Potential Use of Peumansend Creek Regional Jail as a Facility for Individuals with Mental Illness Who are Incarcerated in Virginia Jails

(Item 383.C)

October 1, 2017

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November 30, 2017

TO: The Honorable Terence R. McAuliffe
Governor

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

The Honorable Emmitt W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Secretary of Public Safety and Homeland Security and the Secretary of Health and Human Resources have prepared this report on potential options for continued utilization of Peumansend Creek Regional Jail to serve individuals with mental illness who are incarcerated in Virginia Jails. As part of the process, a multi-disciplinary, multi-agency work group of advisory members from the Center for Behavioral Health & Justice was convened to provide input on the benefits and challenges of creating a specialized mental health jail to serve individuals with mental illness

Several HHR and PSHS staff toured the facility, reporting to the Secretaries and sharing information with the workgroup. This report details many challenges with conversion and use of the facility. These include concerns with the remote location; staffing needs and workforce capacity; limitations on the number of individuals who could be served at the facility; providing defendants access to counsel and court proceedings; and the high capital and operational costs of the program. Please contact our offices if should you have any questions regarding any aspect of the report.

Sincerely,

Brian J. Moran

William A. Hazel Jr.

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Preface

Item 383.C of the 2017 Appropriation Act requires the Secretary of Public Safety & Homeland Security and the Secretary of Health and Human Resources to jointly prepare a report about the possible use of Peumansend Creek Regional Jail as a specialized jail to treat individuals with mental illness who are incarcerated. Specifically, Item 383.C states:

The Secretary of Public Safety and Homeland Security and the Secretary of Health and Human Resources shall jointly prepare a report on potential options for continued utilization of the Peumansend Creek Regional Jail as a state, regional, or local correctional mental health facility. This shall include, but not necessarily be limited to, conversion of this facility into a regional mental health facility for inmates from regional or local jails who have been determined to have mental illness and who could be more appropriately housed in a specialized, minimum security facility rather than in a traditional jail setting. The report shall address financing options; governance and accountability; the appropriate mechanisms for administering the facility; security, operational, medical, and mental health treatment standards; and transport procedures. The Secretaries shall consult with the U.S. Department of the Army and leadership at Fort A. P. Hill to assure continuation of a cooperative agreement for the use of the property, as appropriate. Copies of the report shall be provided to the Governor and the Chairmen of the Senate Finance and House Appropriations Committees by October 1, 2017.

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Executive Summary

The Secretary of Public Safety and Homeland Security and the Secretary of Health and Human Resources have prepared this report on potential options for continued utilization of Peumansend Creek Regional Jail to serve individuals with mental illness who are incarcerated in Virginia Jails. As part of the process, a multi-disciplinary, multi-agency work group of advisory members from the Center for Behavioral Health & Justice was convened to provide input on the benefits and challenges of creating a specialized mental health jail to serve individuals with mental illness. The group members brought expertise from areas to include jail operations, clinical operations, court processes, and human rights advocacy. The input and recommendations of the work group are reflected in this report.

Several HHR and PSHS staff toured the facility, reporting to the Secretaries and sharing information with the workgroup. The workgroup examined issues related to steps necessary to appropriately convert the existing facility and with determining the clinical, legal and safety needs of individuals who might be appropriately housed in such a facility. The report addresses options for financing; governance and accountability; administration; security; operational, medical and mental health treatment standards; as well as transport procedures. The report does not address issues regarding contact with the Department of the Army or leadership at Fort AP Hill, as it was not deemed necessary or appropriate as the state has no role in the agreement regarding the land use, nor given the many challenges which would need to be overcome in order to use the property as a mental health correctional facility. Specifically, this report details many challenges with conversion and use of the facility. These include concerns with the remote location; staffing needs and workforce capacity; limitations on the number of individuals who could be served at the facility; providing defendants access to counsel and court proceedings; and the high capital and operational costs of the program.

It is worth highlighting that the Commonwealth has made significant progress the past two years in supporting the use of evidence based programs and practices as it develops plans to expand access to community-based behavioral health services and improve the care provided to individuals in local and regional jails. Providing resources to renovate and operate Peumansend Creek will divert potential funding needed to continue to support the community services that help individuals with behavioral health disorders manage symptoms and avoid inpatient admissions to state hospitals or interactions with the criminal justice system. Funding for the care and treatment of individuals in local and regional jails will also suffer if more resources are provided to Peumansend Creek. Additionally, there is not a body of research or evidence demonstrating that such a program would improve outcomes for the individuals being served.

Virginia's History with Mental Illness in the Criminal Justice System

Virginia, like many states, has a disproportionately high number of individuals with mental illness in its jails. There have been countless workgroups, initiatives, and pilot projects started to address this challenge. Since the early 2000s there has been more consistent, focused emphasis on this challenge both within the Executive Branch as well as the General Assembly. While it is beyond the scope of this report to provide a comprehensive listing of all the initiatives undertaken to address this issue, it may be informative to review the appendix of this report that describes some of the more recent initiatives in this area.

Despite the progress being made on many fronts, Virginia continues to lack consistent access to services depending on geography. While some communities have a wealth of diversion and jail based services, many communities have few diversion programs and extremely limited jail-based mental health services. While Virginia has seen some improvements, jailers continue to share stories of the challenges they face when having to manage an individual with serious mental illness who is incarcerated in their jail. It is against this backdrop that the current study of the potential uses of the Peumansend Creek Regional Jail as a facility for individuals with serious mental illness was undertaken.

About the Peumansend Creek Regional Jail

On September 26, 1996, the federal government, through the Secretary of the Army, transferred 150 acres on which the Peumansend Creek Regional Jail would eventually be built, to Caroline County via a Quitclaim Deed. The deed specifies that the land was conveyed subject to the condition that it be used for a correctional facility and for no other purposes. There was also a prohibition against using the jail to house federal prisoners or prisoners convicted by, sentenced by, or awaiting trial in the courts of the District of Columbia. Included in the quitclaim deed was a reversion clause that stated that all rights, title, and interest to the tract of land conveyed shall revert to the United States (together with any improvements thereon) in the event the Regional Authority does not "use the land for construction and operation of a correctional facility in compliance with the terms of this deed". Thus the quitclaim deed as currently entered into by Caroline County and the U.S. Government would preclude using the facility for any other purposes other than as a correctional facility unless the parties enter into a mutually agreeable amendment to the deed.

Six local governments (City of Alexandria, City of Richmond, Arlington County, Caroline County, Loudoun County, and Prince William County) originally joined into the regional jail authority and utilized the jail, but over time the localities began to send fewer and fewer inmates to Peumansend Creek. The decrease in referrals was related to increased local capacity to manage census demand and increased costs of referring inmates to Peumansend Creek. Localities then began to sever ties with the jail authority and in March 2017 the last inmate left the facility. The regional jail authority officially disbanded on June 30, 2017.
The facility is located in Bowling Green, VA a rural part of Caroline County, 40 miles north of Richmond and 20 miles southeast of Fredericksburg. Construction of the facility began on March 27, 1997 and the jail received its first inmate on September 7, 1999. The facility was designed utilizing a direct supervision model; meaning that correctional officers remain in the

same area with the inmates, constantly observing, interacting, and reacting to behaviors on the floor instead of from a separate room. As a result of the direct supervision model of management there are a limited number of video cameras in the facility. The facility is unique in that it was also designed as a "campus style" facility meaning many of the inmates were allowed to (and expected) to leave their housing unit to participate in programming and to meet their daily needs. There are seven buildings located on 20 acres (of the 150 acre parcel deeded to the authority). There is a 12 acre garden spot outside the secure perimeter which had been used for growing produce. The jail is surrounded by seven foot double chain link fence with razor wire and intrusion protection. The seven buildings combine for a total of 172,249 square feet of space. There is also a detached 10,640 sq. foot warehouse outside the secure perimeter. The seven buildings consist of:

- Administration
- Food Service, Laundry, and Industries
- Maintenance and Supply Warehouse
- Programming space (to include education classrooms, group rooms, and a gym)
- Medical Services, Intake/Release, (a housing unit which had been used for females but could be used for either gender) and which accommodates both minimum and medium security levels, and a special management housing area (close observation housing)
- Minimum Custody Housing
- Medium Custody Housing

The facility had a total rated capacity of 336 housed in the following manner:

- 32 – 4-person wet rooms (i.e. have toilets and sinks inside the room) for medium security inmates = 128 inmates
- 38 – 4-person dry rooms (no toilets/sinks inside the room, rather there are communal bathroom facilities) for minimum security inmates = 152 inmates
- 42 – Single cells
- 14 – Orientation/dry cells (single cell)

The housing units are two-story, tiered-units that could pose some risks of self-harm with a concentrated population of individuals with serious mental illness. Similarly, the bedrooms have bunk beds, thus there are numerous safety risks that would need to be abated if serving a mental health population. Finally, the housing units currently have no programming or office space. While this may be feasible for some individuals, if the facility were used to treat individuals with serious mental illnesses, accommodations would need to be made to provide some programming directly on the housing unit for those individuals too symptomatic to have full access to the grounds. Similarly, because the jail has limited office space for clinical staff (as when it was in operation they only used part-time clinical staff) some building modifications would need to be made in order to provide for office/treatment space. Water is provided to the facility via two, 600 plus foot wells from the Potomac aquifer.

The facility has a state of the art video-visitation system which allows individuals to visit with family or friends via the web. They can access this technology in the housing units. They can visit with family or friends that have personal computers or smart phones. It is unclear what

privacy safeguards are in place for this system, but it is possible the system could be used to link inmates with CSB discharge providers and other community supports.

Being located on Fort A.P. Hill the facility is adjacent to a military installation. As such, at times the military conducts mock exercises (to include detonation of explosives) which can be heard and felt (via vibrations) inside the jail buildings. This could be deleterious to those with serious mental illness, particularly post-traumatic stress or other anxiety disorders and psychoses, for example.

There are two freestanding medical hospitals which historically have provided medical services (when the need exceeds the capacity of the facility) to the population. Spotsylvania Regional Medical Center is located 20 miles from the facility. Mary Washington Hospital located in Fredericksburg is 25 miles from the facility.

Physical Plant Changes Required to Make Safe & Suitable for Potential Population

1. In each housing unit, remove walls between two cells to create large group room/ programming space. Because some of these walls are load bearing there would be challenges to this necessary renovation.
2. Create an infirmary by converting a part of a housing unit into an infirmary and/or remodeling the vocational area. Each option comes with unique challenges. Given the high prevalence rate of co-morbid medical conditions found among individuals with serious mental illness having an infirmary is essential.
3. Install cameras in close observation cells and throughout the jail to provide for better monitoring and supervision.
4. Remove hanging hazards to include enclosing stair rails (to prevent hanging) and remove bunk beds in certain rooms (to minimize hanging risks).
5. Convert one room on each unit to be used as nurse's station to pass medications.
6. Convert at least one room on each unit to be used as office space for clinical staff.
7. Investigate feasibility of using video remote visitation system for clinical case meetings with community behavioral health providers and ensure it meets HIPAA standards.
8. Roof, HVAC, and back-up generators are nearing end of functional life expectancy so should be replaced.

Given the expedited timeframe for this study and the fact no resources were allocated to complete this study, the workgroup was unable to secure the services of an architect to provide cost estimates of renovations. The workgroup, however, did get information from a regional jail of similar size that recently underwent an HVAC system replacement which totaled over $3 million for the HVAC system. At a minimum, renovation costs would run multi-millions of dollars in one time capital costs and nearly $11 million annually for operating costs.

Potential Target Population

1. **Maximum Census Population** – Given the above referenced physical plant modifications needed to make the jail space conducive to the provision of mental health services, the maximum census of the jail would be between 250 – 275 inmates. The average daily population in Virginia's local and regional jails, calculated as of June 2016,

was over 27,000, according to the State Compensation Board report on Mental Health in Jails (2016). Approximately 40 percent of all inmates are being held pre-trial and 60 percent are post-conviction. Of these inmates, some 16 – 17 percent are known or suspected of having mental illness, or nearly 4,500 individuals. http://www.scb.virginia.gov/docs/2016mentalhealthreport.pdf. Therefore, the facility would not be equipped to handle even 5 percent of the total population of those with mental illness.

2. **Pre-Trial vs. Post-Conviction Inmates** – Due to the logistical challenges of getting inmates to and from court appearances and in providing them ready access to their legal counsel, it is felt this program would best serve those inmates who have been convicted/sentenced. However, feedback from workgroup members indicated that often individuals with serious mental illness spend more time in pre-trial status than those without mental illness. As a result, once they are convicted, individuals with mental illness often have little time remaining to serve. This scenario presents a real barrier should the program serve post-conviction population. On the other hand, the legal community has raised concerns about having the specialized jail target pre-trial defendants as this could present a significant barrier to providing legal representation. While the jails reported being amenable to providing video conferencing and/or transporting defendants long distances from court in order to insure proper legal representation, having defendants long distances away from the court where they have pending legal charges would still pose some significant logistical challenges.
3. **Length of Sentence of 3 months to 24 months** – The ideal inmate for participation in this program would be an individual serving a sentence of 3 to 24 months. Individuals sentenced to shorter sentences likely would not have sufficient time to fully integrate into the treatment program and benefit from participation. Those with longer sentences are transferred to the Virginia Department of Corrections, which has its own behavioral health treatment programs.
4. **Males** – Because the jail is a campus style facility, it is not feasible to separate genders. While it is common for males and females to interact in a behavioral healthcare setting, it is not common for them to interact in a criminal justice setting. Since individuals would be in this program due to being convicted of a crime, it is important that the program adhere to criminal justice practices and principles. While it is true females involved in the criminal justice system are at higher risk of having a behavioral health disorder, in terms of overall numbers there are more males than females in the criminal justice system with behavioral health disorders.
5. **Individuals with Serious Mental Illness, Developmental Disability, and/or Intellectual Disability** – The primary target population is individuals with serious mental illness (SMI), defined as having a psychotic disorder, major mood disorder (including unipolar depression and bipolar disorder), and/or post-traumatic stress disorder. It is possible that some individuals with developmental disabilities and/or intellectual disability would benefit from the therapeutic environment offered in the jail, and they would have to be assessed for entry into the program on a case by case basis. Similarly, it is conceivable that some individuals with less serious mental illnesses (such as adjustment disorders, less severe anxiety disorders, and some types of personality disorders) may benefit from the treatment offered and would also need to be assessed for admission into program on a case by case basis. Given the high prevalence rate of

substance use disorders in the SMI population, the existence of a substance use disorder should probably not be a barrier to admission to the program. That being said, as the program would primarily provide treatment for mental illness, it would not be an appropriate treatment program for those who suffer from addiction without a co-existing mental illness.

6. **Individuals from jails (either local or regional) who have entered into a cooperative agreement with the program** – To be eligible for admission into the program, the local/regional jail where the individual is detained must have entered into a cooperative agreement with the program. The agreement would have to cover roles and responsibilities of the different parties, communication protocols, information sharing, and cost sharing (local and state match).
7. **Individuals classified as minimum security** – The jail is designed as a minimum security prison; thus, inmates would have to be a minimum security level inmate to be eligible for participation. Minimum security classification generally applies to defendants/inmates facing/convicted of relatively minor legal offenses and who are deemed to be low escape risk. Given that the program would only accept individuals with sentences up to 24 months, requiring a minimum security level should not be an issue as generally higher security classifications are associated with more serious crimes/sentences.

Individuals Not Eligible for Admission to the Potential Program

1. **Individuals with serious co-existing medical conditions** – Due to the limited nature of an infirmary, assuming one is built for a program at the jail, individuals with chronic or acute major medical conditions which require significant medical services would not be appropriate for participation in such a program. Examples include (but are not limited to): individuals requiring dialysis, individuals receiving chemotherapy/radiation, individuals with dementia, individuals with traumatic brain injuries, and/or individuals requiring non-elective surgery. If an individual already admitted to the program develops a significant medical need which exceeds the capability of the program they would likely have to be returned to the local/regional jail in order to receive the requisite medical care.
2. **Individuals solely with substance use disorders and no co-occurring mental health issues** – Because the program is intended to be designed as a mental health treatment program, individuals admitted to the program should have a mental illness. While the program might be able to provide some treatment for addiction issues (given the high prevalence rate of addiction in individuals with serious mental illnesses) its main focus would be on treating underlying mental illnesses.
3. **Individuals solely with personality disorders but no mental illness** - It would be difficult for such a program to work with individuals diagnosed with Antisocial Personality Disorder or those who engage in challenging behaviors not associated with an underlying serious mental illness. Such individuals often do poorly in therapeutic environments and respond more favorably in correctional environments where there are swift and immediate consequences for action. While such a program might be effective in helping some individuals with some variants of personality disorders in managing their feelings/emotions, it likely would be of little value to individuals whose primary issue is Antisocial Personality Disorder. Additionally, due to the potential consequences for their fellow inmates, those who are merely management problems (i.e., violent or disruptive

but not due to any underlying mental illness) would not be appropriate for such a program.

4. **Individuals who while convicted of an offense in one jurisdiction have an active legal case in another jurisdiction** – Due to the need for pre-trial individuals to have readily available access to the court/legal counsel, those individuals who have active pre-trial cases would not be considered for admission to the program.

Example of Potential Treatment Program

Since there are no existing models to determine the most efficacious treatment modality for this unique program, should the program be approved, security and clinical staff would need to be hired to develop the ideal treatment program. In the interim, the below is a sample program which could be implemented. The below treatment program was developed based on clinical expertise of workgroup members. Regardless of the ultimately selected treatment model, it is clear the jail would need to employ a significant number of clinical staff if the jail is to provide for the needs of the target population with the intended goal of decreasing recidivism.

The program could have five different treatment levels. Levels would be based on factors such as: clinical stability, treatment adherence, aggression, ability for self-care, compliance with institution rules, self-injurious behaviors, ability to self-manage, and level of recovery. It is likely individuals would move both up and down levels based on current presentation and because recovery from mental illness is not necessarily linear. Individuals at higher privilege levels would be afforded access to more freedoms commensurate with their ability to self-manage. Those at lower levels of privilege would receive services in a more restrictive environment in order to protect themselves and others from harm. It is believed that having various privilege levels would help motivate individuals to fully engage in treatment and would serve as a means to reinforce prosocial/ health maintaining behavior. Having the various privilege levels would also afford the flexibility to adjust the treatment to the person's current presentation. Levels provide both the inmates and the staff more opportunities to work collaboratively towards an established goal by allowing for the tailoring of the treatment approach to the individual. The following are the treatment levels:

Level 1: Designed for individuals who are at acute risk of harm to self or others. Individuals at this level are unable or unwilling to manage their impulses/symptoms and require a highly structured environment to keep themselves and others safe. Due to their risk they would have limited physical access to others (who could become victims of their aggression) and to items which could be used for self-harm. Individuals likely would be housed in a single, locked cell. Individuals in Level 1 likely would receive individual intervention daily by staff as they generally are not safe to be in a group setting. Staff would work with the individual to keep them in this most restrictive environment for the minimum time necessary to address the risk of harm to self or others.

Level 2: Designed for individuals who are actively symptomatic but who do not pose an imminent threat of harm to self or others. Individuals would likely be housed in a shared, wet (i.e. has toilet/sink) cell. Individuals at this level likely would receive some

individual intervention in their cell but would also be allowed out of their cell for structured, small group activities on the unit.

Level 3: Designed for individuals who, while symptomatic, have shown the ability to self-manage to the degree they do not pose a danger to self or/others. They are also able to largely not disrupt the environment or infringe on the rights of others. Individuals at this level would likely be housed in a dry cell with other inmates. Generally the cells likely would remain unlocked for most of the day and individuals are free to access items on the unit (to include free access to TV, video visitation, games on the unit, and can shower at will). Treatment would largely consist of treatment groups provided on the unit. Pre-vocational skills training would likely also be initiated for those who would benefit (would consist of unpaid "work" on the unit). Individuals on level 3 would be eligible for staff escort to dining and would be eligible for in-person visitation on a restricted basis.

Level 4: Designed for individuals who have good control of their symptoms and can self-manage with more freedoms. At this level, individuals would likely live in a cell which is open most of the day and would be allowed to attend treatment/recreational activities off the unit. They likely would transition to the treatment mall to participate in educational and treatment groups. They likely would be enrolled in a paid vocational program either in food services, housekeeping, laundry, or grounds maintenance. Pay likely would be on trainee level (similar to how individuals are paid in other jails). They would be allowed to eat meals in the cafeteria. They likely would have unrestricted visitation to some degree.

Level 5: Designed for individuals who are in final stages of recovery. They have demonstrated ability and willingness to manage their illnesses, are fully engaged in treatment, and are mastering the skills necessary for successful re-entry. In addition to the privileges afforded to individuals at level 4, these individuals likely would be allowed to work outside the secure perimeter either in horticulture or grounds maintenance. Pay likely would be at competitive wages. Individuals likely would serve as recovery coaches for other participants.

Admission Referral Process

1. The referring jail would complete a referral sheet which would contain information about the individual's history of mental health treatment, current mental status, mental health treatment, medical status, and sentence.
2. The clinical director and superintendent would review the referral and determine whether or not the facility can provide for the individual's clinical and security/custody needs.
3. The facility would respond to the referring facility within seven days as to whether or not the individual was accepted for admission. If the individual was accepted for admission a mutually agreeable admission date would be set.
4. The referring facility would forward the individual's medical/mental health records along with the requisite legal paperwork related to the individual's current sentence.
5. While the individual's consent to be transferred is not essential and at times individuals in the midst of a mental health crisis may lack the capacity to consent to transfer, generally

it would be better if the individual at least passively agrees to be transferred to the facility. Ultimately consent /agreement would not be required similar to how other inmates/defendants are unable to choose in which jail they are housed.

Staffing

1. **Correctional Officers** - Correctional officers would be specifically trained in responding to individuals with mental illness (correctionally focused behavioral health training). They would also serve as members of the treatment staff since often the daily interactions have impact on the individual. Each unit would be assigned one officer per shift, except for Level 1; which, due to the acuity of the participants, would have a minimum of two officers per shift. Officers would provide supportive counseling, encouragement, and limit setting. They would be responsible for the orderly running of the unit. There would also be floating correctional officers who would cover the programming area, grounds, control room, visitation, outside transport, dining room, etc. throughout the day. These officers would also be responsible for responding if/when there are behavioral emergencies.
2. **Psychiatry** – Any program of this size would need to employ a minimum of two full time psychiatrists/ psychiatric nurse practitioners. Their role would be to conduct psychiatric assessments, prescribe medications, and provide some level of medication/symptom education. They would evaluate all new admissions and then would set up a schedule for services. Individuals would see the psychiatrist at least once a quarter, but more often for those who are acutely symptomatic.
3. **Nursing** – Any program of this size would need to employ a sufficient number of nurses (registered nurses (RN) and licensed practical nurses (LPN) to provide sufficient clinical coverage. Nurses would be assigned either on the units (psychiatric nurses) or the medical clinic (general medical nurses). There would be one nurse per unit during first and second shift. Overnight there would be a minimum of one nurse on duty to address any medical/behavioral health emergencies and to administer medications that might be needed.
4. **Psychologist** – Any program of this size would need to employ a minimum of one psychologist who would be responsible for overseeing the clinical treatment programs, for conducting specialized risk assessments, and who can conduct psychological testing as needed. The psychologist would supervise the other licenses and non-licensed clinical staff.
5. **Counselors/Therapists** – Any program of this size would need to employ a minimum of eight therapists/counselors. The therapists/counselors would provide individual and group therapies. They would conduct mental health assessments and develop individualized treatment programs. Counselors/therapists would also coordinate peer support groups coming into the facility.
6. **Discharge Planners** – Any program of this size would need to employ a minimum of four discharge planners. The discharge planners would be responsible for coordinating discharges with the CSB where the individual would reside. The discharge planners would also aid individuals in pre-applying for resumption of benefits prior to release. The discharge planners would link individuals to other services (i.e. food bank, Department for Aging and Rehabilitation Services, support groups, etc.) as needed.

7. **Vocational Staff** – Any program of this size would need to employ a minimum of two vocational staff who would oversee the correctional industries operations (currently screen printing and embroidery) and who would aid in career development.
8. **Education** – In order to meet constitutional requirements and to meet the needs of the potential target population, any program of this size would need to employ a minimum of two teachers who would aid in GED/ HS Diploma and college courses.
9. **Medical Staff** – Any program of this size would need to employ a minimum of three professionals to provide for routine medical care for the population. These could be medical doctors, doctors of osteopathic medicine, nurse practitioners, or physician assistants. A contract dentist would also be sought to provide for urgent dental issues. Other, more specialized medical treatment needs would be addressed via contract providers (either taking individuals out to the provider or bringing the provider in to provide services within the clinic. Although, given limited clinical space, bringing providers in may be less feasible.
10. **Records staff** – The facility would employ three medical records staff who would ensure the timely and accurate production of medical records. The facility would also employ other records staff to manage legal paperwork, release paperwork, and other associated correspondence.
11. **Booking and classification staff** - Because all admissions and discharges would be planned, booking and classification would only be staffed Monday – Friday from 8:00 am to 5:00 p.m.
12. **Dietary Services** – While the inmates would provide some of the manpower in the kitchen, the facility would still need to employ some civilian dietary services staff to oversee the inmate work pool.
13. **Housekeeping and Laundry** - While the inmates would provide some of the manpower in housekeeping/laundry, the facility would still need to employ some civilian housekeeping staff to work in the staff areas and to oversee the inmate work pool.
14. **Correctional Management** – The facility would employ a superintendent who would oversee the entire operation. There would be a minimum of one supervisory lieutenant on duty for each shift.
15. **Staff Development** – There would be one staff development employee who would coordinate all staff training
16. **Fiscal and Administrative Services** – The facility would employ fiscal staff (to manage accounts payable and accounts receivable) and administrative staff (to manage correspondence, visitor check-in, etc.).
17. **Human Resources** – The facility would employ two staff to manage the human resources needs of the staff to include recruitment, retention, and severance.

Governance and Accountability

Because a project like this has never been undertaken before in the Commonwealth, there is no generally accepted standard for governance and accountability. One approach could be to operate the facility as a regional jail, although it may have a wider geographical service area than most regional jails. As such, it would be governed by a regional jail authority. Each participating community would have a designated seat on the Authority, although this could be challenging depending on the number of member jurisdictions. The Authority would meet regularly to review operations. The Authority would be responsible for recruiting, hiring, and reviewing the

performance of the Superintendent. Another model would be to operate the facility as a state-run correctional center, but designed for "local responsible" rather than "state responsible" inmates. A final option would be to run the facility as some type of hybrid model, taking the most effective elements of the regional jail model but blending them with state representation/input into the program's operations. Regardless of the model, this facility likely would pose policy and legislative challenges which have not previously been addressed.

Ideally, the jail would be certified by the Board of Corrections (BOC) to operate as a correctional center. The facility, since it would be operated as a correctional center, would likely need to comply with all BOC standards. In addition, ideally the facility would seek American Correctional Association (ACA) accreditation and would strive to meet ACA standards since these provided a heightened standard for the provision of behavioral health care.

Financing

To project the anticipated costs of operating Peumansend Creek Regional Jail as a specialized jail for individuals with SMI, we gathered information from the State Compensation Board about the staffing and cost of running the jail prior to its closure. We then added the costs associated with treating an acute ill population to the basic operating costs. These salary figures were obtained from DBHDS based on their average costs. Below is a rough estimate of the staffing costs associated with the operating the jail as a specialized mental health jail.

Position	# Needed	Avg Salary + Benefits	Total Cost of Positions
Psychiatrists	2	$254,638	$509,276
Nursing	15	$74,914	$1,123,710
Psychologist	1	$110,500	$110,500
Counselors/Therapists	8	$64,258	$514,064
Discharge Planners	4	$58500	$234,000
Vocational Staff	2	$60,000	$120,000
Teachers	2	$60,000	$120,000
Staff Trainer	1	$60,000	$60,000
Medical Staff	2	$254,638	$509,276
Correctional Officers (R C7)	79	$41,118	$3,248,322
Correctional Officer (RC9)	7	$71,280	$498,960
Correctional Officer (RC10)	5	$71,280	$356,400
Correctional Officer (RC11)	3	$71,280	$213,840
Superintendent	1	$111,730	$111,730
Cook	3	$27,661	$82,983
LIDS Tech	1	$46,176	$46,176
Partially Funded Medical (SCB)	8	$21,815	$174,520
Partially Funded Treatment (SCB)	3	$21,815	$65,445
Admin Assistant	4	$27,661	$110,644
General Clerk	5	$27,661	$138,305
Housekeeping	3	$27,661	$82,983
Fiscal Staff	2	$74,914	$149,828
Human Resources	2	$75,000	$150,000
TOTAL			**$8,730,962**

It should be stressed that the above are estimates and should a decision be made to move forward, more detailed costs can be obtained. It is also important to note that the above costs are only for staffing and do not include other expenses such as medications, food, outside medical costs, utilities, supplies, etc. It is difficult to estimate the costs of these expenses as currently there are no facilities like this one in the Commonwealth. It is likely these other expenses would be higher than those incurred in local/regional jails, as Peumansend would be managing a more acute (both psychiatrically and medically) population, thus you would assume higher medication/medical costs. As this population would more closely resemble the state mental health hospital population, a decision was made to use state hospital cost data as a comparator. For state hospitals these indirect costs run between 15-20 percent of the total budget, thus the anticipated total cost to run Peumansend Creek Regional Jail would be approximately **$10,986,828**. If the jail operated on average 250 beds then the average bed day cost would be $120.40.

It could be that the facility would be financed on a 50/50 share basis with the Commonwealth funding 50 percent of the operating expenses and the locality funding the other 50 percent of operating expenses. It is anticipated the cost to run this program would exceed that of most

regional jails currently in existence given the level of services/staffing. Thus, without funding from the state it is unlikely that many communities would seek membership in the authority.

Another model would be to have the facility funded solely by the Commonwealth and operated by the Commonwealth. Obviously this model would require more general funds but would give the Commonwealth more influence in the operations of the facility.

Another model would be to have the member jurisdictions fully fund the operational costs of the facility. As mentioned previously, this model might face obstacles in that the operating costs would likely be greater than the costs associated with operating a local/regional jail. As a result, there likely would be a disincentive for localities to send inmates to this program, unless they felt in the long run it was more cost beneficial to the locality.

Conclusion

The challenges of converting Peumansend Creek Regional Jail to a specialized jail facility for individuals with serious mental illness are significant. There are very complex policy issues which would need to be addressed. Some of these include whether creating this type of program could result in individuals receiving longer sentences as a result of courts/attorneys trying to get individuals treatment that is being paid for in jails but is not available in the community; whether funding this type of program would decrease the availability of funding for community-based diversion/treatment programs and hinder the Commonwealth's attempts to fully shift away from institutional-based towards community-based care; and whether utilization of this jail as a statewide facility would reduce the availability of treatment for those inmates who did not meet the standards for participating in this program. Additionally, there are logistical challenges in identifying the most appropriate population to be served in such a facility. For example, it is important to ensure individuals can be there long enough to benefit from the programs offered. Also, the value of the program needs to be weighed against the negative impacts of significant distance for the majority of people participating in the program, including increasing transportation time and costs to and from court, removing them from local support systems and potentially making their reentry back to their communities less successful. Finally, there are significant capital and operational costs associated with converting the Peumansend Creek Regional Jail to meet the needs of the target population.

Converting Peumansend Creek to a mental health correctional facility would be a policy shift at a time when momentum that is moving toward establishing minimum behavioral healthcare standards in jails across the Commonwealth as was accomplished by the General Assembly via the requirement of uniform mental health screening. There is no research or evidence to suggest that such a project would improve outcomes for this population. Further, the costs of the project would likely reduce resources available for a robust community based behavioral healthcare system, and discourage the development of evidenced based criminal justice diversion programs for individuals with mental illness.

Appendix

- **Early 2000s** – Virginia began supporting the development of Crisis Intervention Teams (CIT) across the Commonwealth. CIT is a community-based collaborative effort among law enforcement, behavioral health, and community members designed to help law enforcement more effectively intervene with people experiencing mental health crisis and make better determinations about whether they should be brought into crisis services rather than incarcerated.
- **2006 – 2011** – Commission on Mental Health Law Reform which made several changes to improve the behavioral health system by bolstering access to services.
- **2008** – Governor Kaine created the Commonwealth Consortium for Mental Health/ Criminal Justice Transformation – a multi-agency, cross systems collaborative workgroup to address issues related to individuals with serious mental illness who are involved in the criminal justice system.
- **2008** – Cross Systems Mapping Initiative – The Consortium spearheaded the Cross Systems Mapping initiative which involves bringing trained facilitators to communities to discuss the unique challenges faced by that community in addressing the needs of individuals with behavioral health challenges who become involved in the criminal justice system. Communities identified gaps in their service systems, identified available resources, and developed an action plan to address the agreed upon community priorities. Over 90 percent of Virginia communities participated in the mapping experience and many communities still use their action plan as a foundation for continuing to refine and bolster their criminal justice/behavioral health initiatives.
- **2008** – Through funds from the General Assembly and administered by the Department of Behavioral Health and Developmental Services (DBHDS), ten model criminal justice diversion programs were funded. These programs operate across the continuum of the criminal justice system and continue to receive funds. Programs provide outcome data on the effectiveness of their programs.
- **2008** – The State Compensation Board began administering an annual survey of the number of persons with mental illness who are incarcerated in local and regional jails. This survey provides valuable information about this vulnerable population.
- **2012** – Code of Virginia is amended to align civil commitment criteria for individuals housed in local and regional jails with that for individuals in community. Previously, the risk of harm to self due to inability to care for self was not included as a criterion for involuntary commitment from jail and it was felt there were many mentally ill individuals in jails who needed hospitalization but who did not qualify because of the restrictive criteria. As a result of this legislation there was a 10 percent increase in involuntary hospitalizations from jail.
- **2013** – General Assembly began funding CIT Assessment Centers (previously known as "drop off centers") to afford police a location to bring individuals in behavioral health crisis in lieu of incarceration. An amendment to the Code of Virginia allowed for transfer of custody thus allowing law enforcement officers to leave the individual in the assessment site and return to their policing duties.
- **2015** – Governor McAuliffe establishes the Center for Behavioral Health & Justice to serve as a clearinghouse of best practice information and to act as a convener of local and

state officials to address the needs of individuals with behavioral health challenges involved in the criminal justice system.

- **2016** – Governor and General Assembly allocate funds to the Department of Criminal Justice Services to fund six model pilot projects in local and regional jails to serve as examples and demonstrate outcomes when a full continuum of care is made available.
- **2016** – DBHDS, in response to requirement from the General Assembly, authors Essential Elements for Mental Health Dockets. Simultaneously, the Chief Justice of the Virginia Supreme Court issues Rules of Court outlining how courts can establish specialty dockets.
- **2016** – Code of Virginia is amended to make clear who can petition for involuntary hospitalization of individuals housed in jails; create an oversight system for pre-trial mental health evaluations to ensure courts are receiving evaluations which meet the standards of practice; create a communication feedback system between Courts and providers to ensure court orders are received by the providers; and establish time-frames for conveyance of court orders, reflecting a sense of urgency.
- **2017** – Legislative changes establish time-frames for admission of individuals adjudicated incompetent to stand trial and in need of inpatient hospitalization; remove a barrier to the temporary detention of jail inmates who are in need of hospitalization; improve communication between jails and community services boards (CSBs) about inmates in need of inpatient psychiatric services; improve communication between multiple CSBs when there is an individual with ties to multiple CSBs; and establish clarity that deaths in jails will be reviewed by the Board of Corrections.
- **2017** – Budget amendments direct the Department of Medical Assistance Services (DMAS) to form a stakeholder group and develop a process for streamlining the application and enrollment process for eligible incarcerated individuals; mandate DBHDS to convene a stakeholder group and submit a plan for the provision of discharge planning services for individuals with serious mental illness who are being released from local and regional jails; require all jails to utilize a standardized, validated screening tool designated by DBHDS for the detection of individuals who may be in need of mental health services; require DBHDS to provide web-based training and shared the tools with all jails; and direct the State Compensation Board to identify the costs and strategies to have Qualified Mental Health Professionals available in jails to perform standardized evaluations on individuals who screen positive on the required screening tool.