



2014

**A REVIEW OF MENTAL HEALTH SERVICES  
IN LOCAL AND REGIONAL JAILS**



**Office of the State Inspector General**

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# 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.*



## A Review of Mental Health Services in Local and Regional Jails

# 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.<sup>1</sup>

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.<sup>2</sup> 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.<sup>3</sup>

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?

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

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

<sup>3</sup>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?<sup>4</sup>
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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<sup>4</sup>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).<sup>5</sup>
- 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.

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<sup>5</sup>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.<sup>6</sup>
- 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.<sup>7</sup>

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<sup>6</sup>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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<sup>7</sup>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.



## A Review of Mental Health Services in Local and Regional Jails

# 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.<sup>8</sup>
- Since 2008 the number of individuals identified with mental illness in jails has increased by 30%, from 4,879 to 6,322.<sup>9</sup>
- 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.<sup>2</sup>
- 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,<sup>10</sup> Pennsylvania,<sup>11</sup> and Virginia<sup>12</sup> for CRIPA compliance.

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<sup>8</sup>Compensation Board. FY 2011 Jail Cost Report.

Available at: <http://www.scb.virginia.gov/docs/fy11jailcostreport.pdf>. Accessed December 5, 2013.

<sup>9</sup>Comparison of the 2008 and 2012 Compensation Board Report on Mental Illness in Jails.

<sup>10</sup>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/7492013522113545964446.pdf>. Accessed December 5, 2013.

<sup>11</sup>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](http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf). Accessed December 5, 2013.

<sup>12</sup>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.<sup>13</sup>

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.<sup>14</sup>

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:<sup>10,11</sup>

- 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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<sup>13</sup>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.

<sup>14</sup>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.



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

## 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.<sup>15</sup>

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.<sup>16</sup>

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.

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

<sup>16</sup>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)<sup>17</sup>*

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.

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<sup>17</sup>Virginia Department of Criminal Justice Services. Virginia's Peculiar System of Local and Regional Jails. 2010. Available at: <http://www.dcj.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.<sup>18</sup> 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.<sup>19</sup>

### ***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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<sup>18</sup>Compensation Board's website: <http://www.scb.virginia.gov/>.

<sup>19</sup>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.<sup>20</sup> 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.<sup>21</sup>

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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<sup>20</sup>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.

<sup>21</sup>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/>.



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

## 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.<sup>22</sup> 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.<sup>23</sup>

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

<sup>23</sup>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.<sup>24</sup>

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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<sup>24</sup>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.<sup>25</sup>

- 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

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<sup>25</sup>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.<sup>25</sup>
- 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.<sup>26</sup>

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.<sup>27</sup> The total expenditure for those services was \$733,749,350, with 50 cents of each dollar being SGF.<sup>28</sup>

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<sup>26</sup>DBHDS. Fiscal Year 2012 Annual Report. 2012. Available at: <http://www.dbhds.virginia.gov/documents/RD360.pdf>. Accessed December 6, 2013.

<sup>27</sup>Behavioral Health includes mental health and substance abuse services.

<sup>28</sup>DMAS. Division of Behavioral Health Services Administrator Fact Sheet. Available at: [http://www.dmas.virginia.gov/Content\\_atchs/obh/bh-admin1.pdf](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 ( $\$184,098,776 \times .71/80,453 = \$1,625$ ). Applied to the 2012 Compensation Board Survey census, an equivalent investment of SGF for mental health services in jails would be approximately \$10.3M ( $6,322 \times \$1,625$ ). 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.<sup>29</sup>

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.

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<sup>29</sup>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.<sup>30</sup>

***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

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<sup>30</sup>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 policies 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.<sup>26</sup> 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.<sup>31</sup>

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

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<sup>31</sup>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.<sup>32</sup>

- 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.<sup>32</sup> 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.<sup>33</sup>

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.

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<sup>32</sup>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>.

<sup>33</sup>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.<sup>34</sup>

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 conducting 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](#)).

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<sup>34</sup>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.<sup>35</sup>

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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<sup>35</sup>F. Osher. Short-term Strategies to Improve Re-entry of Jail Population. 2007. Available at: [http://gainscenter.samhsa.gov/pdfs/reentry/APIC\\_Model.pdf](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.*”<sup>36</sup> 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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<sup>36</sup>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](http://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.<sup>37</sup> 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.

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<sup>37</sup>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.<sup>38</sup>

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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<sup>38</sup>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 <a href="#">§ 37.2-501</a> that provides mental health, developmental, and substance abuse services within each city and county that established it.” <i>Code</i> <a href="#">§ 37.2-100</a> .
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 <a href="#">§ 19.2-169.1</a> , <a href="#">§ 19.2-169.2</a> , <a href="#">§ 19.2-169.5</a> , and <a href="#">19.2-169.6</a> .
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.
<i>Olmstead</i>	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, " <i>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.</i> "
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 identified 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*



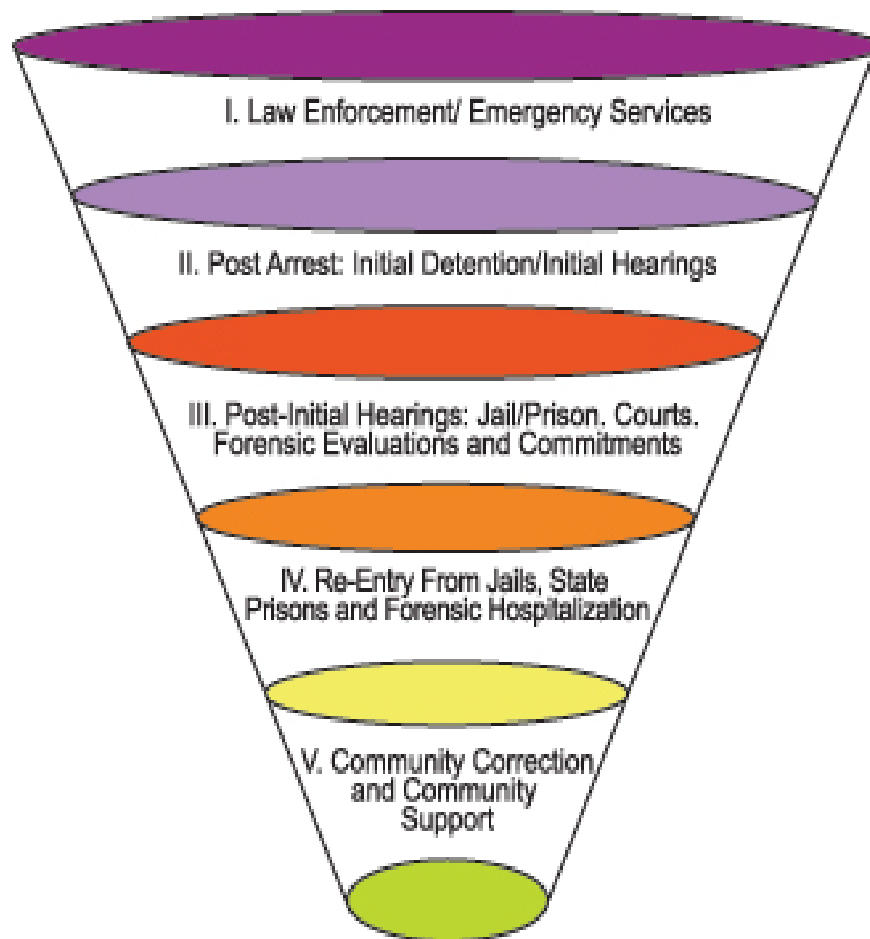
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Document

*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*



Adobe Acrobat  
Document

## 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.