COMMONWEALTH of VIRGINIA

JACK BARBER, M.D.
INTERIM COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

November 1, 2017

TO: The Honorable R. Creigh Deeds, Chair, Joint Subcommittee to
Study Mental Health Services in the Commonwealth in the 21st Century
The Honorable Mark D. Obenshain, Chair, Senate Courts of Justice Committee
The Honorable David B. Albo, Chair, House Courts of Justice Committee
The Honorable Robert B. Bell, Member, House of Delegates
The Honorable John A. Cosgrove, Jr., Member, Senate of Virginia

Fr: Jack Barber, MD
Interim Commissioner

Pursuant to House Bill 1784 (Bell) and Senate Bill 941 (Cosgrove), which instructed the Commissioner of the Department of Behavioral Health and Developmental Services to "*review the availability of forensic discharge planning services at local and regional correctional facilities for persons who have serious mental illnesses who are to be released from such facilities.*", please find enclosed the report on the Forensic Discharge Planning Study Workgroup.

Staff at the department are available should you wish to discuss this report.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Members, Forensic Discharge Planning Study Workgroup

Virginia Department of Behavioral Health & Developmental Services

Forensic Discharge Planning for Persons with Serious Mental Illness in Virginia Jails

(HB1784 & SB941)

November 1, 2017

DBHDS Vision: A Life of Possibilities for All Virginians

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Forensic Discharge Planning for Persons with Serious Mental Illness in Virginia Jails

Preface

During the 2017 Session of the Virginia General Assembly, House Bill 1784 and Senate Bill 941 were passed, mandating that the Virginia Department of Behavioral Health and Developmental Services (DBHDS) prepare a report to the General Assembly outlining a comprehensive plan for the provision of forensic discharge planning services for individuals with Serious Mental Illness incarcerated in Virginia Jails.

> *§ 1. The Commissioner of Behavioral Health and Developmental Services (the Commissioner) shall, in conjunction with the relevant stakeholders, review the availability of forensic discharge planning services at local and regional correctional facilities for persons who have serious mental illnesses who are to be released from such facilities. The Commissioner shall develop a comprehensive plan for the provision of forensic discharge planning services for such persons at local or regional correctional facilities, which shall include the requirement that each facility have access to a discharge planner, and shall detail the cost considerations associated with the implementation of such a plan as well as any cost savings and benefits associated with the successful implementation of such a plan. The plan shall be completed by November 1, 2017, and reported to the Chairmen of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century, the House Committee for Courts of Justice, and the Senate Committee for Courts of Justice. The report on such plan shall also be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports no later than the first day of the 2018 Regular Session of the General Assembly and shall be posted on the General Assembly's website.*

DBHDS convened a Forensic Discharge Planning Study Workgroup, comprised of local and state-level professionals, to review the available literature and research related to forensic discharge planning, provide input based on their experience and expertise, and develop a written plan that that can serve as a guide for legislators, jail administrators, and state and local mental health authorities. The report that follows summarizes the existing literature and research on forensic discharge planning, describes the current picture of forensic discharge planning services in Virginia, proposes a structure for the implementation of comprehensive forensic discharge planning statewide, and outlines the potential costs and cost-savings with successful execution of the plan. It is the hope of DBHDS that this document will inform future practices and policies related to forensic discharge planning in the Commonwealth of Virginia.

Forensic Discharge Planning for Persons with Serious Mental Illness in Virginia Jails

Table of Contents

Executive Summary

The ***Forensic Discharge Planning for Persons with Serious Mental Illness in Virginia's Jails*** report was undertaken to provide a potential solution to the challenges faced by jails, local communities, and the Commonwealth in their attempts to manage the growing problem of persons with serious mental illness (SMI) in Virginia's local correctional institutions. As directed in HB 1784 and SB 941, which passed in the 2017 session of the Virginia General Assembly, DBHDS convened a workgroup to develop a comprehensive plan to address the needs of this population as they are released from jail.[1] Virginia faces growing pressures to address the problem of persons with SMI in jails and the impact of unaddressed mental health needs upon release on criminal justice and behavioral health systems, and the community at large.

Summary of the Problem[2]

- **3,556 individuals in Virginia jails have been reported to have a SMI** such as schizophrenia, schizoaffective disorder, bipolar disorder, or post-traumatic stress disorder (PTSD) on any given day.

- **Virginia jails report spending $14 million per year** in medication and treatment costs alone, but **expenses are likely much higher** due to uncalculated costs for staffing, injuries, emergency hospitalizations, and other indirect costs.

- Individuals with **SMI who are released from jails have higher rates of re-arrests when they are not linked to mental health care in the community** than those who are provided this type of discharge planning services.

Proposed Forensic Discharge Planning Structure

Forensic discharge planning **should be provided by community services board (CSB) staff and should begin as soon as possible upon entry into the jail and prior to jail release**. It should continue **no less than 30 days post-release** to ensure a smooth transition.

- **Caseload size for a full-time forensic discharge planner should be approximately 20 clients**, as these individuals will likely be high need and high intensity.

- Forensic discharge planning should be made available in **every jail in Virginia, for every inmate with an SMI.**

- **DBHDS supports use of the "APIC Model" – Assess, Plan, Identify, and Coordinate – of discharge planning and principles of the Risk Needs Responsivity (RNR) model in identifying levels of risk and needs.[3]**

Proposed Implementation Plan

The total cost to fund a robust forensic discharge planning system from all local and regional jails is **$12,367,400 annually**. DBHDS proposes a **tiered approach to implementation** based upon the percentage of SMI inmates in each jail.

- **Phase 1:** Funding should be allocated to the **five (5) jails with the highest percentage of SMI inmates**, which house one-third of the inmates with SMI in Virginia's local and regional jails. Funding this Phase would total **$4,109,900**.

- **Phase 2:** Funding should be allocated to the ten (10) jails representing the next one-third of inmates with Serious Mental Illness in Virginia jails. Funding this Phase would total **$4,099,200.**

- **Phase 3:** Finally, the remaining 45 jails that represent the remaining third of the inmates with SMI should be funded, totaling **$4,158,400**

Even if funding is unavailable to fully implement each phase of this plan, should additional resources be made available**, priority should be based upon the percentage of SMI in each jail, which will enable most individuals to access to this service as soon as possible**.

In conclusion, funding for the implementation of comprehensive forensic discharge planning services throughout Virginia will enable better use of state and local resources (by allowing for better coordination of care and by more consistently referring individuals to non-crisis care), enhance public safety (by linking individuals to the care they need thus potentially mitigating future involvement in the criminal justice system), and enhance the quality of life for those who are struggling to extricate themselves from criminal justice involvement.

Introduction to Forensic Discharge Planning

Why Forensic Discharge Planning?

Scope of the Problem

According to a 2006 Bureau of Justice Statistics report, approximately 76 percent of jail inmates throughout the country met the criteria for a mental health disorder. An estimated 49 percent of jail inmates met the criteria for both a mental health and substance use disorder.[4] More recent national data indicates that approximately 14-15 percent of males and 20-26 percent of females booked into local jails had a serious mental illness such as schizophrenia, schizoaffective disorder, or bipolar disorder.[5] In a 2011-2012 National Inmate Survey of inmates under correctional supervision, conducted by the Bureau of Justice Statistics, about 1 in 4 jail inmates (26 percent) reported experiences that met the threshold for "serious psychological distress" in the 30 days prior to the survey. Further, 44 percent of jail inmates had been told in the past by a mental health professional that they had a mental disorder. The study found that more jail inmates than federal or state prisoners met the threshold for "serious psychological distress," and that the rate of individuals who met these criteria was five times that of the general population with no criminal involvement.[6]

In Virginia, a State Compensation Board survey conducted in July 2016 indicates that approximately 16.4 percent of inmates in the 59 reporting local and regional jails had a mental illness, and roughly 50 percent of those individuals were reported to have a serious mental illness.[7] That equates to an estimated 6,554 inmates in Virginia's jails who have a mental illness

at any given time. This same survey indicated that the cost of providing psychotropic medications to those 6,554 inmates was $3.7 million per year, and an additional $10.3 million per year was spent on the cost of mental health treatment services. In FY 2016 approximately 70 percent of these costs were funded by the locality, with only 10.43 percent funded by the state, 0.64 percent funded by the federal government, and 23.21 percent by other funding sources.

It is clear that the local and regional jails in Virginia have a substantial number of persons with mental illness in their care, and that this care is costly to the localities and to the commonwealth. In national data, it has been shown that individuals with mental illness can cost local and regional jails twice the amount it costs them to house a general population inmate each day.[8] Additionally, individuals with mental illness remain incarcerated on average two times longer than those without mental illness charged with the same offenses.[9] Further, individuals with mental illness in jails have been shown to result in higher rates of correctional staff contacts, administrative segregation episodes, and crisis services (such as hospitalization) than inmates without mental illnesses.[10] In a 2009 study of one state's justice-involved adults with SMI who received services across public agencies, costs for these individuals was more than double that of serving the non-justice involved population of adults with SMI.[11] These costs included jail supervision and treatment costs, court-ordered evaluation costs, inpatient psychiatric hospitalization during incarceration, crisis services in emergency departments, and medication costs.

Several studies of "high service utilizers" – individuals that make up a relatively small portion of people with SMI but account for a disproportionately high cost of cost public services – have been conducted in recent years, shedding even more light on the impact that these individuals have on a state's bottom line. In Miami, 97 high service utilizers cost taxpayers $13 million in criminal justice costs over a five-year period.[12] In Philadelphia, 438 chronically homeless individuals with SMI cost the city $12 million annually in public service costs, and most of those costs were for psychiatric care and jail stays.[13] Finally, in New York City, 800 frequent inmates at the Riker's Island jail cost the city $129 million from 2008-2014. These particular inmates had a higher rate of SMI than the non-high-utilizers.[14] While research on high-utilizers in Virginia has been limited, results of a three-year study of persons with mental illness involved in the criminal justice system in Albemarle County and the City of Charlottesville have recently been published. The University of Virginia, in partnership with the Thomas Jefferson Community Criminal Justice Board, merged data from various local, state and private agencies, including the jail, CSB, the Police Department, Emergency Communications Center, Offender Aid and Restoration, Virginia Department of Corrections, and University of Virginia Hospital. The findings of their study indicate that 219 "super-utilizers" (5.6 percent of the jail population) made up 20 percent of jail admissions during an 18-month time span. These super-utilizers also made up a disproportionate number of referrals for mental health assessment.[15]

The research outlined above demonstrates that this population not only creates higher costs for the jails themselves, but the entire continuum of local and state mental health services, law enforcement, and medical care providers, as individuals incur more injuries, more psychiatric crisis episodes, and repeated law enforcement contacts following reentry. Forensic discharge planning services would, in theory, lead to an eventual reduction in costs associated with incarceration and crisis services, as more of these individuals become linked with non-crisis outpatient services. The issues surrounding funding for such a service and cost-savings that might be associated with it will be explored later in this report.

Profile of People with Mental Illness in Jails

In an examination of the need for forensic discharge planning services and the development of a model for implementing those services in Virginia, it is important to have a clear picture of those individuals that will be targeted by these interventions, and the specific challenges they represent to various systems.

In terms of general characteristics, data indicates that female inmates are more likely than male inmates to report symptoms of a mental illness, but males are more likely to have symptoms of psychotic illnesses than females.[16] In Virginia, 25.8 percent of females were reported to have mental illness, compared to 16.4 percent of males; in terms of types of illness, males were more likely to be diagnosed with schizophrenia and females were more likely to have diagnoses of mood disorders.[17] In total, of both males and females reported to have mental illness in jail, 31 percent were reported to have bipolar or major depressive disorder, 19 percent had PTSD, and 12 percent had schizophrenia or another delusional disorder. The type of offenses for which they were charged did not vary greatly by diagnosis.[18]

The issue of the "violent mentally ill offender," while a valid concern, has not typically played out in the research. In fact, research has demonstrated that persons with mental illness rarely commit serious violent offenses. There is only a slightly increased rate of violent offending for persons with mental illness than the general population, and typically occurring when they are not in treatment and/or when using as alcohol or drugs.[19] In one study out of Connecticut, the largest portion of arrests in the study sample (43 percent) involved minor offenses such as trespassing, breach of peace, prostitution and technical violations of probation. The second largest category was for property crimes (21 percent).[20] In Virginia jails, of those identified as having a mental illness, 51 percent were charged with non-violent offenses, 20 percent were charged with drug offenses, and only 29 percent were charged with what constitutes a violent offenses. While 80 percent of individuals in jail identified as having a mental illness were charged with felony offenses, a majority of those individuals (approximately 70 percent) were charged with non-violent offenses or drug offenses.[21]

In terms of the impact of mental illness on re-offending post-release, a Washington State study examining released inmates with schizophrenia, major mood disorders, and borderline personality disorder with respect to acquiring charges for new crimes or supervision violations. The study found that 70 percent of the individuals with the above noted disorders either acquired new charges or were charged with supervision violation. However, of those that reoffended, only 10 percent committed new felonies against persons, and only 2 percent committed serious violent offenses (homicide, rape, first-degree robbery or assault) over the follow-up period of 31 months.[22] Therefore, 88 percent of those individuals who did reoffend were only charged with nonviolent offenses. This study highlighted the fact that the presence of mental illness (without receiving proper discharge planning services) was associated with future involvement in the criminal justice system albeit frequently for low-level, non-violent offenses.

It makes both clinical and economic sense to provide follow-up care in the community for mentally ill persons following their release from jails or prisons. In a study conducted at Lucas County Jail in Toledo, Ohio, 261 inmates diagnosed with a mental disorder were tracked for 3 years after their release It was documented that the provision of community-based case management was significantly associated with a lower probability of re-arrest and a longer period before re-arrest for mentally ill offenders. Recipients of community-based case

management were significantly less likely than non-recipients to be arrested for any offense (60 percent vs 77 percent) or for a violent offense (52 percent vs 71 percent).[23] Based upon national trends, and trends in Virginia, it appears that the majority of incarcerated individuals who are diagnosed with mental illness are charged with non-violent offenses, and when violent offending does occur it is typically precipitated by treatment non-adherence. Thus, comprehensive discharge planning that extends into the community upon release would appear to be essential in enhancing treatment outcomes of individuals with mental illness and lowering the risk of future interactions with the legal system.

Legal Implications of Failing to Provide Forensic Discharge Planning Services

In addition to the fact that jail administrators are seeing high numbers of persons with mental illness in their jails, that incarceration of these individuals cost the jails and the state and local governments considerable amounts of funding, and that outcomes are poor for those who re-enter without proper linkage to services, there are also legal implications for failing to provide adequate forensic discharge planning.

Many states have already faced the prospect of civil lawsuits when it has been shown that they have failed to adequately provide discharge planning to returning inmates. *Estelle v. Gamble* in 1976 stated that the standard of deliberate indifference to serious medical needs of prisoners violates the Eighth Amendment.[24] It has since been interpreted by California courts (*Coleman v. Schwarzenegger*, 2009)[25] to assert that treatment plans must be consistent with the standard of care in the community. In looking at the lower court rulings (*Ruiz v. Estelle*, 1980), the court found that the minimum requirements for mental health services in correctional settings must include proper screening, timely access to appropriate levels of care, an adequate medical record system, proper administration of psychotropic medication, competent staff in sufficient numbers, and a basic suicide prevention program.[26]

In other cases involving inmates with mental health needs, *Wakefield v. Thompson* in 1999[27] and *Lugo v. Senkowski* in 2000[28], courts held that a state must provide medical care for a released inmate until it is reasonable for him to be able to provide medical care for himself. The courts' rationale for this finding was based on the fact that the state took away the inmate's ability to provide medical care for himself, and therefore had an obligation to provide medical care until he could be expected to be self-sufficient. While some of the above referenced cases were applicable to Department of Correction's inmates there are similar cases pertinent to jail inmates. In 2000, *Brad H. v. City of New York*[29] took this even further, stating that the purpose of discharge planning is not to return the plaintiffs to the state they were in before their incarceration, but to make them better off than they were before incarceration. In *Brad H.*, the court prohibited the defendants from releasing inmates without adequate discharge planning. A subsequent settlement established a system for access to a 7-day supply of medications that the inmates would need to function in society, a prescription for more medications and the means to fill them, a comprehensive discharge/treatment plan for every inmate to be released, required release during daylight hours, and placement in housing/shelters for those that are homeless. While clearly many of these cases were not specific or necessarily legally applicable to Virginia, they do speak to a trend of requiring states/localities to provide sufficient mental health services (to include discharge planning services) to individuals with SMI involved in the criminal justice system.

Department of Justice settlements have been reached in Indiana (2010), California (2009), and North Carolina (2012) to name a few, all of which stipulate that jails must provide adequate access to timely screening and assessment, referral to appropriately qualified mental health professionals, access to treatment at a level commensurate with what would be found in the community, and adequate discharge planning to ensure successful transition from jail to community.[30] With system overhaul and the costs that come with individual and federal lawsuits, communities can no longer postpone the development of a comprehensive plan to provide care and discharge planning to individuals with mental illness in correctional institutions.

Defining Forensic Discharge Planning

Provided in conjunction with internal service delivery at the jail, forensic discharge planning includes the screening and assessment of psychiatric, medical, social services, employment, and residential needs, as well as risk factors, as soon as possible after the individual's admission to jail. Discharge planning also includes the development of discharge plans which prioritize goals and objectives that reflect these assessed needs. It also consists of care coordination with community providers and community supervision agencies, including the exchange of treatment records, communication of treatment needs, and linkage of clients with available services and support options upon release. Discharge planning should begin as soon as possible upon entry into the jail and prior to release, and it should continue into the community until the individual is connected with the appropriate services and supports, ideally no less than 30 days post-release to ensure a smooth transition.

The areas of focus for comprehensive forensic discharge planning should include, but are not limited to the following:

- Linkage to a mental health provider in the community (CSB or private provider) that provides psychiatric, therapy, and/or case management services. This includes scheduling an appointment for follow-up services, and providing necessary records to the provider to facilitate the intake process.
- Linkage to emergency or transitional housing (i.e., shelter, crisis stabilization, halfway houses).
- Linkage to long-term residential service providers/resources (i.e., referral to assisted living facilities, nursing homes, group homes, permanent supportive housing programs, rental assistance programs, housing grant programs).
- Photo ID assistance (gathering necessary documentation to get DMV identification).
- Birth certificate assistance (i.e., gathering necessary information and submitting application for certified copies of birth certificates).
- Medicaid and/or GAP application/reinstatement assistance (i.e., completing necessary paperwork and providing documentation to begin the process prior to release).
- Transportation assistance (i.e., providing bus tokens, cab vouchers, or actually providing direct transportation from the jail to the follow up appointments/providers/discharge placement).
- Emergency food or clothing assistance (i.e., linkage to a food bank, food vouchers, clothing donation assistance centers, etc.).
- Social Security disability/SSI assistance (i.e., completing the necessary paperwork and providing documentation to begin process of reinstatement/application prior to release).

- Linkage to medical providers for treatment of any identified medical conditions.
- Connection to community support groups (i.e., AA, NA, Grief and Loss).
- Linkage to the Department for the Aging and Rehabilitative Services or other employment assistance services in the community.
- Linkage to substance abuse services.
- Coordination with community-based supervision (i.e., probation or pretrial).
- Linkage to peer support services (i.e., individual peer counseling or peer-led groups such as WRAP) or consumer-operated service programs.

Defining Serious Mental Illness (SMI)

For the purposes of this report, SMI is defined as a mental, behavioral, or emotional disorder in adults 18 years of age or older, which is of sufficient duration, intensity, and functional impairment to meet criteria specified within the Diagnostic and Statistical Manual of Mental Disorders. SMIs substantially interfere with or limit one or more major life activities, including personal relationships, self-care skills, living arrangements, or employment. Individuals with co-occurring substance abuse disorders or developmental disabilities are not excluded from this definition.

Mental disorders typically meeting the criteria for SMI include schizophrenia, schizoaffective, psychotic, major depressive, and bipolar disorders. Anxiety disorders, such as PTSD can also meet criteria for SMI. Adults with SMI as defined above should be the priority population targeted for forensic discharge planning from the jails.

Forensic Discharge Planning Within the Continuum of Diversion Services

Addressing the issues raised by the high number of individuals with SMI in the criminal justice system should include mechanisms that give police, prosecutors, judges, and community corrections agencies effective options for alternatives to arrest or incarceration when appropriate (i.e., when it does not significantly compromise public safety). Forensic discharge planning is just one service across a spectrum of jail diversion activities that should be considered when approaching the problem of people with SMI in jails. In Virginia, progress has been made in some areas, including the proliferation of Crisis Intervention Team (CIT) programs across the state, the expansion of CIT assessment sites, the growth and success of mental health dockets, as well as some limited diversion and reentry programming. Despite these developments, the number of persons with mental illness in Virginia jails has not declined, and both the criminal justice system and mental health safety net systems have continued to bear the burden of treating these individuals in a system that was never designed to do so. The individuals with mental illness in jails are not accessing the necessary treatment and supports upon release that will effectively keep them out of jail in the future and often this process actually creates additional trauma and psychiatric decompensation. Failing to provide adequate discharge planning at the point of reentry can contribute to treatment non-adherence and continued interactions with the legal system.

Generally, local and regional jails have had limited options for obtaining adequate forensic discharge planning and little to no training about the mental health system in Virginia and the availability of services in their localities. Even when good collaborative relationships exist

between the jails and community providers such as the CSBs, inadequate staffing and funding for outpatient services has limited the ability of most localities to perform effective discharge planning , and more often than not the jails will see the same individuals return time and again with new charges.

Some Virginia communities have acknowledged the need for additional options at the point of reentry for individuals with serious mental health needs, and have successfully implemented models of forensic discharge planning that have been successful. This document outlines the options that Virginia communities have chosen to explore in an effort to close the revolving door of criminal justice involvement for persons with mental illness, who the system is poorly equipped to manage and for whom the traditional criminal case processing has been proven ineffective. This report also attempts to outline a structure for the funding of forensic discharge planning in Virginia, which will allow this model to be replicated across the state and therefore accessible to all persons with SMI leaving our regional and local jails. It is important to note, however, that implementation of this proposed plan alone will not solve the problem – a bolstering of services and supports across the continuum of the criminal justice system and at the community behavioral health system is essential to seeing a significant reduction in numbers of persons with mental illness in our jails.

Forensic Discharge Planning Objectives and Outcomes

Reentry into the community from jail can be a vulnerable time, marked by difficulties adjusting to life in the greater community. Some research has indicated that there is a 12-fold increased risk of death in the first two weeks after release, due to various factors such as relapse with symptoms of mental illness or substance use.[31] Providing effective transition planning can minimize the risk of bad outcomes, enhance public safety, and improve individual outcomes.

Forensic discharge planning has traditionally been designed with the following **OBJECTIVES** in mind:

- **Increased public safety** – by linking to necessary treatment, the likelihood of reoffending once back in the community would likely be reduced
- **Increased treatment engagement** – by providing intensive post-release case management and support through the process of community re-integration, the likelihood of long-term engagement increases
- **Improved quality of life for participants** – by providing comprehensive treatment and supports upon release, utilization of crisis services both in jail and in the community (i.e., ED, CSB crisis stabilization, temporary detention to a psychiatric hospital) should be reduced, medication adherence should increase, relapse of substance use should be reduced, and long-term recovery would be more likely
- **Reduction in costs for jails** – as a result of improved collaboration and discharge planning, jails may see a reduction in staff costs associated with management of persons with SMI in jails; it is also projected that jails would see fewer individuals returning to jail post-release, as they are better linked with services that mitigate their risk
- **More effective use of limited community resources** – by assessing an individual's risk, needs and responsivity to potential treatment interventions, and providing treatment from jail into the community that is appropriate to their level of assessed risk, communities should see better outcomes and more effective use of community resources

While exploration into the impact of reentry planning on the above objectives has been limited primarily to individual program analyses, research to date has demonstrated the following promising **OUTCOMES**:

- **Impact on Crime**: In reviewing the impact of existing coordinated and comprehensive discharge planning efforts around the country, one can see many examples of positive impacts on criminal recidivism among individuals with mental illness released from jails or prisons. One such program in Washington State provides case management and coordinated services, including risk assessment, treatment planning, service referrals, and applications for entitlements before an individual with mental illness is released from prison. Data from this program indicates that people with SMI who were linked to Medicaid prior to release had 16 percent fewer re-incarcerations and stayed out of jail longer than those who had not been linked.[32] Results of a separate analysis of the effectiveness of the multidisciplinary team approach to discharge planning showed that the study's treatment group had a 19 percent recidivism rate compared to a similarly matched control group, which had close to 42 percent recidivism rate when not provided this discharge planning service.[33]

  Analysis of a similar program in California indicates that coordinated discharge planning significantly reduced the rate of re-offending, and that even when the treatment group participants did return to jail, length of stay upon return to jail was significantly decreased.[34] Studies of similar programs and policy initiatives related to this issue have also shown statistically significant reductions in recidivism rates when individuals with SMI are provided pre-release discharge planning and case coordination, particularly when the individual leaves with an individually tailored plan and actual appointments for treatment and community supervision.[35]

- **Impact on Mental Health Treatment Engagement and Symptoms**: Research in this area points to a connection between pre-release discharge planning and likelihood of keeping initial appointments with treatment providers post-release. The mere act of receiving an appointment with a specific treatment provider was shown in one study to have been associated with a higher rate of seeking treatment post-release.[36] Additional findings indicate that having community clinicians going into the jails to meet with inmates with SMI who are close to release, the development of a written release plan, and beginning to work on that plan while still in jail produces better engagement upon release and ultimately better outcomes.[37] Research into specific diversion and reentry programs has generally shown that offenders with mental illness who were provided this service showed signs of mental health improvement, reductions in substance use, and improvement in community adjustment.[38]

- **Cost Savings to a Community**: Cost savings are typically seen as a result of reduced recidivism rates – fewer returns to jail means less correctional spending (including costs of arrest and incarceration, reduction in court related costs, reduction in staff injury, transportation costs, medical costs, etc.) – and as a result of increased integration into the community – in terms of increased employment rates, less reliance on tax payer dollars, and fewer interactions with publicly-funded emergency services.[39] An Urban Institute analysis of the costs and benefits of providing jail reentry services suggests that a reduction of recidivism rates of as little as two percent can offset the cost of providing

reentry programming within the jails, so at the very least it would not incur additional costs within the jail.[40] It is worth pointing out, however, that costs of community-based care may increase as a result of this enhanced released planning and increased engagement in treatment, and that there may be more of a cost-shifting than savings in the early stages of implementation.[41]

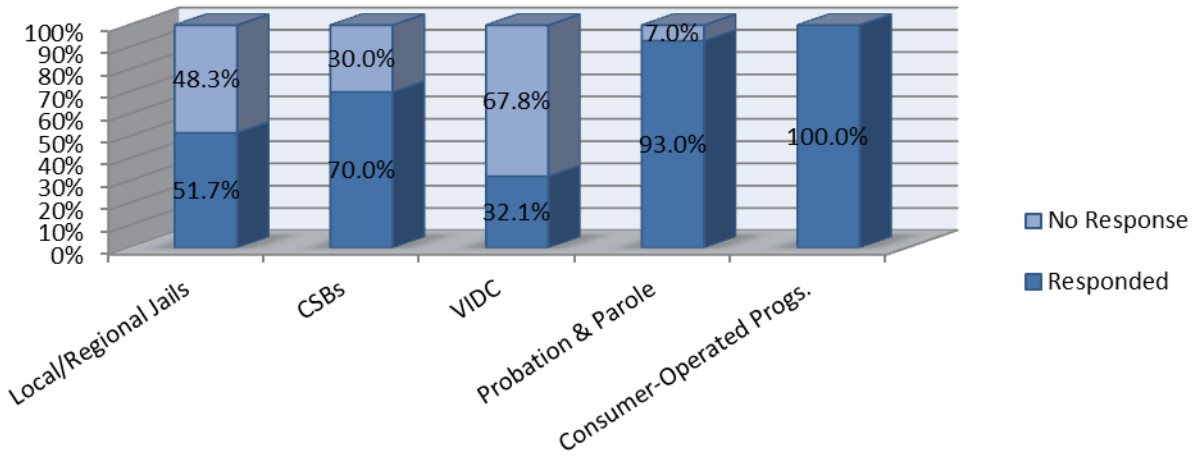
Current Forensic Discharge Planning Efforts in Virginia

A Survey of Jails & Other Partner Agencies

In order to adequately report on forensic discharge planning efforts in Virginia, the Forensic Discharge Planning Study Workgroup issued surveys to 60 local and regional jails, 40 CSBs, 28 local Public Defender's Offices, 43 State Probation District Offices, and to a representation of various consumer-operated services programs throughout the Commonwealth. The results of the survey are summarized below.

Survey Methodology and Response Rates – A 10-question electronic survey was distributed via email to all local and regional jails in Virginia. Separate surveys were designed and emailed to the 40 CSBs, 28 local Public Defenders' Offices, 43 state probation and parole offices, and a variety of consumer-operated service providers. Thirty-one of the 60 local and regional jails, 28 CSBs, 9 local Public Defender Offices, 40 State Probation and Parole District Offices, and 9 consumer-operated services providers responded to this survey.

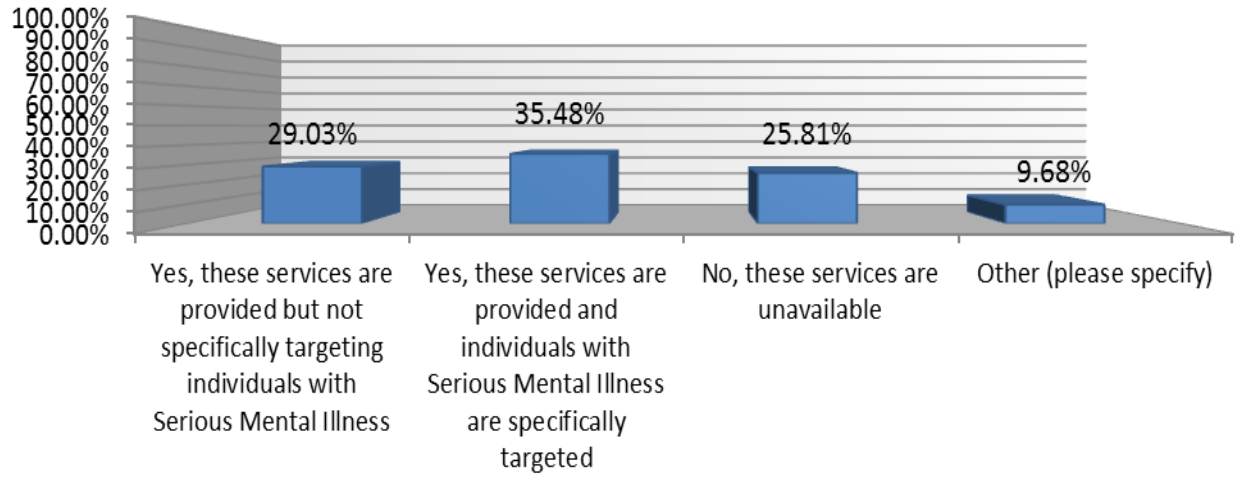
Figure 1: Survey Response Rates



Average Daily Population and Percentage of SMI in Jails – The Average Daily Population (ADP) of the jails responding to the survey ranged from 30 to 1,113 inmates. The 31 jails that responded to the survey represented approximately **52.7 percent of the total number of persons with SMI in all Virginia jails** (based upon the annual State Compensation Board's *2016 Mental Illness in Jails Report*). The large range in size of the responding jails may account for the variability in the amount of services offered that are specific to SMI inmates.

Scope of Forensic Discharge Planning Services in Jail – Prior to assessing the type and quantity of services provided, the jails were asked whether forensic discharge planning occurred in their facilities at all, and then whether that service targeted inmates with SMI. Thirty-five percent of the jail respondents confirmed that forensic discharge planning specific to persons with SMI was occurring in their facilities. It is important to note, however, that roughly 55 percent of the responding jails indicated that services were either not targeting individuals with SMI specifically (29 percent), or were unavailable entirely (26 percent).

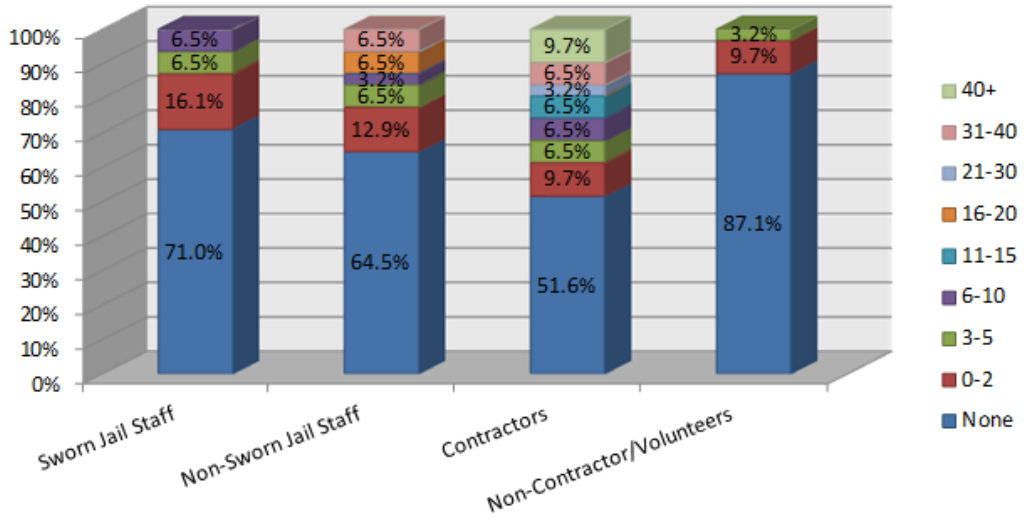
Figure 2: Are Forensic Discharge Planning Services Provided in Your Jail?



Hours Dedicated to Forensic Discharge Planning – Those jails which responded that targeted forensic discharge planning was occurring for inmates with SMI (35 percent) were asked to estimate the number of hours that sworn jail staff, civilian jail staff, contractors, and outside agencies (on a volunteer basis) provided forensic discharge planning services in their facilities. The results indicated that jails may have many different personnel types providing this service in their facilities in varying quantities every week – **48.3 percent reported that contract staff (i.e., contracted vendors or CSBs) were providing this service**, but 35.5 percent also reported that non-sworn jail staff also provided some time toward this effort. Sworn jail staffs were identified as providers by 29 percent of respondents, and finally, 12.9 percent reported that volunteer agencies or non-contracted CSB staff provided these targeted discharge planning services.

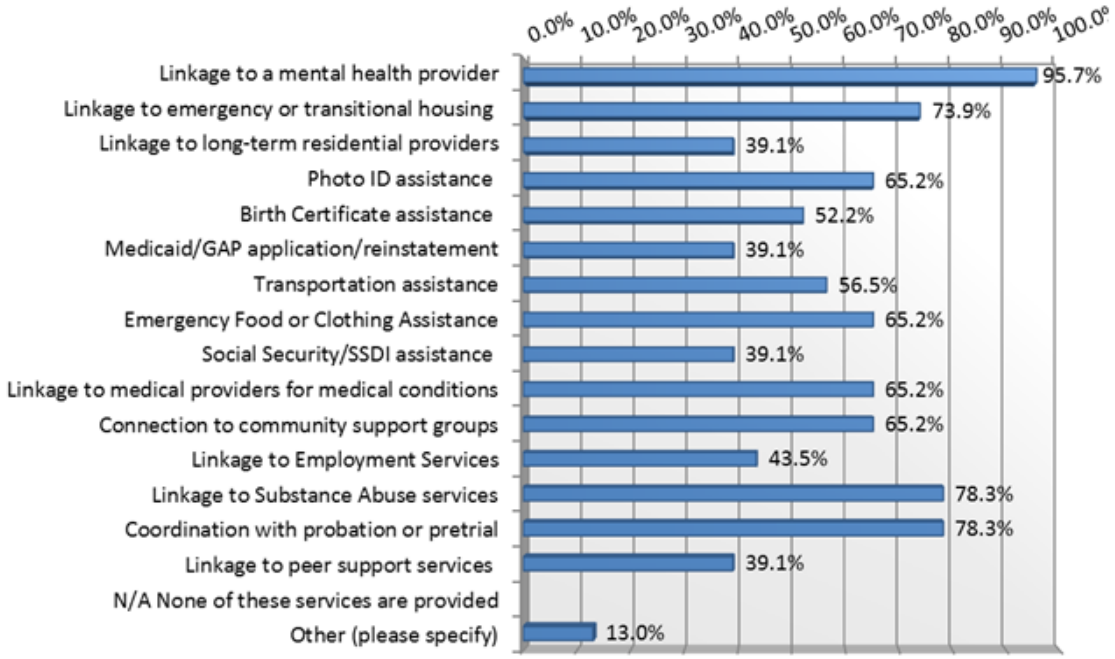
While multiple staff categories may be providing the service at any given time, the majority of hours devoted to forensic discharge planning appear to be provided by contract staff, followed by non-sworn jail staff (i.e. civilian staff employed by the jail), and then by sworn jail staff (i.e. deputies). However, the results indicated that **on average jails providing this service report only around 13 hours per week of targeted discharge planning, while the hours ranged from 2 to 40 hours depending on the jail**. See the chart below for a break-down of the hours dedicated by each type of personnel category towards discharge planning for persons with SMI. It is unclear what percentage of individuals with SMI is actually receiving services and given the data it is likely that many individuals are not receiving services.

Figure 3: Hours Provided by Staff Type



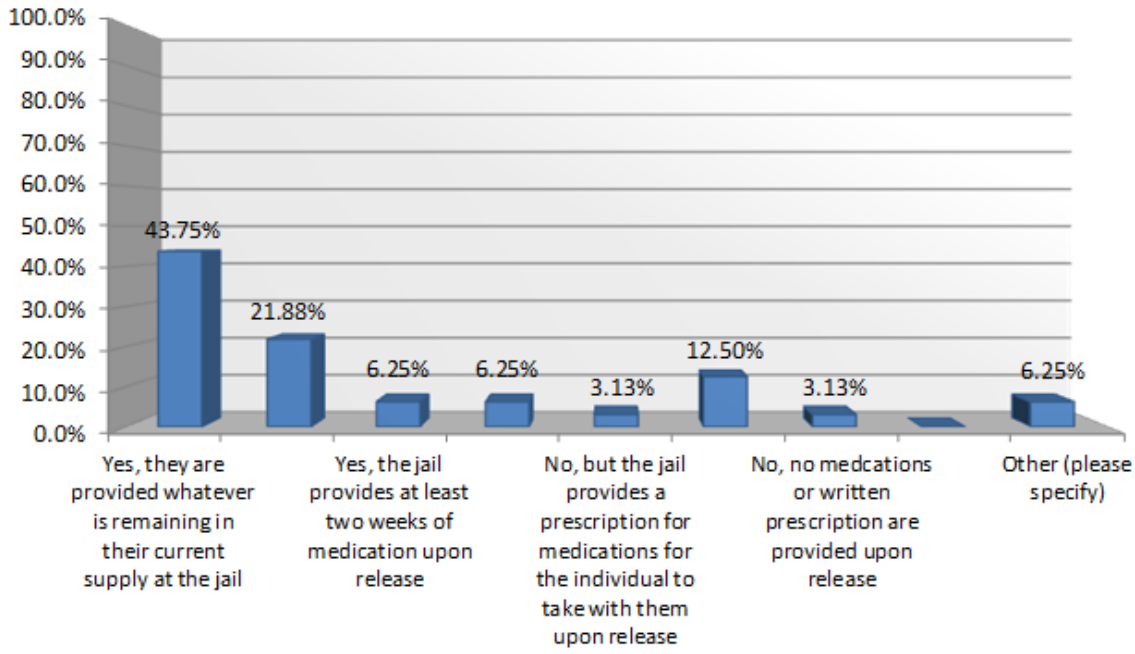
Types of Forensic Discharge Planning Services Provided – The jails reporting that forensic discharge planning was being provided for persons with SMI in their facilities were then asked to specify which services fell under the umbrella of forensic discharge planning. While the vast majority of respondents indicated that linkage to a mental health provider was occurring as part of this service (97 percent), the responses to other categories of discharge planning were more varied. Services directed at reinstatement of benefits such as Social Security/SSDI, Medicaid, and GAP in particular were less commonly provided. However, the data is limited by not specifying how often the staff are *successful* in obtaining the items/services indicated, only that attempts are made to link to those services. Given the variability in service availability throughout the state at the local CSBs, and lack of resources such as housing and transportation, it is probable that communities struggle to meet the needs of these returning citizens, despite the best efforts of those providing the forensic discharge planning services.

Figure 4: Types of Discharge Planning Services Currently Provided



Psychotropic Medication Supplies upon Release – In terms of medications provided upon release, survey results indicated that **43.8 percent of the jail respondents are providing only the remaining supply of their existing medications upon release**. This means that there may be only two days of medications available on one end of the spectrum, or there may be 30 days of medications available at the other end of the spectrum. The remaining jail respondents indicate that there are a specific number of days given to every inmate with SMI, or only a written prescription, or some combination of release medications and prescription. Given that Medicaid benefits take time to reinstate upon reentry, or that a follow up appointment with a psychiatrist can at times take up to a month, the odds of psychiatric decompensation increase when fewer release medications are provided, especially when insurance is unavailable to cover the costs to fill prescriptions or cover doctor visits.

Figure 5: Are Psychotropic Medications Provided at Release?



Staffing and Resource Needs for Comprehensive Discharge Planning – Only 35 percent of jails reported that forensic discharge planning for persons with SMI was occurring in their facilities, and even those respondents indicated that the available services were insufficient to provide comprehensive services to all individuals with SMI leaving their jail. Jails were asked whether they had enough resources to provide "comprehensive" discharge planning and 75 percent of jails answered that they did not. Going further, **jails reported that they would need a significant infusion of additional staff hours per week to provide forensic discharge planning to all individuals with SMI leaving their facilities**.

When given the opportunity to highlight other areas beyond jail staff hours where resources were insufficient to be able to provide comprehensive discharge planning, respondents provided the following feedback:

- **55 percent:** Lack of CSB staff resources to provide discharge planning
- **52 percent:** Lack of community services/resources to support people after jail discharge
- **22 percent:** Lack of probation/pretrial staff to coordinate discharge planning

- **13 percent:** Resources exist but lack coordination/communication between jail and community
- **10 percent:** Lack of jail staff resources to support discharge planning
- **6 percent:** Lack of psychiatric staff hours to support discharge planning
- **6 percent:** Lack of Virginia Indigent Commission staff to support discharge planning

Important Feedback from Partner Agency Respondents – The CSBs, public defender offices, state Probation & Parole district offices, and consumer-operated services programs also provided feedback to enhance the picture of current forensic discharge planning efforts throughout the Commonwealth. They too provided feedback on the types of services, hours devoted to services, and issues impacting their ability to provide comprehensive discharge planning services to their local jails. The following charts summarize the feedback of these agencies.

Figure 6: Are Forensic Discharge Planning Services Provided by Your Agency?

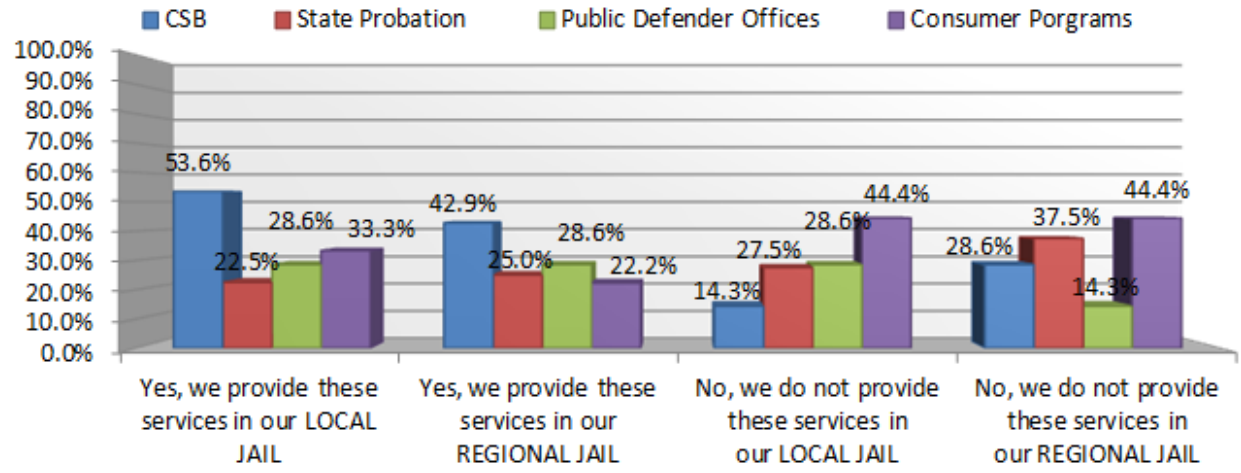


Figure 7: Partner Agencies -Hours of Forensic Discharge Planning Provided

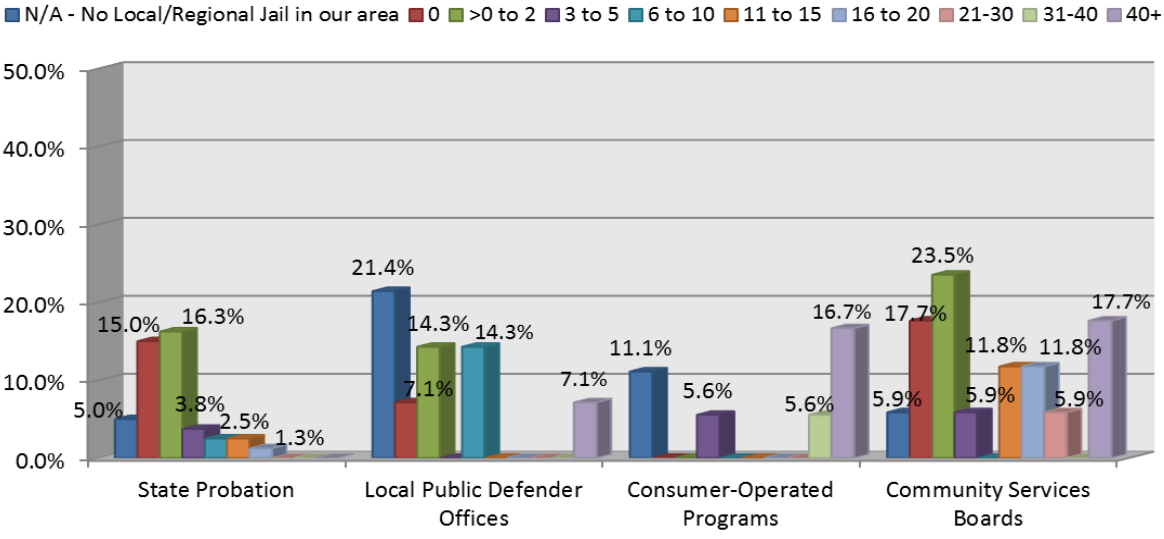


Figure 8: Other Agencies - What Type of Jail Discharge Planning/Reentry Planning is provided by Your Agency to Persons with Serious Mental Illness?

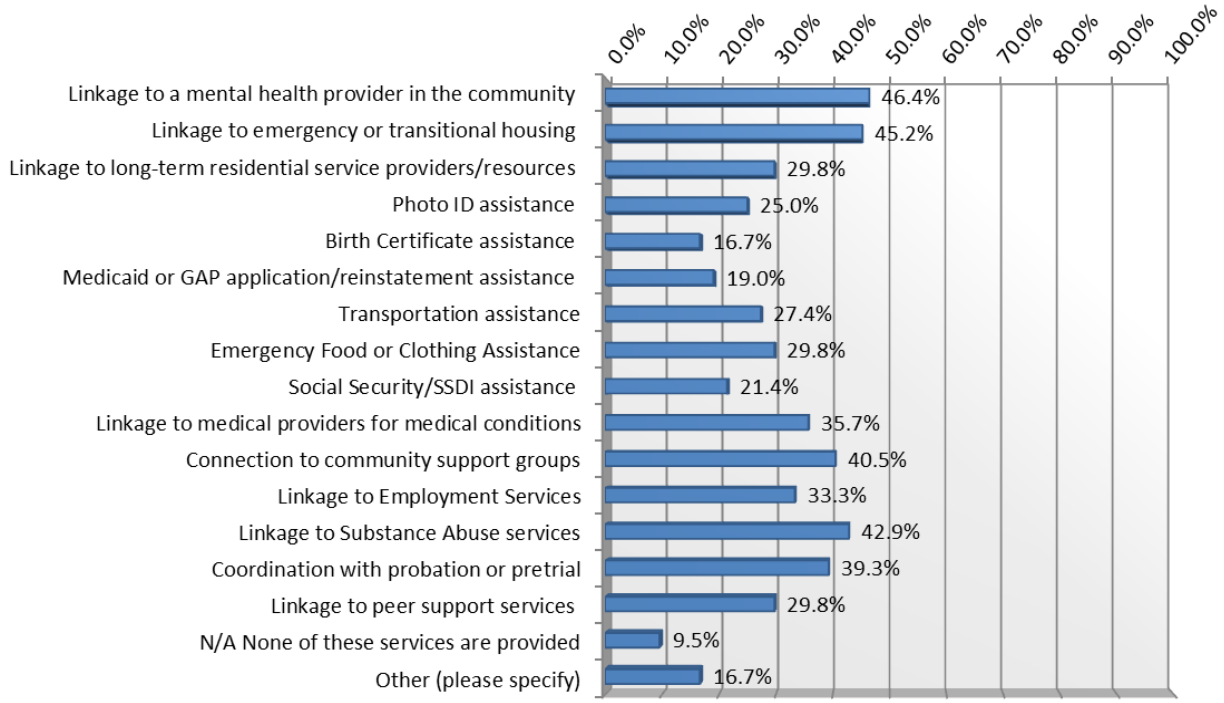
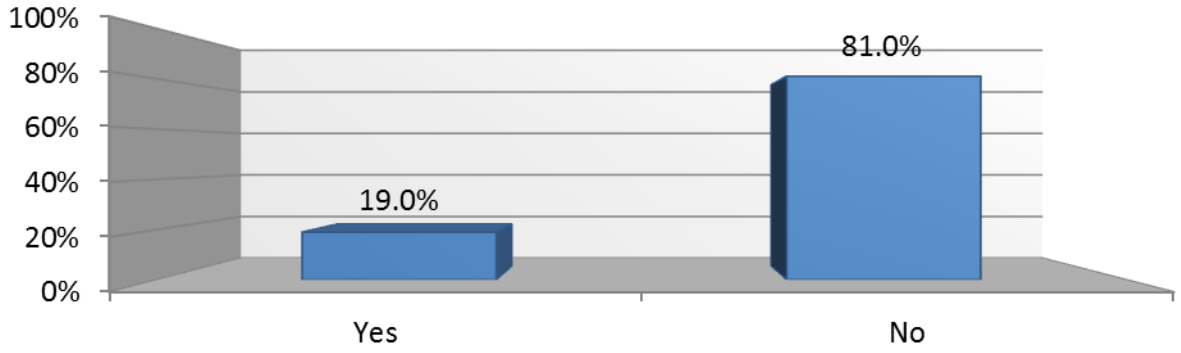


Figure 9: Partner Agencies - Does your agency have enough resources to provide comprehensive discharge planning to individuals with Serious Mental Illness?



Like with the jail data, the data from the partner agencies does not denote what percentage of individuals with SMI are actually receiving services. Similar to the jails, partner agencies similarly reported the need for significantly more hours of staff time in order to meet the current needs.

Funding Sources Supporting Current Forensic Discharge Planning Efforts

Most Virginia jails have limited, if any, formal discharge planning services targeting individuals with SMI. When discharge planning is provided by jail staff, it is usually limited to the setting of aftercare appointments with the CSB or CSB walk-in hours, provision of release medications (albeit limited supplies), and information provided to the individual on connecting with social services, Medicaid benefits, and shelters. This service is limited to the jail's custody over the

individual – once the inmate is released the jail relinquishes all involvement in the discharge planning process and is not involved in the post-release linkage. There is no ability for the jail to track or follow up with the individual to determine if they followed up with the providers to which they were directed. The jails' limitations in providing these services are due primarily to lack of funding to support the effort within the jail, as well as sustain the services beyond the walls of the jail.

In 2014, the Virginia State Inspector General conducted an examination of mental health care in jails, and found that "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." [42] This still rings true today, although it should be noted that the Department of Medical Assistance Services (DMAS) is currently completing a legislative study on how to better link individuals with SMI involved in the criminal justice system to benefits. DMAS will be submitting a report/plan to address some of the barriers and it is likely that forensic discharge planners will be integral to addressing this challenge. According to the State Compensation Board, the total annual cost of mental health treatment in jails was approximately $14 million in FY 2016, with 70.28 percent of these costs funded by the locality, 1.37 percent from the federal government, 18 percent from "other" sources, and only 10.43 percent funded by the state.[43] Given the reliance on local funding to support treatment efforts in the jail beyond the most basic services, there is considerable variability from jail to jail in the amount and quality of forensic discharge planning services. The State Compensation Board highlighted that four of the top five jails reporting the highest number of mental health treatment hours were located in communities with higher median family incomes in the Commonwealth. It was noted that these four jails were <u>not</u> in the top lists for jails with the largest inmate population or the highest percentage of mentally ill inmates. Financial disparities resulting from the availability of local dollars, or the lack thereof, result in significant disparities in the availability of this service to inmates with mental illness.

The disparities in funding and the impact on jail-based forensic discharge planning services can be seen in the realm of community-based treatment as well. In Virginia, state general funds provide for pre-admission screening for hospitalization, discharge planning services from hospitalization, and limited case management services (to the extent that funds are available). State general funds are not universally allocated for outpatient services, psychiatric services, etc. unless the locality has been awarded targeted funds for these services. Many CSBs rely on their local government for funding of operations beyond basic services. If they are not lucky enough to receive that assistance, then they rely primarily on Medicaid revenue. However, when the priority populations of the CSBs are low-income and uninsured citizens, even Medicaid revenue fails to fully support their treatment programming. As a result, communities with large local contributions to their CSB budgets have a greater array of services available, and those without have only the ability to provide the most basic services. In terms of forensic discharge planning from the jails, the CSBs with limited local funding find it difficult to afford to provide this service. Federal guidelines limit Medicaid payments for incarcerated individuals solely to medical hospitalizations. Thus, if CSBs are partnering with their local jails they are likely doing so at a cost for which they will not be reimbursed, which is why the level of CSB participation in pre-release discharge planning for SMI inmates is often limited to the setting of an intake appointment and a referral card or emergency contact numbers.

There are a few CSBs who provide more extensive jail-based services, including diversion or reentry planning. In most cases these programs have been funded with grants awarded through DBHDS for their forensic programming. In all, DBHDS funds 12 CSBs that provide jail reentry planning and linkage via its jail diversion grant funding. It also funds seven CSBs to staff a single discharge planner to coordinate with the jails and state hospitals. In very rare cases throughout the state, jails actually contract with the CSB to provide the MH treatment services within the jail, including crisis assessments and therapeutic intervention. However, this is not common. By and large, CSBs are struggling with the staffing and resources to devote to this purpose, rather than simply a lack of willingness to partner with their local and regional jails.

In short, jails and CSBs lack sufficient funding to support formalized reentry planning efforts. Survey respondents reported that this service was important and that there was a willingness to provide it, but balancing the realities of sustaining day to day operations often means that this service is limited. As a result there is a huge gap in services for a particularly vulnerable population at a particularly vulnerable time.

Summary of Existing Forensic Discharge Planning Services

The results of the survey are helpful in gauging the general scope of forensic discharge planning services in Virginia. Based upon the responses received, it is estimated that **only 35 percent of jails are providing forensic discharge planning services specifically targeting individuals with SMI**. The majority of these services are being provided by contracted staff, including private contractors (typically those who provide both medical and psychiatric care) or at times by CSBs that are contracted by the jail specifically for mental health services. Many jails also employ civilian staff to devote some or all of their time to providing forensic discharge planning, although this is most commonly provided as general reentry planning rather than targeting discharge planning for SMI inmates.

Of those jails responding to this survey, **75 percent report that the staffing and other resources needed to provide "comprehensive" discharge planning services to all inmates with SMI are insufficient at this time**. The CSBs, state probation, public defender offices, local community corrections agencies, and consumer-operated services are also lacking in resources necessary to adequately implement a successful reentry plan for these individuals. This is even more clear when examining the reported number of hours devoted by various types of personnel towards this service – **on average jails providing this service report only around 13 hours per week of targeted discharge planning, while the hours ranged from 2 to 40 hours depending on the jail**. Not only is it important to note that the number of staff hours for this targeted service is minimal, the majority of jails (65 percent) do not report the availability of targeted forensic discharge planning at all.

While staff hours dedicated to providing the services appear to be lacking, there are also other resources needed to ensure successful reentry. When asked to identify areas beyond staff hours that are needed in order to provide comprehensive forensic discharge planning, 51.6 percent of respondents reported that the resources and services in the community necessary to support individuals upon release are insufficient. In breaking out the specific resources or services that would fall under this category, 26 percent of all respondents indicated that housing is unavailable in sufficient quantities to result in effective discharge from the jail, and 14.5 percent of all respondents indicated that treatment services, such as psychiatric hours and case management were also insufficient to promote successful reentry. Essentially, the results indicate that even

with a bolstering of dedicated staff hours toward this service, without additional community resources the discharge planning effort will only be so successful. Given the demonstrated impact of treatment engagement, timeliness of linkage and availability of stable housing and uninterrupted medication adherence on relapse and recidivism rates, limited community resources would appear to be a major barrier to comprehensive forensic discharge planning in the commonwealth. That being said, the availability of discharge staff would allow for better linkages to already existing resources such as permanent supportive housing, crisis stabilization units, homeless shelters, medication assistance plans, food pantries, etc. Thus while it may not be realistic to immediately resolve all the resource shortages, Virginia can make significant improvements by having dedicated staff available to link individuals to services.

In sum, given the current difficulties with funding this service, it appears unlikely that it will expand beyond its current level without additional funding sources. Both a significant number of additional staff hours and community-based services and resources would be needed to implement comprehensive forensic discharge planning in every jail in Virginia. The following sections outline what would be needed to accomplish this goal.

A Plan for Comprehensive Forensic Discharge Planning for Persons with Serious Mental Illness in Virginia Jails

There will continue to be differences among individual communities in how they approach forensic discharge planning from jails, based upon the unique needs and operational environments of the local and regional jails, the availability of needed services at the local CSBs, and the target populations to be served. However, there is also a need for consistency as to basic program components and principles.

A Model for Forensic Discharge Planning Services

A comprehensive definition of the term forensic discharge planning is contained in an earlier section of this report, however in this section a process for a coordinated and consistent application of those services is outlined in more detail. One model for which there is significant support is the "APIC Model" of discharge planning. This model was developed by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation in partnership with the Council of State Governments Justice Center in 2013 and has been further elaborated on in a more recent implementation guide published in 2017.[44]

The APIC Model, which stands for *Assess, Plan, Identify, and Coordinate*, was developed as a tool to guide communities in implementing the principles of the Risk Need Responsivity Model (RNR) with individuals being released from jails in order to improve clinical and legal outcomes.[45] It is strongly recommended that communities follow the principles of the APIC and RNR models when implementing their forensic discharge planning services, as they have been proven effective.[46] Essentially, the focus of these models, and therefore to forensic discharge planning, should be prioritizing limited criminal justice and community resources.

The following sections outline the recommended processes for providing forensic discharge planning, and are based on the principles of RNR and the APIC model developed by SAMHSA's GAINS Center and the Council of State Governments Justice Center.

Screening and Assessment

- Screening for the possible presence of a SMI should occur as soon as possible after admission to the jail. DBHDS has recently rolled out statewide training and guidance to jails on the provision of the Brief Jail Mental Health Screen for men (BJMHS)[47] and the Correctional Mental Health Screen (CMHS). [48] These tools are the ones recommended by DBHDS after a thorough literature review and should be utilized by every local and regional jail in the Commonwealth. In fact 2017 budget language requires all jails to utilize screening tools designated by the Commissioner. A positive screening on the initial mental health screening tool should prompt an immediate referral for comprehensive mental health assessment. The 2017 budget language also tasked the State Compensation Board, in consultation with DBHDS, to identify a plan for the provision of comprehensive mental health assessment for individuals who screen positive for a potential mental illness. An assessment of criminogenic risk should also be conducted on all individuals prior to the development of any discharge plans.

- The **"Risk-Need-Responsivity"** (RNR) Model[49] should be used as a guide to identify and prioritize inmates for discharge planning, as well as the intensity of supervision and clinical interventions upon release.

- Criminogenic risk factors (i.e., antisocial thinking, antisocial peer associations, poor family relationships, substance use) should be assessed using validated assessment instruments such as those used by community corrections and/or pretrial services agencies and state probation (i.e., the Virginia Pretrial Risk Assessment Instrument[50], the Offender Screening Tool and the Modified Offender Screening Tool[51], and the Correctional Offender Management Profiling for Alternative Sanctions[52]).

- Clinical or treatment needs (i.e., mental health case management, psychiatric services, substance abuse treatment, individual or group therapy) and responsivity factors should be identified during the clinical assessment, which should consist of a combination of structured clinical interview and validated assessment instruments.[53] Careful consideration should be given to the inmate's ability to effectively participate in treatment and respond to the required interventions. The presence of substance use or dependence itself should not exclude an individual from eligibility, but it should be addressed carefully in the discharge plan (both as a risk factor and responsivity factor).

- Eligibility for receiving discharge planning services should be prioritized based on the presence of a SMI as defined in an earlier section of this report. Services to individuals who do not meet these criteria but who have identified needs can be considered only if resources are available.

- If the need to provide for individuals with SMI outweighs the resources, communities should prioritize medium to high risk inmates for forensic discharge planning services, as discharge planning services have been shown to have the greatest impact on recidivism

for this group, and overprescribing services for low-risk inmates may actually increase their risk for reoffending.[54]

- Participation in forensic discharge planning services should be voluntary. That being said, at times individuals with SMI may lack the capacity to make informed decisions or may make decisions which ultimately are not in their best interest. Thus providers should still offer services and make appropriate after-care referrals. Communities should conduct a thorough assessment of community treatment capacity to see if the needs of the identified target population and available services align. If not, services/interventions may need to be added or adjusted to meet the needs of the target population.

Plan and Identify

- Based upon the results of the risk and clinical assessments that are conducted at the earliest stages of incarceration, a detailed written plan should be developed that addresses every identified risk factor and need.

- The level of intensity of services and community supervision outlined in the discharge plan should align with the individual's assessed levels of risk and identified needs, and should take into consideration the individual's ability to respond to those interventions. Criminogenic factors should be first priority and should be reassessed periodically, as they have been shown to have the greatest impact on criminal recidivism.[55]

- Plans should include services and interventions that the individual will receive not only in the community upon release from jail, but also those that will begin in the jail prior to release, such as referrals to psychiatric services, medical services, and treatment programming if available in the jail.

- In addition to addressing criminogenic risk and mental health treatment needs, plans should also address social connectedness, and should incorporate the use of peer counselors, referral to consumer-operated services programs, and other recovery support services options. Consideration should also be given to the appropriateness of referral to supported housing, supported employment, vocational training, or job search assistance.

- Jail staff and community partners should be involved in the development of the discharge plan, as well as the individual inmate. As applicable, family members and other supportive individuals should be included in planning.

- All providers, both in the jail and in the community, should be clearly identified and their specific roles in the implementation of the plan should be clearly delineated.

- In sum, the plan should be individualized, comprehensive, and well-coordinated with jail staff and administrators, community based supervision providers, and community based mental health and social services providers. Once written, the plan should be routinely reviewed and modified as needs change.

Coordinate Release and Community Services

- A system for transitioning from jail to community with direct and smooth linkages to providers, and ongoing support to ensure those transitions are successful (i.e., a "warm hand-off") should be in place and parameters should be set for the length of time those transition services will be available. DBHDS recommends that the discharge planner be the entity that follows the individual until connection to treatment and supervision agencies is successful, but not less than 30 days post-release.

- Forensic discharge planning should involve linkage and rapid admission to continuous, comprehensive, and evidence-based treatment and supports upon release, to ensure the best possible outcomes.

- Agreements should be made, prior to implementation of discharge planning services, that local CSB providers will be available to provide expedited linkages to psychiatric and case management services upon an individual's eligibility determination.

- Services provided should be evidence-based, individualized, and adjustable based on a participant's response, rather than tied to the programmatic structure.

- Treatment, supervision, and support services should target all of the identified risk factors and behavioral health and social service needs that were identified at the point of assessment. The mental health issues alone should not be the only focus of treatment interventions. Equal focus on criminal risk factors should be applied.

- Evidence-based interventions should be well-researched, and appropriate for the target population. There are numerous examples of evidence-based practices that can be utilized, such as cognitive behavioral therapy and motivational interviewing. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation has published helpful articles that define these practices and direct providers to resources and training opportunities.[56]

- Regardless of the supervision practices and treatment programs that are implemented, it is essential that staff is appropriately trained to implement these programs and do so with fidelity to the model in order for them to be effective.

- Clear communication between providers and community supervision agencies, with clear expectations regarding the handling of problematic behaviors should be discussed in advance and the individual receiving services should be informed.

- A system for exchange of information between providers is essential and should be in place prior to the individual's release from jail.

Forensic Discharge Planner – Role & Expectations

- The forensic discharge planner is the single point of contact responsible for coordinating all necessary referrals and linkages within the jail and in the community upon release. This individual should be a "boundary spanner," capable of navigating various criminal justice, clinical, and social services systems to ensure proper linkage.

- This role also involves the development of a written discharge plan which prioritizes goals and objectives that reflect the assessed needs of the inmate. It also consists of care coordination with community providers and community supervision agencies, including the exchange of treatment records, communication of treatment needs, and linkage of clients with available services and support options upon release.

- The forensic discharge planner should focus on the following areas in the development and implementation of a discharge plan, and these services should begin in jail and continue following release:

    - Linkage to a mental health provider in the community (CSB or private provider) that provides psychiatric, therapy, and/or case management services. This includes scheduling an appointment for follow-up services, and providing necessary records to the provider to facilitate the intake process.
    - Linkage to emergency or transitional housing (shelter, crisis stabilization, halfway houses).
    - Linkage to long-term residential service providers/resources (referral to assisted living facilities, nursing homes, group homes, permanent supportive housing programs, rental assistance programs, housing grant programs, etc.).
    - Photo ID assistance (gathering necessary documentation to get DMV identification).
    - Birth certificate assistance (gathering necessary information and submitting application for certified copies of birth certificates).
    - Medicaid and/or GAP application/reinstatement assistance (completing necessary paperwork and providing documentation to begin the process prior to release).
    - Transportation assistance (providing bus tokens, cab vouchers, or actually providing direct transportation from the jail to the follow up appointments/providers/discharge placement).
    - Emergency food or clothing assistance (linkage to a food bank, food vouchers, clothing donation assistance centers, etc.).
    - Social Security disability/SSI assistance (completing the necessary paperwork and providing documentation to begin process of reinstatement/application prior to release).
    - Linkage to medical providers for treatment of any identified medical conditions.
    - Connection to community support groups (AA, NA, Grief and Loss, etc.).
    - Linkage to the Department for Aging and Rehabilitative Services or other employment assistance services in the community.
    - Linkage to the Department of Veterans Affairs
    - Linkage to substance abuse services.
    - Coordination with community-based supervision (probation or pretrial).
    - Linkage to peer support services (individual peer counseling or peer-led groups such as WRAP) or consumer-operated service programs.

- DBHDS recommends that the forensic discharge planner continue to provide support and follow-up with the individual at the point of release and until successful linkage with outpatient providers, but no less than 30 days post-release.

- Provided that funding is available, it is the recommendation of the workgroup that the forensic discharge planner position should be based in the CSB, given that a majority of individuals with SMI involved in the criminal justice system are or will be consumers of CSB services (due to being uninsured or underinsured).

- The CSB and the jail should develop a memorandum of understanding or memorandum of agreement, outlining the specific role of both the CSB and the jail in regards to discharge planning and supervision of the forensic discharge planner, the functions and limitations of the forensic discharge planner position, and the level of participation and financial obligations of all entities in the process of discharge planning.

Local and Regional Jails – Roles & Expectations

- The local and regional jails are responsible for providing the jail-based mental health screening as soon as possible after an individual's admission to the jail. The 2017 General Assembly required the use of a DBHDS-approved mental health screening tool on all inmates upon admission to the jail.

- The jail should develop mechanisms for recording positive screening results and referring individuals who screen positive for the possible presence of a SMI to appropriately qualified staff. The State Compensation Board is currently conducting a study of the costs associated with having qualified staff available to every jail to conduct the above referenced assessment.

- If/when forensic discharge planning positions are funded; jails should develop mechanisms to refer individuals with SMI to the forensic discharge planner. While the individual remains incarcerated, jails should provide sufficient mental health services/supports (to include psychiatric assessment, access to psychotropic medications, group/individual therapies, etc.) to facilitate the individual remaining psychiatrically stable.

- Policies and procedures should be in place to ensure effective communication between jail medical and mental health providers, jail correctional staff, and the forensic discharge planner, to ensure that any changes in the inmate's mental or physical health, level of risk to self or others, or discharge needs are effectively communicated and incorporated into the discharge plan.

- Ideally, the jail would have a counterpart to the forensic discharge planner – a qualified mental health professional (QMHP) position dedicated to providing referrals and updates to the forensic discharge planner, monitoring release date/time, and coordinating care within the jail (including medication referrals and refills prior to release). The State Compensation Board is currently conducting its own study of the need for such a position, and the costs associated with hiring a QMHP to work in every jail. The

recommendations of that study were not readily available to DBHDS during the drafting of this report.

- As noted in the previous section, the jail should enter into a memorandum of understanding or agreement, outlining its role in relation to the CSB in the provision of discharge planning services.

- The jail should provide adequate physical space for the forensic discharge planner to perform their duties in the jail and liberal physical access to the individual so that services can be coordinated.

- Jails should distribute an agreed upon amount of medications to all inmates receiving forensic discharge planning services upon release. DBHDS recommends that every inmate who is participating in this service be provided no less than two weeks of medication and a written prescription for a refill. While it is understood that the majority of jails give either the remaining balance of the current medication supply, or a one-week supply, given the amount of difficulty in securing a psychiatric appointment in the community within a short time span and obtaining a means to fill written prescriptions, this is likely insufficient. The recommendation of a minimum 2-week supply is an attempt to ensure the highest likelihood of continued medication adherence and lessen the likelihood of an individual cycling back into the criminal justice system. DBHDS appreciates that currently there is no funding source for such medications but hopefully the DMAS study on entitlements/benefits will create an avenue to create a billable source for medications.

- When possible, the jail should notify the forensic discharge planner of the scheduled release date and time for each inmate served. If this is known in advance, all possible attempts should be made to release the individual during regular business hours, and with notification of the discharge planner in advance.

- If possible, jails should include notations in their information management systems when an individual is being served by the forensic discharge planner, so that when releases are unscheduled or unexpected, they can be notified and potentially respond to the jail to see the inmate prior to leaving the facility.

- Jails should partner with CSBs to develop or review existing protocols for the secure and reliable exchange of this information (e.g., by encouraging interagency agreements for information sharing, working towards compatibility of information management systems, and employing written releases to satisfy legal requirements).

Additional Services & Supports Required for Success

- Forensic discharge planning should involve linkage and rapid admission to continuous, comprehensive, and evidence-based treatment and supports upon release, to ensure the best possible outcomes. The CSB should institute policies and procedures to allow for prioritization of this population for case management and psychiatric appointments immediately following release. It should be noted that DBHDS, along with the administration, the General Assembly and system stakeholders, are working to reform

Virginia's public behavioral health system through the statewide implementation of new services through System Transformation, Excellence and Performance in Virginia (STEP-VA). The STEP-VA model includes the provision of same day access services and robust outpatient services. STEP-VA services will improve access to a consistent array of high quality services that will result in positive impacts for this population.

- All aftercare appointments for case management and psychiatric services should be scheduled in advance and should occur as soon as possible following release from jail. Ideally, a follow up appointment for case management services (e.g., intake appointment or appointment with previously assigned case manager), would occur within seven calendar days of release if not sooner, and an appointment with a psychiatrist within 14 days of release. Most referrals will be made to the CSB, unless an individual has private insurance and private providers are available to provide these services.

- Until Virginia opts to expand Medicaid, most inmates will return to the community without health insurance coverage, and given that the length of time between release and approval of benefits or reinstatement of existing benefits can range anywhere from one month to three months on average, there should be resources allocated to the funding of medication refills until such time as those benefits become active.

- Transportation has been highlighted as a major barrier to services for most inmates upon reentry. Resources should be allocated for the provision of transportation services or vouchers to individuals without resources, from the jail to their place of residence and to all appointments scheduled as part of the discharge plan.

- Lack of available housing is a huge barrier to treatment engagement and can subsequently result in future decompensation, utilization of expensive crisis services, violations of the law, and return to incarceration. Resources should be made available to allow for temporary/transitional housing options for those individuals who are identified as homeless. All measures should be taken to ensure that an individual is not released to the streets, and when transitional or permanent housing is unavailable at the time of release arrangements for admission to a shelter or hotel may need to be employed until more permanent options are made available.

Estimated Costs for Staff Positions

Methodology

In order to estimate the costs and make recommendations for the implementation of comprehensive discharge planning at all local and regional jails in Virginia, the workgroup first had to determine the total number of individuals with SMI in Virginia jails, in which jails those individuals were located, and estimate the capacity of each discharge planner's caseload in order to be able to recommend a fair distribution of resources.

The workgroup utilized the State Compensation Board's 2016 *Mental Illness in Jails Report* as a tool for estimating the number of persons with mental illness in jails. According to this report, a total of 6,554 inmates had some form of mental illness at the time of the survey, and of those 3,356 were reported by the jails to be SMI.

Given the intensity of services provided under the umbrella of forensic discharge planning, and the prioritization of medium to high risk and high needs inmates, the workgroup agreed that a single forensic discharge planning should have a maximum caseload size of 20 clients. This caseload will be continuously revolving, and may have a mix of high and low risk and high and low need clients. The workgroup agreed that given that the intensity of the services was similar to program for assertive community treatment (PACT) services, the caseloads should also be consistent with that model.

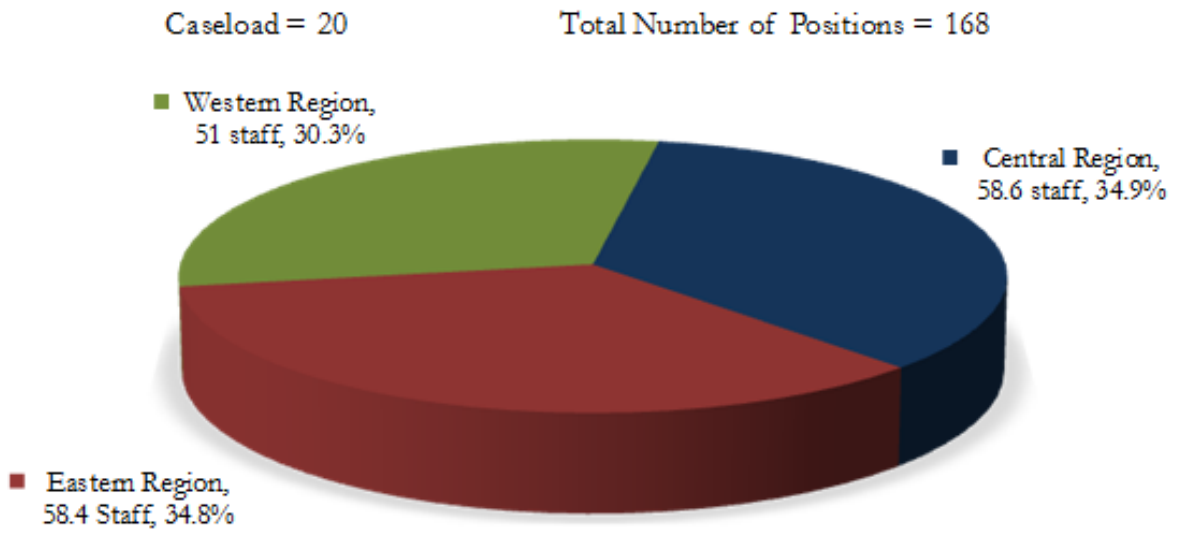
Therefore, assuming a 20-person caseload and calculating the total number of SMI adults in the local and regional jails to be approximately 3,356 individuals, the workgroup estimates that ultimately 168 forensic discharge planner positions will be needed to provide comprehensive discharge planning from jails in the Commonwealth.

The workgroup then took this one step further to estimate the number of positions needed in each region of the state, and within each region the number of positions needed to serve each individual jail. The recommendations that follow were based upon the jails' self-reported number of persons with SMI and their calculated percentage of the statewide total number of SMI inmates in Virginia jails.

Regional Calculations of Staff Positions and Funding Requirements

In order to be consistent with the Compensation Board, the workgroup utilized the Compensation Board's regional designations as a guide for distributing the number of positions and make recommendations regarding funding to support those positions. The Compensation Board divided the jails into Central, Eastern, and Western Regions. Based on the numbers reported by each jail, and utilizing these regional designations, the following chart depicts the calculated percentage and total number of full-time staff positions that should be allocated by region.

Figure 10: Proposed CSB Staffing Totals by Region



Next, the workgroup estimated the cost of funding positions in each region by examining the average annual salaries for comparable positions at the local CSB. Combined with the number of positions estimated by region and within each region by individual jail, the workgroup was able to estimate the total costs of funding the 168 forensic discharge planning positions and recommend a system for distributing those funds fairly among the jails.

Figure 11: Central Region Jails

Jail Name	# of SMI	% of Total SMI	CSBs Served by Jail	Estimated Number of F/T Positions	Estimated F/T Position Annual Salaries
Albemarle-Charlottesville Regional Jail	86	2.56%	1. Region Ten	4.3	$38,000.00
Alexandria Detention Center	69	2.06%	1. Alexandria	3.5	$50,000.00
Arlington County Detention Facility	135	4.02%	1. Arlington 2. Fairfax-Falls Church (Falls Church City only)	6.8	$50,000.00
Central Virginia Regional Jail	22	0.66%	1. Rappahannock-Rapidan 2. Region Ten	1.1	$38,000.00
Charlotte County Jail	2	0.06%	1. Crossroads	0.1	$47,000.00
Chesterfield County Jail	37	1.10%	1. Chesterfield	1.8	$47,000.00
Culpeper County Jail	17	0.51%	1. Rappahannock-Rapidan	0.9	$38,000.00
Fairfax Adult Detention Center	104	3.10%	1. Fairfax-Falls Church	5.2	$50,000.00
Fauquier County Jail	13	0.39%	1. Rappahannock-Rapidan	0.7	$38,000.00
Henrico County Jail	89	2.65%	1. Henrico Area MH & MR 2. Goochland-Powhatan	4.5	$47,000.00

Jail Name	# of SMI	% of Total SMI	CSBs Served by Jail	Estimated Number of F/T Positions	Estimated F/T Position Annual Salaries
Loudoun County Adult Detention Center	49	1.46%	1. Loudoun	2.5	$50,000.00
Meherrin River Regional Jail	27	0.80%	1. Southside 2. District 19	1.3	$47,000.00
Northwestern Regional Jail	75	2.23%	1. Northwestern 2. Rappahannock-Rapidan	3.7	$38,000.00
Northern Neck Regional Jail	15	0.45%	1. Middle Peninsula-Northern Neck	0.8	$43,000.00
Page County Jail	8	0.24%	1. Northwestern	0.4	$38,000.00
Pamunkey Regional Jail	23	0.69%	1. Hanover 2. Rappahannock Area	1.2	$47,000.00
Prince William-Manassas Detention Center	72	2.15%	1. Prince William	3.6	$50,000.00
Rappahannock-Shenandoah-Warren Regional Jail	51	1.52%	1. Rappahannock-Rapidan 2. Northwestern	2.6	$38,000.00
Rappahannock Regional Jail	63	1.88%	1. Rappahannock Area	3.2	$38,000.00
Richmond City Jail	165	4.92%	1. Richmond BHA	8.3	$47,000.00
Rockingham-Harrisonburg Regional	40	1.19%	1. Harrisonburg-Rockingham	2.0	$38,000.00
Jails = 21	**Total = 1,163**	**Total = 34.9%**	**CSBs =19**	**Total = 58.6**	**Avg. Annual Salary + 30% Fringe $56,000/FTE**

Figure 12: Western Region Jails

Jail Name	# of SMI	% of Total SMI	CSBs Served by Jail	Estimated Number of F/T Positions	Estimated F/T Position Annual Salaries
Alleghany County Regional Jail	26	0.77%	1. Alleghany Highlands	1.3	$38,000.00
Blue Ridge Regional Jail Authority	172	5.13%	1. Central/Horizon 2. Southside	8.6	$35,000.00
Botetourt-Craig Jail	30	0.89%	1. Blue Ridge BHC	1.5	$35,000.00
Bristol City Jail	19	0.57%	1. Highlands	1.0	$35,000.00
Danville City Jail	18	0.54%	1. Danville-Pittsylvania	0.9	$35,000.00
Danville City Jail Farm	0	0.00%	1. Danville-Pittsylvania	0.0	$35,000.00
Franklin County Jail	0	0.00%	1. Piedmont Regional	0.0	$35,000.00
Henry County Jail	22	0.66%	1. Piedmont Regional	1.1	$35,000.00
Martinsville City Jail	13	0.39%	1. Piedmont Regional	0.7	$35,000.00
Middle River Regional Jail	105	3.13%	1. Valley	5.3	$38,000.00
Montgomery County Jail	25	0.74%	1. New River Valley	1.2	$35,000.00
New River Valley Regional Jail	28	0.83%	1. New River Valley 2. Mount Rogers MH & MR	1.4	$35,000.00
Patrick County Jail	12	0.36%	1. Piedmont Regional	0.6	$35,000.00
Piedmont Regional Jail	72	2.15%	1. Crossroads	3.6	$47,000.00
Pittsylvania County Jail	26	0.77%	1. Danville-Pittsylvania	1.3	$35,000.00
Roanoke City Jail	140	4.17%	1. Blue Ridge BHC	7.0	$35,000.00
Roanoke County Jail	0	0.00%	1. Blue Ridge BHC	0.0	$35,000.00
Rockbridge Regional Jail	9	0.27%	1. Rockbridge Area	0.5	$38,000.00
Southwest VA Regional Jail	186	5.54%	1. Cumberland Mountain 2. Highlands 3. Planning District 1 4. Dickenson	9.3	$35,000.00
Western VA Regional Jail	114	3.40%	1. Blue Ridge BHC 2. New River Valley 3. Piedmont Regional	5.7	$35,000.00
Jails = 20	**Total = 1017**	**Total = 30.3%**	**CSBs = 15**	**Total = 51**	**Avg. Annual Salary + 30% Fringe $47,000/FTE**

Figure 13: Eastern Region Jails

Jail Name	# of SMI	% of Total SMI	CSBs Served by Jail	Estimated Number of F/T Positions	Estimated F/T Position Salaries
Accomack County Jail	36	1.07%	1. Eastern Shore	1.7	$43,000.00
Chesapeake City Jail	165	4.92%	1. Chesapeake	8.2	$43,000.00
Gloucester County Jail	11	0.33%	1. Middle Peninsula Northern Neck	0.5	$43,000.00
Hampton City Jail	20	0.60%	1. Hampton Newport News	1	$43,000.00
Hampton Roads Regional Jail	359	10.70%	1. Norfolk 2. Portsmouth 3. Hampton Newport News	18	$43,000.00
Lancaster County Jail	1	0.03%	1. Middle Peninsula-Northern Neck	0.05	$43,000.00
Middle Peninsula Regional Jail	14	0.42%	1. Middle Peninsula-Northern Neck	0.7	$43,000.00
Newport News City Jail	40	1.19%	1. Hampton-Newport News	2	$43,000.00
Norfolk City Jail	70	2.09%	1. Norfolk	3.5	$43,000.00
Portsmouth City Jail	19	0.57%	1. Portsmouth	0.95	$43,000.00
Riverside Regional Jail	230	6.85%	1. District 19 2. Chesterfield 3. Henrico Area MH & MR	11.5	$47,000.00
Southampton County Jail	3	0.09%	1. Western Tidewater	0.1	$43,000.00

Jail Name	# of SMI	% of Total SMI	CSBs Served by Jail	Estimated Number of F/T Positions	Estimated F/T Position Salaries
Southside Regional Jail	9	0.27%	1. District 19	0.4	$47,000.00
Sussex County Jail	3	0.09%	1. District 19	0.1	$47,000.00
Virginia Beach City Jail	105	3.13%	1. Virginia Beach	5.2	$43,000.00
Virginia Peninsula Regional Jail	43	1.28%	1. Colonial MH & MR	2.1	$43,000.00
Western Tidewater Regional Jail	48	1.43%	1. Western Tidewater	2.4	$43,000.00
Jails = 17	**Total = 1176**	**Total = 34.8%**	**CSBs = 12**	**Total = 58.4**	**Avg. Annual Salary + 30% Fringe $57,000/FTE**

Statewide Total Staffing Costs

Below is a summary table outlining the steps taken to estimate the total number of positions and costs by region and then statewide. **The costs for funding the 168 forensic discharge planner positions needed to serve every individual who is diagnosed with a SMI in every jail in Virginia total $9,007,400**.

Figure 14: Statewide Cost for Staffing

Cost Calculated by % of SMI in Jails	Central Region	Western Region	Eastern Region
Regional % of SMI	34.9% of SMI	30.3% of SMI	34.8% of SMI
# FTEs Per Region Based on % SMI	58.6 FTEs	51 FTEs	58.4 FTEs
Avg. Total Compensation Per FTE	$56,000	$47,000	$57,000
Cost Per Region Based on Avg. FTE Cost	**$3,281,600**	**$2,397,000**	**$3,328,800**
Total Cost to Fund 168 Positions in Virginia = $9,007,400/year			

Estimated Costs for Services & Supports

Development of an effective forensic discharge planning program cannot be accomplished by focusing solely on the staffing of discharge planning positions and coordinating care within the jail. As referenced earlier in this report, many individuals with SMI being discharged for jail lack many basic resources (food, shelter, medications, etc.). Additional resources will be necessary to accomplish the goal of successful reentry planning in Virginia. DBHDS encourages communities to conduct a comprehensive assessment of their current capacity for providing services in the community for this population. While staffing resources are needed to adequately assess, plan, identify, and coordinate care at the point of reentry, this will mean little if there are no services and supports in the community with which to link these individuals.

In order to appropriately address the criminogenic and clinical needs of individuals with SMI returning to the community from jail, localities must anticipate the needs and placement challenges that will be faced upon release. While these needs will vary by individual, there are areas which are consistently lacking in resources throughout Virginia. The significance of the lack of appropriate housing options, affordable transportation, and even CSB outpatient clinical services cannot be underestimated when planning for a successful forensic discharge planning initiative. In this section, the cost of providing community-based programming and addressing basic physiological and safety needs are estimated for the population of special needs inmates targeted by these discharge planning efforts. Without additional support in these areas, the ability to produce significant impacts on recidivism, crisis services utilization, and treatment engagement and quality of life will be limited.

Areas of need identified in the survey of local and regional jails, CSBs, and other stakeholders include housing, transportation, and outpatient services (i.e., case management and psychiatric services). It is difficult to estimate the true costs associated with filling these gaps and it is possible the results of the DMAS study may result in practices which facilitate the timely access to benefits; however, our experience suggests a portion of individuals with SMI leaving jail will not have benefits upon release from jail. While Virginia has invested significant resources in permanent supportive housing, these resources continue to be somewhat limited. Many communities not only lack these options, but also lack a homeless shelter year-round where basic safety needs can be met. While efforts are currently being made to increase permanent supportive housing within the Commonwealth, the workgroup proposes some additional funding sources for forensic discharge planners to utilize for the immediate housing needs upon jail release. With additional funds in this area, CSBs may be able to partner with local housing providers to purchase short-term transitional beds in existing residential placements, lease apartments for short-term housing, enter into agreements with their local shelters for the prioritizing of this population, or at the very least purchase a specified number of nights in a hotel until other arrangements can be made.

Similarly, with some localities lacking an adequate public transportation system, the individuals being released from jail will face barriers in simply getting from jail to their discharge placement and from the placement to their appointments with providers. Many CSBs have negotiated reduced cab fare vouchers, bus tokens and the like, but just as many CSBs lack transportation at all. Combined with the fact that these individuals will not have any benefits immediately upon release (unless or until some of the DMAS study recommendations are implemented), the lack of options at the CSB level often means that people are falling through the cracks. Given previously referenced research on the fragility of this population in particular, and that the first week to two

weeks post-release are the most dangerous and the most crucial in ensuring success, additional funding to support transportation needs would help reduce the likelihood of missed case management, psychiatric, and social services appointments that are essential in maintaining stability in the community.

Finally, and perhaps the most complicated issue that must be addressed, is the limited amount of outpatient services available at the CSB itself. As mentioned in earlier sections, CSBs rely on a limited amount of state funds, combined with Medicaid revenue, to support their daily functions. In some cases, CSBs are lucky to also have the addition of local funding, but this is not the case in all CSBs. The limitations on funding means that often there are long waits for initial intake appointments, and even longer waits for psychiatric appointments. Most CSBs will be unable to accommodate the influx of new clients in a timely manner. Again, with the need for rapid transition and follow-up care immediately upon release in order to ensure continued treatment engagement, medication availability and adherence, additional funding in this area would enhance outcomes for the individuals as well as the systems that support them.

To estimate the amount of funds that might be needed for these and other emergency needs (i.e., hygiene products, food, and clothing), the following steps were taken:

- To calculate the number of individuals with SMI that could be served by the 168 forensic discharge planners per year, the workgroup first estimated the average length of time that an individual would remain on a discharge planner's caseload. Given that the most intensive services will occur at the point of release until linkage, and given that the recommendation of workgroup is that the planner will continue to monitor the case for at least 30 days post-release, it is estimated that each case would be open for approximately 60 days in total. This will likely vary drastically from individual to individual, and is only an estimate; however this appears to be a reasonable amount of time for most discharge planners to complete assessment, release planning, and linkage upon release.

- With a recommended caseload size of 20, an estimated turnover rate of 60 days, and an estimated rate of 5 new cases per month, **each of the 168 discharge planners could serve in the range of 60-70 individuals per year**.

- Estimating the costs of transitional housing, transportation, and services is challenging. At the far end of the spectrum are those individuals who will need a month of hotel stays (using the average government rate of $91/night + taxes), a month of transportation funds ($10/day), and a month of basic needs such as food and self-care products ($20/day). Adding on to that the costs of boosting the availability of case management or psychiatric hours, the workgroup estimates that **the most intensive individuals could require up to $4,500 during their time transitioning from jail to community**.

- If one in twenty individuals served require the maximum amount of funding, and down from there, **each full-time discharge planning position serving approximately 65 people per year would need roughly $20,000 in additional funds to cover supports and services that enhance stability and likelihood of successful transition (approximately $308 per client on average)**.

The chart below details the estimated funding needs by region, and the total funding estimated for the entire state per year assuming the amounts above.

Figure 15: Costs for Additional Supports and Services

	Central Region	Western Region	Eastern Region
# FTEs Per Region Based on % SMI	58.6 FTEs	51 FTEs	58.4 FTEs
Number of Clients Served per Year (Est. 65 per FTE)	**3,786**	**3,315**	**3,822**
Cost Estimate by Region (Est. $20,000 per FTE)	**$1,172,000**	**$1,020,000**	**$1,168,000**
Total Cost to Fund Additional Services & Supports in Virginia = $3,360,000/year			

Estimated Cost-Savings

While the cost of funding staff positions and support services for forensic discharge planning is considerable, an investment in these strategies will greatly improve the systems that are impacted directly by this population. Every system loses out with the current approach to individuals with mental illness in jail. When left to return to the community with no assistance addressing their basic human needs and no assistance in navigating the complex mental health and social services systems, these individuals incur significant costs to the state and local mental health systems, private healthcare systems, law enforcement, courts, community corrections agencies, and ultimately the taxpayers.

Studies on the so-called "high utilizers" have shown that costs are considerable for this particularly high need and high risk group.[57] While it is difficult to assess the costs incurred by local and state governments in Virginia, Virginia jails reported spending roughly $14,000,000 per year on mental health treatment and medications for inmates with mental illness.[58] Additional costs related to management of this population within the jail, including additional staff coverage and medical care for staff and inmates from incidents of aggression, pushes the annual costs even higher. DBHDS calculates that inpatient psychiatric care of inmates transferred from jail to a state-operated hospital for emergency treatment, court-ordered evaluations, or competency restoration can cost approximately $900 per day per patient. The four-year average length of inpatient stay for forensic evaluation admissions is 26 days, the average length of stay for restoration admissions is 87 days, and the average length of stay for emergency jail transfers is around 53 days. With a total of 1,356 admissions for these categories alone in FY 2017, financial impact on the state mental health system is huge. Costs associated with incarceration of individuals with SMI can quickly add up, and while the exact cost per SMI inmate in Virginia is extremely complicated and difficult to calculate, it is the position of DBHDS that it is considerably higher than the costs needed to appropriately treat these same individuals in the community.

Costs associated with funding staff and resources as proposed in this report are quite significant, but providing high-intensity discharge planning services and amplifying the support services and access to treatment upon release should result in fewer subsequent interactions with law enforcement, fewer rearrests, and lessening of the costs associated with that process that are outlined above. One might see this more as a cost-shifting than a cost-savings, at least in its initial phases of implementation. However, it is hypothesized that communities and the state will see cost savings as a result of these initiatives. Historically, it has been difficult for communities to calculate costs and cost-savings associated with reentry planning. One study estimated the

average spending on jail-based reentry in several communities, and how much crime would have to be prevented for the reentry investment to break even. Overall, the researchers found that only very modest reductions in reoffending are necessary to offset the costs of discharge planning services, and that there is compelling evidence to expect that communities would see cost-savings associated with reductions in crime.[59] Other research studies have pointed to similar promising results in regards to crime reduction, reduced re-incarcerations, and the savings to the criminal justice system that result.[60]

In all, while existing research shows promising trends of reduced recidivism and enhanced treatment engagement and stability with the use of forensic discharge planning, the costs associated with providing those services and bolstering community-based care are high. However, research also seems to indicate that these improved outcomes will result in cost-savings in the criminal justice systems with time. While it is yet to be seen whether there will be significant cost-savings or merely a shifting of resources from one system to another, at the very least these practices have a high probability of resulting in a better quality of life for the individuals served.

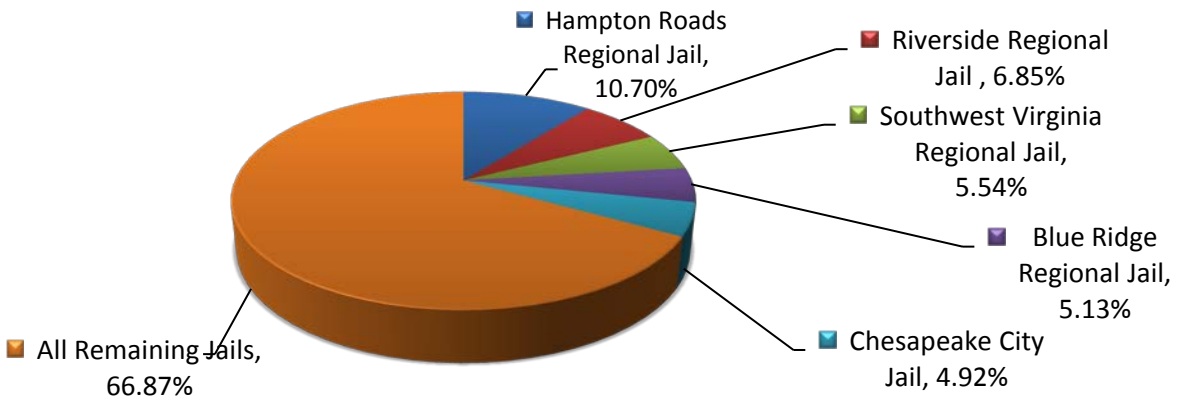
Proposal for Implementation

Below is a proposal for a tiered implementation of the services and funding that would be needed at each phase of the implementation plan.

Implementation Phase One

In order to get the most impact from limited resources, DBHDS proposes that initial funding be allocated to those catchment areas containing jails with the highest percentage of individuals with SMI. As shown in the pie chart below, **the top five jails represent just over one-third of the total number of inmates with SMI in Virginia Jails**. Funding forensic discharge planning services to these five jails would capture a significant number of individuals with SMI who are incarcerated every year. DBHDS would solicit applications for funds from those communities representing jails with high prevalence rates of SMI, realizing that not all jails, CSBs, and communities may be ready to implement such a robust system of forensic discharge planning. Funds would be awarded contingent on agreement to adhere to the recommended best practices and to provide outcome data on program recipients.

Figure 16: Percentage of SMI in the Top 5 Virginia Jails



By breaking out the top five jails with the highest percentage of mentally ill inmates, and then calculating the number of positions needed to serve those inmates and the average salaries for those positions and the additional funding needed for supports and services, the following is a breakdown of the costs to fund discharge planning services within those five jails.

Figure 17: Funding for Phase 1of Forensic Discharge Planning Implementation Plan

	Hampton Roads Regional Jail	Riverside Regional Jail	Southwestern VA Regional Jail	Blue Ridge Regional Jail Authority	Chesapeake City Jail
# FTEs Based on % SMI	18 FTEs	11.5 FTEs	9.3 FTEs	8.6 FTEs	8.3 FTEs
Avg. Total Compensation per FTE	$57,000	$57,000	$47,000	$47,000	$57,000
Total Funding Needed for Staffing	$1,026,000	$655,500	$437,100	$404,200	$473,100
Total Funding Needed for Supports & Services (est. $20,000 per FTE)	$360,000	$230,000	$186,000	$172,000	$166,000
Total Cost Estimate by Jail	**$1,386,000**	**$885,500**	**$623,100**	**$576,200**	**$639,100**
Total Cost to Fund Services to the Top 5 Virginia Jails in Phase 1 = $4,109,900/year					

Although costs are broken out by jail in the above chart, DBHDS recommends that funding be allocated to the CSBs that serve those jails. The numbers above are cost estimates intended to gauge the scope of costs – decisions about which CSBs to fund and at what amounts should be made at a later time.

Implementation Phase Two

Should additional funding be made available to extend forensic discharge planning services to other jails in Virginia beyond the five listed above, DBHDS recommends that funding be allocated to the jails that maintain custody over the second highest one-third of inmates with

SMI. As before, DBHDS would seek applications for funds. Below is a list of those jails and the total cost to provide discharge planning based on the same calculation steps taken above.

Figure 18: Funding for Phase 2 of Forensic Discharge Planning Implementation

Jail	Total Cost
Richmond City Jail	$630,800
Roanoke City Jail	$469,000
Arlington County Detention Facility	$516,800
Western VA Regional Jail	$381,900
Middle River Regional Jail	$355,100
Virginia Beach City Jail	$400,400
Fairfax Adult Detention Center	$395,200
Henrico County Jail	$342,000
Albemarle-Charlottesville Regional Jail	$326,800
Northwestern Regional Jail	$281,200
Number of Jails in Phase Two = 10	**Total Funding Phase 2 = $4,099,200**

Implementation Phase Three

The final phase of the proposed implementation plan would fund services to inmates at the jails representing the remaining one-third of SMI inmates. As demonstrated below, the remaining one-third of individuals with SMI are spread widely among the remaining 45 local and regional jails. Below is a list of those jails and the total cost to provide discharge planning based on the same calculation steps taken above.

Figure 19: Funding for Phase 3 of Forensic Discharge Planning Implementation

Jail	Total Cost
Accomack County Jail	$130,900
Alexandria Detention Center	$266,000
Alleghany County Regional Jail	$87,100
Botetourt-Craig Jail	$100,500
Bristol City Jail	$67,000
Central Virginia Regional Jail	$83,600
Charlotte County Jail	$7,600
Chesterfield County Jail	$136,800
Culpeper County Jail	$68,400
Danville City Jail	$60,300

Jail	Total Cost
Danville City Jail Farm	$0
Fauquier County Jail	$53,200
Franklin County Jail	$0
Gloucester County Jail	$38,500
Hampton City Jail	$77,000
Henry County Jail	$73,700
Lancaster County Jail	$3,850
Loudoun County Adult Detention Center	$190,000
Martinsville City Jail	$46,900
Meherrin River Regional Jail	$98,800
Middle Peninsula Regional Jail	$53,900
Montgomery County Jail	$80,400
New River Valley Regional Jail	$93,800
Newport News City Jail	$154,000
Norfolk City Jail	$269,500
Northampton County Jail	$0
Northern Neck Regional Jail	$60,800
Page County Jail	$30,400
Pamunkey Regional Jail	$91,200
Patrick County Jail	$40,200
Piedmont Regional Jail	$241,200
Pittsylvania County Jail	$87,100
Portsmouth City Jail	$73,150
Prince William-Manassas Detention Center	$273,600
Rappahannock Regional Jail	$243,200
Rappahannock-Shenandoah-Warren Regional Jail	$197,600
Roanoke County Jail	$0
Rockbridge Regional Jail	$33,500
Rockingham-Harrisonburg Regional	$152,000
Southampton County Jail	$7,700
Southside Regional Jail	$30,800
Sussex County Jail	$7,700
Virginia Peninsula Regional Jail	$161,700
Western Tidewater Regional Jail	$184,800
Number of Jails in Phase Three = 44	**Total Funding Phase 3 = $4,158,400**

Although costs are broken out by jail in the above charts, DBHDS recommends that funding be allocated to the CSBs that serve those jails, as the forensic discharge planner positions should be employed and managed by those agencies. The numbers above are cost estimates intended to gauge the scope of costs – decisions about which CSBs to fund and at what amounts should be made at a later time. **In total, full funding for comprehensive forensic discharge planning**

services at the levels recommended in this report would cost the Commonwealth $14,456,285 per year. Funding these measures in phases, such as those proposed above, would make the implementation of these measures more realistic and attainable. DBHDS recommends that these positions and additional costs be funded as proposed in this report. Regardless of implementation timing, ensuring that the appropriate amounts of funds are spread according to need is essential to be able to demonstrate positive outcomes.

Post-Implementation Data Collection & Program Evaluation

DBHDS will collect data from all localities receiving funds for forensic discharge planning services to ensure a good return on investment, to monitor program outcomes, and to monitor adherence to best practices.

- Outcome data has a large impact on funding and sustainability, and is part and parcel of the Risk-Needs-Responsivity Model – by applying the right services and supervision to the right people, communities should see an impact on the clinical and legal outcomes for participants. If no impact is observed, assessment of program structure and modifications should be made as appropriate.

- Data collected should address procedural components, availability and quality of interventions, appropriateness of interventions for the population served, as well as clinical and legal outcomes.

- The data should be used to perform regular outcome and process evaluations of the program, and to inform any decisions about modifications to program structure or policies and procedures.

- Program evaluation should be based on reliable and valid processes for collecting and analyzing the data.

- All outcome measures should correlate with clear and measurable goals delineated at the outset of the program.

- Often, forensic discharge planning data addresses the following goals: reducing recidivism, improving clinical outcomes, enhancing engagement in treatment, improving quality of life for the defendants, and reducing costs.

- Generally, data should be collected in the following categories:

    - Characteristics of the Participants –number of individuals referred, screened, and accepted, length of time between referral and screening and acceptance, age, gender, race, diagnoses, charge level, charge type, number of days spent in jail on current charges criminal history, risk level, reason for non-acceptance, and reasons for refusal to participate.

    - Clinical Outcomes –number of appointments scheduled versus appointments kept, utilization of crisis services (pre implementation and post implementation), number of days in crisis stabilization or inpatient hospitalization during

participation, self-reported quality of life upon admission and at conclusion of participation, types of services offered vs. types of services utilized, level of utilization of services post-program completion, residential stability, and access to entitlements/benefits.

- Legal Outcomes –average yearly jail days prior to and after receiving forensic discharge planning services, number of new charges incurred after receiving forensic discharge planning services, jail days for new offenses after receiving forensic discharge planning services, new charges incurred after program completion, types and level of new charges incurred post-program completion, length of time between program completion and new charges.

- Other areas for data collection include cost savings and public safety. Cost savings are generally estimated by calculating the amount of jail bed days that were saved as a result of participation and the cost of services and supports received in the community. Public safety can be captured in different ways depending on how the locality defines public safety. This might include public perception surveys, reduction in crime rates, reduced recidivism of participants, etc. Other measures may be included beyond those listed here, in order to measure the areas that are important to that locality.

- Data collection should be done from the time of the program inception and maintained over time. Programs should consider the way data is collected and analyzed, and the costs associated with data collection and evaluation when planning for their program. This analysis needs to be thoughtful. Data should be gathered for participants after completion of the program in order to assess the longer term clinical and criminal justice outcomes associated with participation in the docket.

- Data should be reported regularly to regulating bodies, including the locality's own stakeholder group, Community Criminal Justice Board, local reentry council, and DBHDS as required.

Conclusion

There is strong evidence to support the development of forensic discharge planning services in jails across Virginia. There clearly are a significant number of individuals with SMI housed in local and regional jails and the evidence is clear that absent comprehensive discharge planning services these individuals are at risk of recycling through the criminal justice system. There are many legal precedents which suggest that states/localities have an obligation to provide adequate mental health services to individuals with SMI involved in the criminal justice system and several states have fallen under Department of Justice oversight for failure to do so.
DBHDS would like to stress that while forensic discharge planning may be a helpful tool for connecting individuals to needed treatment and supports in the community at jail release, this should never be the only way to assure jail diversion of persons with mental illness in the criminal justice system. Communities should conduct thorough analyses of their programs, services, and existing resources; they should develop comprehensive action plans that address diversion opportunities at every point in the criminal justice process. Crisis intervention team (CIT) training, opportunities for police diversions such as CIT Assessment

Sites, post-booking diversion programs, mental health dockets, and specialized probation/parole programs for individuals with mental health issues should all be available within a community. Forensic discharge planning services should be only one option along the continuum of diversion opportunities in order to truly have an impact.

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Forensic Discharge Planning Study Workgroup Members

Melanie Adkins, LPC
Emergency Services Director/Jail Diversion Coordinator
New River Valley Community Services
700 University City Boulevard
Blacksburg, VA 24060

Andrew Molloy, Jr.
Director
Chesterfield/Colonial Heights Community Corrections Services
P.O. Box 40
Chesterfield, VA 23832

Sheriff Beth Arthur
Arlington County Sheriff's Office
1425 North Courthouse Road
Arlington, VA 22201

Yolanda Marrow, LCSW
Social Worker
Western State Hospital
103 Valley Center Drive
Staunton, VA 24401

Sheriff Joseph Baron
Norfolk Sheriff's Office
811 East City Hall Avenue
Norfolk, VA 235100000

Jennifer L. Matovich, Psy.D.
Region IV Jail Team Program Manager
Central State Hospital
P.O. Box 4030, B43
Petersburg, VA 23803

Jana Braswell, M.S.
Coordinator
Center for Behavioral Health & Justice
Virginia Dept. of Behavioral Health & Developmental Services
P.O. Box 1797
Richmond, VA 23218

Stephany Melton Hardison
Interim Executive Director
National Alliance on Mental Illness (NAMI) Virginia
P.O. Box 8260
Richmond, VA 23226-0260

Sarah Conlon
Executive Director
Offender Aid and Restoration of Richmond
3111 West Clay Street
Richmond, VA, 23230

Annette Miller, Esq.
Senior Assistant Public Defender
City of Virginia Beach Office of the Public Defender
P.O. Box 6160
Virginia Beach VA 23456

Colonel K.W. Craig, CJM
Superintendent
Southside Regional Jail
244 Uriah Branch Way
Emporia, VA 23847

Hilary Page, MSW
Reentry Program Manager
Offender Aid and Restoration of Richmond
3111 West Clay Street
Richmond, VA, 23230

Bruce Cruser
Executive Director
Mental Health America of Virginia
2008 Bremo Road, Suite #101
Richmond, VA 23226

Tara Portee, LCSW
Forensic Social Work Supervisor
Central State Hospital
P.O. Box 4030, B43
Petersburg, VA 23803

Robyn M. deSocio
Executive Secretary
State Compensation Board
102 Governor Street, Suite 120
Richmond, VA 23219

Caitlin Reynolds-Vivanco
Virginia Indigent Defense Commission
1604 Santa Rosa Road, Suite 200
Richmond, VA 23229

Michael E. Ellyson
Director
Recovery Refuge Peer Support Center
322 Third Avenue
Danville, VA 24540

Michael Schaefer, Ph.D., ABPP
Assistant Commissioner for Forensic Services
Virginia Dept. of Behavioral Health & Developmental Services
P.O. Box 1797
Richmond, VA 23218

LaShawn Fisher
Inmate Services Manager
Arlington County Sheriff's Office
1425 North Courthouse Road
Arlington, VA 22201

Thomas Fitzpatrick
Acting Division Director
Division of Programs and Services
Virginia Department of Criminal Justice Services
1100 Bank Street, 12th Floor
Richmond, Virginia 23219

Jimmy Hadder, MS, QMHP
Assessment Team Lead
New River Valley Community Services
700 University City Boulevard
Blacksburg, VA 24060

Shaun R. Huband, Esq.
Deputy Public Defender
Petersburg Public Defender's Office
105 Marshall Street, 2nd Floor
Petersburg, VA 23803

John Kuplinski
Superintendent
Virginia Peninsula Regional Jail
9320 Merrimac Trail
Williamsburg, VA 23185

Colonel Martin Kumer
Superintendent
Albemarle - Charlottesville Regional Jail
160 Peregory Lane
Charlottesville, VA 22902

Sarah Shrum, M.A.
Diversion Program Coordinator & Forensic Mental Health Consultant
Virginia Dept. of Behavioral Health & Developmental Services
P.O. Box 1797
Richmond, VA 23218

DeVon E. Simmons
Reentry Coordinator
Office of the Attorney General
202 North 9th Street
Richmond, Virginia 23219

Auriel Walker
Director
Community Based Probation/Pretrial & Offender Re-entry
Northern Neck Regional Jail
P.O. Box 1090
Warsaw, VA 22572

Sheriff Jack Weisenburger
Bristol City Sheriff's Office
417 Cumberland Street
Bristol, VA 24201

Leslie Weisman, LCSW
Client Services Entry Bureau Chief
Arlington Community Services Board
Crisis Intervention Center
2120 Washington Boulevard
Arlington, VA 22204

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