the Chris Atwood Foundation (CAF). A CAF PRS trainer brings this class to the ADC approximately twice a year for STAR participants. Following this training and upon receiving certificates of completion, participants then start to accrue the 500 training hours required to take the Virginia

Diversion Engagement Success

James stated that he could not attend an assessment due to lack of transportation. The team offered bus tokens and helped him identify the correct bus route to get to his appointment. However, it was soon learned that James was experiencing significant paranoia and did not feel safe coming to the CSB for his appointment. The team met him outside of the building and provided supportive counseling while he waited for his assessment to begin. James reported that he would not have been able to complete this task without the staff support and encouragement he received.

Victor's Success Story

Victor struggled with symptoms of depression and anxiety and had accrued several charges for public intoxication and trespassing. He was directed to Outpatient Competency Restoration services through the Diversion Engagement Team and the clinician quickly identified a need for a psychiatric evaluation to determine next steps in this individual's treatment. He was connected to a psychiatrist through the CSB, however, he continued to struggle to learn the information necessary to be deemed competent to stand trial. The clinician sought assistance from the Office of the Public Defender, the probation officer, the assigned treatment provider and family/collateral sources. The clinician also referred him to Neighborhood Health, a federally qualified health care provider, where it was discovered that Victor had several cataracts in his eyes and he was unable to see, let alone read any of the materials that were provided during the restoration process. The clinician persistently advocated for Victor's eye surgery and ongoing medical care, which also included a neuropsychological evaluation that identified cognitive impairment from a traumatic brain injury as a child. Without such thorough and thoughtful engagement work, Victor was at risk of falling through the cracks, when he was unsure of how to navigate treatment services or advocate for himself.

PRS certification examination upon release. Not only does this training help participants strengthen their own recovery, but they learn how to build peer relationships with those who are currently struggling with substance use disorder (SUD). Supporting others in a peer relationship keeps recovery at the forefront and emphasizes the principle that by helping others, they help themselves.

The PRS training and the accrual of training hours take place in addition to the mandatory weekly groups STAR participants must attend in all three phases of the program. All phases also require setting and achieving goals.

Participants are usually hesitant to set certain kinds of employment goals due to having a criminal history. They have become used to shying away from employment opportunities that require background checks. When participants learn that they are eligible for employment in a position that requires a background check, they often begin considering career choices that have never occurred to them before. They become motivated and excited about their future.

Another component of peer work is advocacy. PRSs advocate not just for themselves but also for those they support. In 2024, Sheriff Kincaid welcomed a Congressional delegation to see first-hand the life-transforming addiction treatment and recovery programs in the ADC, including the STAR program. STAR program participants, as well as the CSB's PRSs who work with them, shared their lived experience regarding their struggles with substance use disorder and their efforts to recover. STAR participants talked with the delegation about what brought them to this point in their lives and also how the STAR program has supported them with finding their own individual pathways to recovery.

A participant was selected by his peers to explain the three 18-week phases of the program, reveal his own experience that led to incarceration and share how he holds himself accountable on the path to recovery. He also described the essential family component of the program. Other participants voluntarily shared what the program means to them individually. The group took questions from the visitors and willingly answered.

Jail-Based Behavioral Health Services

John was struggling with untreated mental health issues which contributed to his involvement in the justice system and incarceration. Through the CSB Jail-Based Team and Sheriff's Office, John's journey took a pivotal turn.

It was quickly determined that John needed intensive behavioral health services and he was transferred out of the ADC for competency evaluation and treatment at Western State Hospital. This step ensured that his mental health needs were addressed and he received stable medication management, which was a crucial step in his recovery.

After a period of stabilization, John returned to the ADC and was housed in the mental health unit where he continued to receive the specialized care he needed. During this time, John made significant strides in managing his mental health issues. His engagement with services and commitment to treatment helped him regain stability, and soon he was ready for the next step.

In a remarkable turnaround, John made tremendous progress and was stable enough to move out of the intensive mental health unit. This marked a profound shift in his journey toward recovery and rehabilitation. His progress was a testament to the transformative power of focused mental health support, as well as the compassion and resources provided by the team.

But John's story didn't end there. Upon his release, he was immediately admitted to a CSB residential treatment program. In this program, John found a community that supported both his mental health and his recovery efforts. With a structured environment and continuous access to care, John is now working on his long-term recovery and taking active steps to rebuild his life.

John's success underscores the power of diversion, ongoing mental health treatment and support in breaking the cycle of incarceration. He has gained the tools he needs to thrive, demonstrating that with the right resources and care, individuals can rebuild their lives, find stability and move toward a brighter future.

"We will continue to welcome visitors from all over the state and nation. I truly hope that our programs can be replicated across the country, not only by other jails and prisons but also outside of a confinement setting. We must work together so that substance use disorders become destigmatized and a sustainable path to recovery becomes the norm."

- Sheriff Stacey Kincaid

One former STAR participant who was released from incarceration in 2024 is now volunteering with the CAF and hopes to become employed as a PRS. This individual recently finished accruing the 500 training hours needed, passed the exam and is now a certified PRS in Virginia. Prior to being in the STAR program, this individual had never considered the struggles he had with substance use disorder and his subsequent recovery would lead to employment goals in which others could benefit from him sharing his experiences and the recovery pathway that works for him.

His story is one of many that demonstrate the transformative power of recovery, peer support and the importance of creating pathways for success, both inside and outside of incarceration. The STAR program shows that recovery is possible with the right support, structure and opportunities. By investing in participants' personal growth and professional development through peer recovery training, STAR not only changes individual lives but also strengthens communities. As more participants move forward in their recovery journeys and take on roles as certified PRSs, they become powerful examples of resilience and hope. Their success stories serve as reminders that no matter what the past, a new future built on purpose and service is always within reach.

Court Services

Court Services remains committed to providing exceptional service to individuals by continuing to enhance diversion efforts. Court Services is an essential part of the Mental Health Docket and Competency and Compliance Docket teams. The Competency and Compliance Docket, which works with individuals who have been found incompetent to stand trial as they undergo competency restoration services and individuals who struggle to comply with recommended treatment services as conditions of their probation, continues to yield positive results through the collaborative efforts of probation officers, the treatment team, service providers and participants.

To make it easier to obtain assessments and access treatment in a timely manner, Court Services staff collaborate with the CSB's Courthouse Assessment Team. In collaboration with Court Services probation officers, the team meets with clients on the day of supervision appointments and are able to see individuals on a walk-in basis, which is especially helpful for those who are unhoused and/or struggle with transportation.

In 2024, Court Services made it easier for individuals who are court ordered to supervision to report to pretrial services. Court Services opened a Pretrial Intake Unit located in the lobby of the ADC, with extended hours (8 a.m. to 6 p.m.) five days a week. This makes walk-in services as well as transportation and support services in a location easily accessible for participants and their families. Upon release, a probation officer engages pretrial participants to complete a required intake. While Court Services makes contact with individuals prior to release whenever possible, this new Intake Office provides a safety net to ensure connection.

The Intake Unit has streamlined the process for post-release services, ensuring that individuals can readily access services and support. Since opening the Pretrial Intake Unit, there has been a 40% increase in the number of individuals who completed an intake being referred to a pretrial program.

Mental Health Docket

In November 2024, the Fairfax County Mental Health Docket celebrated the achievements of participants as they graduated from the program. Mental Health Docket graduations are, above all, a celebration – an opportunity to pause and reflect on the achievements of each graduate.

Graduating from the docket is not easy; the program is a combination of mental health treatment and intensive court supervision, taking anywhere between 12-36 months to complete. When participants choose to enter the docket, they agree to reflect on the choices, behaviors and circumstances that contributed to their involvement

in the criminal justice system. They commit to making significant changes in their lives and commit to recovery.

Change can be difficult and maintaining the patterns that contributed to successfully completing the Mental Health Docket and graduating means choosing every day to live a life dedicated to stability and sobriety.

The November 2024 graduation featured a program alumni speaker for the first time in docket history. Daniel "Dan" Lopez Riviera was one of the first participants in the program, officially joining in August of 2019 (the program launched in July). He successfully completed the program and was a graduate at the first Mental Health Docket graduation in October 2020. Dan is an active member of the Mental Health Docket Alumni Group which meets twice monthly. The groups are an opportunity for alumni to come together, catch up with one another, laugh, tell stories and build fellowship. They are also a safe place for alums to talk to a trusted group of staff and peers, seeking guidance and support as they navigate their current life situations. Dan has been a leader in this community, fostering relationships with other alums, as well as current participants, providing encouragement as they navigate treatment and sobriety.

Four years after his own graduation, Dan stood in front of the 2024 graduates and spoke about choices. An avid chess player, Dan compared life's ups and downs to the plays, moves, decisions and choices that one makes during a game of chess. Dan encouraged the graduates, reminding them that, like chess, life requires us to plan ahead, set goals and develop strategies to navigate different life scenarios. Every choice, every move can lead to potentially different outcomes. Dan's life and his choices have been, and continue to be, an example for all.

Recovery Court

The Fairfax County Recovery Court Program, formerly known as Drug Court, is a critical component of the county's efforts to support individuals battling substance use. One of the most notable changes in 2024 was the introduction of a dedicated track for young adults aged 18-25, established with opioid settlement funds. Recognizing that this age group faces unique challenges when it comes to substance use, and with the rise in fentanyl and other harmful substances in recent years, the program's team developed a track tailored to the needs of this vulnerable population. While the new track, launched in August, provides all of the same support, supervision and treatment as the current Recovery Court, it also includes interventions that target the needs of young adults: peer-based supports, education, evidence-based trauma groups and life skills groups.

The new track doubled the Recovery Court capacity from 25 to 50 participants, responding to the growing need for recovery services in the community. This increase in capacity allows the program to serve more individuals in their recovery journey while maintaining high standards of care and support.

In addition to the young adult track, the program has also significantly increased access to PRSs across all participant tracks through an expanded partnership with the Chris Atwood Foundation. PRSs play a key role in guiding individuals through the recovery process, offering support and sharing their own experiences to encourage lasting change. Enhanced access to PRSs ensures that participants receive the individualized support necessary to navigate the complexities of recovery.

Looking ahead to 2025, there is excitement among the multi-agency team about expanding the program's impact even further and providing more individuals with the resources needed to overcome addiction and rebuild their lives. As the program evolves, the commitment to fostering a compassionate, supportive environment where participants can achieve sustainable recovery and reintegrate into their communities will deepen.

Veterans Treatment Docket

In military tradition, the "changing of the guard" is a formal ceremony where soldiers are relieved of their duties and replaced by a new shift, symbolizing a smooth transition in responsibility and leadership. In 2024, the Veterans Treatment Docket (VTD) experienced its own

"changing of the guard," with a new presiding judge for the High Risk/High Needs track and other key members of the Veterans Docket Team. Despite these changes, the program maintained its unwavering commitment to supporting justice-involved veterans and ensuring continued success in fulfilling its mission.

Since its inception in 2015, 80% of VTD graduates have completed the High Risk/High Needs track and 20% have completed the newly established Low Risk/High Needs track. Last year, two of those recent graduates returned to join the mentor program, a vital component of VTD that pairs veterans with volunteer mentors for support, guidance and camaraderie throughout the program's phases. This reflects the program's profound impact, making a lasting difference in veterans' lives well after graduation and inspiring them to pay it forward.

In October 2024, VTD reached a significant milestone with a memorable graduation on Halloween. Seven veterans from all three courts (Circuit, General District and Juvenile and Domestic Relations) were honored for their hard work and dedication during the ceremony. The event was highlighted by the inspiring words of Brig. Gen. Shannon O'Harren who said, "You are wiser, stronger, more resilient and standing proud." Among the graduates, one veteran shared a powerful reflection, noting that through the docket, "I was able to keep my (security) clearance, find a job to support it and get back into school." This graduation not only celebrated the personal resilience of its graduates but also underscored the program's role in helping veterans overcome obstacles and rebuild their lives.

In November, the VTD was recognized for its impact and Carmen Vest, a current participant in the Low Risk/High Needs track, was selected as a panelist for the Verizon and American University's Voices of Valor: Transformative Journeys Through Veteran Treatment Courts event. The televised event highlighted the effectiveness of veteran treatment courts in addressing the unique needs of justice-involved veterans. Vest shared that she owed her success in the program to

"My children, also the (VTD) team here. I know if I need help, I can reach out to anyone on the team." Throughout her time in the program, she has overcome many challenges with remarkable strength and resilience, and always with a positive attitude. Vest is currently in the final phase of the Low Risk/High Needs track and is expected to complete the program in May 2025. Her journey, like that of many veterans in the program, demonstrates the power of determination and the vital support provided by VTD, helping veterans build brighter futures for themselves and their families.

As the VTD continues to support veterans, it is also focused on expanding its community partnerships and growing its reach to better serve more. Looking ahead, the program remains dedicated to helping the veterans who have given so much to this country overcome challenges and start new chapters in their lives.

Diversion First Housing

Diversion First Housing, a partnership between the CSB, the Dept. of Housing and Community Development and New Hope Housing, provides permanent supportive housing to individuals who struggle with behavioral health issues and have had repeated psychiatric hospitalizations and involvement with the criminal justice system. The program provides housing, connection to services and wraparound support to prevent leasing violations or a return to homelessness or institutions.

- 42 individuals were served in 2024
- 90% had no psychiatric hospitalizations
- 90% were not booked into jail, and 90% had no interactions with law enforcement going to or at MCRC
- 95% were engaged in CSB/private services
- Close to 80% maintained stable housing

As Diversion First Housing Specialist Odilia Raphael with New Hope Housing shared, "One story alone

doesn't fully capture the transformative impact the Diversion First Housing program has had on our clients' lives. I am honored to perform this job, which brings both challenges and moments of satisfaction. Observing the collective impact of the Diversion First Housing program on my clients is truly rewarding."

Many have shared how stable housing has transformed their lives:

> ***"Having a roof over my head has enabled me to secure a steady job, reconnect with my family and maintain regular appointments with my therapist. This stability has given me a renewed sense of purpose and hope for the future."***
>
> ***"Thanks to the Diversion First Program, I am no longer living on the streets. I feel safe and supported, which has made a huge difference in my life. I am now able to focus on my recovery and personal growth."***
>
> ***"The support I received from New Hope Housing and the Diversion First Program has been lifechanging. I have a place to call home and it has motivated me to pursue my goals and stay on the right path. I am currently working towards earning a vocational training program."***
>
> ***"With the stability provided by the program, I have been able to set and achieve goals that I never thought possible. I am now concentrating on stabilizing my own pet sitter small business."***

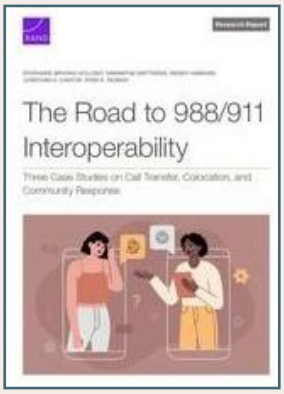
By providing stability and support, the program empowers individuals to rebuild their lives, pursue their dreams and find renewed hope and purpose.

new hope housing
It's time to rethink homelessness.

Empowering Communities, Building Futures.

In the Spotlight

In 2024, Fairfax County was one of three jurisdictions featured in a published RAND Corporation research study, "The Road to 988/911 Interoperability: Three Case Studies on Call Transfer, Colocation and Community Response." With information gleaned from a site visit and interviews with partners, the study featured details related to 988/911 interoperability in each of the three jurisdictions; agency roles; and decision points that can affect the way 988/911 calls flow through local systems. The research also identified facilitators, barriers and equity-related considerations of each jurisdiction's approach, as well as lessons learned from implementation. The study was designed to serve as a resource for jurisdictions considering local implementation.



Fairfax partners also presented on a National Association of Counties webinar, "Advancing Crisis Communications," to highlight the RAND study findings, as well as planning and implementation considerations for other jurisdictions.

What's Ahead in 2025

Diversion First will continue to leverage resources to advance the mission of this cross-system initiative.

In 2025, Diversion First partners will:

- Update the local Sequential Intercept Model map to illustrate resources and identify gaps.
- Serve as a national Stepping Up Peer Mentor Innovator, consulting with other counties and engaging in peer knowledge exchange.
- Bolster supports for community transitions and reentry post jail release.
- Enhance behavioral health training for first responders.

2024 Year in Review — By the Numbers

	2016 (Baseline)	2020	2021	2022	2023	2024
Police Department						
Total calls for service with police response involving mental illness[1]	3,566	9,989	10,534	10,466	9,402	9,093
- Involved Merrifield Crisis Response Center (MCRC) for all jurisdictions[2]	1,580	2,165	2,170	2,280	2,421	2,587
Merrifield Crisis Response Center/Emergency Services						
Total service encounters	5,024	5,145	5,811	6,174	5,996	5,542
- General emergency services (non-law enforcement involved)	3,444	2,980	3,641	3,894	3,575	2,955
- Involved law enforcement	1,580	2,165	2,170	2,280	2,421	2,587
- Voluntary transports to MCRC	547	550	661	341	310	268
- Emergency Custody Order (ECO) transports to MCRC	1,033	1,615	1,509	1,939	2,111	2,319
Diverted from potential arrest	375	438	505	588	598	616
Unduplicated number of people served at emergency services	3,081	3,150	3,536	3,727	3,726	3,510
Mobile Crisis Unit[3]						
Total number of services (attempts and contacts)	1,484	1,458	1,813	1,425	1,118	829
- Total number of services (contacts)	1,029	862	1,013	743	629	546
Services with law enforcement or referral	467	489	420	465	326	249
Unduplicated number of people served (contacts)	791	704	784	605	499	461
Office of the Sheriff						
Criminal Temporary Detention Orders (CTDOs) from jail	35	11	25	20	10	9
Transports from MCRC to out of region MH hospitals	128	109	35	34	47	42
Jail transfers to Western State MH Hospital (forensic)	23	59	53	78	73	86
Crisis Intervention Team Training (CIT)						
Graduates[4]	265	952	1,044	1,075	1,161	1,268
Dispatchers (condensed version of training)[5]	42	163	163	171	190	200
Mental Health First Aid (MHFA) and Mental Health Literacy Training						
Fire and Rescue (Mental Health Literacy)[6]	NA	1,624	1,736	1,847	1,936	2,124
Sheriff's Deputies, correctional health nurses, administrative staff[7]	254	675	691	715	742	772
Court Services						
Total number of Pretrial Supervision	NA	1,966	2,316	2,864	3,828	3,716
- Screened positive on the Brief Jail Mental Health Screen (BJMHS)	NA	330	377	396	496	306
- Screened positive on the BJMHS, had an advanced screen and were referred to treatment	NA	181	242	240	235	157
Total number of Juvenile and Domestic Relations District Court Pretrial Services Program (PSP)	NA	497	575	641	717	753
- Ordered to have a mental health assessment or treatment	NA	78	136	131	124	149

[1]Changed from mental health investigations written in the field (2016/2017)
[2] Jurisdictions include (Cities of Fairfax & Falls Church, Towns of Herndon & Vienna, George Mason University, Northern Virginia Community College, Virginia State Police)
[3] 2022 numbers have been updated to remove Co-Responder pilot program data reported through other data sources
[4] Graduates since September 2015
[5] Trained to date
[6] Trained to date
[7] Participation since September 2016

Diversion First Partner Agencies

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