Mental Health Standards for Virginia's Local and Regional Jails

Department of Behavioral Health & Developmental Services (DBHDS)

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EXECUTIVE SUMMARY

The over-representation of individuals with behavioral health challenges in the criminal justice system is not a new problem or a problem isolated to the Commonwealth of Virginia. Rather, for many years most states have reported having more individuals with behavioral health challenges incarcerated than are reported in national community prevalence rates. While the Department of Behavioral Health & Developmental Services (DBHDS) continues to encourage and support the development of criminal justice diversion programs for individuals with serious mental illness who can be more effectively treated in the community (without significantly increasing community risk), it remains likely that individuals with behavioral health challenges will continue to be incarcerated as not all cases can or should be diverted. To that end, it became evident that there was a need for the development of recommendations for minimum standards for behavioral healthcare in jails.

During the Spring/Summer of 2018 DBHDS formed a workgroup comprised of criminal justice professionals, behavioral health professionals, advocates, and other stakeholders to aid in the development of recommended minimum standards for behavioral healthcare in local/regional jails. The workgroup used existing, published best practice standards to guide its work. In the end the workgroup identified 14 standards for behavioral healthcare which should be available to all individuals incarcerated in jails within the Commonwealth. Thirteen of the standards were identified as essential and one was identified as a best practice (but not necessarily essential). The workgroup identified compliance indictors, explored the degree to which jails were already meeting the recommended standards, barriers to implementation, and what, if any resources would be required for full adoption. The workgroup also made recommendations regarding compliance monitoring and enforcement of the standards. Finally, the workgroup offered some insights about the benefits and challenges of having Community Service Boards (CSBs) serve as the primary provider of jail based mental health services. The 14 recommended minimum standards for behavioral health/mental health presented in this report include:

1. Access to Care - Inmates have access to care to meet their mental health needs.
2. Policies & Procedures - The facility has a manual or compilation of policies and defined procedures regarding mental health care services which may be part of larger health care manual.
3. Communication of Patient Needs - Communication occurs between the facility administration and treating mental health care professionals regarding inmates' significant mental health needs.
4. Mental Health Training for Correctional Officers - A training program established or approved by the responsible health authority in cooperation with the facility administration guides the mental health related training of all correctional officers who work with inmates.
5. Mental Health Care Liaison - A designated, trained mental health care liaison coordinates the health services delivery in the facility on those days when no qualified health care professionals available for 24 hours.
6. Medication Services - Medication services are clinically appropriate and provided in a timely, safe and sufficient manner.

7. Mental Health Screening - Mental health screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met.
8. Mental Health Assessment - All inmates receive mental health screening; inmates with positive screens receive a mental health assessment.
9. Emergency Services - The facility provides 24 hour emergency mental health services.
10. Restrictive Housing - When an inmate is held in restrictive housing, staff monitor his or her mental health.
11. Continuity & Coordination of Health Care During Incarceration - All aspects of health care are coordinated and monitored from admission to discharge.
12. Discharge Planning - Discharge planning is provided for inmates with mental health needs whose release is imminent.
13. Basic Mental Health Services - Mental health services are available for all inmates who need services.
14. Suicide Prevention Program - The facility identifies suicidal inmates and intervenes appropriately.

OVERVIEW OF THE PROBLEM

It is generally well accepted that there is a higher prevalence of individuals with behavioral health disorders in jails and prisons than in the general public. While the National Institute of Mental Health (NIMH) estimates that approximately 4.2% of adults in the United States suffer from serious mental illness (generally defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities), comparable figures in state prisons and jails are 16 percent and 17 percent, respectively[1]. In Virginia, per the annual Mental Illness in Jails survey conducted by the State Compensation Board, approximately 18 percent of jail inmates have a mental illness, and roughly 54 percent of those have a serious mental illness[2]. This data suggests the prevalence rate for serious mental illness in Virginia jails is at least double that of what is found in the community. It should be noted that the reported rate of serious mental illness in Virginia jails is significantly lower than that reported in other states in national research projects. It's unclear whether this is a reflection of the reality in Virginia jails or whether there are other factors effecting the accuracy of reporting. Regardless, the percentage of individuals with SMI in Virginia jails is double that in the community, despite the fact there are no known strong correlations between the existence of serious mental illness and criminal behavior.

Individuals living with serious mental illness and co-occurring disorders are at greater risk for being incarcerated and often remain incarcerated for longer periods of time than their counterparts in the general population[3] . Although research has shown that the symptoms of mental illness have a weak correlation with criminal behavior, offenders with mental illness are still overrepresented in the criminal justice system[4]. Stigma and discrimination likely play a role, as well as other factors including flaws across multiple systems not able to respond to the unique needs of individuals with behavioral health issues. Consider the following research[5]:

- **Likelihood of Arrest**: the probability of being arrested is greater for suspects exhibiting symptoms of a mental disorder (Teplin, 1984)
- **Bail:** many individuals with mental illness have no source of funds and may be detained because they cannot post even very low bail and are not offered release on personal recognizance (Health and Hospitals Corporation, New York City, 1998)
- **More Serious Charges:** Persons with mental illness will often be charged with more serious crimes than other people arrested for similar behavior (Hochstedler, 1987, New York State Office of Forensic Mental Health Taskforce, 1991)

[1] Substance Abuse and Mental Health Services Administration. Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide. (SMA)-16-4998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.
[2] Virginia State Compensation Board, 2017 Mental Illness in Jails Report (See Appendix A)
[3] Munetz M.R., Grande T.P., Chambers, M.R., The Incarceration Of Individuals With Severe Mental Disorders. Community Mental Health Journal. 37(4):361-72, 2001.
[4] How Often And How Consistently DO Symptoms Directly Precede Criminal Behavior Among Offenders With Mental Illness. Accessible at: http://www.apa.org/pubs/journals/releases/lhb-0000075.pdf
[5] Working with People with Mental Illness Involved in The Criminal Justice System: What Mental Health Service Providers Need to Know. Accessible at: http://www.ce-credit.com/articles/100933/Massaro.pdf

- **Stiffer Sentences:** People with mental illness are charged, convicted and sentenced more severely than other people convicted of similar crimes (Hochstedler, 1987, Axelson, 1992, New York State Office of Forensic Mental Health Taskforce, 1991)
- **Time in Jail:** Persons with mental illness spend two to five times longer in jail than persons without mental illness (Criminal Justice/Mental Health Consensus Project, 2003)
- **More Fights, Prison Infractions and Sanctions**: In prison, people with mental illness are involved in more fights, more likely to be charged with prison infractions, and more likely to be sanctioned for prison infractions (Ditton, 1999)
- **Time in Prison:** Persons with mental illness in state prison can be expected to serve 15 months longer than other inmates with similar charges and sentences (Ditton, 1999)

Over the past 10 years Virginia has made considerable strides to better understand how individuals with mental illness flow through local criminal justice systems, where gaps in service exist, and where specific systems and processes could be improved to ensure better coordination and continuity of care. One particular area of concern that has been consistently cited is the need for standards of care provided to individuals with behavioral health disorders who are incarcerated in local and regional jails, which is the focus of this report.

Prevalence Rates of Mental Illness in Virginia's Local and Regional Jails

The Virginia State Compensation Board (SCB) conducts an annual, point in time, survey of all local & regional jails to estimate the number of persons with behavioral health challenges who are incarcerated. The survey is mandated by budget language and DBHDS collaborates with the SCB in the development and refinement of the survey. SCB has conducted the surveys since 2008 thus Virginia has a decade worth of data about the prevalence rates of behavioral health challenges in jails. The survey gathers data on the number of individuals suspected of having any mental illness and those suspected of having a serious mental illness. For the purposes of the survey mental illness is defined as "an individual who has been diagnosed with schizophrenia or a delusional disorder, bi-polar or major depressive, mild depression, an anxiety disorder, posttraumatic stress disorder (PTSD), or any other mental illness as set out by the Diagnostic & Statistical Manual of Mental Disorders (DSM-V), published by the American Psychiatric Association, or those inmates who are suspected of being mentally ill but have received no formal diagnosis.". For the purposes of the survey serious mental illness is defined as "A serious mental illness includes diagnoses of schizophrenia/delusional, bi-polar/major depressive or post-traumatic stress disorder". The survey has undergone multiple revisions to better understand the population and how local and regional jails respond to their needs. Despite the many projects and initiatives that have occurred over the last decade to reduce the rates of incarceration for individuals with behavioral health disorders, the number of individuals reported as having a mental illness continues to grow. Whether this is a result of increased awareness, more accurate data collection, or an increase in the rates of individuals with behavioral health disorders being sent to jail is unknown. What we do know, per the SCB survey, is that the numbers are high and continue to rise (See Appendix A for 2017 Mental Illness in Jails Report).

In 2017, nearly 18 percent of inmates incarcerated in Virginia's jails were known or suspected to be mentally ill. Of that group, 54 percent had been diagnosed with a Serious Mental Illness[6].

[6] Virginia State Compensation Board, 2017 Mental Illness in Jails Report (See Appendix A)

Despite a variety of efforts to address the growing number of inmates with behavioral health disorders across Virginia, local and regional jails continue to struggle to provide for the behavioral healthcare needs of individuals placed into their care. The table below highlights the growth (both in terms of overall number of individuals as well as percentage of the jail population) in both the numbers of individuals suspected of having any form of behavioral health challenges and those suspected of having a serious mental illness. It is unclear how much of this "growth" can be attributed to actual increase in the number of individuals with mental illnesses in Virginia jails vs. improved identification of those individuals with mental health challenges. Regardless, the chart below shows that a relatively large portion of individuals in jail are suspected of having some form of mental illness.

Year	# of Individuals suspected of having any mental illness	% of total jail population suspected of having any mental illness	# of Individuals suspected of having a serious mental illness	% of total jail population suspected of having a serious mental illness
2017	7,451	17.63%	4,036	9.55%
2016	6,554	16.43%	3,355	8.41%
2015	7,054	16.81%	3,302	7.87%
2014	6,787	13.95%	3,649	7.50%
2013	6,346	13.45%	3,553	7.53%
2012	6,322	11.07%	3,043	5.33%

Virginia's jails are ill prepared to respond to the unique needs of individuals with behavioral health disorders. Although some jails have specialized programs and staff, most jails do not due to a lack of funding and resources. A 2014 Review of Mental Health Services in Local and Regional Jails conducted by the Office of the State Inspector General (OSIG) highlighted many of the challenges to include lack of available treatment capacity to address the needs, lack of continuity of care between the community and jail, lack of consistent screening processes, and environmental issues which at times are inconsistent with the treatment needs of individuals in the jails' custody (See Appendix B). The OSIG made many recommendations to address the challenges (some of which have been done) and notably included the establishment/adoption of standards for behavioral health services provided in the jail.

According to the State Compensation Board's 2017 Mental Illness in Jails report, the total annual cost of mental health treatment across Virginia's Jails was estimated at approximately $16.1 million, with 76 percent of costs funded by the locality, 6 percent funded by the state, 2 percent funded by the federal government, and 15 percent by "other" funding sources. Since the majority of funding (76 percent) comes from the locality, regional jails and local jails that serve wealthier localities tend to have more resources than smaller jails serving rural areas. The quality, type, and frequency of mental health treatments and services vary across Virginia's jails. Some jails may have a full time psychiatrist or general practice physician (MD), while others may contract with outside professionals to have services on certain times/days of the week or month. Community Service Boards (CSBs) are the primary behavioral health care providers for Virginia jails, but they are not statutorily obligated to provide behavioral health services beyond pre-screening inmates who may be in need of a temporary detention order (§19.2-169.6). Although on average the CSB is the most often used provider of mental health treatment, use of the local CSB as the primary treatment provider is most prevalent in jails in the Central Region. In the Eastern

and Western Regions the largest overall provider of treatment is still private contractors. This provider arrangement seems to stem from both budget and/or resource constraints of the local CSBs in those regions combined with the preference/budget constraints of the local or regional jail.

"The Virginia system is the most peculiar one in the nation. The grounds and buildings are owned by the counties and cities, the jails are operated by the sheriffs and city sergeants, authority is divided between these officials and the county supervisors or town councils and the circuit or corporation courts, and the state pays the cost of keeping the prisoners. ...The State, although paying the bills, has no actual authority over the jails other than the power of inspection and recommendation by the Department of Public Welfare, truly an anomalous situation". - Virginia Legislative Jail Commission, 1937

In addition to inconsistent resources, there is no *legally mandated* minimum standard of mental health care required, in part due to the fact that in Virginia there is no single authority responsible for the operation of local and regional jails. Each jail operates under the authority of an elected official (a Sheriff, in the case of a local jail) or a Superintendent (in the case of a regional jail) and a handful of other authorities, each providing oversite of a particular aspect of the jails overall operations.

A Review of the Organization and Oversite of Local and Regional Jails

Unlike other States where a singular entity or authority has control over the operations of its local and regional jails, there is no singular entity with ultimate administrative authority in Virginia. Instead, several state agencies share oversight responsibilities. In 2010, the Research Division of the Department of Criminal Justice Services (DCJS) published a report titled, '*Virginia's Peculiar System of Local and Regional Jails*', which provides an excellent overview of our Commonwealth's local and regional jail oversite system. While the quote to the right is outdated and does not fully reflect the current status of jails, some of the peculiarities still exist and exemplify the challenges. Below are a few excerpts from the DCJS Report[7]:

- The Board of Corrections (BOC) sets the "standards for the construction, equipment, administration and operation" of jails. The BOC can decertify a jail if the sheriff or jail administrator does not comply with life, health, and safety standards set forth by the BOC within the time allotted, and the Board can begin the process of closing the facility in conjunction with an appropriate circuit court. (p.4)

- The Department of Corrections (DOC) monitors the jails' compliance with BOC standards through monitoring visits, annual inspections, and accreditation and certification audits. Jails must meet BOC standards to be certified by DOC. (p.4)

- The State Compensation Board (SCB) provides the state portion of operating costs for jails, including salaries and benefits of correctional officers and support staff, costs for

[7] Commonwealth of Virginia - Virginia's Peculiar System of Local and Regional Jails. Accessible at: https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/research/virginias-peculiar-system-local-and-regional-jails.pdf

certain programs and services, and office expenses. Additionally, the Compensation Board dispenses inmate per diem payments. As part of fulfilling this role, the SCB maintains the LIDS database, which tracks persons entering and exiting jails, for the purpose of determining appropriate per diem levels. (p.4)

- The Department of Criminal Justice Services (DCJS) establishes "compulsory minimum entry-level, in-service, and advanced training standards for persons employed as deputy sheriffs and jail officers by local criminal justice agencies." (p.4)

- The Department of Health inspects jails to ensure that the kitchen facilities comply with the state's Food Regulations, and that all areas of the facility comply with BOC standards of facility cleanliness. (p.4)

Although it is not mandatory in Virginia, a number of jails have gone beyond what is minimally required and have become accredited facilities (a recommendation of the 2014 OSIG report). Two national organizations, the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) are the two primary correctional accrediting organizations. Accreditation is achieved by adhering to standards set by the accrediting agency and compliance verification through site visits, interviews, charts and administrative record reviews, and observing how jail medical facilities operate[8].

The Current Status of Behavioral Health Care Standards in Virginia Jails

As stated earlier, minimum standards for mental health care do not currently exist for Virginia's local and regional jails. Unless a jail opts to seek accreditation through a national accrediting agency and agree to adhere to that agency's standards, jails simply need to meet the life, health, and safety standards established by the Virginia Board of Corrections. The Virginia Board of Corrections has oversite of 43 life, health, and safety standards and of those standards, only 11 relate either directly or indirectly to incarcerated individuals with behavioral health needs. Below are the 11 standards that relate in some way to incarcerated individuals with behavioral health disorders.

LIFE, HEALTH, SAFETY STANDARD
6VAC15-40-320. Licensed Physician – A licensed physician shall supervise the facility's medical and health care services. Facilities that contract with private medical facilities or vendors shall maintain a current copy of the agreement, unless employed by the facility.
6VAC15-40-340. Health Care Provider and Licensing, Certification and Qualification of Health Care Personnel – Each facility shall have a minimum of one licensed or qualified health care provider who is accessible to inmates a minimum of one time per week. Health care personnel shall meet appropriate and current licensing, certification, or qualification requirements.
6VAC15-40-360. Twenty-Four Hour Emergency Medical Care - Written policy, procedure, and practice shall provide 24-hour emergency care medical and mental health care availability.

[8] See: Jails Inadvertent Health Care Providers: Accessible at: http://www.pewtrusts.org/~/media/assets/2018/01/sfh_jails_inadvertent_health_care_providers.pdf

LIFE, HEALTH, SAFETY STANDARD
6VAC15-40-370. Receiving and Medical Screening of Inmates - Written policy, procedure, and practice shall provide that receiving and medical screening be performed on all inmates upon admission at the facility. The medical screening shall: 1. Specify screening for current illnesses, health problems and conditions, and past history of communicable diseases; 2. Specify screening for current symptoms regarding the inmate's mental health, dental problems, allergies, present medications, special dietary requirements, and symptoms of venereal disease; 3. Include inquiry into past and present drug and alcohol abuse, mental health status, depression, suicidal tendencies, and skin condition; and 4. For female inmates, include inquiry into possible pregnancy or gynecological problems. 5. All inmates shall receive a tuberculosis (TB) skin test within seven days of admission to the facility.
6VAC15-40-380. Inmate Access to Medical Services - Written policy, procedure, and practice shall be developed whereby inmates can be informed, at the time of admission to the facility, of the procedures for gaining access to medical services.
6VAC15-40-400. Management of Pharmaceuticals - Written procedures for the management of pharmaceuticals shall be established and approved by the medical authority or pharmacist, if applicable. Written policy, procedure, and practice shall provide for the proper management of pharmaceuticals, including receipt, storage, dispensing and distribution of drugs. These procedures shall be reviewed every12 months by the medical authority or pharmacist. Such reviews shall be documented.
6VAC15-40-420. Transfer of Summaries of Medical Record – Medical record summaries shall be transferred to the same facility to which the inmate is being transferred. Required information shall include: vital signs, current medications, current medical/dental problems, mental health screening, mental health problems, TB skin test date and results, special inmate needs/accommodations, pending medical appointments, medical dispositions, overall comments, health care provider/personnel signature and date, and any additional pertinent medical information such as lab work, x-rays, etc.
6VAC15-40-450. Suicide Prevention and Intervention Plan – There shall be a written suicide prevention and intervention plan. These procedures shall be reviewed and documented by an appropriate medical or mental health authority prior to implementation and every three years thereafter. These procedures shall be reviewed every 12 months by staff having contact with inmates. Such reviews shall be documented.
6VAC15-40-1010. Mental Health Inmates - Written policy, procedure, and practice shall specify the handling of mental health inmates, including a current agreement to utilize mental health services from either a private contractor or the community services board.
6VAC15-40-1030. Assessment of Inmates in Disciplinary Detention or Administrative Segregation –Written policy, procedure, and practice shall require that a documented assessment by medical personnel that shall include a personal interview and medical evaluation of vital signs, is conducted when an inmate remains in disciplinary detention or administrative segregation for 15 days and every 15 days thereafter. If an inmate refuses to be evaluated, such refusal shall be documented.
6VAC15-40-1040. Staff Training – The facility shall provide for 24-hour supervision of all inmates by trained personnel.

While the standards do provide some general guidance on how healthcare (to include behavioral healthcare) should be provided, the standards provide very little guidance about the scope of services, robustness of services, and timelines for providing services. As is plainly evident, the existing standards mostly address the existence of policies about services but do not provide any details about compliance indicators. While jails are subject to routine reviews by the BOC/DOC those reviews tend to focus mainly on the safety standards and do not routinely delve into the behavioral health/health standards. This is partly due to the fact that the DOC accreditation division is staffed with staff who while competent in reviewing jails safety/operational practices often lack the expertise to fully assess the quality of behavioral health services being provided in the jail.

Why MH Standards, Why Now?

The establishment of this workgroup to help draft behavioral healthcare standards was the culmination of many different factors. As mentioned earlier in this report DBHDS has been actively involved in addressing the intersection of criminal justice and behavioral health for the last two decades. Over the last 10 years there has increasing interest and emphasis on the need to address the challenge of over-representation of individuals with SMI in the criminal justice system within the three branches of government both at the state level but also at the federal level. In addition to increased interest, there has been markedly improved collaboration and partnerships between the criminal justice and behavioral health leaders at both the local and state level. While some of these partnerships developed decades ago, it was with the joint venture by behavioral health & criminal justice with the Cross Systems Mapping initiative that we witnessed the forging of strong partnerships and collaboration in most communities. Beginning with the Cross Systems Mapping initiative we also began to witness strengthening in the state/local collaboration and partnerships which culminated in the formation of the Center for Behavioral Health & Justice (CBHJ) in 2015.

While ultimately the CBHJ ceased to exist, the established partnerships/collaboration endured thus facilitating the establishment of this workgroup. During the winter of 2017 and 2018 legislative sessions, there appeared to be much interest in addressing the behavioral health needs of individuals involved in the criminal justice system. Through budget language the General Assembly mandated universal behavioral health screening in all jails, tasked DBHDS with making recommendations regarding discharge planning for individuals with SMI from jail, tasked SCB with studying the costs associated with completing standardized behavioral health assessments within 72 hours of screening, and tasked DMAS with studying the costs/benefits and challenges of linking individuals with SMI leaving jails with Medicaid (if they qualified) or the Governor's Access Plan (GAP). In addition, six pilot behavioral health programs in local/regional jails were funded. Both the Joint Commission on Health Care (JCHC) and SJ47 were tasked with reviewing the issues around individuals with SMI involved in the criminal justice system.

Additionally, in the 2018 Session there were two bills (SB878/ Dunnavant & HB1487/ Stolle) which among other things would have required the establishment of behavioral healthcare standards in jails. While ultimately those bills were left in appropriations/ carried over, it became clear that there was growing interest in the establishment of standards. Given the increased interest, coupled with the fact there were legislative groups grappling to address the needs of individuals with SMI involved in the criminal justice system, and the strongly forged relationships the timing seemed ripe to attempt to reach consensus on minimum standards for behavioral healthcare in local/regional jails.

In March/April 2018 DBHDS established the workgroup. The workgroup was comprised of senior level leadership as well as front line staff and included representation from public safety, behavioral health, family and consumer advocates (See Appendix C for the names and titles of workgroup members). Members were selected due to their known interest in this issue. A conscious attempt was made to include members from both urban and rural jurisdictions, from large & small CSBs, from local & regional jails, and to include advocates who could bring a counterbalancing perspective. The purpose of the Workgroup was to build on efforts that had previously been done across the state and to further explore the following questions:

1. *What are the existing standards of care being implemented across Virginia's local and regional jails?*
2. *What is working well, what is not?*
3. *What can we recommend as acceptable minimum standards of care?*
4. *What would be required to adopt the recommended minimum standards?*
5. *What are the foreseeable barriers to implement each standard?*
6. *What agency/entity should be responsible for ensuring compliance to providing minimum standards of care?*
7. *What are the advantages and disadvantages of requiring the Community Services Boards (CSBs) to be the provider of behavioral health care services in jails*

The workgroup met during the Spring/Summer of 2018. While not every member attended every meeting there was good cross discipline participation in each meeting and members were given work products to review. The group operated under a consensus model for decision making and ultimately there seemed to be a lot of consensus on most issues. The workgroup was clearly passionate about the subject matter and despite knowing ultimately we had no authority to mandate adoption of the standards, members were very invested in providing a comprehensive list of minimum standards. There was clear consensus that while some of the standards could be achieved with little to no infusion of new resources, implementation of some of the standards would require the infusion of new funds/resources. The group also made clear that while funding was essential there were also practical workforce challenges which would need to be addressed. Additionally, there was broad consensus that in order for there to be true improvement, a system of oversight/ compliance monitoring would need to be established and funded. Finally, there was consensus that meeting the standards SHOULD NOT become an unfunded mandate from the state to localities.

At the conclusion of the workgroup, **14 Mental Health Standards** were agreed upon, each complete with compliance indicators, barriers to implementation, resources needed, and other costs and considerations. The workgroup utilized standards recommended by the National Commission on Correctional Heath Care (NCCHC) but then modified them to address the unique needs and challenges facing Virginia jails. Below is a summary of each standard:

MENTAL HEALTH STANDARDS FOR VIRGINIA'S LOCAL AND REGIONAL JAILS

In line with the actions of the 2018 General Assembly intending to reduce involvement of individuals with behavioral health disorders in the criminal justice system, the Mental Health Workgroup respectfully submits the following standards for consideration:

Standard #1: ACCESS TO CARE Inmates have access to care to meet their mental health needs.
Compliance Indicators The responsible health authority (RHA) identifies and elevates any barriers to inmates receiving health care.
Status/ Barriers to Implementation: None identified. Jails routinely monitor their internal processes to identify systemic issues which impede access to care. Lack of staffing is often a barrier to care, but there are no easy resolutions to this.

Standard #2: POLICIES AND PROCEDURES The facility has a manual or compilation of policies and defined procedures regarding mental health care services which may be part of larger health care manual.
Compliance Indicators 1. Mental Health care policies are site specific. 2. Each policy and procedure in the mental health care manual is reviewed at least annually and revised as necessary under the direction of the responsible health authority (RHA). The manual bears the date of the most recent review or revision and, at a minimum, the signatures of the facilities RHA and responsible physician. 3. The manual or compilation is accessible to mental health staff. 4. All aspects of the standard are addressed by written policy and defined procedures.
Status/ Barriers to Implementation: Most jails likely already have something similar in place thus this should not be a difficult standard to implement. State would need to provide sample manual with sample best practices.

Standard #3: COMMUNICATION OF PATIENTS NEEDS Communication occurs between the facility administration and treating mental health care professionals regarding inmates' significant mental health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or safety of the institution/staff. Communication is bi-directional and occurs on a regular basis either through planned meetings or impromptu meetings as the need arises.
Compliance Indicators 1. Correctional staff are advised of inmates' mental health needs that may affect housing, work and program assignments; disciplinary measures; and admissions to and transfers from institutions. Such communication is documented. 2. Mental health providers and custody staff regularly communicate about the mental health needs of inmates. 3. All aspects of the standard are addressed by written policy and defined procedures.
Status/ Barriers to Implementation: Most jails likely already have this in place thus this should not be a difficult standard to implement. Some jails may need to formalize their processes. 42 CFR can become a barrier for those who have SA issues. Will need to share best practices and will require Memorandum of Understanding or Business Associates Agreement in order to facilitate information sharing. Need to ensure there is internal communication across shifts. State should provide template MOU/ BAA. Additional case worker positions would be helpful/ essential in many jails. (See Appendix D for Council for State Government publication on information sharing in criminal justice).

Standard #4: MENTAL HEALTH TRAINING FOR CORRECTIONAL OFFICERS
A training program established or approved by the responsible health authority in cooperation with the facility administration guides the mental health related training of all correctional officers who work with inmates.

Compliance Indicators

1. Correctional officers who work with inmates receive mental health related training at least every 2 years. This training includes, at a minimum:
    a. Recognizing the need for emergency care and intervention during a mental health crisis
    b. Recognizing acute manifestation of intoxication and withdrawal, and adverse reaction to medications
    c. Recognizing signs and symptoms of mental illness
    d. Procedures for suicide prevention
    e. Procedures for appropriate referral of inmates with mental health concerns to staff
2. An outline of the training including course content and length is kept on file.
3. A certification or other evidence of attendance is kept on site for each employee.
4. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their mental health related trainings.
5. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: Officers already receive some basic mental health training in the academy (and in some locations on an annual basis). Some jails have implemented Crisis Intervention Training (CIT) for officers; whereas others have implemented Mental Health First Aid (or similar program). While CIT may be the "gold standard", it may be sufficient for most officers to have mental health first aid (or similar training). Need to work with DCJS on training standards to ensure what is being taught in the academy and provides officers with the necessary skills. There would be a cost to train everyone initially. Then there would be ongoing costs to train new staff. Notable that CIT would be more expensive as it requires facility to send staff for 40 hour training class. Jails would also need to build up cadre of trainers. MHFA is shorter, thus less expensive to train but would come with some costs for staff to attend training and trainer costs.

Standard #5. MENTAL HEALTH CARE LIAISON
A designated, trained mental health care liaison coordinates the health services delivery in the facility on those days when no qualified health care professionals available for 24 hours. The liaison can be a supervisory correctional staff member or any designated staff member as long as they have received training on their role and have the authority to intervene when situations arise.

Compliance Indicators

1. The mental health care liaison is instructed in role and responsibilities by the responsible physician or his or her designee.
2. A plan is in place that tells custody staff what to do when a mental health situation arises when other mental health staff are not present.
3. The mental health care liaison receives instruction in and maintains confidentiality of the

patient information.
4. Duties assigned to the mental health care liaison post are appropriately carried out.
5. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: In small facilities this may be more challenging to make sure they have sufficient coverage afterhours and on weekends. Workgroup acknowledged that while this would be an ideal standard, it is less critical than the rest of the standards, thus could be considered a best practice but not necessarily a minimum standard.

Standard #6. MEDICATION SERVICES

Medication services are clinically appropriate and provided in a timely, safe and sufficient manner - within 48hrs (unless there is data/evidence to suggest a more timely intervention is needed) there will have been an evaluation of the situation either by nurse, PA, etc. to develop a medication plan which could include referral to a physician and prescriptions (as indicated).

Compliance Indicators

1. Prescription medications are administered or delivered to the patient only on the order of a physician, nurse practitioner, physician's assistant or other legally authorized individual.
2. Medications are delivered in a timely fashion. The facility has a policy identifying the expected time frames from ordering to delivery and a backup plan if the time frames cannot be met.
3. The responsible physician determines prescribing practices in the facility (consider security implications).
4. Medications are prescribed only when clinically indicated.
5. Inmates entering the facility on prescription medication continue to receive the medication in a timely fashion and as prescribed, or acceptable alternative medications are provided as clinically indicated. This process should happen quickly so as to avoid missed medications (which could result in psychiatric decompensation).
6. The ordering clinician is notified of the impending expiration of an order so that the clinician can determine whether the drug administration is to be continued or altered.
7. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: Most jails are already doing this although some likely would struggle to meet the 48 hour requirement. Might be able to use telepsychiatry to help jails meet the standard. There are many variables which affect how feasible this is to accomplish. Best practice standard would be to have a method of communication between the jail/CSB to determine if individual was a client of CSB and what current medication regimen is.

Standard #7. MENTAL HEALTH SCREENING

Mental health screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met.

Compliance Indicators

1. Intake personnel ensure mental health screening occurs and those that screen positive are referred for further assessment.
2. A mental health screening takes place for all inmates as soon as possible.
3. The mental health screening tool shall be one designated by the Commissioner of DBHDS.
4. The disposition of the inmate (e.g., immediate referral to services, placement in the general population) is appropriate to the findings of the mental health screening and is

indicated on the screening form.

5. Mental health screening forms are dated and timed immediately on completion and include the signature and title of the person completing the form.
6. Screening includes identification of prescribed medications.
7. Correctional personnel performing the mental health screen shall be trained in the use of the screening tool and appropriate referral processes.
8. Mental health staff/ mental health provider/designee regularly monitors screenings to determine the effectiveness of this process.
9. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: Uniform screening processes were mandated by the GA via budget language effective July 1, 2017. DBHDS provided web-based training on screening and copy of training is located on DBHDS website. Most jails should already be meeting this standard. SCB has indicated they will audit for compliance when they perform their audits of jails (although they do not audit every jail, every year). Notably, no data is being collected on the results of screening at this time.

Standard #8. MENTAL HEALTH ASSESSMENT

All inmates receive mental health screening; inmates with positive screens receive a mental health assessment.

Compliance Indicators

1. Within 14 days of admission to the correctional system, a qualified mental health professional or mental health staff conducts an assessment on those inmates scoring positive on the initial mental health screen. Those individuals who are in acute mental health distress should be seen more quickly (within 48 hours). Those individuals who appear suicidal should be assessed immediately.
2. The mental health assessment includes a structured interview with inquiries into:
    a. A history of:
        I. Psychiatric hospitalization and outpatient treatment
        II. Substance use treatment
        III. Detoxification and outpatient treatment
        IV. Suicidal behavior
        V. Self Injurious Behavior
        VI. Violent behavior
        VII. Victimization / traumatic experiences
        VIII. Special education placement
        IX. Cerebral trauma or seizures
        X. Sex offenses
        XI. Gender Dysphoria or Gender Identity issues.
    b. The current status of:
        I. Psychotropic medications
        II. Suicidal ideation
        III. Drug or alcohol use and substance use treatment
        IV. Orientation to person, place and time

c. Emotional response to incarceration
d. A history of issues with cognitive impairments, learning disabilities, deficits in adaptive functioning.
e. History of benefits and entitlements

3. The health record contains results of the assessment with documentation of referral or initiation of treatment when indicated.
4. Patients who require acute mental health services beyond those available on site are transferred to an appropriate facility.
5. There is a written policy and defined procedures addressing the postadmission mental health screening and evaluation process.

Status/ Barriers to Implementation: State Compensation Board worked on a plan for implementation during 2017. Priority populations for those who need to be seen sooner should be developed. Ideally would want licensed professional conducting these assessments, but there is a statewide shortage of licensed professionals and they cost more to hire. Tele psychiatry may be necessary. Explore carve out/ exemption option for jails who are unable to hire/retain licensed professionals. Plan to use QMHPs to perform more general (non-diagnostic assessments) with processes to refer individuals to qualified/licensed staff when there clearly is a significant mental health issue.

Standard #9. EMERGENCY SERVICES
The facility provides 24 hour emergency mental health services.

Compliance Indicators

1. A written plan includes arrangements for the following, which are carried out when necessary:
   a. Emergency transport of the patient from the facility
   b. Use of an emergency medical vehicle
   c. Use of one or more designated hospital emergency departments or other appropriate facilities
   d. Emergency on call physician or mental health services when the emergency health care facility is not nearby
   e. Security procedures for the immediate transfer of patients for emergency mental health care
   f. Notification to the person legally responsible for the facility
2. A written plan that includes the process and procedure for contacting the responsible CSB to request a pre-admission screening (documentation of agreement to plan).
3. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: Most jails are likely already meeting this standard. No known new resources needed to implement this standard.

Standard #10. RESTRICTIVE HOUSING
When an inmate is held in restrictive housing, staff monitor his or her mental health

Compliance Indicators

1. Upon notification that an inmate is placed in restrictive housing, a qualified mental health care professional (RN/LPN/QMHP or other health professional can conduct rounds) reviews the inmates mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation. It should be noted that at

times placement in restrictive housing may be detrimental to an individual's mental health the overall security needs and safety of the individual, other individuals, and staff may necessitate the continued placement in a restrictive housing setting. In such cases, mental health staff shall try to identify strategies to minimize the deleterious effects of restrictive housing. Such review is documented in the health record.

2. The mental health professionals monitoring of an inmate in restrictive housing is based on the degree of isolation:
   a. Inmates who are in restrictive housing and have limited contact with staff or other inmates are monitored every day by medical or mental health staff
   b. Inmates who are allowed periods of recreation or other routine social contact among themselves while being held in restrictive housing are checked weekly by medical or mental health staff
   **Depending on clinical judgment the frequency of contacts could be altered. Evaluation by mental health professional does not substitute for required checks by correctional officers.
3. Documentation of restrictive housing rounds is made on individual logs or cell cards, or in an inmates health record and includes:
   a. The date and time of the contact
   b. The signature or initials of the health staff member making the rounds
4. Any significant mental health findings are documented in the inmates' health record.
5. Medical and mental health staff promptly identify and inform custody officials of inmates who are physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health.
6. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: Some jails lack a sufficient supply of trained, qualified mental health professionals to complete these functions. Even if funding is addressed, there may be a shortage of qualified professionals in the Commonwealth who are willing and able to complete these functions. This standard is elevated from existing BOC standards and would require more resources.

Standard #11. CONTINUITY AND COORDINATION OF HEALTH CARE DURING INCARCERATION

All aspects of health care are coordinated and monitored from admission to discharge.

Compliance Indicators

1. Clinician orders are evidence based/evidence informed, are consistent with current standards of care, and are implemented in a timely manner.
2. Deviations from standards of practice are clinically justified, documented and shared with the patient.
3. Diagnostic tests, if indicated, and completed and reviewed by the clinician in a timely manner.
4. Treatment plans may be modified as clinically indicated by diagnostic tests and treatment results.
5. Treatment plans, including test results, are shared and discussed with patients.
6. Patients are reviewed by a qualified provider upon return from a hospitalization, urgent care, or emergency department visit to ensure proper implementation of the discharge orders and to arrange appropriate follow up.
7. Recommendations from specialty consultations are reviewed and acted upon by the

clinician in a timely manner.
8. If changes in treatment recommendations are clinically indicated, justification for the alternative treatment plan is documented and shared with the patient.
9. Chart reviews are done to assure that appropriate care is ordered and implemented and that care is coordinated by all health staff including medical, dental, mental health and nursing.
10. The responsible provider determines the frequency and content of periodic health assessments based on protocols promulgated by nationally recognized professional organizations.
11. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: None. Most if not all jails are likely meeting this standard already.

Standard #12. DISCHARGE PLANNING
Discharge planning is provided for inmates with mental health needs whose release is imminent.

Compliance Indicators

1. For planned discharges, the provider:
    a. Arrange for a minimum of a two week supply of current psychotropic mediations + ideally script for a minimum of two weeks.
    b. Request signed releases of information so that treatment information can be sent to the next behavioral health provider (template of ideal MOU for information exchange – BAA. Include signing privacy notice).
    c. For inmates with serious medical or mental health needs, make arrangements or referrals for follow up services with community clinicians, including exchange of clinically relevant information. SMI is more complicated and requires cross agency, multiagency intervention and resources. Discharge planning services should follow the best standards from DBHDS prior report. Consideration should be given to making forensic patients a priority population for services. With Same Day Access this should be partly addressed by significantly reducing the wait time for a mental health assessment by the CSB in the community.
2. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: GA has partially funded the implementation of Forensic Discharge Planners (See Appendix E for report on Forensic Discharge Planning). Additional resources will be needed to implement statewide. It should be noted that implementation of 1a above will be a significant funding and resource issue. Some jails also have liability concerns about discharging individuals with such a large supply of medications. Further funding of all the recommended STEP VA services would be needed to build out the community resources required to provide sufficient community based services.

Standard #13. BASIC MENTAL HEALTH SERVICES
Mental health services are available for all inmates who need services.

Compliance Indicators

1. Patients mental health needs are addressed on site or by referral to appropriate alternative facilities. They are addressed by a range of mental health services of differing levels and focus, including residential components when indicated.

2. Regardless of facility type or size, basic on site outpatient services include, at a minimum:
   a. Identification and referral of inmates with mental health needs
   b. Crisis intervention services
   c. Psychotropic medication management, when indicated
   d. Treatment documentation and follow-up

   When available:
   e. Individual counseling, group counseling and psychosocial/psychoeducational programs
3. Those who require transfer to an inpatient psychiatric setting is clinically indicated, required procedures are followed and the transfer occurs in a timely manner. Until such transfer can be accomplished the patient is safely housed and adequately monitored daily.
4. Basic mental health services are offered as clinically indicated.
5. An attempt is made every 30 days to reengage individuals with a serious mental illness who have declined treatment.
6. Mental health, medical and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of any of these conditions on each other is adequately addressed.
7. All aspects of the standard are addressed by written policy and defined procedures.

Status/ Barriers to Implementation: Comprehensive analysis of costs will need to be completed.

Standard #14. SUICIDE PREVENTION PROGRAM
The facility identifies suicidal inmates and intervenes appropriately.

Compliance Indicators

1. A suicide prevention program includes the following:
   a. Facility staff identify suicidal inmates and immediately initiate precautions
   b. Suicidal inmates are evaluated promptly by the designated health professional who directs the intervention and assures follow up as needed
   c. Acutely suicidal inmates are placed on constant observation
   d. Non-acutely suicidal inmates are monitored on a random schedule with no more than 15 minutes between checks. If however the non-acutely suicidal inmate is placed in an isolation cell constant observation is required
2. Key components of a suicide prevention program include the following:
   a. Training
   b. Identification
   c. Referral
   d. Evaluation
   e. Treatment
   f. Housing and monitoring
   g. Communication
   h. Intervention
   i. Notification
   j. Review
   k. Debriefing
3. The use of other inmates in any way (e.g., companions, suicide prevention aids) is not a substitute for staff supervision.
4. When an inmate is taken off suicide precautions an assessment is completed to determine

if they remain at elevated future risk and if so then a plan is implemented to monitor and manage the ongoing risk.

5. The responsible health authority approves the facilities suicide prevention plan; training curriculum for staff, including development of intake screening for suicide potential and referral protocols, and training for staff conducing the suicide screening at intake.
6. All aspects of the standard are addressed by written policy and defined in procedures.

Status/ Barriers to Implementation: Most (if not all) jails have a suicide prevention program, however some may not be as robust as is recommended by these standards. (Especially as it pertains to assessment by mental health professionals). Some funding will be required to fully implement this standard.

COMPLIANCE MONITORING

There was consensus in the workgroup that while establishing standards was an important first step towards improving mental health services in jails, without a system of compliance monitoring the standards would simply be aspirational and would not markedly improve services in the jails. This sentiment was not an indictment of the commitment and passion of jail staff to do the right thing, but rather an acknowledgment that without compliance monitoring and with scarce resources; efforts to improve services would fall by the wayside. While admittedly, compliance monitoring alone does not guarantee that individuals will receive quality care, it does ensure some level of uniform access to care and provides a means to identify when an organization is at risk of not meeting the standards of care. Compliance monitoring is also a mechanism to share best practices, provide information about new practices, and to gather data/information to shape future standards.

The workgroup discussed which entity (ies) should provide the compliance monitoring for these standards. Ultimately, it was the consensus of the workgroup that because the Board of Corrections/Department of Corrections already accredits and re-accredits all jails via review of life, health, and safety standards that they were well situated to perform the compliance monitoring for these standards. With that being said, however, the group agreed that the current staffing of the BOC/DOC is insufficient to take on this new monitoring requirement and additionally the current auditing division lacks staff with expertise in mental health, which would be an essential qualification in order to truly monitor/enforce implementation of these standards. The BOC/DOC would need a relatively modest amount of funding to hire FTEs to join the existing compliance & accreditation teams.

ROLE OF THE COMMUNITY SERVICES BOARDS IN THE PROVISION OF MENTAL HEALTH SERVICES IN JAILS

Increasingly, over the last several years, the question about the role of the Community Services Boards (CSBs) in the provision of jail based mental health care has been raised. Discussions have centered on whether the CSB should provide more jail based treatment, differing relationships between the CSBs and the jails they work with, and whether CSBs should become the mandated provider of jail based services.

An important first step to addressing what the role of the CSBs in the provision of jail based mental health services should be to understand what CSBs are/are not mandated by the Code of Virginia and/or funded to do. The Code of Virginia does task the CSB with providing some basic core services – some of which are applicable to a jail setting. First the Code does recognize CSBs as the sole entity who can conduct Pre-Admission Screenings of individuals thought to be in need of involuntary inpatient psychiatric care (see §37.2-809). This role/duty also applies to persons in local/regional jails who are thought to be in need of involuntary, inpatient psychiatric care (see §19.2-169.6 A 2). Additionally, the CSBs are implicitly the designated provider of outpatient restoration of competency to stand trial services (either in the jails or in the community) pursuant to §19.2-169.2 B. The workgroup was unaware of any other code mandated functions of the CSBs relative to the provision of services to incarcerated individuals.

With regard to what services CSBs are obligated to provide via their Performance Contract with DBHDS relative to the state general funds they receive from the Department, the Performance Contract does require CSBs to provide: i) pre-admission screening for involuntary hospitalization; ii) discharge planning for individuals hospitalized in DBHDS facilities; and iii) case management services (to the degree funds are available). While indeed discharge planning (ii) above does include discharge planning for individuals leaving state hospital to return to jail, in practice it is often limited to briefly monitoring the individual's return to jail but often does not include ongoing monitoring/planning for the individual's ultimate release to the community (as often an actual release date is unknown). Currently there is no ongoing general funds allocated across the continuum of CSBs for the provision of jail based mental health services, although it should be noted DBHDS does provide some modest state general funds to select CSBs for criminal justice diversion services – which can include some jail based services. Additionally, there are six jails who did receive state general funds for jail based behavioral health service pilot programs. The funding was granted to the jails (not the CSBs). Most of the pilot projects do not provide comprehensive services to all inmates within the jail but rather targeted certain subsets of inmates in need of care (and who meet eligibility criteria). The General Assembly did allocate $1.6 million in FY '19 & again in FY '20 to fund forensic discharge planning in two jails which have high concentrations of individuals with serious mental illnesses. While it is anticipated this funding will have very positive effects, it is targeted funding to specific regions/localities for a portion of mental health treatment, rather than funding for the provision of the continuum of mental health care in the jail.

With regard to the disparity in services provided by CSBs to the jails they serve, as mentioned earlier in the report CSBs are only mandated to provide some minimal services in jails, and the bulk of funding for jail services is reported to be funded with local dollars not state dollars (albeit the state does fund a portion of staff positions via the State Compensation Board). Some localities have provided more funding to their jails for services (or have provided targeted funding to their CSBs to provide specific services), thus in those jails there are more services. In other localities, jails and CSBs are provided limited local funding thus there are minimal services in those jails. Generally speaking the lack of jail based services is not the lack of desire of the sheriff/jail administrator to have those services nor is it reflective of the CSB not wanting to

provide the services but rather it is reflective of the lack of a funding source for such services (especially because in most cases insurance plans will not pay for services rendered to incarcerated individuals) and because of lack of sufficient resources (i.e. licensed staff) for the CSB to provide for its Code mandated core services and in addition jail based services.

The workgroup embarked on identifying both the benefits and challenges/limitations of having the CSB as the designated provider of all mental health services in the jails.

Benefits of Having the CSB as the Provider of Jail Based Mental Health Services

- Enhanced Continuity of Care – Having the CSB as the provider would enhance continuity of care for those individuals being released from the jail (in cases where they are returning to the same community where the jail is located). This benefit would be less true in regional jails (where inmates come from various communities and thus would be returning to a community where the CSB had not been the provider of jail based services) and for those individuals arrested and jailed in communities away from their primary residence.
    - Sharing of records would be easier when individuals are released from jail (see caveats/exceptions above).
    - There would theoretically be a consistent formulary – thus the individual could access the same medications in the jail as he/she could access in the community. This is presuming the CSB could require the jail to adopt the CSB's formulary, which might have some cost implications.
    - There is a perception that many of the individuals with SMI who are in the jail are current or former CSB clients thus when they are arrested there would be easier access to prior treatment records which would overall enhance care.
    - As clients would have established relationships with their provider (from their time in jail) they may be more likely to keep their after-discharge appointment thus enhancing the likelihood they would remain treatment adherent in the long run, although it must be noted there are many factors which impact on an individual's level of treatment engagement/adherence.
- Indigent Care – As many of the individuals in jail are indigent, upon their release from the jail they will be dependent on indigent care, a portion of which is already provided by CSBs. However, it must be noted that funding for the indigent population is currently inadequate and would need to be addressed. Thus having the CSB as the provider of jail based mental health care will improve linkage of individuals in need of indigent care upon their release from jail.
- CSBs have a better understanding of the array of community based services thus are better equipped to link individuals to other social services (i.e. housing, food programs, etc.)
- By requiring the CSB to be the provider of jail based services more individuals will ultimately receive community based mental health services (as they will be linked and will

not need to wait for an intake appointment) and ultimately over time this might decrease the number of individuals in jails with SMI.

- CSBs are Code recognized entities which exist in all localities across the Commonwealth and are less prone to go bankrupt or stop providing services in the Commonwealth as are private provider companies. Additionally, CSBs are not for profit entities thus there is less likely to be large cost increases over time.
- CSBs have access to a broader array of services (i.e. PACT, clubhouse, permanent supportive housing) than do private providers and many individuals being released from jail are in need of these services. It must be noted, however, that some of these services are not reimbursed by Medicaid thus the CSBs likely would need a funding source to provide these services to more individuals.

Challenges/Limitations of Having the CSB as the Designated Provider of Mental Health Services in Jails

- Most CSBs are already struggling to recruit, hire, and retain a cadre of competent staff in particular licensed staff members for behavioral health and medical services and would be unable to provide sufficient staff to meet the needs of the jails.
- Many CSBs lack staff with specific expertise in providing forensic mental health services and are ill equipped to provide this unique service. While CSBs are experts in providing community based mental health services, most are unfamiliar with the challenges and special needs for providing such services in jails. There are significant cultural differences between the two environments and these differences could pose significant challenges for the CSBs.
- The target population in jail is broader than the population generally served by the CSBs. More specifically, often times individuals in jails identified as having mental health needs do not suffer from a psychotic or affective disorder (the current priority populations for most CSBs). Thus having the CSB as the provider of jail based services could result in the CSBs having to serve populations in the community that have not previously been considered priority, safety-net populations by the General Assembly in the past – thus further straining an already strained system.
- Jails often combine their medical services with their mental health services and pharmacy services in a broad contract for services. Requiring jails to contract with the CSB for mental health services could result in a cost increase in their medical/pharmacy contract as private contractors often give discounts for larger/bundled contracts. Jails would have to have a minimum of two providers (the CSB and the provider of medical services (as clearly CSBs are not medical providers and would be totally unable to provide medical services in jails) which could create more confusion due to having two separate medical/clinical records, potentially two formularies, and would require enhanced communication to address the entirety of needs of the individual.
- Currently the Code of Virginia requires the Sheriff/jail administrator to obtain the best value contract generally via a request for proposal. The Virginia Procurement Act/Code

of Virginia might need to be amended as at times the CSB might not be able to provide services that match the level of clinical need deemed by the CSB at a cost that is as low as behavioral health costs have traditionally been in the jail setting.

- Some CSBs are unfamiliar with providing day to day comprehensive quasi residential mental health services to include comprehensive nursing services, pharmacy services, immediate access to medical services etc. that would be required if the CSB were to be required to provide the jail based services.
- Some of the larger private providers are better able to recruit and retain qualified staff as they are not hampered by local hiring practices and local mandated pay scales which can hinder recruitment/retention.
- Ultimately, the workgroup agreed that while there clearly are some real benefits of requiring the CSB to be the provider of jail based mental health services, there are some real operational challenges/limitations to this approach. The work group did not feel a 'one size fits all' would work in the Commonwealth given the differing resources available across CSBs and the differing needs across jails. Rather, the workgroup opined that rather than focusing on who the provider should be, the most important step is to establish (and fund) some minimum standards and then ensure the standards are met regardless of who is the provider. Ultimately this will result in the overall improvement in wellbeing of those citizens who happen to become incarcerated.

DISCUSSION/CONCLUSIONS

Jails across the Commonwealth and across the country are designed to serve a public safety role in society. Their role is to incapacitate the individual by restricting his/her access to engage in criminal activities, to act as a deterrent for future criminal activities (for the individual and for society), to provide a means for retribution to society for the crimes committed, and to the degree possible provide for the rehabilitation of the individual so as to mitigate risk for future criminal behavior. Over time, the United States (and Virginia) has seen an increase in the number of individuals with behavioral health challenges incarcerated in jails. While the existence of a behavioral health disorder is not a factor which can or should necessarily preclude incarceration (and the above mentioned functions of incarceration), clearly if incarcerated the existence of a behavioral health condition does pose unique challenges for the jail in managing the inmate and addressing his/her needs. Failing to provide for the mental health needs of inmates undermines the core functions of incarceration. Releasing inmates with serious mental illness without having provided treatment and without solid aftercare plans places the individual and the community at heightened risk. In essence, providing good clinical treatment not only is the right thing to do, it is good public safety practice.

This report articulates the 14 minimum standards for mental health care for jails. It should be stressed these are minimum standards and jails/communities should strive not only to meet these standards but to exceed them. The workgroup included descriptive "performance indicators" so that there could be some uniformity/common understanding as to how to measure compliance with these standards. Obviously, if implemented, it will become necessary to build out these

compliance indicators to fully assess the continuum of care being provided in jails. This report also provides some general information about the current status of jails in meeting these minimum standards. This information was provided by members of the workgroup, who obviously do not have full knowledge of the status of every jail in the Commonwealth on meeting every standard but instead was based on general knowledge about the system in general.

While this report focused on the standards for mental health care in jails, it must be stressed that there was uniform agreement that the Commonwealth must continue to build criminal justice diversion programs for individuals with serious mental illness who are largely caught in the criminal justice system secondary to the symptoms of their illness, for whom diversion would be better clinically, and for whom diversion would not negatively impact public safety (indeed often criminal justice diversion actually improved community safety by addressing the factors which place the individual at risk for involvement in the criminal justice system). While the workgroup fully embraced the concept of expanding criminal justice diversion alternatives, there was an appreciation that even with the most robust criminal justice diversion programs in place, individuals with mental health challenges will still become involved in the criminal justice system and require incarceration. The workgroup was clear that improving access to mental health services for incarcerated individuals was essential in addition to continuing to build out diversion programs. The workgroup was clear this is not an either/or scenario (i.e. build out the mental health services in jails or build out criminal justice diversion programs) but that the Commonwealth must do both, simultaneously. This will allow the low risk offenders to be diverted away from jail to mental health services, thus leaving jails with fewer individuals with mental health challenges and allowing jails to provide more robust services to those offenders who cannot be released. This multi-prong approach will result in the best public safety outcomes.

In terms of next steps, DBHDS agreed to share the written report from the work of the workgroup with the Joint Subcommittee on Mental Health in the 21st Century, with the Joint Commission on Health Care, with the Secretary of Health & Human Resources, with the Secretary of Public Safety, and with the respective associations of the workgroup members. DBHDS will also respond to any inquiries about the report, will follow-up on questions unanswered by the report, and will work with local/state partners to attempt to bring attention to this vital topic. Finally, DBHDS will continue to provide technical assistance to implement these standards (if/when they become mandatory). Until that time, DBHDS will continue to support voluntary compliance with the standards and provide resources, to the degree they are available, to aid jails in addressing the needs of justice involved individuals with mental health challenges.

APPENDICES

Appendix A

2017 Mental Illness in Jails Report

Mental Illness in Jails Report

2017

Compensation Board

November 1, 2017

Compensation Board Mental Illness in Jails Report (2017)

Authority: Virginia Acts of Assembly, 2017, Chapter 836

Item 70 J.1. "The Compensation Board shall provide an annual report on the number and diagnoses of inmates with mental illnesses in local and regional jails, the treatment services provided, and expenditures on jail mental health programs. The report shall be prepared in cooperation with the Virginia Sheriffs Association, the Virginia Association of Regional Jails, the Virginia Association of Community Services Boards, and the Department of Behavioral Health and Developmental Services and shall be coordinated with the data submissions required for the annual jail cost report. Copies of this report shall be provided by November 1 of each year to the Governor, Director, Department of Planning and Budget, and the Chairmen of the Senate Finance and House Appropriations Committees."

Executive Summary: In the month of June, 2017 the Commonwealth of Virginia supported 59 local and regional jails and jail farms. Of this number there are 24 county jails, 12 city jails, 22 regional jails and 1 jail farm. City and county jails are operated under the authority of the sheriff in that locality. The jail farm is operated under the authority of the locality it serves by an appointed superintendent. Regional jails are operated under the authority of a regional jail board or authority consisting of at least the sheriff and one other representative from each participating jurisdiction.

A survey to identify mental illness in Virginia jails was initially developed by staff of the Department of Behavioral Health and Developmental Services (DBHDS), staff of the Senate Finance Committee, and staff of the Compensation Board. The Compensation Board distributed a mental health survey in July 2017 for completion by local and regional jails. With the support of the Virginia Sheriffs' Association and the Virginia Association of Regional Jails, the Compensation Board received surveys from 55 out of 59 local and regional jails, excluding Charlotte County Jail, Franklin County Jail, Sussex County Jail, and the Danville City Farm. Although a survey was completed by Prince William-Manassas Regional Jail, their data regarding the number and diagnoses of mentally ill was not in the correct format. Due to a number of circumstances, the jail was unable to resubmit its corrected data prior to analysis of survey data. Therefore the data included in this report is from 54 out of 59 local and regional jails. The data in this report is as provided to the Compensation Board by local and regional jails in their 2017 mental health surveys, submitted as of August 22, 2017

The goal of the survey is to provide information regarding the incidence of mental illness among individuals incarcerated in Virginia jails, characteristics of this population and methods by which jails seek to

manage mental illness within their facility. Survey questions directed jail personnel to report data for the month of June 2017, with the exception of treatment expenditures which were reported for the entire fiscal year (July 1, 2016 – June 30, 2017).

Significant changes to the survey instrument this year include the addition of questions that identify: 1) number of inmates screened using the Brief Jail Mental Health Screen (BJMHS) or the Correctional Mental Health Screen (CHMS); 2) number of those screened utilizing the BJMHS or the CHMS that were recommended for a further comprehensive mental health assessment; and 3) if state funding were available to assist jails with mentally ill populations, in which area would it be most beneficial. Although the report includes statistics on the average daily population of federal and out of state inmates housed in jail this year, the data regarding inmates with mental illness is reflective only of local and state responsible inmates housed in local and regional jails.

Acknowledgement: The Compensation Board would like to express its appreciation to the Sheriffs, Regional Jail Superintendents, and all jail staff involved in the collection and reporting of the data requested in the 2017 Mental Health Survey. The Board and Staff are thankful for the cooperation and efforts of jail leadership and staff in this reporting process.

Note: The Danville City Farm did not respond to the survey, as they indicated that all mentally ill offenders are held at the city jail, which is operated separately by the city sheriff. The Farm housed an average daily population of 130 offenders in June, 2017. Charlotte County Jail did not respond to the survey; their average daily population in June was 69. Franklin County Jail did not respond to the survey; their average daily population in June was 60. Sussex County Jail did not respond to the survey; their average daily population in June was 47. Prince William-Manassas Regional Jails' survey was removed from data analysis as they were unable to resubmit corrected data; their average daily population in June was 989. Peumansend Creek Regional Jail discontinued housing inmates by March 31, 2017 and closed effective June 30, 2017.

Survey Background

The Compensation Board developed a mental illness survey for completion by all local and regional jails, requesting statistical information for the month of June, 2017. Information relating to screening and assessment, diagnoses, housing, and most serious offense type of mentally ill inmates was collected by the survey instrument. The survey also collected data regarding inmates' access to mental health programs and assistance in the facility, including medication and treatment services. Additionally, the survey is used to identify the providers of screening/assessment and treatment in each facility, whether they are private mental health professionals, Community Services Board (CSB) staff, or jail staff. Jails also reported how inmate mental health data is collected and stored, as well as the amount of mental health and/or Crisis Intervention Team training provided to the jail staff, if any. Finally, jails were asked to provide the fiscal year cost of all mental health services and medications.

Data gleaned from surveys of 54 out of 59 local and regional jails is included in this report. A copy of the survey instrument is included in Appendix A.

Population & Demographics in Jails

Based upon LIDS data for the month of June, 2017 there was an average daily inmate population (ADP) of 27,477 in jails in the Commonwealth of Virginia (5 jails were excluded from this report and this number). Of these, 7,214 were state responsible (SR) inmates. A state responsible inmate (SR) is any person convicted of one or more felony offenses and (a) the sum of consecutive effective sentences for felonies, committed on or after January 1, 1995, is (i) more than twelve months or (ii) one year or more, or (b) the sum of consecutive effective sentences for felonies, committed before January 1, 1995, is more than two years. An additional 18,947 were local responsible (LR) inmates. A local responsible inmate (LR) is any person arrested on a state warrant and incarcerated in a local correctional facility prior to trial, any person convicted of a misdemeanor offense and sentenced to a term in a local correctional facility, any person convicted of a felony offense on or *after* January 1, 1995 and given an effective sentence of (i) twelve months or less or (ii) less than one year, or any person convicted of one or more felony offenses committed *before* January 1, 1995, and sentenced to less than two years. A further 189 inmates were local ordinance violators. Unlike SR and LR offenders, who have been arrested on a state warrant, offenders held for ordinance violations have been arrested on a local warrant, having been charged with an offense specific to that locality which may or may not also appear in the code of Virginia. The remaining 1,127 of the ADP were federal and out of state inmates; however these inmates are not included in the jails' reporting or in the analysis of any statistics in this report. Therefore the average daily population included for analysis in this report is 26,350.

Of these 26,350 inmates, 41.65% were pre-trial and 58.35% were post-conviction. Pre-trial refers to inmates held in a local jail awaiting trial. Post-conviction refers to inmates who have been found guilty of one or more criminal charges, with or without additional pending charges, and are serving sentence in the jail or awaiting transfer to a Department of Corrections (DOC) facility. Of the 26,350 ADP, 17.38% were female, 82.56% were male and .07% were an unknown gender.

Table 1: Jail Population Percentages-Average Daily Population

Year	Pretrial	Post-Con	Female	Male
2017	42%	58%	17%	83%
2016	40%	60%	16%	84%
2015	40%	60%	15%	85%
2014	39%	61%	14%	86%
2013	34%	66%	13%	87%
2012	32%	68%	14%	86%

From this point forward in the report, statistics will be noted that refer to the percentages of certain populations that are mentally ill. Where these statistics are cited, staff has calculated percentages using inmate counts, not the average daily inmate population. The annual survey submitted by jails requires them to indicate the number of inmates mentally ill within their facility for a specific month. To most accurately make comparisons between this population and the general population, specific inmate counts within the jails for the same time period are required. The following are the counts of the general population used to calculate mental illness percentages in the following section: Total, 42,257; Female, 8,278; Male, 33,919; and Unknown, 60.

Note: The population count used to calculate mental illness percentages is the number of inmates confined long enough to have received a comprehensive mental health assessment by a qualified mental health professional, should a screening indicate that an assessment was necessary. The determination of whether or not an inmate was confined long enough to have been assessed is made based upon each jail's answer to question 25 of the survey. The count also excludes inmates held solely on a drunk in public or simple drug possession charge for jails which indicated in questions 4b and 4d that they would not screen these inmates.
Note: Total General Population Inmate Count = 47,134; Projected General Population Inmate Count incarcerated long enough to be assessed = 42,257.
Note: The total inmate count includes inmates counted one time for each jail in which they were held during the month of June, 2017.
Note: Total General Population Inmate Count does not include the Danville City Jail Farm, Charlotte County Jail, Franklin County Jail, Sussex County Jail or Prince William-Manassas Regional Jail.

Mental Illness Statistics

Mental illness is defined as an individual who has been diagnosed with schizophrenia or a delusional disorder, bi-polar or major depressive, mild depression, an anxiety disorder, post-traumatic stress disorder (PTSD), or any other mental illness as set out by the Diagnostic & Statistical Manual of Mental Disorders (DSM-V), published by the American Psychiatric Association, or those inmates who are suspected of being mentally ill but have received no formal diagnosis.

Of the female population count, 2,320 (28.03%) were reported to be mentally ill. Of the male population count, 5,131 (15.13%) were reported as having a mental illness. Of the total general population count, 7,451 (17.63%) were known or suspected to be mentally ill.

Table 2 includes the percentage of the female/male general population diagnosed as mentally ill for the current as well as previous 5 years.

Table 2: Percentage of Female/Male and Total General Population with Mental Illness Using Inmate Counts

Year	Female	Male	Total
2017	28.03%	15.13%	17.63%
2016	25.79%	14.35%	16.43%
2015	25.29%	13.63%	16.81%
2014	20.87%	12.43%	13.95%
2013	16.13%	12.64%	13.45%
2012	14.40%	10.35%	11.07%

There were a total of 7,451 inmates known or suspected to be mentally ill in jails during the month of June, 2017. Of these mentally ill inmates, 31.14% were female and 68.86% were male, and 52.01% were pre-trial and 47.99% were post-conviction.

Table 3: Number of Inmates with Mental Illness

Year	Num Inmates with MI	Female %	Male %	Pre-Trial %	Post-Con %
2017	7,451	31.14%	68.86%	52.01%	47.99%
2016	6,554	28.75%	71.25%	48.95%	51.05%
2015	7,054	29.43%	70.57%	45.92%	54.08%
2014	6,787	27.04%	72.96%	49.90%	50.10%
2013	6,346	27.80%	72.20%	48.12%	51.88%
2012	6,322	23.16%	76.84%	47.33%	52.67%
2011	6,481	28.30%	71.70%	45.55%	57.66%
2010	4,867	26.81%	73.19%	n/a	n/a
2009	4,278	27.07%	72.93%	n/a	n/a
2008	4,879	n/a	n/a	n/a	n/a

Note: Beginning with the 2014 Mental Illness in Jails Survey, mental illness percentages were calculated using inmate counts, and not average daily populations. In Table 2, 2013 and 2012 have been recalculated using counts instead of ADP.

While an inmate may have multiple diagnoses each inmate is counted only once, in the category of the most serious illness for which they have been diagnosed. Figure 1 reflects the number of mentally ill inmates housed in June, 2017 and the type of disorder.

Figure 1: Number & Diagnoses of Inmates with Mental Illness

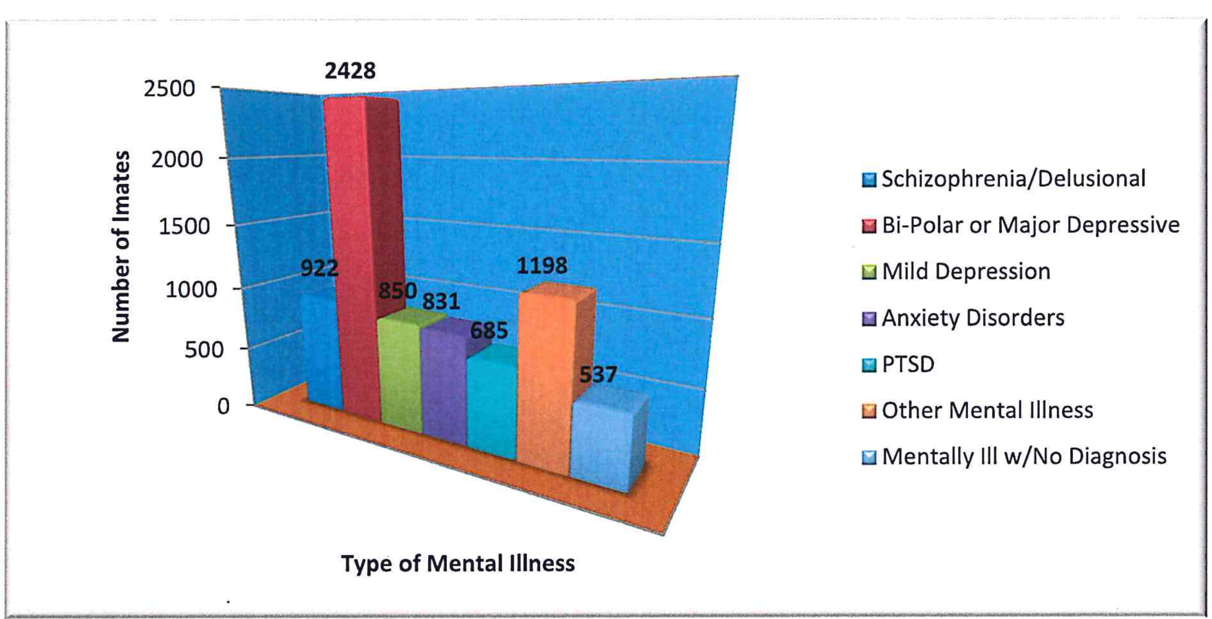


Figure 2 shows the number and percentage that each mental illness represents in both the Female and Male mentally ill populations.

Figure 2: Number & Percentage of M/F Mentally Ill Population Diagnoses

	Schizo/ Delusional	Bi-Polar/Major Depressive	Mild Depression	Anxiety Disorders	PTSD	Other Mental Illness	Mentally Ill w/no Diag
Female	193	935	245	266	249	311	121
Male	729	1493	605	565	436	887	416
Female	8.32%	40.30%	10.56%	11.47%	10.73%	13.41%	5.22%
Male	14.21%	29.10%	11.79%	11.01%	8.50%	17.29%	8.11%

- A diagnosis of bi-polar/major depressive continues to be the most prevalent for both males and females. In this year's survey, a diagnosis of bi-polar/major depressive accounted for 32.59% of all reported mental illness.

A serious mental illness includes diagnoses of schizophrenia/delusional, bi-polar/major depressive or post-traumatic stress disorder. Survey responses indicate that 54.15% of the mentally ill population and 9.55% of the general population have been diagnosed as having a serious mental illness.

Table 4: Percentage of the General Population with Mental Illness/Serious Mental Illness

Year	Mental Illness	Serious Mental Illness
2017	17.63%	9.55%
2016	16.43%	8.41%
2015	16.81%	7.87%
2014	13.95%	7.50%
2013	13.45%	7.53%
2012	11.07%	5.33%
2011	12.08%	5.99%

Figure 3: Percentage and Number of Mentally Ill Populations by Region

	Central Region	Western Region	Eastern Region
Number of Mentally Ill inmates in Region	2,847	2,751	1,853
Percentage of Total MI Pop by Region	38.21%	36.92%	24.87%
Percentage of Mentally Ill inmates in Region w/ Serious MI	49.63%	52.27%	63.90%
Percentage of Mentally Ill inmates in Region Pretrial	56.73%	46.06%	53.59%
Percentage of Mentally Ill inmates in Region Post-Conviction	43.27%	53.94%	46.41%

Note: Regional percentages of the total ADP: Central, 37.67%; Western, 29.53%; Eastern, 32.80%.
Note: The percentage of mentally ill inmates in the total general population without excluding inmates which the jails indicated would typically not have been assessed due to release prior to having received a comprehensive mental health assessment, or incarceration solely for drunk in public or simple drug possession charges, would have been 15.81%. The percentage of seriously mentally ill inmates in the total general population without excluding inmates which the jails indicated would typically not have been assessed due to release prior to having received a comprehensive mental health assessment, or incarceration solely for drunk in public or simple drug possession charges, would have been 8.56%.

Veterans and Homeless

Recent additions to the survey are questions regarding inmates' veteran and homelessness status. Collection of this data is a step toward quantifying a connection between mental illness and certain outside factors. The data regarding veteran and homelessness status is as reported to the jail by the inmates and not all jails currently collect this data. Therefore these figures are likely an incomplete representation of the numbers of veterans and homeless incarcerated in jails.

- Out of 949 inmates identifying themselves as veterans, 288, or 30.35%, were identified by the jail as having a mental illness. Of the veteran group, 172, or 18.12%, were identified by the jail as having a mental illness as well as a co-occurring substance abuse disorder.
- Out of 816 inmates identifying themselves as being homeless, 322, or 33.93%, were identified by the jail as having a mental illness. Of the homeless group, 229, or 24.13%, were identified by the jail as having a mental illness as well as a co-occurring substance abuse disorder.

Screenings & Assessments

Screening

The purpose of a mental health screening is to make an initial determination of an individual's mental health status, using a standardized, validated instrument. Out of all reporting jails, 49 of 54, or 89.09%, reported conducting a mental health screening for all inmates upon admission to the jail. The provider conducting mental health screenings, as well as the screening instrument used, may differ between facilities. The Brief Jail Mental Health Screen is the instrument cited as used most often (by 54.72% of jails who screen).

New language included in paragraph J.2., of Item 70, Chapter 836 (2017 Appropriation Act) requires that, beginning July 1, 2017, all local and regional jails are required to screen each individual booked into jail for mental illness using a scientifically validated instrument, provided that jail staff performing booking is trained in the administration of the validated instrument. The Commissioner of the Department of Behavioral Health and Developmental Services is responsible for designating the instrument to be used for the screenings, and the instrument must be capable of being administered by a jail employee (that does not have to be a health care or mental health care provider). The Commissioner has designated the use of either the Brief Jail Mental Health Screen (BJMHS) or the Correctional Mental Health Screen (CMHS, for Women or for Men) as meeting the requirement of the new language.

Although the survey period covers the month of June, 2017, prior to the implementation of the new language and the requirement to screen all individuals booked, new questions were included in this year's survey to gather information regarding current screenings and results using the designated instruments. Nineteen jails specifically reported using the BJMHS and/or the CMHS to screen 6,789 inmates and 195 inmates, respectively. Of these 6,984 screened inmates, jails report that 1,090 (16%) were referred for a comprehensive mental health assessment by a qualified mental health professional, however referral percentages varied widely from 1% to 45% among reporting jails, with an average referral percentage of 18%.

Note: A copy of the Brief Jail Mental Health Screen and the Correctional Mental Health Screen (for Men and for Women) may be found in Appendices O and P.

Figure 4 shows the percentage of screenings conducted by each provider.

Figure 4: Provider of Jail Mental Health Screenings.

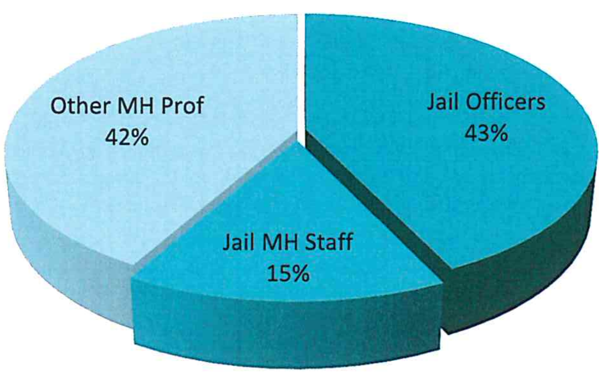


Table 5: Percentage of Jails That Reported All Inmates Screened for MI at Admission

Year	Percentage
2017	89.09%
2016	86.44%
2015	91.38%
2014	94.74%
2013	89.66%
2012	77.42%
2011	85.71%

Note: "Other Mental Health Professionals" includes psychiatrists, medical doctors, nursing staff, etc.

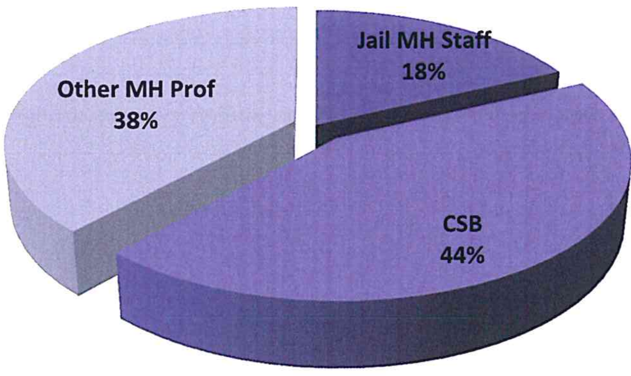
Assessment

Dependent upon the results of an initial mental health screening, a comprehensive mental health assessment may also be conducted. A comprehensive mental health assessment is a review of a client's clinical condition conducted by a trained mental health or medical professional which provides an in depth determination of a person's mental health status and treatment needs.

- 46 jails, or 83.64%, reported conducting comprehensive mental health assessments on all inmates who receive a positive screening for mental illness.
- 8 jails, or 14.55%, reported conducting comprehensive mental health assessments only on inmates with acute symptoms of mental illness.
- 14 jails reported that their procedures are adjusted over the weekends or on holidays. Most of these jails reported that they do continue to screen, during booking, but assessments are not conducted during the weekend unless jail staff deems it to be an acute case.

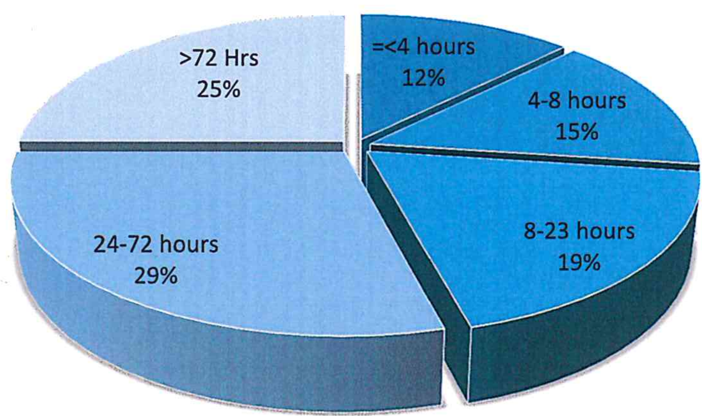
As with initial screenings, the type of individual conducting comprehensive mental health assessments, as well as the method of assessment, differs between facilities. Jails identify that comprehensive mental health assessments are performed in their jail by either community services boards, by jail mental health staff (which include jail employees that are licensed medical or mental health professionals), or by other mental health professionals (which include private or contracted medical or mental health professionals such as psychiatrists, medical doctors, nursing staff, etc.), as shown in Figure 5.

Figure 5: Provider of Jail Comprehensive Mental Health Assessment.



The average number of hours an inmate is confined in jail before receiving a comprehensive mental health assessment, if needed, varies from jail to jail. Figure 6 reflects the percentage of jails that reported they typically conduct mental health assessments within specific time periods from the time of commitment.

Figure 6: Average Hours of Confinement before Mental Health Assessment



It is reasonable to assume, based upon survey responses, that a certain percentage of the population, based upon their brief length of stay, would not be confined long enough to receive a comprehensive mental health assessment, even if a screening indicated assessment would be appropriate. To include these inmates in the general population count for the purpose of calculating percentages of the population that are mentally ill, could lead to understated statistics. To more accurately reflect the mental illness percentages of the general population, Compensation Board staff has removed from its calculations the general population count of all inmates from each jail for which that jail's response regarding average hours of confinement prior to assessment indicated that the inmate would not typically be incarcerated long enough to be assessed.

Eighteen (18) jails indicated that they do not conduct mental health screenings on inmates confined solely on a drunk in public charge. Nineteen (19) jails indicated that they do not conduct mental health screenings on inmates confined on a simple possession of marijuana charge. For each of these jails, inmates that met one of these criteria have been removed from the total general population count. Inmates held solely on a drunk in public or simple possession charge in jails which indicate that they do screen these populations were not removed from the total general population count.

Note: Responses for figure 6 are based upon the typical assessment time reported by jails in the survey. These assessment times do not take into account inmates who are in acute crisis.
Note: Statistics regarding mental illness may still be somewhat understated, as some jails may need further clarification to report time lapse prior to assessment versus screening, thus actual assessment times may be longer than reported in some cases.

Housing

The housing of mentally ill inmates differs from jail to jail.

- 21 out of 54 reporting jails have mental health units or bed areas separate from the General Population. In these 21 jails, there are 133 beds for Females and 479 beds for Males. This is a reduction of 339 reported in 2016, resulting from one jail reporting beds in 2016 that did not report them in 2017.
- Jails reported that a total of 2,756 beds would be needed to house all inmates with non-acute mental illness in mental health beds or units, which would currently require 2,144 additional beds.
- Of the 7,451 identified mentally ill inmates, 1,335 were housed in isolation. 27 of the 48 jails that housed mentally ill inmates in isolated or segregated cells did not operate a Mental Health Unit (442 inmates). If a mental health unit existed in the facility, it is possible that these inmates may not have had to be housed in isolation.
- Twenty-one jails have noted that they would consider hosting a state-funded Mental Health Residential Treatment Program.

There is no state funded Mental Health Residential Treatment Program operating within jail facilities at this time.

A temporary detention order (TDO) may be issued by a court or magistrate if an individual meets the criteria as set out by § 19.2-169.6. and/or § 37.2-809. Prior to the issuance of a TDO an evaluation must be conducted by the local Community Services Board or their designee. Within 72 hours from the issuance of a TDO a hearing must be held to determine whether there is justification for a psychiatric commitment.

- A total of 11 inmates were housed in jails more than 72 hours following the issuance of a TDO during the month of June, 2017.

Note: In 2016, Roanoke City Jail reported 122 separate beds for Females and 254 separate beds for Males, but did not provide a response to this question in 2017, resulting in a 339 bed reduction (35%) from the 2016 report.
Note: 2014 Virginia Acts of Assembly, Chapters 691 and 761, amended §19.2-169.6 and §37.2-809, increasing the maximum length of time an individual may be held under temporary detention prior to a hearing from 48 hours to 72 hours.

Mental Health Treatment Services Provided

Mental health treatment services offered, as well as providers of those services, differ from jail to jail. Some jails may have a full time psychiatrist or general practice physician (MD) to attend to mental health needs and dispense psychotropic medications; other jails may contract with an outside psychiatrist/general practice physician (MD) to provide services on certain days of each month, etc. Nursing staff may also provide mental health treatment.

Treatment Hours & Providers

In 2017, Community Service Boards (CSBs) were again reported to provide the most significant portion of mental health treatment in jails. Community Services Boards have a statutory requirement to evaluate inmates for whom a temporary detention order is being sought (§37.2-809), however they have no statutory obligation to provide treatment in the jail.

Although on average the CSB is the most often used provider of mental health treatment, use of the local CSB as the primary treatment provider is most prevalent in jails in the Central Region (see Appendix C for a list of jails). In the Eastern and Western Regions the largest overall provider of treatment is still private contractors. This may also be due to the budget and/or resource constraints of the local CSBs in those regions, or may be by preference of the local or regional jail. Community Services Boards are both state and locally funded so their ability to provide services may vary greatly.

Figure 7: Average Number of Treatment Hours per Type of Provider in June, 2017

Provider	Average # of MH Trtmt Hrs Provided
Psychiatrists	31.38
Medical Doctors	8.83
Jail Mental Health Staff	27.68
Community Services Board	233.08
Private Contractors	87.45

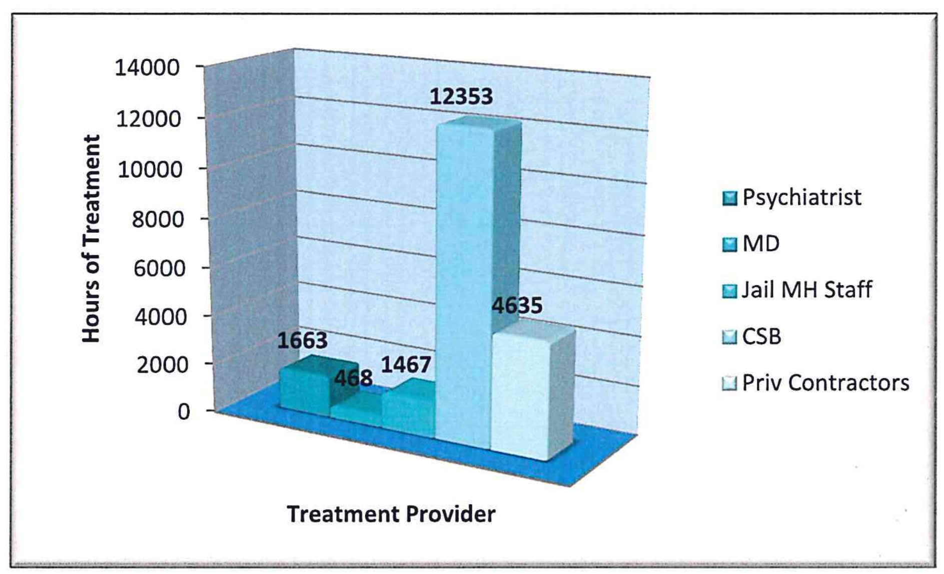
Provider	Central Region	Western Region	Eastern Region
Psychiatrists	27.28	26.39	41.88
Medical Doctors	11.74	3.50	11.38
Jail Mental Health Staff	24.11	18.22	42.56
Community Services Board	474.89	47.51	154.69
Private Contractors	25.16	68.61	182.63

The information provided below is for the month of June, 2017.

- A total of 20,587 treatment hours were provided in 53 of 54 jails, including treatment by any provider included in Figure 7.
- All data reflected in Figures 7, 8 and 9 and Tables 6 and 7 are for a mentally ill population of 7,446 plus a population of 3,878 inmates reported to have a substance abuse disorder without co-occurring mental illness.
- In addition to in-jail treatment, 46 jails reported providing follow-up case management for mentally ill inmates after their release from the jail. Hours related to follow-up case management are not included in any figures in this section. Specific information regarding type of post-release assistance is not currently collected by the survey.

Figure 8 reflects the hours of treatment given by provider

Figure 8: Hours of Treatment Provided



The 2017 top five jails with the highest number of hours of treatment provided for the month reported in the survey were: Alexandria City Jail (6,273), Hampton City Jail (1,624), Hampton Roads Regional Jail (1,232), Loudoun County Jail (975) and Fairfax County Jail (720).

Note: Lancaster County Jail did not submit responses to the survey questions regarding provider of treatment.

Table 6: Historical Treatment Hours

Year	Psychiatrist	MD	Jail MH Staff	CSB	Private Contractor
2017	1,663	468	1,467	12,353	4,635
2016	1,529	290	3,307	9,903	4,998
2015	1,411	235	1,246	4,810	6,061
2014	1,125	309	1,715	5,649	3,700
2013	1,235	212	2,667	5,935	6,744
2012	1,316	406	1,436	7,204	7,013
2011	1,160	260	4,286	6,681	5,351
2010	1,309	202	2,666	4,760	2,484
2009	1,008	229	2,673	9,336	2,163
2008	251	100	520	1,872	935

Figure 9 shows the percentage that each provider comprises of the total treatment hours reported.

Figure 9: Providers of Treatment

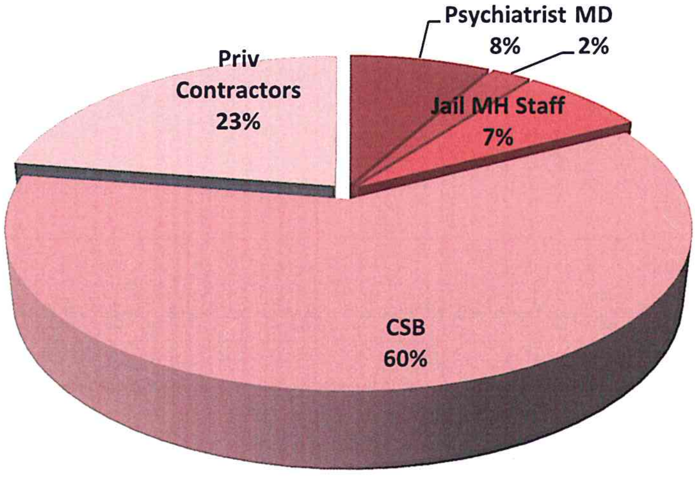


Table 7: Historical Percentage of Treatment by Provider

Year	Psychiatrists	MD	Mental Health Staff	Private Contractors	CSB
2017	8%	2%	7%	23%	60%
2016	8%	1%	17%	25%	49%
2015	10%	2%	9%	44%	35%
2014	7%	2%	10%	23%	58%
2013	7%	2%	16%	40%	35%
2012	8%	2%	8%	40%	42%
2011	7%	1%	24%	30%	38%
2010	11%	2%	23%	22%	42%
2009	7%	1%	17%	14%	61%

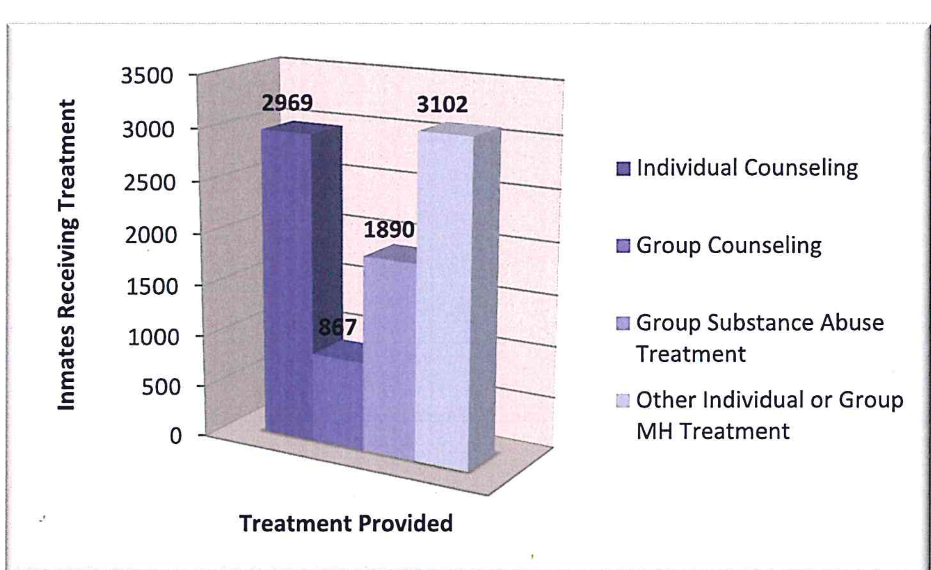
Treatment Services

An inmate may receive multiple types of treatment. Treatment may be given by any of the providers referenced previously in Figure 7 (psychiatrists, medical doctors, jail mental health staff, community services board, private contractors). Treatment includes any individual/group counseling or substance abuse services, but does not include dispensing of medication.

Fifty (50) of the 54 reporting jails provided data on the number of inmates receiving treatment services in the categories shown below in their facilities. All inmate numbers reflected in Figures 10, 11, and 12 are from a general population of 39,172 and a mentally ill population of 7,035.

- 8,828 inmates received an individual type of mental health or substance abuse treatment during the month of June, 2017 (indicating some inmates received multiple types of treatment).

Figure 10: Type of Treatment Provided



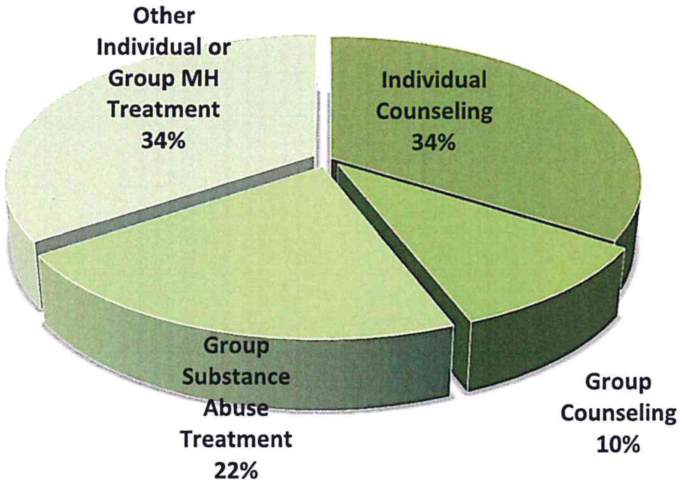
Not all facilities provide all of the above services.

Note: Chesapeake City Jail, Danville City Jail, Lancaster County Jail and Piedmont Regional Jail did not submit responses to the survey question regarding number of inmates receiving treatment.

Figure 11: Hours of Treatment Provided by Region

	Central Region	Western Region	Eastern Region
Individual Counseling	1786	1341	1218
Group Counseling	3816	11	364
Group Substance Abuse Treatment	2923	652	448
Other MH Treatment	378	9515	186

Figure 12: Type of Service Percentage by Number of Inmates Treated



Medication

Some inmates with mental illness require the assistance of psychotropic medications. Psychotropic refers to mood altering drugs which affect mental activity, behavior, or perception. Often these medications are provided and dispensed by the jail. However, as noted in the survey, there are certain medications that some jails do not provide. In certain cases an inmate's medication may be delivered to the jail by a 3rd party, such as a physician treating the offender pre-incarceration, or a family member authorized by the jail to bring the necessary prescribed medication.

Psychotropic medications are broken down into 4 categories: antipsychotic, mood stabilizer/anticonvulsant, anti-depressant and anti-anxiety.

- Antipsychotic medications include drugs such as: Haldol, Zyprexa, Risperdal, Seroquel, Triliafon, Prolixin, Thorazine, Abilify, Geodon, Clozaril

- Mood Stabilizer/Anticonvulsant medications include drugs such as: Depakote, Lithium, Tegretal, Topamax, and Trileptal

- Anti-depressant medications include drugs such as: Prozac, Zoloft, Lexapro, Wellbutrin, Paxil, Elavil, Pamelor, and Desyrel

- Anti-anxiety medications include drugs such as: Ativan, Xanax, Librium and Valium

During June, 2017 there were 11,547 prescriptions for psychotropic medications being dispensed in local and regional jails. The number of medications administered may exceed the number of inmates receiving treatment, as an inmate may be taking more than one medication. There were 824 more distributed medications reported in 2017 than in 2016 (10,723). It has been noted by several jails that it is less expensive to provide mentally ill inmates medication than it is to provide treatment services.

A total of 955 jail inmates with mental illness refused psychotropic medication. This is 12.82% of the mentally ill population (there is no current statute that gives jails the authority to forcibly administer medications).

In the 2017 survey, jails were asked to report their procedure when an inmate refuses medications. Responses varied, but the most commonly reported actions taken were: require the inmate to sign a refusal form; refer the inmate to the psychiatrist or other qualified mental health professional for counseling; and monitor inmate for changes in behavior.

Table 8: Historical Trend of Medications Dispensed

Year	Number of Medications Dispensed
2017	11,547
2016	10,723
2015	11,052
2014	8,894
2013	9,316
2012	6,576
2011	6,490
2010	6,274
2009	5,746
2008	4,965

Figure 13: Number and Type of Psychotropic Medications Dispensed

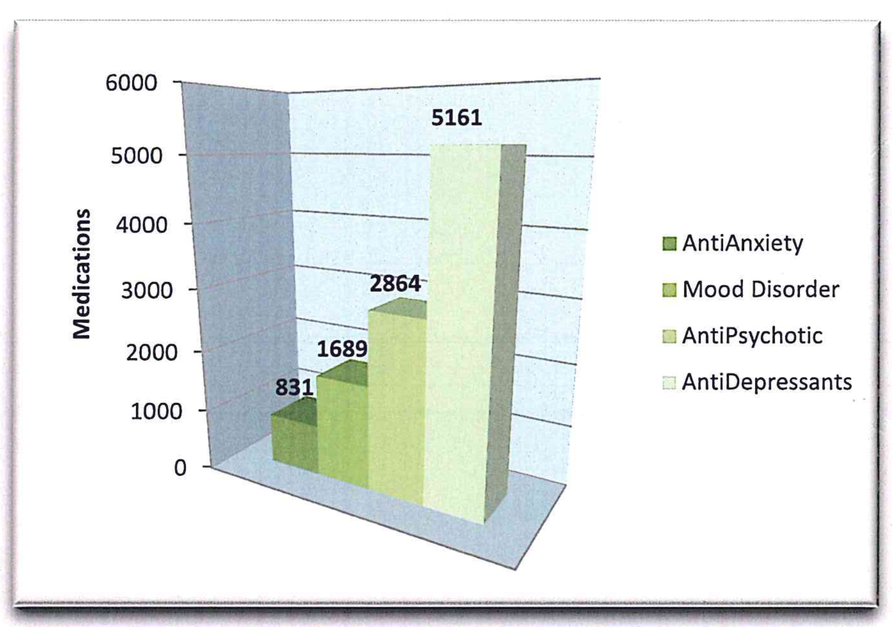
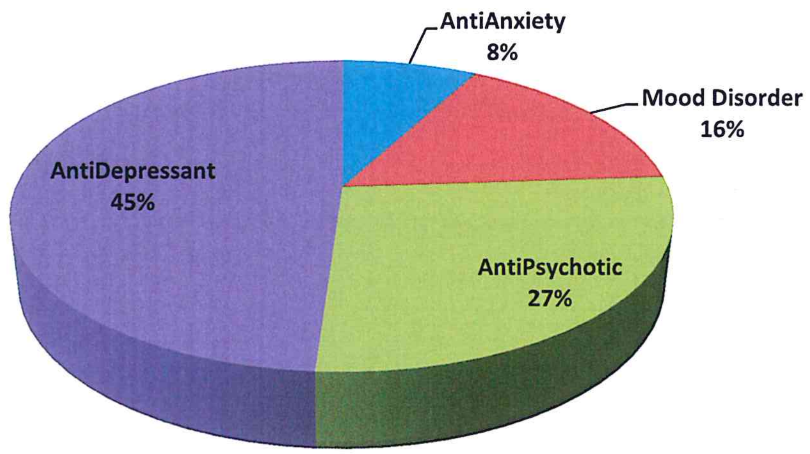


Figure 14: Percentage of Psychotropic Medication Dispensed by Type



The 2017 top five distributors of psychotropic medications for the month reported in the survey were: Virginia Beach City Jail (1,114), Hampton Roads Regional Jail (1,079), Western Virginia Regional Jail (835), Riverside Regional Jail (819), and Southwest Virginia Regional Jail (858).

Substance Abuse/Special Education

- Of the 7,451 inmates with mental illness, 3,878 had a co-occurring substance use/abuse disorder, or about 59.17% of the mentally ill jail population.
- Those inmates with co-occurring mental illness and substance use/abuse disorder comprised 9.18% of the general jail population.
- 4,604 inmates without mental illness were reported to have substance use/abuse disorders, representing about 10.90% of the general population.
- As illustrated earlier in Figure 12, 22% of all inmates receiving jail provided treatment services are receiving group substance abuse treatment.

The general population inmate count used to calculate the percentages of mental illness and substance abuse in this section is 42,257.

Federal regulations mandate that all correctional facilities provide access to special education for inmates. During the month of June, 2017, 142 inmates were receiving special education.

Note: The population counts used to calculate mental illness percentages are the number of inmates confined long enough to have received a comprehensive mental health assessment by a qualified mental health professional, should a screening indicate that an assessment was necessary. The determination of whether or not an inmate was confined long enough to have been assessed is made based upon the jails answer to question 25 of the survey. This count also excludes inmates held solely on a drunk in public or simple drug possession charge in jails which indicated in questions 4b and 4d that they would not screen these inmates.

Mental Illness & Offense Type

For each inmate identified as mentally ill, jails were asked to note the most serious offense type on which the offender was held. The following are the offense types, listed in order of severity: violent felony, drug felony, non-violent felony, violent misdemeanor, drug misdemeanor, and non-violent misdemeanor. Most serious offense classification is based on the most serious offense with which an inmate is currently charged, and not necessarily of which the inmate is ultimately convicted.

Of the 7,451 inmates with mental illness, jails reported the most serious offense type for 96.64%, or 7,201 of them. Of the inmates for whom the most serious offense type was reported, 76.93% had felony offenses, 20.52% were held on misdemeanor offenses and 2.54% were held on ordinance offenses.

Table 9: Percentage of Mental Illness by Offense Type-Crime Type

Year	Felony	Misdemeanor	Ordinance
2017	76.93%	20.52%	2.54%
2016	80.58%	16.85%	2.57%
2015	75.85%	22.04%	2.12%
2014	76.96%	20.68%	2.36%
2013	69.70%	26.93%	3.38%
2012	73.39%	24.02%	2.60%
2011	76.95%	20.96%	2.09%

Table 10: Percentage of Most Serious Offense-Crime Type of the General Population

Year	Felony	Misdemeanor	Ordinance
2017	70%	27%	3%
2016	67%	29%	4%

Figure 15 illustrates the percentage each offense type comprises of the total mentally ill population reported in question 8 of the survey, which references Most Serious Offense. The count of mentally ill inmates used for this graph does not include 183 inmates held for ordinance violations.

Figure 15: Percentage of Mental Illness by Most Serious Offense Type (Crime Severity)

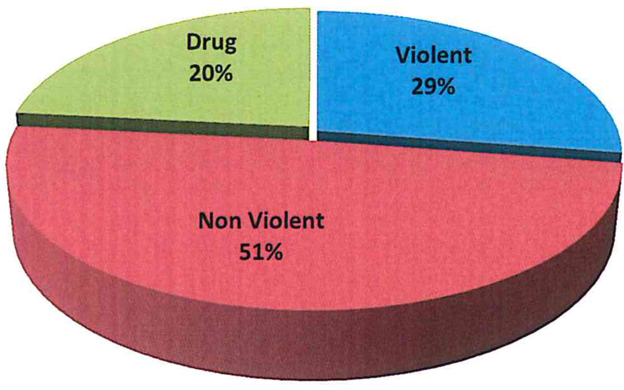


Figure 16 illustrates the percentage each offense type comprises of the total general population.

Figure 16: Percentage of General Population by Most Serious Offense Type (Crime Severity)

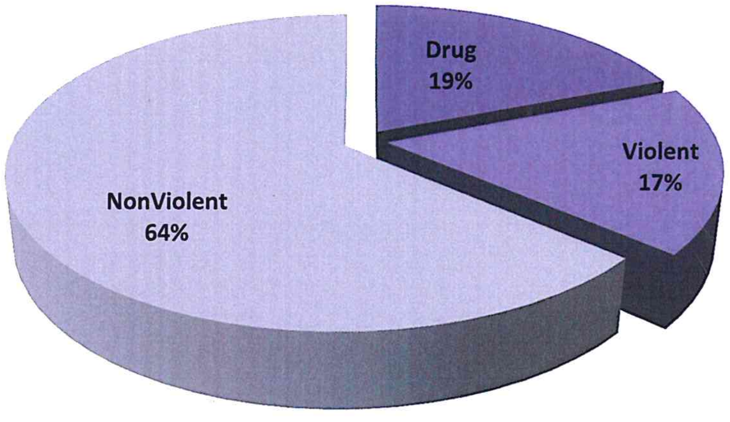


Figure 17 illustrates the percentage each offense comprises of each diagnosis.

Figure 17: Mental Illness Categories & Offense Type

	Felony Violent	Felony Drug	Felony Non-Violent	Mis Violent	Mis Drug	Mis Non-Violent	ORD
Schizophrenia/Delusional	26.95%	13.53%	36.36%	3.68%	1.62%	16.23%	1.62%
Bi-Polar/Major Depressive	23.65%	17.64%	40.11%	2.50%	2.46%	11.85%	1.80%
Mild Depression	19.40%	20.95%	33.33%	3.10%	5.36%	15.95%	1.90%
Anxiety Disorder	18.45%	20.23%	28.88%	6.62%	5.09%	15.90%	4.83%
PTSD	27.19%	19.02%	35.96%	1.78%	3.86%	8.92%	3.27%
Other Mental Illness	24.48%	19.23%	33.21%	3.19%	4.32%	11.91%	3.66%
Mentally Ill w/ No Diagnosis	18.48%	24.49%	28.44%	4.58%	6.16%	15.96%	1.90%

Figure 18 illustrates the regional offense type percentage of mentally ill inmates for whom most serious offense type was reported.

Figure 18: Mental Illness and Offense Type Percentage by Region

	Central Region	Western Region	Eastern Region
Felony	78.49%	72.12%	81.61%
Misdemeanor	17.61%	25.53%	17.49%
Ordinance	3.90%	2.35%	0.90%

Figure 19 illustrates the regional crime type percentage of mentally ill inmates for whom most serious offense type was reported. This table does not include inmates whose most serious offense was an ordinance violation.

Figure 19: Mental Illness and Crime Type Percentage by Region

	Central Region	Western Region	Eastern Region
Violent	24.54%	26.80%	28.44%
Non-Violent	48.69%	43.45%	50.88%
Drug	20.75%	26.69%	18.82%

Figure 20: Mental Illness & Offense Type Percentage of Increase/Decrease since 2016

	Felony Violent % Change	Felony Drug % Change	Felony Non-Violent % Change	Mis Violent % Change	Mis Drug % Change	Mis Non-Violent % Change	ORD
Schizophrenia/ Delusional	-5.34%	2.35%	0.31%	-0.88%	-0.76%	3.42%	-0.64%
Bi-Polar/Major Depressive	-1.16%	1.74%	-1.40%	-1.84%	-0.86%	1.55%	-0.08%
Mild Depression	-3.92%	4.20%	-3.27%	-2.57%	2.50%	1.68%	-1.57%
Anxiety Disorder	-0.70%	-0.18%	-7.38%	1.84%	1.95%	2.25%	0.28%
PTSD	2.19%	-0.11%	-0.22%	-9.22%	0.45%	-1.50%	0.24%
Other Mental Illness	-2.89%	0.87%	-4.24%	0.28%	2.61%	2.65%	0.90%
Mentally Ill w/ No Diagnosis	2.26%	5.42%	-18.22%	-0.82%	2.51%	3.58%	1.08%

Note: The percentages in Figures 15, 17, 18 and 19 are from a total mentally ill population of 7,201.

Inmate Aggression

There were 317 documented incidents of inmate aggression (to include physical or sexual assault and/or threats of violence) toward other inmates and 137 documented incidents of inmate aggression toward jail staff in the month of June, 2017. 92 inmate perpetrators had been diagnosed as mentally ill, and 36 victims of inmate aggression had been diagnosed as mentally ill.

Table 11: Inmate Aggression

Year	Toward Inmates	Toward Jail Staff	Perpetrators MI	Victims MI
2017	317	137	92	36
2016	321	108	134	53
2015	288	104	133	56
2014	353	132	97	74
2013	287	90	91	33
2012	297	208	90	35

During FY2017, there were 30 inmates who died while in the custody of a local or regional jail. Ten of these inmates were reported by jails to have died due to an unnatural cause. Of the ten unnatural deaths in custody, eight were confirmed as suicide. Whether or not these inmates were suffering from a mental illness is unknown.

Table 12: Deaths in Jails

Year	Death by Natural Cause	Death by Unnatural Cause
FY2017	20	10
FY2016	25	6
FY2015	0	15
FY2014	33	11
FY2013	5	6
FY 2012	27	13
FY 2011	29	6

Note: Deaths in Custody figure includes 2 federal inmates. Figures do not include potential deaths of individuals on Home Electronic Monitoring

Treatment Expenditures

The following reflects the cost of all mental health treatment, including medications, as reported by the jails for FY17. Some jails provided estimated or pro-rated annual costs; total figures have not been audited. Seven jails did not report cost information for medications; seven jails did not report the cost of mental health services, excluding medications.

- The total reported cost of all psychotropic medications administered was $3.8 million.
- The total reported cost of mental health services, excluding medication but including medical doctors and nursing, was $10.5 million.
- Total cost of mental health treatment was estimated at approximately $16.1 million in FY17, with 76.39% of these costs funded by the locality, 6.27% funded by the state, 1.71% funded by the federal government, 15.43% by other funding sources.

Table 13: Treatment Expenditures

Year	Medication	MH Services	Total Cost
2017	$3.8 million	$10.5 million	$14.3 million
2016	$3.7 million	$10.3 million	$14 million
2015	$5.1 million	$9.1 million	$14.2 million
2014	$3.6 million	$9.1 million	$12.7 million
2013	$2.7 million	$8 million	$10.7 million
2012	$3.7 million	$9.6 million	$13.3 million

Note: Alleghany Regional Jail, Arlington County Jail and Hampton Roads Regional Jail reported a mentally ill population with medications dispensed but did not report the cost of medications.
Note: Henry County Jail, Fauquier County Jail, and Hampton Roads Regional Jail reported that mental health services were provided but did not report the cost of such services.

Jail Staff & Maintenance of Mental Health Data

Depending on the operational capacity of the jail, the number of staff members, including jail officer/sworn deputies and civilian personnel, ranges from 15 to 541.

- 47 of 53 reporting jails provide mental health training to each new jail officer/deputy prior to his/her initial assignment to the jail. Of these jails, there is an average of 9.06 hours of mental health training provided per jail officer/deputy. Six jails provide 20 hours or greater of mental health training per jail officer/deputy prior to initial assignment.
- 39 of 53 reporting jails require jail officers/deputies to complete additional training in mental health topics annually. Of these jails, jail officers/deputies are required to complete an average of 3.53 hours of training in mental health topics each year.

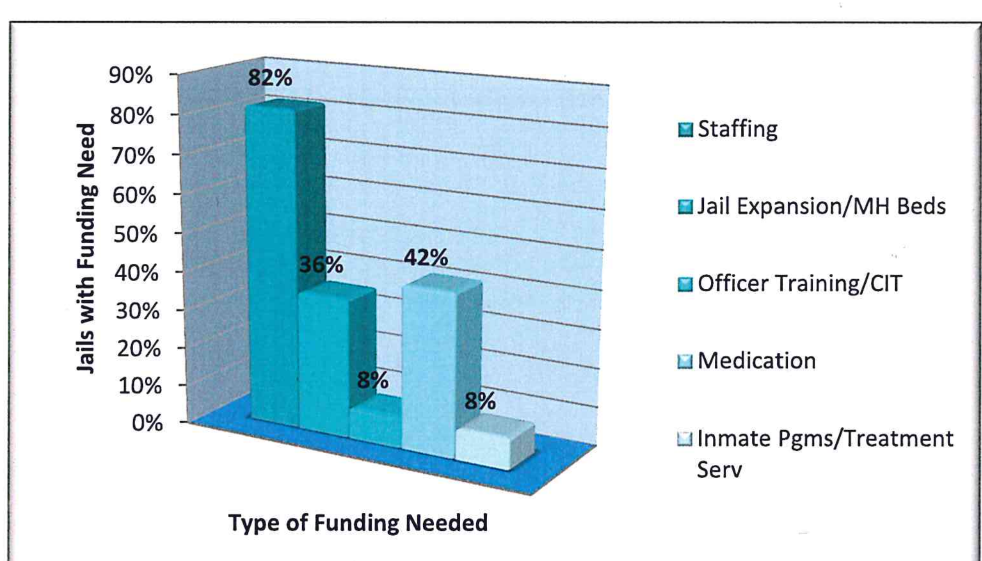
Forty three (43) jails indicated that their jail's electronic inmate management system includes mental health screening items, while 10 jails indicated that their electronic inmate management system includes inmate psychiatric diagnoses.

Areas of Greatest Need for Funding

Jails frequently report that housing mentally ill offenders creates unique challenges, and that additional funding is needed to assist with these challenges. In the 2017 survey, jails were asked to report the areas in which they felt additional funding would be most beneficial, if additional funding were made available. Fifty jails (50) responded to the question regarding additional funding needs, and the top responses were: staffing, medication costs, and jail expansion/mental health beds.

Figure 21 illustrates the percentage of responding jails reporting each type of funding that would be most beneficial. Each jail may have reported more than one type of funding that would be of greatest benefit.

Figure 21: Type of Funding Needed



Crisis Intervention Teams

The Department of Criminal Justice Services (DCJS) and the Department of Behavioral Health and Developmental Services (DBHDS) collaborate to support and administer Crisis Intervention Team (CIT) programs across the Commonwealth. At its core, CIT provides 1) law enforcement crisis intervention training to enhance response to individuals exhibiting signs of a mental illness; 2) a forum to promote effective systems change and problem solving regarding interaction between the criminal justice and mental health care systems; and 3) improved community-based solutions to enhance access to services for individuals with mental illness. Successful CIT programs improve officer and consumer safety, reduce inappropriate incarceration and redirect individuals with mental illness from the criminal justice system to the health care system when to do so is consistent with the needs of public safety.

Although CIT training is primarily for law enforcement, it is also offered to other first responders such as Fire and EMS, mental health staff, correctional officers, and others. In local and regional jails, the primary purpose of the CIT training is to help jail officers recognize when a person may be suffering from a mental illness, to give them a better awareness of the needs of individuals with mental illness and to give them the tools and strategies needed for de-escalation in a situation where a mentally ill offender appears to be in crisis.

Fifty (50) of 53 reporting jails have jail officers/deputies who have completed Crisis Intervention Team (CIT) training. Of these jails, an average of 45.74 jail officers/deputies in each jail has completed CIT training, an increase of 13% from 2016 (40.49). Eleven jails reported that at least half of their total staff has completed CIT training.

CIT Programs are comprised of three components: a community engagement component, a training component, and an access to services component. The access to services component is typically achieved though Crisis Assessment Sites. Thirty-two Crisis Assessment Sites currently operate, under the authority of 28 Community Services Boards. Assessment Sites are designed to enable police officers or sheriffs' deputies to take a person experiencing a mental health crisis for quick and appropriate mental health assessment and linkage to treatment in lieu of arrest or jail. Additional information about Crisis Assessment Sites (including funding, assessment time and outcomes) may be reviewed in DBHDS's FY2016 report at http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20fy2016%20cit%20assessment%20site%20annual%20report.pdf

Note: Fairfax County Jail did not provide responses to the questions regarding number of jail staff, funding needs, Crisis Intervention Team Training and mental health training provided to jail staff annually.

Current Initiatives, Final Remarks & Future Measures

Sheriffs and Jail Superintendents were notified in June, 2017 of survey deadlines and instructions, and were directed to an advanced copy of the mental health survey posted to the Compensation Board website. There were several updates to the survey instrument this year, possibly the most notable questioning if state funding were to be made available to assist jails with mentally ill populations, in which area would they find new funding most beneficial. Responses varied, but the response given most often was related to staffing need. Jails feel that they are not adequately staffed to effectively assess and treat all inmates who may be suffering from mental illness in jail.

Recent years have seen added attention of numerous committees and agencies focused on the intersection between behavioral health and criminal justice, including the specific issue of mental illness of offenders in jail. In addition to this survey and report on the incidence of mental illness in jails, there have been a number of initiatives in the past year to also examine and/or work toward addressing this issue

During the 2017 legislative session, new language was added in the 2017 Appropriation Act, Chapter 836, Item 70, paragraph J., to address consistency in initial screening for mental illness, and to identify resource needs to more comprehensively assess all inmates who screen positively for potential mental illness.

Paragraph J.2. requires that, beginning July 1, 2017, all local and regional jails shall screen each individual booked into jail for mental illness using a scientifically validated instrument, provided that jail staff performing booking is trained in the administration of the validated instrument. The Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) is responsible for designating the instrument to be used for the screenings, and the instrument must be capable of being administered by a jail employee (that does not have to be a health care or mental health care provider). The Commissioner has designated the use of either the Brief Jail Mental Health Screen (BJMHS) or the Correctional Mental Health Screen (CMHS, for Women or for Men) as meeting the requirement of the new language.

In support of the new screening requirement DBHDS, in conjunction with the Center for Behavioral Health and Justice (an interagency collaborative designed to improve coordination between behavioral health and criminal justice systems) conducted training sessions to instruct jail staff on how to properly administer both screening instruments.

Paragraph J.3. further directs the Compensation Board to conduct a review of its staffing standards with respect to the provision of mental health treatment in local and regional jails, and to evaluate the costs and benefits of requiring all jails to perform comprehensive mental health assessments within 72 hours of initial mental health screening in cases where the initial screening indicates the individual may have a mental illness. The Compensation Board is currently finalizing its report regarding staffing needs to complete comprehensive mental health assessments in cases of a positive screening, however data is limited at this time given the newness of the screening requirement, and the Board anticipates improved data will be available in the coming year.

The 2016 Appropriation Act, Chapter 780, Item 398, paragraph J. directed the Department of Criminal Justice Services (DCJS) to establish mental health pilot programs at six local and regional jails to provide behavioral health services to inmates while incarcerated, and a continuum of care when they are released back into communities. The Act appropriated $1 million in FY17 and $2.5 million in FY18 for the establishment of the pilot programs.

DCJS, in consultation with the Compensation Board and the Department of Behavioral Health and Developmental Services (DBHDS), solicited and reviewed grant applications from nineteen jails. Eighteen-month grants were awarded to two local jails and four regional jails. The grant awards were made to Chesterfield County Sheriff's Office ($416,281 awarded); Hampton Roads Regional Jail ($939,435 awarded); Middle River Regional Jail ($536,384 awarded); Prince William Adult Detention Center ($9410,898 awarded); Richmond City Sheriff's Office ($670,813 awarded); and Western Virginia Regional Jail (awarded $526,185).

To ensure continuity of care for inmates after release, each project received over $100,000 in transition/emergency housing, $15,000 in medication assistance, $20,000 for training, and $55,000 for a full-time reentry coordinator position.

DCJS reports that despite some initial startup delays, all six pilot sites successfully implemented services to enhance their ability to provide care for inmates with mental illness. Evidence-based screening tools are being utilized during intake at all pilot sites to screen inmates for mental illness. Approximately 3,000 inmates have been screened during the first six months of this project. Many sites have implemented cognitive based programming, peer support services, protocols for medication management before and after release from jail, and assistance with transportation for appointments. To ensure the continuity of care, several pilot sites developed housing pods specifically for inmates with mental illness. Pilot sites have also trained jail staff on how to properly interact with mentally ill inmates. One jail reported that the staff training and the implementation of cognitive based programing to help inmates regulate emotions has decreased incidents resulting in injuries to other inmates or staff.

Overall, pilot sites developed treatment plans for 954 inmates, provided 90 hours of peer support services, and provided almost 400 hours of therapy during incarceration. During the first six months of operations, pilot sites provided post release services to 113 individuals with mental illness.

The first six months of data received by DCJS from the pilot program jails has provided an initial benchmark for this project. This data, along with future data, will be analyzed by DCJS and compiled into a final report in October 2018.

Virginia's Department of Behavioral Health and Developmental Services (DBHDS) has been funding jail diversion programming at 10 sites across the Commonwealth since 2009. These 10 sites were expanded to 12 in FY2016, with the addition of two new programs. Data from these sites is collected quarterly, but DBHDS has been limited in its ability to fully evaluate the impact of these programs on criminal justice outcomes pre- and post-program involvement. This is due to the limited duration of program participation, and challenges associated with accessing incarceration data from across the state. Most programs have up to this point been limited to reporting outcomes based on their facilities. To assist in addressing these challenges, DBHDS has entered into an agreement with the Compensation Board for a data exchange from the Local Inmate Data System (LIDS). The Compensation Board will begin sending DBHDS monthly data files that include confinement and offense information for inmates in local and regional jails for the purpose of examining data from across the Commonwealth to determine if the jail diversion programs are having an impact on incarceration rates and lengths of jail stay for the individuals who are served. This is an exciting collaboration, which will help round out the picture of jail diversion program impact on persons with mental illness, particularly those who have come into contact with the criminal justice system.

During FY17, Compensation Board staff was contacted by researchers from the University of Virginia (UVA) wishing to perform additional analysis on the 2015 and 2016 data submitted by jails

in their mental health surveys. The data was provided and UVA published its supplemental reports in October, 2017. Those supplemental reports may be reviewed from UVA's ILPP Mental Health Policy and Practices website at https://uvamentalhealthpolicy.org/documents.

The Compensation Board, with input and assistance from other appropriate agencies, the Virginia Sheriffs' Association and the Virginia Association of Regional Jails, and staff of the Senate Finance and House Appropriations Committees, will continue to review the survey instrument on an annual basis and make improvements and updates as needed.

For FY18, the survey will seek more extensive data regarding initial mental health screenings upon booking and referrals for a more comprehensive mental health assessment by a qualified mental health professional in all jails, along with an improved accounting for timing for these processes. Although data has been sought in prior years' surveys regarding some aspects of these practices, new questions this year have allowed for the collection of better quantified data from some jails. However, the convergence of other initiatives (assessment staffing review, DCJS pilot programs) seeking similar information indicates some jails may need better clarification of the questions about screening and assessment in order to better respond and for this report to better identify existing practices.

The Compensation Board recommends a more thorough review of the survey instrument with other agencies and in consideration of other current, ongoing initiatives in order to gather data that will be worthwhile for analysis by multiple groups. A significant increase in initiatives, workgroups and committees focusing on medical and mental health and criminal justice, all seeking answers to similar questions but framed slightly differently, creates a risk of over-surveying of jails where staff time already runs short, and could result in conflicting priorities resulting in lesser quality data.

Data in this report continues to be utilized by executive and legislative agencies and committees for research, as well as to assist in the development of funding needs analysis for jail mental health treatment, jail diversion programs, expansion of Crisis Intervention Teams and post-confinement follow-up care.

Further details of data gleaned from the 2017 mental health survey and summarized in this report, including the survey instrument and organization of jail regions, are available in the appendices of this document.

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Appendix A: 2017 Virginia Local & Regional Jail Survey: Assessment and Treatment of Inmates with Mental Illness

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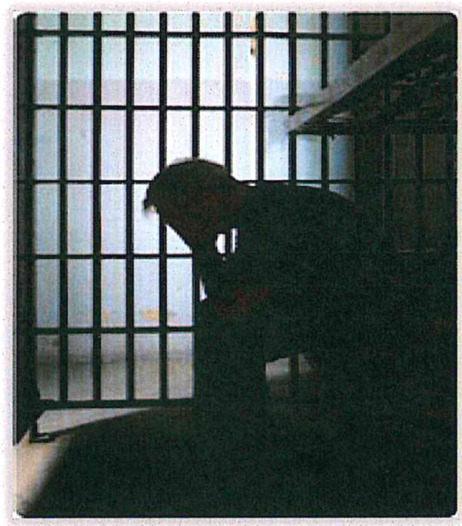
Appendix B

Office of the State Inspector General: Review of Mental Health Services in Local and Regional Jails (2014)

2014

A REVIEW OF MENTAL HEALTH SERVICES IN LOCAL AND REGIONAL JAILS



Office of the State Inspector General

Michael F. A. Morehart, CPA
State Inspector General
January 2014

COMMONWEALTH of VIRGINIA

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January 13, 2014

The Honorable Terence Richard "Terry" McAuliffe, Governor of Virginia
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 23219

Re: *A Review of Mental Health Services in Local and Regional Jails*

Dear Governor McAuliffe and Members of the General Assembly,

The attached Report contains the results of the Office of the State Inspector General's (OSIG) review of mental health services provided in the Commonwealth's local and regional jails. This review was conducted between July 17, 2013 and September 25, 2013, pursuant to the OSIG's authority as stated in the *Code of Virginia* § 2.2-309.1(B)(1)&(2), and included a site visit to 25 of the state's 62 local and regional jails.

According to the Compensation Board's *2012 Mental Illness in Jails Report*, one in four inmates in local and regional jails was known, or suspected, to be mentally ill—making Virginia's jails one of the Commonwealth's largest providers of mental health services for persons with mental illness.

In July 2013, Virginia's local and regional jail systems reported 6,346 incarcerated persons with mental illness, of which 56% qualified for a diagnosis of serious mental illness. In September 2013, the Commonwealth's state-operated behavioral health hospitals census consisted of 1,200 individuals with mental illness. Moreover, according to the Compensation Board's Annual Reports, since 2008 the number of individuals identified with mental illness in jails has increased by 30%.

The OSIG initiated this review in order to understand how Virginia's jails are addressing the challenge of serving individuals with mental illness. This examination focused on answering nine questions relevant to the policies and practices developed and utilized by Virginia's jails to supervise incarcerated individuals with mental illness.

This Report has been circulated among the Department of Corrections (DOC), the Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Sherriff's Association (VSA), and the Virginia Association of Regional Jails (VARJ). Excerpts from the DOC and VSA comments are below:

> ***Virginia Department of Corrections***: Thanks for providing me the opportunity to review the document. I believe the report is comprehensive and I agree with the assertions pertaining to the problems with the delivery of mental health services. I also believe that the recommendations are sound and merit implementation. – Harold Clarke, Director, Virginia Department of Corrections
>
> ***Virginia Sheriffs' Association***: Mental health has appropriately become a priority for the Governor and General Assembly. The sheriffs appreciate the opportunity to participate in this study and commend the Inspector General for producing a quality report in a short time frame. The sheriffs are particularly interested in addressing the needs of the 3,000 plus individuals in jails that are in serious need of mental health services that are there because they are sick, not because they have committed serious crimes.
>
> Virginia's jails have become the largest mental health providers in Virginia. The current mental health system uses resources intended by policy makers to address traditional public safety needs, and the transportation requirements relating to the ECO and TDO processes use valuable law enforcement resources routinely to serve a growing mental health population, placing significant burdens on local law enforcement agencies.... – John W. Jones, Executive Director, Virginia Sheriffs' Association

If you have any questions concerning this Report, please contact me at (804) 625-3248, or I am always happy to meet with you at your convenience.

Respectfully,

Michael F. A. Morehart
State Inspector General

CC: Paul Reagan, Chief of Staff
Harold W. Clarke, Director, Department of Corrections
John Jones, Executive Director, Virginia Sheriffs' Association
Walter Minton, Executive Director, Virginia Association of Regional Jails
John J. Pezzoli, Interim Commissioner, Department of Behavioral Health and Developmental Services

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Acknowledgment

This review would not have been possible without the cooperation of the Commonwealth's Sheriffs, the regional jail Superintendents, the Virginia Department of Corrections, the Virginia Sheriffs' Association, and the Virginia Association of Regional Jails. Throughout the review process, Virginia's correctional professionals expressed genuine interest and concern for the mentally ill individuals in their care.

Executive Summary

Authority, Scope, and Focus of Review

The Office of the State Inspector General (OSIG) conducted a review of the mental health services provided in the Commonwealth of Virginia's (Commonwealth) local and regional jails pursuant to the *Code of Virginia* (*Code*) §2.2-309.1(B)[1][2]. The review's scope included site visits to a representative sample of the state's local and regional jails (25 of 62 facilities) between July 17, 2013 and September 25, 2013, the review of 172 medical records of incarcerated individuals with mental illness, and interviews with leadership at all jails visited.[1]

In July 2012, Virginia's local and regional jail systems reported 6,322 incarcerated persons with mental illness. Of this group, 48% (3,043 individuals) qualified for a diagnosis of serious mental illness.[2] According to the Compensation Board's *2012 Mental Illness in Jails Report*, one in four inmates in local and regional jails was known, or suspected, to be mentally ill—making Virginia's jails one of the Commonwealth's largest provider of mental health services for persons with mental illness.

The OSIG initiated this review in order to understand how Virginia's jails are addressing the challenge of serving individuals with mental illness. This examination focused on answering the following questions concerning the policies and practices developed and utilized by Virginia's jails to supervise incarcerated individuals with mental illness.[3]

1. Are jail policies and practices sufficient to identify and meet the needs of individuals with mental illness?
2. Do inmates with mental illness receive the minimum treatment required by state or local standards of care for incarcerated persons?

[1]Throughout this Report the term "jail" or "jails" is used, and unless otherwise noted, "jails" includes the Commonwealth's 62 local and regional jails.

[2]Compensation Board. 2012 Mental Illness in Jails Report. 2012. Available at: http://www.scb.virginia.gov/docs/2012mentalhealthreport.pdf. Accessed December 5, 2013.

[3]This review was limited to examining jail-based services for persons with mental illness in local and regional jails and did not consider mentally ill individuals incarcerated in the Commonwealth's prison facilities managed by the state's Department of Corrections.

3. Is appropriate and proven medication available during an inmate's incarceration?
4. How are individuals with an acute episode of mental illness, accompanied with behavioral problems, housed and treated?
5. Do services provided by Community Service Boards (CSB) or private providers of jail-based services meet the needs of incarcerated individuals with mental illness?[4]
6. Are policies and practices in place to effectively link incarcerated individuals with mental illness to community-based services when they leave jail?
7. Are the total costs for providing mental health care incurred by local and regional jails accurately accounted for?
8. Has Crisis Intervention Team (CIT) training had an impact on jails' mental health-specific policies, procedures, and practices?
9. What do jail administrators believe contributes to the incarceration of individuals with mental illness, and what are the priorities for addressing the needs of this population?

OSIG Observations

The OSIG review of jail-based mental health services resulted in the following observations:

1. All sheriffs, regional jail superintendents, and facility staff voiced concern for the mentally ill individuals in their care as well as the lack of options for addressing the needs of these individuals.
2. Jails lack the capacity to satisfy the current demand for mental health services.
3. Inmates that had been receiving community mental health services prior to their incarcerations were not always tracked or monitored by their previous community provider(s).
4. Local and regional jails applied screening tools to identify individuals with mental illness; however, there was no consistency in the screening tools utilized or the level of staff training with the screening tools.
5. Jails were designed to control inmate movement in order to maximize safety as opposed to creating an environment that promotes recovery from mental illness through active treatment and interaction with others—common elements in psychiatric facilities.
6. Some jails established separate mental health units or pods in order to decrease the isolation of individuals with mental illness. These units were likely to have staff with additional mental health training.

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[4]According to the DBHDS's *Comprehensive State Plan 2012-2018*, there are 39 CSBs and one BHA in the Commonwealth. While there are some structural differences between a CSB and a BHA, for the purposes of this Report, there is no material difference and we will use the term CSB to include the BHA.

7. The lack of coordination between jails and community services providers, such as CSBs, generally led to poor continuity of care for persons with mental illness.
8. Treatment gains made while individuals with mental illness are incarcerated are at-risk once the individuals are released. This is attributable, in part, to the following:
    a. The lack of any funding to support successful transition from jail to community—including case management and housing.
    b. Delay in reactivation of Medicaid.
    c. A lack of planning for accessing Medicaid, or other available health coverage.
9. Jail administrators confirmed the value of CIT mental health training for jail staff.

OSIG Recommendations

Below are several recommendations that if implemented, will improve the services provided to incarcerated individuals with mental illness.

FUNDING FOR MENTAL HEALTH TREATMENT IN JAILS

- In order to reduce the number of mentally ill individuals in jails, Virginia should continue to prioritize funding for jail diversion alternatives defined in the Sequential Intercept Model (SIM).[5]
- The state should develop a strategy for funding mental health treatment for individuals in local and regional jails that is proportional with the Commonwealth's investment in support services for the same population in the community. The first phase of the alignment process for the funding strategy recommendation should be guided by a comparative analysis of the Department of Behavioral Health and Developmental Services' (DBHDS) *FY 2013 Annual Report* and the Compensation Board's *2013 Report on Mental Illness in Jails*.

PHYSICAL ENVIRONMENT

- The Virginia State Board of Corrections (BOC), in concert with mental health practitioners, should review BOC Standard 6VAC15-40-990 on the use of administrative segregation in order to provide additional guidance on segregation of individuals with serious mental illness.
- Future jail construction and renovations should place greater focus on the safety and treatment needs of mentally ill individuals.

[5]An illustration of the *Sequential Intercept Model* is discussed below and appended to this Report.

Variation in Practice

- Jails should consider the use of brief and validated instruments at the initial booking screening in order to standardize the process and minimize risks of under-identifying individuals with mental illness.[6]

- Jails that are not certified by the American Correctional Association (ACA) or National Commission on Correctional Health Care (NCCHC) should consider applying the standards of these accrediting agencies to mental health services.

The Relationship between CSBs and Jails

- CSBs and local jails should develop written and joint agreements among affected CSBs when individuals with mental illness are in regional jails. At a minimum, these agreements should address:

    i. The timely exchange of information at point of entry and release.

    ii. The capacity for CSBs to provide onsite engagement with individuals identified as current consumers or likely to need CSB community follow-up on release.

    iii. Transition procedures for individuals who are actively receiving mental health treatment at release.

    iv. Pre-admission screening roles and responsibilities, including time limits for responding to jail requests.

- The CSBs and local or regional jails should develop Business Associate Agreements to facilitate the effective exchange of mental health treatment information.

- The DBHDS should continue to seek funding for CSB clinicians to provide individualized mental health treatment in jails.

Mental Health Pods or Regional Mental Health Facilities

- The BOC should work with the jails that operate mental health units to identify standards for such units, including staff training and availability of treatment.

- Consideration should be given to the creation of mental health pods in local and regional jails. This would serve to expand active treatment for individuals with mental illness.

Recidivism and Linkage with Community on Release

- Jails should develop mechanisms for tracking recidivism of individuals with mental illness that were engaged in treatment at release.

- An initiative similar to the Discharge Assistance Program (DAP) should be created to help individuals with mental illness successfully transition from jails to their communities.[7]

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[6] The Correctional Mental Health Screen for Women (CMHS-W) and the Brief Jail Mental Health Screen (BJMHS) are in the appendices of this report.

- The BOC should consider a new standard, distinct from Standard 6VAC15-40-1090, to address transition planning for individuals with mental illness.

- Jails, probation and parole offices, other providers, and CSBs should seek to help individuals with mental illness being released from jail gain access to health care that may be available to them through new health care exchanges and develop strategies to facilitate timely enrollment or re-activation of Medicaid.

- The DOC should continue to advance the *Thinking for a Change: Integrated Cognitive Behavior Change Program* curriculum for use in jails, and the DBHDS should support similar initiatives in the community for individuals who have been incarcerated in local and regional jails.

TRAINING/CROSS-TRAINING

- Continue current efforts to provide CIT training to jail personnel.

- The BOC should consider expanding its Standard 6VAC15-40-1040 to include a basic level of mental health training for jail personnel who interact with individuals with mental illness.

- The BOC should consider establishing training standards for CSBs and private providers furnishing jail services to ensure their understanding of the distinctions between mental health care in a community and mental health care in a jail.

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[7]The Discharge Assistance Project (DAP) provides supplemental state general funding to assist individuals who have been discharged from state behavioral health facilities with reintegrating into their communities.

Background

Why review jail-based mental health services?

The Office of the State Inspector General's (OSIG) review of mental health services provided in local and regional jails was predicated on the following:

- The Commonwealth has a financial interest in the operation of local and regional jails. According to the Compensation Board FY 2011 Jail Cost Report, the state provided $291 million in state general fund dollars (SGF) to support the operation of jails and underwrote 35.1% of the operating cost of this system.[8]
- Since 2008 the number of individuals identified with mental illness in jails has increased by 30%, from 4,879 to 6,322.[9]
- Each year, several thousand people with mental illness move among CSBs, state-operated behavioral health facilities, and local jails. Over 1,000 inmates in local jails are transferred each year to state behavioral health facilities for treatment under the forensic chapters of the *Code of Virginia (Code)*. During FY 2011, adults with a forensic status occupied 36% of state hospital beds.[2]
- Jails have become an essential part of the Commonwealth's mental health system and the quality of the services provided in each venue impacts this interdependent system.
- Individuals incarcerated in local and regional jails fall under the protection of the *Civil Rights of Institutionalized Persons Act* (CRIPA) and are entitled, by law, to receive medical treatment—including treatment for mental health issues.
- During 2013 the U.S. Department of Justice (DOJ) investigated the treatment of incarcerated individuals in Florida,[10] Pennsylvania,[11] and Virginia[12] for CRIPA compliance.

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[8]Compensation Board. FY 2011 Jail Cost Report.
Available at: http://www.scb.virginia.gov/docs/fy11jailcostreport.pdf. Accessed December 5, 2013.

[9]Comparison of the 2008 and 2012 Compensation Board Report on Mental Illness in Jails.

[10]U.S. Department of Justice, Civil Rights Division. Escambia County Jail Findings Letter. Escambia County, Florida. 2013. Available at: http://www.justice.gov/iso/opa/resources/749201352211354596446.pdf. Accessed December 5, 2013.

[11]U.S. Department of Justice, Civil Rights Division. Investigation of State Correctional Institution at Cresson and Notice of Expanded Investigation Findings Letter. Cambria County, Pennsylvania. 2013. Available at: http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf. Accessed December 5, 2013.

[12]This jail was not selected by the OSIG for an on-site review.

The Civil Rights of Institutionalized Persons Act

The courts, as discussed in the JLARC Report cited below, no longer overlook the adequacy of mental health standards for incarcerated individuals. Pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA) and *Americans with Disabilities Act* (ADA), the DOJ began investigating a number of states to assess availability of quality mental health care, excessive use of isolation and force, inadequacy of mental health training for jail personnel, and inadequate housing of mentally ill inmates.

In the 1994 *Evaluation of Inmate Mental Health Care* report, the Joint Legislative Audit and Review Commission (JLARC) noted:

> The legal question about the rights of inmates to mental health care was addressed in the late 1970s by the Supreme Court, when it held that inmates have a Constitutional right to care. Broad standards have been developed for mental health treatment by several associations as part of their overall medical treatment standards. Generally, the adequacy of these standards has not been addressed by the courts.[13]

In a hearing before the House Subcommittee on Human Rights and the Senate Law Committee, the DOJ's Deputy Assistant Attorney General, Samuel Bagenstos, summarized this issue:

> Inadequate mental health care in the nation's jails and prisons poses a critical problem for inmate safety, and can stand in the way of real rehabilitation for those incarcerated without access to treatment...We have aggressively pursued reforms to ensure that inmates are afforded their constitutional rights.[14]

The two recent DOJ investigations in Florida and Pennsylvania cited above identified the following as the most common deficiencies that led to findings and settlement agreements:[10,11]

- Failure to commit sufficient resources to provide adequate mental health care.
- Failure to provide adequate mental health training to jail personnel.
- Prolonged isolation of individuals with mental illness.
- Use of excessive force on individuals with mental illness.

The DOJ and a Virginia jail recently reached a settlement agreement arising out of a CRIPA investigation requiring that prisoners suffering from mental illness receive treatment appropriate to their conditions and adequate to prevent unnecessary suffering or risk of harm.

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[13]Joint Legislative Audit and Review Commission. Evaluation of Inmate Mental Health Care. Available at: http://jlarc.virginia.gov/reports/Rpt153.pdf. Accessed December 5, 2013.

[14]Bagenstos, S. Written statement for the Joint Hearing on Human Rights at Home: Mental Illness in U.S. Prisons and Jails. September 15, 2009. Available at: http://www.judiciary.senate.gov/pdf/09-09-15%20Bagenstos%20Testimony.pdf. Accessed January 9, 2014.

Proper treatment will also assist prisoners in successfully reentering the community upon release.

2013 Compensation Board Report

In 2005 and annually since 2009, the Compensation Board has produced a report on mental illness in Virginia's local and regional jails. While the OSIG was conducting its review, the Compensation Board conducted and published its 2013 survey of local and regional jails. The 2013 *Mental Illness in Jails Report* is available on the Compensation Board's website.[15]

The results of the 2013 survey confirmed a continued presence of individuals with mental illness in local and regional jails and further recognized that an increasing number of incarcerated individuals have a serious mental illness (SMI). While the number of jails submitting surveys (58 of 64 or 90.6%) was the lowest in four years, the total number of individuals with mental illness increased slightly from 2012, growing from 6,322 to 6,346, and the percentage of those individuals identified as having an SMI increased from 48% to 56%—the highest rate of SMI in any Compensation Board survey to date.[16]

While there are response variables complicating a multi-year analysis, it is clear that Virginia's local and regional jails continue to be a primary setting for the identification and treatment of individuals with mental illness and that this population is growing more acute.

[15] Compensation Board. Mental Illness in Jails Report. 2013. Available at: http://www.scb.virginia.gov/docs/2013mentalhealthreport.pdf. Accessed December 5, 2013.

[16] The OSIG recommends caution when using the previous Compensation Board's Reports for comparative trend analysis because the response rate for the survey has varied in each of the past five years.

Commonwealth Local and Regional Jails System

> *The Virginia system is the most peculiar one in the nation. The grounds and buildings are owned by the counties and cities, the jails are operated by the sheriffs and city sergeants, authority is divided between these officials and the county supervisors or town councils and the circuit or corporation courts, and the state pays the cost of keeping the prisoners.*
>
> *...The State, although paying the bills, has no actual authority over the jails other than the power of inspection and recommendation by the Department of Public Welfare, truly an anomalous situation. (Virginia Legislative Jail Commission, 1937)*[17]

The Virginia system of local and regional jails has changed considerably since 1937, but the system continues to be unique in that responsibilities (e.g., construction, operation, certification, funding, etc.) are spread across multiple state and local agencies. The state still provides substantial funding for jails, but other than certifying and inspecting the facilities, it has little direct authority over their operation.

The key components of the Commonwealth jail system include the:

- Board of Corrections
- Department of Corrections
- Compensation Board
- Local jails
- Regional jails

A brief description of the system's components follows to provide context and clarity about the operation of the Commonwealth's jail system.

[17]Virginia Department of Criminal Justice Services. Virginia's Peculiar System of Local and Regional Jails. 2010. Available at: http://www.dcjs.virginia.gov/research/documents/2010%20JailReport-2.pdf. Accessed December 5, 2013.

The Board of Corrections

In addition to other responsibilities, the BOC develops and establishes operational and fiscal standards governing the operation of local, regional, and community correctional facilities per the *Code* § 53.1-5 and certifies that these facilities meet BOC standards.

The Department of Corrections

The DOC monitors jails' compliance with BOC standards through monitored visits, annual inspections, and accreditation and certification audits.

The Compensation Board

The Compensation Board establishes "a reasonable budget" for the state portion of operating costs for jails, including salaries and benefits of correctional officers and support staff, costs for certain programs and services, and office expenses.[18] According to the Compensation Board *FY 2011 Jail Cost Report,* the state provided 35.1% of the total cost of local and regional jail operations, but no dedicated funds for mental health treatment.[19]

Local Jails

Local jails generally serve the single locality in which they are located (though they may hold inmates for other localities). Locally elected sheriffs are constitutional officers and manage these facilities. There are 37 local jails (city and county) in Virginia.

Regional Jails

Regional jails serve multiple localities that may or may not operate their own local jails. A superintendent, who serves the regional jail board or jail authority, administers these facilities. The superintendents have the same authority as sheriffs with respect to individuals committed to their facilities. The jail boards consist of, at minimum, the sheriffs of participating localities and one appointed representative of each municipality. According to the Compensation Board there are 25 regional jails in Virginia.

This funding and compliance structure places great authority and responsibility on local and regional jail administrators to determine how they address the needs of individuals with mental illness within their jails using available resources.

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[18]Compensation Board's website: http://www.scb.virginia.gov/.

[19]Compensation Board. FY 2011 Jail Cost Report. 2011. Available at: http://www.scb.virginia.gov/docs/fy11jailcostreport.pdf. Accessed December 5, 2013.

Linkage of Mental Health and Criminal Justice

Mental health services within the jail setting represent only one element of a comprehensive SIM approach to addressing the interface of mentally ill individuals with the criminal justice system.[20] A graphic illustration of the SIM is attached hereto as Appendix IV.

The points of interception depicted in the SIM include law enforcement and emergency services; initial detention and hearing; jails, courts, forensic evaluation and hospitalizations; reentry from jails, prisons, and hospitalization; and community supervision and support services. According to the SIM at each of these points, there are unique opportunities to assist a person in getting appropriate services and preventing further involvement with the criminal justice system.

Anecdotal reports provided by corrections professionals suggest that without support or interventions during this process, many individuals will ultimately come back into contact with law enforcement during another crisis and repeat the revolving door cycle.

Jail Diversion Initiatives

The Substance Abuse and Mental Health Services Administration (SAMHSA), primarily through the work of its GAINS Center for Behavioral Health and Justice Transformation, has worked for years to strengthen the linkages between the mental health and criminal justice systems. Much of the work in Virginia can be traced directly to SIM initiatives that originated with the GAINS Center.[21]

During the 2008 session of the Virginia General Assembly, budget provisions were adopted that directed the DBHDS to coordinate the implementation of a jail diversion treatment program with the Department of Criminal Justice Services (DCJS). This led to the DBHDS establishing the position of Director, Office of Behavioral Health and Criminal Justice Services in 2009.

Since 2009 the DBHDS and the DCJS have collaborated to advance a range of initiatives intended to divert individuals with SMI from the criminal justice system, including, but not limited to: mental health training of community law enforcement officers, development of "drop-off" assessment centers for law enforcement officers to use in place of arrest, and intensive case management of individuals who are incarcerated in order to promote improved coordination and follow-up on release from jail.

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[20]Patti Griffin, ATTC Grantee Meeting. A Tool For System Transformation: Sequential Intercept Mapping. 2013. Available at: http://gainscenter.samhsa.gov/cms-assets/documents/103893-516686.sim.pdf. Accessed December 5, 2013.

[21]SAMHSA's Gains Center website. http://gainscenter.samhsa.gov. Accessed January 6, 2014.

Approximately 5,712 individuals, including law enforcement officers, emergency dispatchers, mental health treatment providers, and other first responder personnel, have participated in Crisis Intervention Team (CIT) training. The CIT training programs have enabled the diversion of many individuals with mental illness from the courts and criminal justice system. There are currently 13 CIT assessment sites, including six sites developed in FY 2013/14 with $1.5 million from SGF specifically allocated for these programs.

The DBHDS/DCJS partnership has also supported the cross-systems mapping process that brings community stakeholders together to:

- Improve the early identification of people with mental illness and/or co-occurring substance abuse, who intersect with the criminal justice system.
- Increase effective service linkage.
- Reduce the likelihood of recycling through the criminal justice system.
- Enhance community safety and improve quality of life for individuals with mental illness.

According to the DBHDS, 97 of Virginia's 134 localities (72%) have participated in cross-systems mapping. A current summary of these collaborative efforts and community initiatives may be accessed through the "Resource – Behavioral Health and Criminal Justice" link found on the DBHDS website at http://www.dbhds.virginia.gov/.

Review Results

Question 1: Are jail policies and practices sufficient to identify and meet the needs of individuals with mental illness?

Observations

This review found that local and regional jails lacked the resources to develop and implement the policies and practices necessary to provide needed mental health services to incarcerated individuals with mental illness. Inadequate resources increased the risk that individuals with mental illness would deteriorate during their incarceration. Individuals in the Commonwealth's jails are denied access to the array of mental health services that are available to non-incarcerated mentally ill persons in the community.

The Role of the CSBs and Their Relationship with the Jails

Policies and practices governing the relationship between jails and CSBs are not always aligned in a manner that serves the treatment needs of individuals with mental health issues. Individuals with mental illness who enter jails frequently have a history of treatment in their community, and many people with psychiatric disabilities are either covered by a public program, such as Medicaid or Medicare, or have no health coverage at all.[22] The interface between the jail and the local CSB is important for fashioning effective treatment for many individuals entering jail because their treatment history is most often with the CSB and the public provider is most likely to be the setting for post-release mental health services.[23]

According to the *2012 Compensation Board Survey*, 40% of jail-based mental health services were delivered by private providers (non-CSBs); a rate that has grown from 14% in 2009. The continuity of care for incarcerated individuals is threatened because the trend data supports a

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[22]Chris Koyanagi. How Will Health Reform Help People with Mental Illness. 2010. Available at: http://www.bazelon.org/News-Publications/Publications/List/1/CategoryID/8/Level/a/ProductID/54.aspx?SortField=ProductNumber,ProductNumber Accessed December 5, 2013.

[23]A CSB was identified as the community mental health provider in 67% (113 of 168) of the records that had the provider identified.

conclusion that CSBs are increasingly unlikely to provide treatment for this cohort as they move from community venues to jails and return to their communities when released.

In the jails visited by the OSIG, we observed that the relationship and interaction between jails and local CSBs varied significantly. Jails with the most positive comments about CSBs cited the responsiveness of the CSB in providing onsite visitation within 24 hours or less when called. Moreover, in 11 jails, the CSB staff person worked regular hours within the jail. In two jails, the CSB staff person worked a full-time schedule. The role of the CSB and the jail in these settings was often documented in a Memorandum of Agreement.

The OSIG team reviewed agreements between jails and CSBs that stressed a commitment to provide continuity of care for individuals that had been treated by the CSB. These jails and CSBs also had a "Business Associate Agreement" in place to facilitate the exchange of mental health information. In two jails, the CSB staff person had immediate access to the CSB electronic health records of individuals, eliminating delay in accessing important treatment information. Jails that complained about the relationship with their local CSB cited difficulty accessing current or previous mental health treatment information and the reluctance of CSB staff to provide onsite visits.

Regional administrators noted an additional challenge when an individual associated with a CSB outside of their region was transferred to their jail. Distance from the CSB, variation in resources devoted to jail follow-up, and lack of working relationships were the primary challenges noted by administrators. Several jail administrators and medical staff noted challenges in getting CSB staff to conduct pre-admission screenings at the jail. Jail staff also cited an instance when an individual's mental condition had to deteriorate to extreme levels in order to meet the criteria for hospitalization.

Providing effective, cohesive, and timely mental health treatment is often challenging regardless of the setting, but for jails this is particularly true. Limited professional resources, legal considerations, and other environmental risks make the handling of both chronic and acute mental health situations in jails complicated. The OSIG learned first-hand that determining a path for treatment was often complicated because persons with SMI often had a co-morbid physical illness that also placed them at risk. The case study that follows highlights this challenge.

Pre-admission Screening Challenges in Jail Setting

While the OSIG conducted this study, OSIG staff members assisted jail staff with securing necessary services for an individual with a significant history of mental illness who was experiencing acute medical problems along with acute symptoms of mental illness. The individual had been in a state hospital, but was transferred to the jail after assaulting a hospital staff member. While in the jail, the individual refused to take medication and developed life-threatening medical complications. OSIG staff members questioned the treatment of this individual who was subsequently transferred to a community hospital and admitted to its intensive care unit.

Several issues were identified and resolved as a result of the incident:

- A prior history of ineffective communication between the jail and the local CSB contributed to a delay in securing the needed services for the individual. Even though the poor working relationship between the jail and local CSB was well-known, outreach by either party geared toward resolving the issue had not recently occurred until this case.
- OSIG staff received anecdotal information that requests for prescreenings by jails in the region were often unsuccessful because the "person was already in a secure setting under observation" blocking legal pathways for securing services.
- The professional mental health staff person onsite was relatively new to the position and had not been faced with such a critical situation before. Efforts to secure treatment did not include the local CSB charged with the responsibility for conducting the required prescreening.
- The interconnectedness of the individual's medical and psychiatric problems raised questions regarding competency, informed consent, and other legal and ethical issues.

Trying to address long-standing issues during an acute situation is not optimal. It is recommended that CSBs in conjunction with DBHDS assure that open communications with local and regional jails be re-established to identify and resolve any problems that exist, reconfirm working relationships and identify best practices that can be modeled across the state.

Jail Screening Practices for Identifying Mental Illness and Treatment Needs

Jail screening practices to identify individuals with mental illness and the training and qualifications of the mental health screeners, varied throughout the Commonwealth. According to a DOJ Report, effective mental health triage in the corrections setting can be viewed as a three-stage process:

1. Routine, systematic, and universal mental health *screening* performed by corrections staff during the intake or classification stage, to identify those inmates who may need closer monitoring and mental health assessment for a severe mental disorder.
2. A more in-depth *assessment* by trained mental health personnel conducted within 24 hours of a positive screen.
3. A full-scale psychiatric *evaluation* when an inmate's degree of acute disturbances warrants it.[24]

The OSIG review revealed a consistent presence of screening for mental illness, but the screening process lacked consistency or standardization. Of the 172 records we reviewed, 156 contained a documented screening for mental illness. Of these 156 records, 149 (96%) revealed the individual's mental illness had been identified during the jail entry (screening) process.

While not a focal point of the study, the OSIG noted that there were examples of the screening for mental illness beginning with the arresting officer. This practice focused on the jails receiving information from the arresting officer, family members, or through staff observation or interaction with the individual during transport to the jail.

In the jails visited, the initial screening for mental illness was conducted during the booking process by correctional staff as part of the overall first level screening for medical concerns. The "receiving screenings" varied, ranging from "yes/no" check boxes to broader "comment" formats. Questions related to mental health during the booking process focused on medications, suicide history or ideation, past mental health treatment, and use of alcohol or drugs. On several forms, there were rating systems that required referral for more detailed mental health assessments or immediate action based on risk of suicide.

Qualifications of Staff Conducting Screenings and Providing Treatment

The individuals conducting initial screenings were not medical personnel and their mental health-related training varied from two hours to 40 hours of CIT training. All individuals had received annual training on suicide prevention. It was noted that in most jails these screenings took place in open areas with little to no privacy.

Many of the mental health concerns noted during this initial process were based on the correctional staffs' observations of unusual behavior or the individual's reported use of medications associated with mental illness.

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[24] U.S. Department of Justice. Mental Health Screens for Corrections. 2007. Available at: https://www.ncjrs.gov/pdffiles1/nij/216152.pdf. Accessed December 5, 2013.

In all jails visited, a secondary screening was conducted in a private setting, and an LPN, an RN, or a mental health staff person usually performed this screening. The secondary screening repeated the questions asked during the booking process, but medical personnel frequently observed that the more private interview often led to greater disclosure of current or past mental health treatment histories.

Depending on the information provided during the booking and secondary screenings, the jails arranged for a third screening by an individual they identified as their qualified mental health provider. That individual was often a social worker or another qualified mental health provider.

In two jails, a full-time CSB staff person interviewed all individuals entering the jail, regardless of whether the issue of mental illness had been raised during the booking or medical screening process.

This multistep screening and evaluation process determined how the jail classified an inmate. This, in turn, influenced decisions on housing, including placement in any special mental health sections, medical units, or special observation areas due to risk of harm to self or others, or high vulnerability, such as with an intellectual disability.

Mental Health Treatment in Jails

The qualifications of mental health providers included: psychiatrists, licensed professional counselors (LPC), licensed clinical social workers (LCSW), counselors, nurse practitioners, and case managers. The qualifications of the provider of mental health services was identified in 96% (165 of 172) of the records reviewed.[25]

- Of the 165 records, 127 (77%) identified the provider as a psychiatrist.
- In 54% (69 of 127) of the records where the psychiatrist was providing treatment, the individual was also being seen by another provider.
- In 89% (34 of 38) of the records that did not involve a psychiatrist, mental health treatment was provided by an LPC, LCSW, general physician, counselor, case manager, or nurse practitioner.

Of the 25 jails visited, private contract staff provided mental health services in 12 (48%), CSBs provided services in 11 (44%), and full-time jail employees provided services in two (8%). CSB jail services were often associated with pre-admission screenings to determine the need for hospitalization.

Records indicated that LCSWs, LPCs, or a non-licensed counselor or case manager primarily provided "supportive counseling." Not including some individuals receiving substance abuse

[25]Of the 172 medical records reviewed, 165 identified the individual as having mental illness.

counseling, there were only limited instances of individuals with mental illness participating in group counseling.

Community vs. Jail-based Behavioral Health Services

This review determined that incarcerated individuals with mental illness did not have access to the level of mental health services that could be found in the community.

- In 55% (92 of 167) of the records documenting treatment, the only service documented was medication management.[25]
- Of the 167 records reviewed, 35% (59) documented medication management with "supportive counseling," which focused primarily on medication adherence.
- Additional services, such as case management, group, or psychosocial services were documented in 17% (28 of 167) of the records.

State Funding for Behavioral Health Services

The Commonwealth annually appropriates $762 million to support community-based mental health treatment, but there are no comparable SGF appropriated to jails for the treatment of individuals with the same behavioral health treatment needs.

In FY 2012, Virginia appropriated $184 million in SGF and $11.2 million of federal block grant dollars for community-based mental health treatment, spent an additional $366 million as the state share of Medicaid mental health payments for treatment in the community, and invested $211.7 million in support of state hospital mental health treatment for individuals whose treatment needs could not be met in the community.[26]

Individuals with mental illness who are living in the community, especially those with serious mental illness, are likely to have health coverage under Medicaid or Medicare. The Virginia Department of Medical Assistance Services (DMAS) reported that 12% of the Medicaid-enrolled population in Virginia received behavioral health services (109,908) in FY 2012.[27] The total expenditure for those services was $733,749,350, with 50 cents of each dollar being SGF.[28]

[26]DBHDS. Fiscal Year 2012 Annual Report. 2012. Available at: http://www.dbhds.virginia.gov/documents/RD360.pdf. Accessed December 6, 2013.
[27]Behavioral Health includes mental health and substance abuse services.
[28]DMAS. Division of Behavioral Health Services Administrator Fact Sheet. Available at: http://www.dmas.virginia.gov/Content_atchs/obh/bh-admin1.pdf. Accessed December 6, 2013.

Considering the percentage of the total community mental health services CSBs provided to adults (71%) and the number of adults with mental illness served by CSBs in FY 2012 (80,453), the per person investment of SGF alone was $1,625 ($184,098,776 * .71/80,453 = $1,625). Applied to the 2012 Compensation Board Survey census, an equivalent investment of SGF for mental health services in jails would be approximately $10.3M (6,322 x $1,625). This amount represents a portion of what the full state investment would be if there was parity in treatment for individuals in the community and jails.[29]

Beyond SGF support for mental health services, the array of Medicaid-funded services and supports that exist have been successful in supporting individuals in the community; however, once an individual enters a jail, Medicaid eligibility is terminated and the funding for any current services terminates. Since most community providers rely on Medicaid reimbursement to underwrite mental health, CSBs and other providers frequently have no reimbursement mechanism to serve individuals in jails. The cessation of Medicaid funding and the absence of SGF lead to a breakdown in the continuity of care in the Commonwealth.

The loss of Medicaid combined with the lack of any proportionate dedicated state funding for jails to provide mental health treatment, means individuals do not have access to the same level of treatment they available to them in the community. Absent a comprehensive array of psychiatric interventions, overreliance on medication develops as a means to address inmate mental health treatment needs. When resources do not exist for an individualized treatment response, control of symptoms through medication is often the only intervention available to jails.

RECOMMENDATION NO. 1-A

Virginia should develop a strategy for funding mental health treatment for individuals in local and regional jails that is proportional to the investment in support services for the same population in the community. A comparative analysis of the DBHDS's *FY 2013 Annual Report* and the Compensation Board's *2013 Report on Mental Illness in Jails* would serve as a starting point for implementing this recommendation.

RECOMMENDATION NO. 1-B

The Commonwealth should establish a process for suspending, rather than terminating, Medicaid when individuals enter local and regional jails.

[29]It is worth noting that $1,625 per capita represents only a portion of the Commonwealth's FY 2012 funding for community mental health. Moreover, the community mental health system is supported by an infrastructure that has been created over decades at a cost of billions of dollars.

RECOMMENDATION NO. 1-C

CSBs and local jails should develop written and joint agreements among effected CSBs when individuals are in regional jails. The agreements should clearly address:

i. The timely exchange of information at point of entry and release.

ii. The capacity of CSBs to engage with incarcerated individuals identified as current consumers or likely to need community follow-up on discharge.

iii. Transition procedures for individuals who are actively receiving mental health treatment at release.

iv. Pre-admission screening roles and responsibilities, including time limits for responding to jail requests.

RECOMMENDATION NO. 1-D

CSBs and local or regional jails should develop Business Associate Agreements to facilitate the effective exchange of mental health treatment information.

RECOMMENDATION NO 1-E

DBHDS should continue to seek state funding for individualized mental health treatment in jails by CSB clinicians.

RECOMMENDATION NO. 1-F

Jails should consider the use of brief and validated instruments at the initial booking screening in order to standardize the process and minimize risks of under-identifying individuals with mental illness.[30]

Question 2. Do inmates with mental illness receive the minimum treatment required by state or local standards of care for incarcerated persons?

Observations

Every jail visited by the OSIG met, or exceeded, the BOC standards and jail policies for the identification, treatment, and housing of individuals with mental illness.

BOC standards for local jails define the expectations for the operation of Virginia's jails, including the manner in which jails are expected to address the health care needs of inmates—including those with mental illness.

To ensure compliance with BOC's standards, DOC's Compliance & Accreditation Unit's Local Facilities Section conducts annual unannounced *Life, Health, and Safety Inspections*, while the

[30] The Correctional Mental Health Screen for Women (CMHS-W) and the Brief Jail Mental Health Screen (BJMHS) are in the appendixes of this report and have been endorsed by SAMHSA.

Certification Section conducts triennial *Certification Audits*. Each of the jails visited during this review had met DOC standards and were certified.

The OSIG study relied primarily on 32 BOC standards selected because they included at least one reference to mental health/mental illness, or the selected standards were judged by the OSIG review team to address areas where the jail's mental health policies or practices would be evidenced (Appendix VIII).

The OSIG found that, in most instances, jail polices were written to meet the minimal compliance indicators that DOC uses for their inspections or certification visits. However, in every jail tested, the OSIG found that practices related to the identification, treatment, and housing of mentally ill individuals exceeded the policies written in response to the BOC standards.

The OSIG did observe that jails that had obtained accreditation from the American Correctional Association (ACA) or the National Commission on Correctional Health Care (NCCHC) had more comprehensive policies and practices specific to the identification and treatment of individuals with mental illness.

RECOMMENDATION NO. 2

Jails that are not ACA or NCCHC accredited should consider applying ACA and NCCHC mental health standards to individuals under their supervision.

Question 3. Is appropriate and proven medication available during an individual's incarceration?

Observations

Medication management is the primary form of mental health treatment in local and regional jails. This was verified by the observation that in 55% (92 of 167) of the medical records reviewed, medication management was the only treatment documented.[26] While each jail has a capacity to provide medications to individuals with mental illness, the variation in funding by localities for local or regional jails, the emphasis on medication cost containment, variation in jail formularies, and the differences between jail versus state-operated facility formularies created a fragmented and inconsistent system of treatment.[31]

Medical staff reported that the inability of jails to provide medication over objection sometimes meant that individuals with mental illness deteriorated during incarceration—often to the point

[31]Since it is impossible to stock every type of medicine for every disease, jails and hospitals create formularies listing the drugs they keep in house. It is possible for a jail or a hospital to obtain non-formulary drugs by ordering them from a neighboring hospital or pharmacy.

where hospitalization in a state-operated behavioral health facility was required. The fact that individuals with mental illness are in secure and supervised settings in jails may contribute to delay in transferring these individuals to state hospitals because CSB emergency staff look for imminent risk of harm to self or others and inability to care for self as key criteria for involuntary hospital admission and people in jails are deemed to be "safe."

In interviews of forensic staff at the DBHDS Central Office and one state facility in advance of initiating this study, there were reported patterns of deterioration in mental conditions for individuals that had medications discontinued or changed when returning to jails.

Access to general practitioners and psychiatrists varied significantly at the jails reviewed. Each jail had a unique medication formulary, and cost considerations were most often cited by jail staff as the only factor that would influence prescribing practices.[32]

- OSIG reviewers noted formulary restrictions in eight (32%) of the jails; although medical staff consistently noted that generic medications were a primary consideration.
- Seven jails reported having a physician onsite between 30 and 40 hours a week. Nine jails reported eight hours or less.
- For the jails surveyed, the onsite time of a psychiatrist in the 30 days prior to the OSIG site visit varied from zero hours to 80 hours. Eight jails reported less than 20 hours of onsite psychiatric time in the 30-day period.

Jail medical staff noted that efforts would be made to use generic medications and formulary-based medications, unless there was clear justification of an individual responding to a particular non-formulary medication. Of the 25 jails surveyed, eight (32%) had policies prioritizing the use of generic medications whenever possible.

Medical and mental health personnel reported that efforts were made to continue medications that had been prescribed for individuals in active community treatment at the time of their incarceration, or that had been initiated during a period of hospitalization. The OSIG observed instances of the jails providing continuing "bridge" medications until a physician or psychiatrist could make a full assessment.

RECOMMENDATION NO. 3-A

The BOC should work with the Virginia Sherriff's Association (VSA) and Virginia Association of Regional Jails (VARJ) to determine if creation of a single pharmacy contract would be more cost effective and aligned with the formulary used by state behavioral health facilities.

RECOMMENDATION NO. 3-B

A workgroup consisting of jail medical staff, CSB emergency staff, and DBHDS facility medical staff should develop protocols to guide the pre-admission screening process for individuals with

mental illness who are in local and regional jails, focusing on reducing the risk of individuals deteriorating solely as a result of their jail residency.

Question 4. How are individuals with an acute episode of mental illness, accompanied with behavioral problems, housed and treated?

Observations

All jails reviewed were designed to house individuals in a manner that maximized safety and ensured the greatest capacity to control inmate movement. The design was consistent with the objectives of a correctional facility, but was not always conducive to addressing the treatment needs of inmates with mental illness, especially the most severe forms of mental illness and those individuals with active psychotic symptoms.

All jails reviewed had policies in place for the segregation of inmates based on suicide concerns, but this review revealed that guidance on segregation of individuals with mental illness, or acute mental illness, was lacking in 16 of the 25 (64%) jails visited. In each jail, the medical staff emphasized that the focus during an acute episode was primarily on "control and safety," not the active treatment of mental illness.

Nine (36%) of the jails specifically referenced mental illness in their policy on segregation; while 13 (54%) had a procedure in place for segregation of individuals identified as having mental illness during the screening process, or for an individual experiencing an acute episode.

As noted, the screening process on entering a jail was intended to identify concerns that would influence a decision regarding where an individual with mental illness should be housed. During this review, individuals with mental illness that were in an acute phase were observed in single cells, located in the medical section of the jails, and in administrative segregation cells, or rooms, where they could be monitored.

Monitoring was observed to be either in the form of cameras, regularly scheduled observation, or a combination of both. At one large jail with a significant mental health population, the facility Administrator reported that he frequently needed to have a corrections officer placed outside an observation room 24 hours a day.

In each jail, the medical staff emphasized that the focus during an acute episode was primarily on "control and safety," not treatment. Medication management was cited as the primary tool for intervention in an acute episode and inability to medicate over objection was cited as a barrier to treatment.

Suicide Prevention

Suicide is the number one cause of death for inmates in jails.[32] Merely being in custody is one of the top ten risk factors for suicide. Correctional staff are the frontline defense for suicide prevention.

Individuals who had been placed on suicide watch were seen wearing safety vests in their cells, and in one instance, an individual who was attempting to harm himself was in a restraint chair with staff providing arms-length observation. The staff noted the need for more specialized rooms for individuals who were suicidal or experiencing acute psychiatric episodes.

Serious mental illness affects an individual's perceptions and judgment, adding to the risk that they will be non-compliant with jail rules, which places them at increased risk for use of segregation. Segregation cells or rooms offer safety for the individual or others, but studies indicate isolation in a room with little space and limited contact through a small window or slot could actually exacerbate the individual's illness.[33]

While not a focal point of this study, the OSIG believes that the problem of suicide attempts and death by suicide warrants a joint mental health and correctional study of suicides that have occurred in jails and prisons across the Commonwealth in the last five years. To promote full participation, this suicide study could be a simple paperwork review with anonymous results.

Six of the 25 (25%) jails visited had established mental health units or pods in order to decrease the isolation of individuals with mental illness and expand opportunities for engagement. These units were likely to have dedicated staff with additional mental health training and were able to interact more readily, although much of that interaction lacked privacy. That said, there were significant differences in mental health units or pods in the jails visited.

If there was a regional jail with a mental health unit or pod, the local jails reported that they transferred individuals with mental illness to the regional facility. The movement of individuals from local jails to regional jail settings can create additional barriers to effective linkages between the regional jail and the CSB serving the locality of the individual's residence.

[32]L. Hayes. National Study of Jail Suicide: 20 Years Later. National Center on Institutions and Alternatives (NCIA) (Mansfield, MA) National Institute of Corrections. Jails Division (Washington, DC). 2010. Available at: http://static.nicic.gov/Library/006540.pdf.

[33]J. Metzner, J. Fellner. Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics. *Journal of the American Academy of Psychiatry and the Law*. 2010. Available at: http://www.jaapl.org/content/38/1/104.full.pdf+html. Accessed December 6, 2013.

Recommendation No. 4-A
Virginia should continue to prioritize funding the array of jail diversion alternatives defined in the Sequential Intercept Model (SIM) in order to reduce the number of mentally ill individuals in local and regional jails.

Recommendation No. 4-B
The BOC should involve current jail mental health practitioners in a review of BOC Standard 6VAC15-40-990 on the use of administrative segregation in order to provide greater guidance on segregation of individuals with serious mental illness.

Recommendation No. 4-C
Future jail construction and renovations should place greater focus on the safety and treatment needs of mentally ill individuals.

Recommendation No. 4-D
The BOC should work with jails that operate mental health units to create standards for such units, including staff training and availability of treatment.

Recommendation No. 4-E
Consideration should be given to the creation of mental health pods in local and regional jails. This would serve to expand active treatment for individuals with mental illness.

Question 5. Do services provided by CSBs or private providers of jail-based services meet the needs of incarcerated individuals with mental illness?

Observations

Life, health, and safety needs are the first priority, and the reality is that jails have been designed primarily to be "management and control" settings—not treatment settings.

Interviews of jail administrators, corrections officers, medical staff, and mental health providers point to thoughtful efforts to meet the needs of individuals with mental illness, but it was clear that mental health services in jails did not rise to the level of what is available in the community.

In the jails reviewed, private providers had good screening tools in place, and they offered medication management via tele-psychiatry or scheduled hours, but there was limited supportive counseling provided. While all local and regional jails used screening tools to identify individuals with mental illness, there was no consistency among these tools, or in the level of mental health training for the jail staff that conducted the initial screening.

The Compensation Board's Annual Reports of Mental Illness in Jails in recent years suggest that jails rely more on contracted private providers for overall health care, including mental health services, than on the CSBs. In 2009, 14% of the mental health services were delivered by private (non-CSB) providers. The percentage of mental health treatment from private providers in 2012 was 40%. While CSBs still were identified as providing 42% of mental health services, that percentage has dropped from 61% in 2009.[34]

The CSBs that were funded to provide targeted jail diversion/treatment were actively engaged at five jail study sites, and there was significant engagement in five other jails that had purchase of service agreements with the CSBs for onsite services. CSBs had good screening tools in place, offered psychiatric coverage with their own staff, and provided supportive counseling, although these services appeared to be limited to "check-in visits" of no more than three to four hours weekly.

Cognitive behavior therapy or other forms of individualized therapy were almost non-existent and direct engagement in even supportive counseling was brief. Psychiatric time in the study jails was limited, with 32% (8 of 25) jails reporting 20 hours or less a month for the jail's mentally ill population.

In some jails, each person that entered was interviewed by a mental health clinician, while in others that interview only took place based on information collected at the booking or during medical screenings. The level of experience of the mental health staff conducing actual mental health assessments ranged from bachelor level and associate degree personnel to licensed social workers and licensed professionals.

Jails that were currently, or previously, accredited by the ACA or the NCCHC had policies and practices with greater specificity on screening and treatment of individuals with mental illness.

Recommendation No. 5-A

Jails that are not ACA or NCCHC accredited should consider applying ACA and NCCHC mental health standards to individuals under their supervision (Recommendation No. 2).

[34]Compensation Board. 2012 Mental Illness in Jails Report (and a comparison of Reports from prior years). 2012. Available at: http://www.scb.virginia.gov/docs/2012mentalhealthreport.pdf. Accessed December 6, 2013.

Question 6. Are policies and practices in place to effectively link individuals with mental illness to community-based services when they leave jail?

Observations

Jails seek to identify if individuals entering jail were receiving, or had a history of receiving, mental health treatment in the community, but efforts to follow-up on community linkage on release were less productive. Jails in the review were not able to provide information about the rate of recidivism for individuals with mental illness, but staff at each jail commented on numerous "frequent flyers" in their facility. While jail administrators, medical staff, and mental health staff frequently commented on the problem of recidivism, only 39% (9 of 25) of jails had policies with a provision to link the individual with community mental health providers on release.

Recidivism, and the incidence of community mental health treatment, is a meaningful performance measure that could serve as the focus of future inquiry to better understand the root cause(s) of recidivism.

The capacity of individuals to access treatment in the community was hindered by a lack of funding to support successful transition from jail to community, delay in reactivation of Medicaid, and a lack of planning for accessing Medicaid or other health care coverage that may be available.

In every jail surveyed, administrative and treatment staff discussed the issue of recidivism—a revolving door for some individuals, often times convicted of minor offenses. All jail staff identified individuals that were at-risk for a felony conviction, due to habitual offender status, where the underlying issue was the person's mental illness and the lack of stability in the community.

"Release" occurred when a jail relinquished responsibility and custody for the individual when they exited the jail facility; however, the release of an individual with mental illness is only one-step in a "transition plan." The lack of effective transition planning increased the risk of recidivism, because without effective linkage with community mental health providers, mentally ill individuals could deteriorate and resume the recidivism cycle.[35]

The process of linkage between the jail and the community at the time of release varied greatly. The OSIG observed that the coordination or linkage at release was best when there was active engagement by the CSB at the point of entry into jail, when the CSB had staff onsite on an

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[35]F. Osher. Short-term Strategies to Improve Re-entry of Jail Population. 2007. Available at: http://gainscenter.samhsa.gov/pdfs/reentry/APIC_Model.pdf. Accessed December 6, 2013.

ongoing basis, and when there was a memorandum of agreement between the jail and the CSB that addressed release planning.

Areas of concern for the release of individuals with mental illness included:

- Medication: All jails reviewed provided mentally ill individuals with the medication they had been receiving during their incarceration. The supply of medication provided released individuals ranged from three to 30 days.
- Appointments: Jails reported that follow-up appointments were often weeks after a release date, and jails could not confirm if individuals had been seen by community mental health providers following their release.
- Recidivism: The jails noted that individuals often returned to jail after arrest for minor or "nuisance" offenses like vagrancy, shoplifting, etc. During this review, jails did not have a tracking mechanism to monitor rates of recidivism for individuals with mental illness.
- Lack of Health Care Coverage: Individuals who had been receiving Medicaid prior to their incarceration can face weeks or months of delay following release, while those entitlements re-activated. Additionally, individuals who were eligible for Medicaid, or other health insurance, may have experienced a delay in accessing coverage, or were unable to initiate applications without direct assistance.

There were promising practices observed and reported during site visits that may emerge as best practices, including:

- Regular meetings among jail, CSB, and probation staff as part of a coordinated re-entry program (these initiatives appeared to be a result of community cross-systems mapping efforts that identified the release process as a gap in the continuity of care).
- Onsite CSB "jail diversion" staff that developed transition plans.
- A CSB-targeted case manager who met with the individual at release.

Based on the data contained in the Compensation Board's *2013 Mental Illness in Jails Report,* the population served by jails and CSBs—mentally ill and seriously mentally ill persons—was increasingly overlapping. However, this review revealed that all too often, there was no defined relationship between the two entities (jails and CSBs), which led to poor continuity of care.

Part of the definition for serious mental illness in the CSBs' *Performance Contract* stated, "*The person exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.*"[36] Per their *Performance Contract*, CSBs were expected to provide services and support specific to the needs of this population, for which they received funding or payments, mostly from Medicaid.

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[36]FY 2013 and FY 2014 Community Services Performance Contract. Page 5. (Also see Core Services Taxonomy. Available at: www.dbhds.virginia.gov/occ-default.htm. Accessed January 8, 2014.)

Once an individual who had been receiving active treatment in the community entered jail, the CSB had no obligation to continue the therapeutic relationship and funding for services and supports terminated. As such, the CSB and jail relationship was either self-directed based on the belief there was common interest in working together, there was a financial connection because the jail contracted for behavioral health services, or the CSB was receiving targeted jail diversion and treatment funds.

RECOMMENDATION NO. 6-A
Jails should develop mechanisms for tracking recidivism of individuals with mental illness that were "engaged" in treatment at release.

RECOMMENDATION NO. 6-B
An initiative similar to the Discharge Assistance Program (DAP) should be created to support successful jail-to-community transition.

RECOMMENDATION NO. 6-C
The BOC should consider a new standard, distinct from Standard 6VAC15-40-1090, to address transition planning for individuals with mental illness.

RECOMMENDATION NO. 6-D
Jails and CSBs should seek to help individuals gain access to health care that may be available to them through new health care exchanges and develop strategies to facilitate timely re-activation of Medicaid or enrollment therein for individuals being released from jail.

RECOMMENDATION NO. 6-E
The DOC should continue to advance the *Thinking for a Change: Integrated Cognitive Behavior Change Program* curriculum for use in jails, and the DBHDS should support similar initiatives in the community for individuals that have been incarcerated in local and regional jails.

Question 7. Are the total costs for providing mental health care incurred by local and regional jails accurately accounted for?

According to the Compensation Board's *2012 Mental Illness in Jails Report*, the cost of serving individuals with mental illness was $13.3 million.[37] Based on our review, the OSIG estimated that the cost is likely higher because the jails visited lacked mechanisms to capture all costs associated with supervising incarcerated individuals with mental illness.

[37]Compensation Board. 2012 Mental Illness in Jails Report (and a comparison of Reports from prior years). 2012. Available at: http://www.scb.virginia.gov/docs/2012mentalhealthreport.pdf. Accessed December 6, 2013.

The review revealed that jails typically only tracked the following direct costs for providing mental health care to incarcerated individuals:

i) Annual contract costs.

ii) The cost of psychiatric time plus the cost of medical staff with mental health treatment responsibilities.

iii) The cost of providing psychotropic medication purchased through their pharmacies.

Thus, when the jails respond to the Compensation Board's annual mental illness in jails survey questions, they refer to these cost centers.

The review revealed that the 2012 Compensation Board survey of jails did not capture all direct and indirect costs associated with supervising individuals with mental illness in their custody. To cite a few omissions, the annual survey does not document:

i) The staff cost for providing one-to-one supervision of mentally ill inmates experiencing acute episodes.

ii) The staff and equipment cost of transporting mentally ill individuals to hospitals.

iii) The cost (including medical care) of injuries resulting from inmate-on-staff aggression arising from behaviors associated with mental illness.

Recommendation No. 7

The Virginia Association of Regional Jails (VARJ) and the Virginia Sherriff's Association (VSA) should work with their members to account for all direct and indirect costs associated with housing and treatment of individuals with mental illness.

Question 8. Has CIT training had an impact on jails' mental health-specific policies, procedures, and practices?

Crisis Intervention Team (CIT) training provides 40 hours of training to law enforcement officers, emergency dispatchers, mental health treatment providers, and other first responders in order to improve their ability to: respond safely and effectively to persons with mental illness, reduce the use of force and restraint, divert arrest, and link individuals to mental health supports whenever possible.

Jail Administrators consistently described positive impressions about the CIT training their staffs received. Administrators reported a reduction in the use of force, inmate-on-inmate violence, and inmate-on-staff aggression following this training.

Since 2008, the number of CIT programs has increased from 22 to 33. This means that 85 percent of Virginia's population now lives in areas served by CIT-trained personnel. As this Report was being drafted, approximately 5,712 individuals consisting of law enforcement officers, emergency dispatchers, mental health treatment providers, and other first responder personnel have now participated in CIT training.[38]

Jail Administrators confirmed the value of mental health training for jail staff and expressed a preference for having all staff trained in CIT. Several Administrators indicated they had established goals for 100% training of jail personnel that regularly interacted with inmates. Jail Administrators, medical staff, and mental health staff also recommended that any mental health provider who was going to work in a jail needed to be trained on the goals, objectives, and philosophy of the jail.

Recommendation No. 8-A
Continue current efforts to provide CIT training to jail personnel.

Recommendation No. 8-B
The BOC should consider expanding BOC Standard 6VAC15-40-1040 to include a minimum level of mental health training for jail personnel who work with individuals with mental illness.

Recommendation No. 8-C
The BOC should consider a standard for training any CSB or private provider working in a jail to ensure they have an understanding of the differences between mental health care in a community-based program versus a jail setting.

Question 9. What do jail administrators believe contributes to the incarceration of individuals with mental illness, and what are the priorities for addressing the needs of this population?

During the planning phase of this review, representatives of the VSA and the VARJ requested an opportunity to provide comments related to the growth in the mentally ill population in their jails, and to offer suggestions for addressing the challenges they face in housing this population.

In consideration of this request, Jail Administrators (or their designees) responded to four open-ended questions. A full account of their comments is appended to this report. A summary of the concerns we received from these corrections professionals during this review appears below:

- The number of incarcerated individuals with mental illness has increased due to the loss of large numbers of public and private psychiatric beds, the limited community

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[38] A current summary of these collaborative efforts and community initiatives may be accessed through the DBHDS website at http://www.dbhds.virginia.gov/.

resources available to treat mentally ill persons, and the difficulty of placing forensic individuals in community settings.

- Changes that could decrease jail census included a diversion option for minor offenses, creation of more drop-off centers, the establishment of regional mental health jails, and additional mental health training for law enforcement officers.
- What was most needed to support efforts to address the needs of incarcerated mentally ill persons included Compensation Board reimbursement for mentally ill individuals, and more resources, overall; access to inpatient (non-jail) psych beds; greater CSB participation and community resources at release; and the creation of mental health pods/areas.
- The top priorities for responding to inmates with mental illness are psychiatric bed access, creation of a regional mental health correctional center, onsite pre-admission screening, establishing a structured "hand-off" at release, funding for mental health, access to a state pharmacy to help control drug costs, and funding for additional mental health staff.

Appendix I—Glossary of Terms

ACA	American Correctional Association. A professional organization for individuals working in criminal justice.
ADA	Americans with Disabilities Act of 1990. The ADA is a wide-ranging civil rights law that prohibits, under certain circumstances, discrimination based on disability.
BH	Behavioral Health. Refers to the collective field of mental health and substance abuse.
BHA	Behavioral Health Authority. A public body and a body corporate and politically organized in accordance with the provisions of Chapter 6 of Title 37.2 of the Code of Virginia, that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, developmental, and substance abuse services.
CIT	Crisis Intervention Team. A model of intervention for law enforcement officers that improves their ability to respond to individuals with mental illness.
Community-based	Services provided in community settings and most often managed by a community services board or behavioral health authority.
CSB	The public body established pursuant to § 37.2-501 that provides mental health, developmental, and substance abuse services within each city and county that established it." *Code* § 37.2-100.
CRIPA	Civil Rights of Institutionalized Persons Act. A United States federal law intended to protect the rights of people in state or local correctional facilities, nursing homes, mental health facilities and institutions for people with intellectual and developmental disabilities.
DAP	Discharge Assistance Program. A funding initiative that helps individuals transition from state behavioral health facilities to the community.
DBHDS	Department of Behavioral Health and Developmental Services. Formally known as the Department of Mental Health, Mental Retardation and

	Substance Abuse Services.
DOJ	U.S. Department of Justice.
FORENSIC STATUS	State hospitals provide forensic evaluation, emergency, continuing treatment, and competency restoration services. These various pre-trial and post-trial services are required by *Code* § 19.2-169.1, § 19.2-169.2, § 19.2-169.5, and 19.2-169.6.
JLARC	Joint Legislative and Audit Review Commission. An oversight agency of the Virginia General Assembly, established to evaluate the operations and performance of state agencies and programs.
NCCHC	National Commission on Correctional Health Care. An accrediting body that establishes standards for correctional settings.
Olmstead	Refers to a 1999 United States Supreme Court decision holding that, under the Americans with Disabilities Act, individuals with mental disabilities have the right to live in the community rather than in institutions if, in the words of the opinion of the Court, "*the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities*."
OSIG	Office of the State Inspector General
Performance Contract	A contract between DBHDS and the CSBs that defines the responsibilities of the parties for the delivery of services, service quality and fiscal accountability.
SAMHSA	Substance Abuse and Mental Health Services Administration
SGF	State General Fund Dollars
SMI	Serious Mental Illness

Appendix II—Summary of Medical Records Review

A total of 172 medical records of individuals identified as having mental illness were reviewed for this study. At each of the 25 jails visited, between five and ten records were reviewed, unless the number of individuals in the jail indentified with mental illness on the day of the visit was fewer than five.

Ability of the jail to identify the number of individual in the jail that had a mental illness:

All but one of the 25 jails visited was able to identify the number of individuals with mental illness. This information was either accessible from a database, from records maintained by the medical staff, or from tracking tools used by the mental health staff.

Screening Forms Had Identified Mental Illness:

Of the 172 records reviewed, 156 (91%) contained documentation of a formal screening. Of those, 149 (96%) had the need for mental health services identified during the jail entry process. The remaining 4%, who were receiving mental health services, were identified after the screening and classification process.

Diagnosis of mental illness from jail medical staff or other provider of mental health services present:

Of the 156 records that identified mental illness through a screening process, 146 (94%) contained a formal mental health diagnosis. In the records where there was no formal diagnosis, the individual was still receiving medication(s). A prior history of the person being treated with medication appeared to be the basis for the treatment.

Record contains determination of the individual having been an active consumer/client at the time of their admission to the jail:

In 113 (67%) of the records, the screening indicated that the individual was receiving or had received mental health treatment in a community setting; however, only 93 (of 113) records identified the source of those services.

A CSB was identified as the community provider in 58 (62%) of those records. A private provider was identified in 31 (33%) of the records. The remaining records referenced the Veterans Administration or another prison as the prior provider.

Record contains documentation of jail notifying the CSB or Private Provider of the individual being admitted to the jail:

Of the 113 records with a reference to the individuals having received community treatment, 89 records (78%) included documentation of efforts to contact the provider. The contact was most often tied to seeking treatment information.

Record Contains documentation of the individuals receiving mental health services in the jail:

Mental health treatment was documented in 165 (97%) of the 172 records we reviewed. Of the 165 records:

- Medication management was the only service documented in 92 (55%) of the records.
- Fifty (30%) of the records documented medication with "supportive" counseling that focused primarily on medication adherence.
- Twenty-seven (16%) of the records included documentation of additional services such as case management, group or psychosocial services.

Record contains documentation of who prescribed medication:

A private contract physician/psychiatrist or full-time jail physician prescribed medications in 68% (17 of 25) of the study jails and a CSB psychiatrist was identified in eight (32%).

Record documents qualifications of the person providing mental health services:

Of the 165 (of 172) records wherein mental health treatment was documented, 127 (77%) identified a psychiatrist as the provider.

Record documents efforts to encourage the individual to take an active role in managing their illness:

Of the 158 (of 172) records that documented active mental health treatment, 102 (65%) included documentation relating to efforts to actively engage the individuals managing their illness. In most instances, this effort took place during medical visits or when "supportive counseling" was provided. Wellness Recovery Action Plan (WRAP) groups were noted in one jail.

Record documents efforts to encourage the individual to continue treatment in the community upon release from jail:

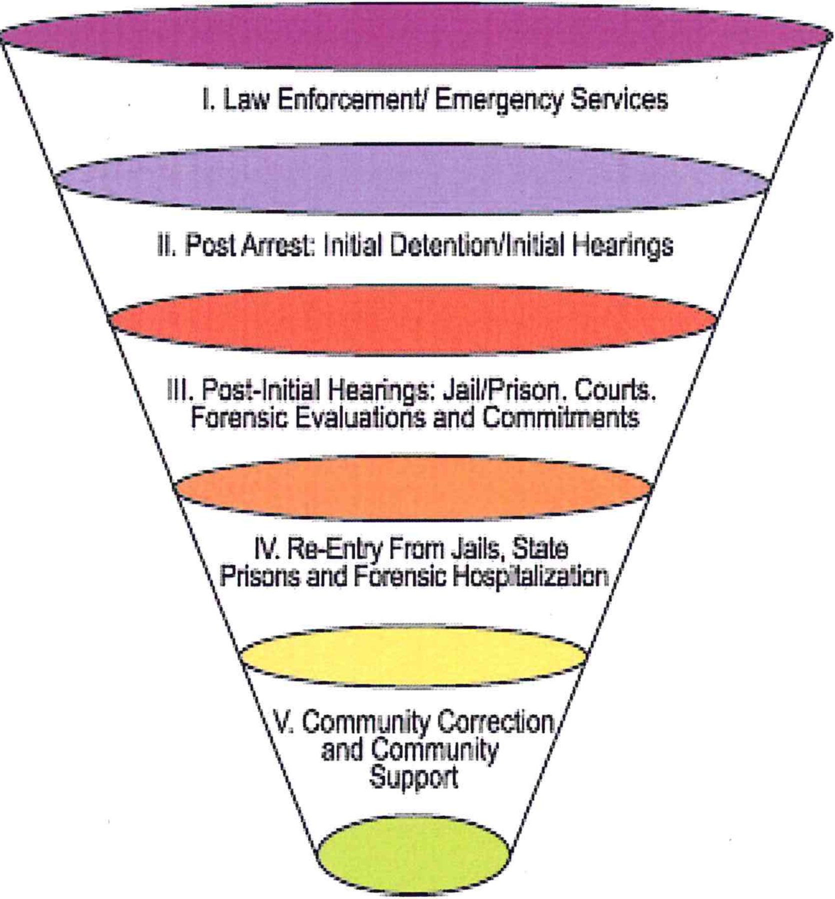
Of the 172 records, we reviewed 168 for this criterion, and efforts to promote continuity of mental health treatment on release from jail were noted in 29% (49 of 168) of the records reviewed.

Appendix III—Study Instruments

Study Instrument 1: Review Instrument for Medical Records of Jail Inmates Identified as Receiving Mental Health Treatment Services

Study Instrument 2: Board of Corrections Minimum Standards Selected by OSIG Relevant to Reviewing Policy and Practice Specific to Identifying/Treating/Releasing Individuals with Mental Illness

Appendix IV—Sequential Intercept Model



For full details: http://www.dbhds.virginia.gov/documents/Adm/080513Griffin.pdf

Appendix V—Brief Jail Mental Health Screen/Correctional Mental Health Screen for Women (CMHS-W)

Brief Jail Mental Health Screen

Adobe Acrobat Document

Correctional Mental Health Screen for Women (CMHS-W)

Adobe Acrobat Document

Appendix VI—Sheriff and Superintendent Responses to Open-Ended Questions

What factors do you believe contribute to any increase of persons with mental illness in your jail population?

- Societal issues...PTSD (post-traumatic stress disorder) issues
- Closure of state beds
- Inability to place forensic individuals in community settings
- Arrest for misdemeanor crimes and then sitting for months or even a year
- Lack of options for judges
- Lack of options on release that lead to recidivism
- Lack of community resources
- Restricted bed access at state and local hospitals
- Lack of hospital beds
- Better ability to identify mental illness
- Without intervention of community services, police bring all individuals to the jail
- Community outplacement without needed support for inmates with mental illness
- Societal issues
- Increased involvement with alcohol, drugs, etc.; Societal breakdown
- Undiagnosed in general population
- Better diagnosis of mental illness
- Loss of inpatient beds at local hospital
- Lack of understanding by arresting officer (jail becomes dumping ground for mentally ill)
- General increase in MH population reflects the society issues
- Reflection of the problems in society
- General population increase of individuals with mental illness; Lack of CSB support
- Overall increase in MH inmates from society
- Law enforcement has no other place to put individuals with mental illness
- Alcohol and drugs – Lack of skills and services – Lack of access to services

What changes do you believe are needed to decrease the growth of persons with mental illness in the jails?

- Better diagnostic efforts
- Diversion options for minor offenses
- Drop-off centers
- Regional treatment setting for individuals that are arrested

- Drop-off center
- More funding for community care
- Inpatient beds
- Better follow-up after discharge from jail may reduce repeat bookings
- "I don't really have an answer"
- More psychiatric beds
- More community resources
- Greater access to hospital treatment
- A release follow-up to ensure MH individuals receive continued treatment
- Awareness, and staff onsite to help individuals
- Better diagnosis of MH
- Training of law enforcement officers on MH
- Intervention at the earliest possible time in life
- Greater support of MH ($) and diversion courts
- Follow-through with MH services in the community upon inmate discharge
- More cooperation from CSB
- More Funding
- Additional funding for specific MH needs
- More state facility MH beds available
- Additional funding for medications
- Increase in availability of services

What would be needed to support your efforts at addressing the needs of persons with MI in the jails?

- Additional staffing
- Capacity to provide more stimulation
- Housing resources for transition
- Pilot programs for MH probation
- Specific funding for MH efforts
- Active involvement of CSB during incarceration
- Help with medication costs
- Compensation Board payments adjusted for mental health inmates
- Increased funding and physical facilities
- Funding to support the MH needs
- Dedicated capacity for housing mentally ill inmates
- Additional mental health counseling resources

- Funding
- Education, funding
- Additional funding for specific MH treatment
- Funding for proper treatment
- More hands-on time with deputies; In–house training for jail CSB would be helpful
- Additional funding specific to MH
- Increased funding
- More cooperation from CSB. More Funding
- Funding
- Money – Personal responsibility and accountability – Discharge manager

What would be your top priority for responding to your MH inmates in your jail if you had the capacity to address the priority?

- Establish structured "hand-off" of the discharged MH inmate
- Seamless transition; services in the jail/housing/monitoring
- Better housing environment in jail "doors/more open/more interactive"
- Access to emergency forensic beds
- Drop-off center
- Funding for MH psychiatric services and medication
- A state pharmacy to help drive down costs
- Funding to hire additional MH support staff
- A mental health correctional center
- Utilizing Western Regional
- Increased staffing to cover MH inmates
- Increased treatment in jail to allow for future community-based treatment
- Training of personnel on MH
- Life skills training for inmates
- Developing steps to set-up and address all MH issues
- Ensuring that the inmates really should be in jail and not in some treatment facility
- Establish on-going treatment beyond discharge from jail
- Out-sourcing of support needs, once discharged from the jail
- Cost of medications
- More psychiatric hours

Appendix VII—Review Methodology

Stakeholder Engagement: The OSIG worked with the VSA and the VARJ to conduct two stakeholder conference calls before initiating the study in order to clarify the purpose of the study and to answer questions from sheriffs, jail superintendents, and other interested parties.

Jail Selection Criteria: The 12 city or county jails and 13 regional jails were selected based on the following criteria:

(1) Regional representation of the three regions identified in Appendix B of the Compensation Board *2012 Mental Illness in Jails Report*.

(2) Representation within regions of Regional/County/City Jails.

(3) Representation within region based on overall jail population and number of individuals identified in the Compensation Board *2012 Mental Illness in Jails Report* as having mental illness. The 2012 data was assumed a reasonable projection of the mental health population at the time of the study.

(4) Jails identified by the DBHDS as being "primary feeder" jails for state mental health hospitals.

(5) Jails that serve areas or communities that have participated in DBHDS and Department of Criminal Justice trainings for identification, diversion, or treatment of individuals with mental illness. (Based on information provided by DBHDS)

(6) Jails that serve areas or communities where the CSBs are funded to provide jail-based mental health treatment (based on DBHDS information).

Announced Visits/Entry and Exit Meetings: The State Inspector General provided a list of selected jails to leadership of the VSA and the VARJ for dissemination to sheriffs and jail superintendents. The announced visit clarified the purpose of the study for the jails beforehand and identified individuals that ideally would be onsite during the OSIG team visit. The OSIG conducted entry and exit meetings with jail personnel at each location.

Review Instruments: The OSIG used two instruments to conduct the study of each local or regional jail. A copy of both instruments is included in at Appendix III of this report.

(1) Policy and Procedures—A 57-question instrument linked to 32 selected BOC Standards. The standards were selected from the 124 standards that jails housing adults must meet to be certified by the DOC.

The standards were selected based on whether they included specific references to mental illness/mental health, or if it was an area of emphasis within the jail, the OSIG behavioral health staff believed the standard could drive policies that focused on the needs of individuals with mental illness.

a. Financial Management—The instrument included one question to identify how the jail determined and documented their expenditures for mental health services.

b. Jail Administrator Perspectives—The instrument included four open-ended questions to gain input from jail administrators.

(2) Medical Records—A ten-question instrument focused on determining the type of mental health treatment provided, qualifications of the mental health treatment provider, linkages with a community mental health provider if the individual was active in treatment at the time of jail entry, and release linkages with community mental health providers.

Walk-Through: The OSIG toured each jail visited to understand where individuals were screened for mental illness; where individuals with mental illness were housed, including general population areas and any special housing areas identified by the jail; and where individuals were housed in the event they required special observation due to their mental illness or threats of suicide.

Record Reviews: At each jail, the OSIG team reviewed randomly selected medical records of individuals identified as having a mental illness. The number reviewed was determined by the number of individuals in the jail on the day of the visit that had been identified through the screening process as having a mental illness. The maximum number of reviews at any jail was 10. A total of 172 medical records were reviewed.

Research on National Best Practice Models: The OSIG conducted research in advance and during the study to identify resources that offered information on best or promising practices specific to jail-based mental health services. Resources or materials are referenced directly in this report or included in the appendices.

Appendix VIII—Department of Corrections—Standards Compliance Form for Jails

DEPARTMENT OF CORRECTIONS

STANDARDS COMPLIANCE FORM

FOR JAILS

LHS: Refers to Life/Health/Safety Standards – reviewed annually by DOC

1. **6VAC15-40-30. Requirement for Written Statement** – The facility shall have a written statement and policy discussing its philosophy, goals and objectives. The written statement shall be reviewed every 12 months by administrative staff.
2. **6VAC15-40-40. Policy and Procedures Manual** – Written policy and procedures shall be maintained and available 24 hours a day to all staff. The facility's policies and procedures shall be reviewed every 12 months by administrative staff and updated to keep current with changes.
3. **6VAC15-40-60. Annual Report** – A written annual report of the availability of services and programs to inmates shall be reviewed by the facility administrator and provided to the sentencing courts and may be provided to relevant community agencies.
4. **6VAC15-40-90. Content of Personal Inmate Records** – Personal records shall be maintained on all inmates committed or assigned to the facility. Inmate records shall be kept confidential, securely maintained, and in good order to facilitate timely access by staff. Inmate records shall contain, but not be limited to:

   Inmate data form;

   Commitment form or court order, or both;

   Records developed as a result of classification;

5. **6VAC15-40-100. Daily Logs** – The facility shall maintain a daily log(s) that records the following information:

   Inmate count and location, to be verified with a minimum of one formal count per shift, observing flesh and movement;

   Intake and release of inmates;

   Entries and exits of physicians, attorneys, ministers, and other nonfacility personnel; and

   Any unusual incidents that result in physical harm to, or threaten the safety of, any person or the security of the facility.

6. **6VAC15-40-110. Serious Incident Reports** – A report setting forth in detail the pertinent facts of deaths, discharging of firearms, erroneous releases, escapes, fires requiring evacuation of inmates, hostage situations, and recapture of escapees shall be reported to the Local Facilities Supervisor of the Compliance and Accreditation Unit, Department of Corrections (DOC), or

designee. The initial report shall be made within 24 hours and a full report submitted at the end of the investigation.

7. **6VAC15-40-120. Classification** – Classification instruments enable objective evaluation and/or scoring of:

   Mental health or medical treatment history or needs.

   Identified stability factors.

   The classification system includes administrative review of decisions and periodic reclassification and override procedures that are documented and maintained on file.

   The classification system addresses both the potential security risks posed and treatment needs of the inmate.

8. **6VAC15-40-140. Awareness of Programs** – The facility administrator or designee shall make each inmate aware of available programs.

9. **6VAC15-40-320. Licensed Physician** – A licensed physician shall supervise the facility's medical and health care services. Facilities that contract with private medical facilities or vendors shall maintain a current copy of the agreement, unless employed by the facility. ***LHS***

10. **6VAC15-40-330. Restrictions on Physician** – No restrictions shall be imposed by the facility in the practice of medicine. However, administrative and security regulations applicable to facility personnel shall apply to medical personnel as well.

11. **6VAC15-40-340. Health Care Provider and Licensing, Certification and Qualification of Health Care Personnel** – Each facility shall have a minimum of one licensed or qualified health care provider who is accessible to inmates a minimum of one time per week. Health care personnel shall meet appropriate and current licensing, certification, or qualification requirements. ***LHS***

12. **6VAC15-40-350. Private Examination and Treatment of Inmates** – Where in-house medical and health care services are provided, there shall be space for the private examination and treatment of inmates.

13. **6VAC15-40-360. Twenty-Four Hour Emergency Medical and Mental Health Care** – Written policy, procedure, and practice shall provide 24-hour emergency medical and mental health care availability. ***LHS***

14. **6VAC15-40-370. Receiving and Medical Screening of Inmates** – Written policy, procedure, and practice shall provide that receiving and medical screening be performed on all inmates upon admission to the facility. The medical screening shall:

   Specify screening for current illnesses, health problems and conditions, and past history of communicable diseases;

   Specify screening for current symptoms regarding the inmate's mental health, dental problems, allergies, *present medications*, special dietary requirements, and symptoms of venereal disease;

   Include inquiry into past and present drug and alcohol abuse, mental health status, depression, suicidal tendencies, and skin condition;

15. **6VAC15-40-380. Inmate Access to Medical Services** – Written policy, procedure, and practice shall be developed whereby inmates shall be informed, at the time of admission to the facility, of the procedures for gaining access to medical services. ***LHS***

16. **6VAC15-40-400. Management of Pharmaceuticals** – Written procedures for the management of pharmaceuticals shall be established and approved by the medical authority or pharmacist, if applicable. Written policy, procedure, and practice shall provide for the proper management of pharmaceuticals, including receipt, storage, dispensing and distribution of drugs. These procedures shall be reviewed every 12 months by the medical authority or pharmacist. Such reviews shall be documented. ***LHS***

17. **6VAC15-40-410. Inmate Medical Records** – The medical record for each inmate shall be kept separate from other facility records and shall include the following:

    The completed screening form; and

    All findings, diagnoses, treatments, dispositions, prescriptions, and administration of medication.

18. **6VAC15-40-420. Transfer of Summaries of Medical Record** – Medical record summaries shall be transferred to the same facility to which the inmate is being transferred. Required information shall include: vital signs, current medications, current medical/dental problems, mental health screening, mental health problems, TB skin test date and results, special inmate needs/accommodations, pending medical appointments, medical dispositions, overall comments, health care provider/personnel signature and date, and any additional pertinent medical information such as lab work, x-rays, etc. ***LHS***

19. **6VAC15-40-440. Medical Care Provided by Personnel Other than Physician** – Medical care provided by personnel other than a physician shall be pursuant to a written protocol or order. Protocols or orders shall be reviewed and signed by the supervising physician every 12 months. ***LHS***

20. **6VAC15-40-450. Suicide Prevention and Intervention Plan** – There shall be a written suicide prevention and intervention plan. These procedures shall be reviewed and documented by an appropriate medical or mental health authority prior to implementation and every three years thereafter. These procedures shall be reviewed every 12 months by staff having contact with inmates. Such reviews shall be documented. ***LHS***

21. **6VAC15-40-470. Medical Co-Payment** – Jail medical treatment programs, wherein inmates pay a portion of the costs for medical services, shall be governed by written policy and procedure.

22. **6VAC15-40-490. Policy and Procedure Information** – Written policy and procedure shall specify, at a minimum, the following information:

    Medical services that are subject to fees;

    Fee amounts;

    Payment procedures;

    Medical services that are provided at no cost;

    Fee application to medical emergencies, chronic care and pre-existing conditions; and

Written notification to inmates of proposed fee changes.

23. **6VAC15-40-970. Restrictions of Physical Force** – Written policy, procedure, and practice shall restrict the use of physical force to instances of justifiable self-defense, protection of others, protection of property, orderly operation of the facility and prevention of escapes. In no event is physical force justifiable as punishment. A written report shall be prepared following all such incidents described above and shall be submitted to the facility administrator, or designee, for review and justification. ***LHS***

24. **6VAC15-40-980. Restraint Equipment** – Written policy, procedure and practice shall govern the use of restraint equipment. A written protocol pertaining to the monitoring of inmates in restraint equipment shall be established and approved by the medical authority.

25. **6VAC15-40-990. Administrative Segregation** – Written policy, procedure, and practice shall provide for administrative segregation of inmates who pose a security threat to the facility or other inmates, and for inmates requiring protective custody.

26. **6VAC15-40-1000. Physical Living Conditions for Disciplinary Detention and Administrative Segregation** – Written policy, procedure, and practice shall ensure that, inmate behavior permitting, the disciplinary detention and administrative segregation units provide physical living conditions that approximate those offered in the general population.

27. **6VAC15-40-1010. Mental Health Inmates** – Written policy, procedure, and practice shall specify the handling of mental health inmates, including a current agreement to utilize mental health services from either a private contractor or the community services board. ***LHS***

28. **6VAC15-40-1020. Record of Activities in Disciplinary Detention and Administrative Segregation** – Written policy, procedure, and practice shall ensure that a record is kept of scheduled activities in disciplinary detention and administrative segregation units. Documented activities shall include the following: admissions, visits, showers, exercise periods, meals, unusual behavior, mail, and release.

29. **6VAC15-40-1030. Assessment of Inmates in Disciplinary Detention or Administrative Segregation** – Written policy, procedure, and practice shall require that a documented assessment by medical personnel that shall include a personal interview and medical evaluation of vital signs, is conducted when an inmate remains in disciplinary detention or administrative segregation for 15 days and every 15 days thereafter. If an inmate refuses to be evaluated, such refusal shall be documented. ***LHS***

30. **6VAC15-40-1040. Staff Training** – The facility shall provide for 24-hour supervision of all inmates by trained personnel. ***LHS (Mental Health training)***

31. **6VAC15-40-1090. Release of Inmates** – Written policy, procedure, and practice shall require that, prior to the release of an inmate, positive identification is made of the release, authority for release is verified, and a check for holds in other jurisdictions is completed.

32. **6VAC-15-40-1180. Special Purpose Area** – The facility shall have a special purpose area to provide for the temporary detention and care of persons under the influence of alcohol or narcotics, who are uncontrollably violent or self-destructive, or those requiring medical supervision.

Appendix C

MH Standards Workgroup Roster

MH STANDARDS WORKGROUP ROSTER

First Name	Last Name	Organization
Ms. Stephanie	Arnold	Department of Criminal Justice Services
Ms. Jana	Braswell	Department of Behavioral Health and Developmental Services - OFS
Mr. Bruce	Cruser	Mental Health America of VA
Ms. Robyn	DeSocio	State Compensation Board
Ms. Beth	Dugan	Prince William CSB
LTC Steve	Eanes	Henry County Sheriff
Mr. Emmanuel	Fontenot	Board of Corrections Liaison, Department of Corrections
Mr. Tom	Fitzpatrick	Department of Criminal Justice Services
Ms. Melissa	Gibson	DisAbility Law Center
Capt. Eric	Hairston	Henry County Sheriff
Ms. Angie	Hicks	VA Beach CSB
Ms. Kari	Jackson	State Compensation Board
Sup. Martin	Kumer	Albemarle-Charlottesville Regional Jail
Maj. Mandy	Lambert	Prince William County Jail
Dr. Denise	Malone	Department of Corrections
Sheriff Gabe	Morgan	Newport News Sheriff's Office
Sheriff Lane	Perry	Henry County Sheriff
Ms. Renee	Robinson	Department of Behavioral Health and Developmental Services - OFS
Sup. Bobby	Russell	Virginia Association of Regional Jails
Dr. Mike	Schaefer	Department of Behavioral Health and Developmental Services - OFS
Ms. Christine	Schein	Department of Behavioral Health and Developmental Services - OFS
Ms. Aileen	Smith	VA Beach CSB
Ms. Tamara	Starnes	Blue Ridge CSB
Sheriff Kenneth	Stolle	Virginia Beach Sheriff's Office
Ms. Leslie	Weisman	Arlington CSB
Mr. Stephen	Weiss	JCHC