Report to the Chairmen of the House Appropriations
and Senate Finance Committees

Options to Reduce the Number of Seriously Mentally Ill State Responsible Offenders in Local and Regional Jails

Virginia Department of Corrections
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Executive Summary

The 2018 Special Session I Acts of Assembly, Chapter 2, Item 391, P., directs the Department of Corrections (DOC) to report on potential options to reduce the number of serious mentally ill state responsible (SR) offender population who serve their sentences in local or regional jails.

> *The Department of Corrections shall evaluate potential options to reduce the number of state-responsible inmates with serious mental illness who serve the entirety of their state-responsible sentences in, and are released directly from, local and regional jails. In its evaluation, and using the definition of serious mental illness in accordance with the American Correctional Association, the Department shall give consideration to (i) the number of state-responsible inmates identified by jail staff with serious mental illness held in regional jails, the jails in which they are held, their diagnostic category as delineated in the DSM-V, the length of their state-responsible sentence and the type of their offense, and whether they were assigned to a DBHDS facility from the jail for evaluation; (ii) which among these offenders should be prioritized for transfer to a state correctional facility; (iii) the current inmate population with serious mental illness held in state correctional facilities, their diagnosis and the acuity of their symptoms, and the length of their sentence and the type of their offenses; (iv) the facilities and services currently provided for the treatment of inmates with serious mental illness held in state correctional facilities; and, (v) what additional capital and operating resources would be needed by the Department to facilitate a reduction in the number of state-responsible inmates with serious mental illness serving the entirety of their sentence in local and regional jails. The Department shall provide the results of its evaluation to the Chairmen of the House Appropriations and Senate Finance Committees no later than October 15, 2018.*

A comprehensive review of available Department of Corrections' (DOC) data and data collected from local and regional jails in Virginia, as part of the State Compensation Board's (SCB) 2018 Mental Illness in Jails Survey, revealed information that could be utilized to determine the length of state-responsible sentence, the type of offense, and whether the state-responsible (SR) offender with mental health diagnoses (MH) was assigned to a Department of Behavioral Health and Developmental Services (DBHDS) facility from the jail for evaluation. Based on the lack of consistent sourcing of data and variety of clinical services available across Virginia's jails, data to support identification of which among these offenders should be prioritized for transfer to a state correctional facility is not readily possible; however, the DOC Jail Intake Unit, based on the request of the jail and with input from DOC Qualified Mental Health Professionals, already expeditiously prioritizes and intakes offenders with MH issues.

The DOC utilizes the American Correctional Associations' (ACA) definition of SMI, which indicates there are only five diagnoses that qualify as a SMI--bipolar or major depressive disorder, dysthymic disorder, anxiety disorder, post-traumatic stress disorder, schizophrenia or schizoaffective disorder. Utilizing this definition, DOC determined 811 offenders (3%) currently incarcerated in the state prison system were diagnosed with a SMI. The five most prevalent diagnoses were schizophrenia, schizoaffective disorder, major depressive disorder, PTSD, and Bipolar I.

Utilizing all available data, DOC determined there are several variables that prevented the Department from providing a true picture of the number of SR offenders with serious mental illness serving the entirety of their state-responsible sentence of two years or less in local and regional jails. Certainly, those with more significant offense histories and longer sentences serve their sentences in DOC facilities. Of the 811 SMI offenders in DOC facilities, 119 offenders were serving Single Life, Multiple Life, or Three Strikes sentences. The remaining 692 SMI offenders were serving a total imposed sentence of an average of 22.7 years and 81% of these offenders were convicted of a violent most serious offense.

Within the DOC, most mental health services are provided on an outpatient basis, and include but are not limited to, crisis management, groups, and brief solution-focused individual treatment sessions. Psychiatric services, including medication management, are also available. There are 548 total DBHDS licensed mental health beds in the DOC system currently, including 112 Acute Care level inpatient beds for offenders who currently meet "commitment status" at Fluvanna Correctional Center for Women and Marion Correctional Treatment Center.

Offenders who require less structure than Acute Care but more services than are available in general population settings may be referred to one of the 436 beds in six Residential Treatment Mental Health Units in the DOC.

The DOC does not have sufficient resources to determine the mental health status of SR offenders in jails. In addition to the lack of standardized screenings, or even the type of personnel conducting the screenings, there is also a sizeable population categorized as "suspected of having a mental illness" in the jail data from the SCB 2018 survey. If DOC does not know about a SR offender's mental health condition, we cannot provide assistance with helping SR offenders upon release or determining if an offender would be better served, even in the short term, with intake into DOC. We currently have a model to address mental health concerns in the community utilizing District Mental Health Clinicians that can be expanded to include evaluation and services to SR offenders in the jails as a means to ensure a continuum of care.

While identification, diagnosis and treatment of mental health concerns is consistent within the DOC incarcerated populations, there is no common language or protocols between DOC and the individual jails around the Commonwealth. The 28 Regional Jails and 31 Local Jails (jails that run multiple locations were only counted once) assess offenders differently for MH issues. Some have mental health staff, others have Community Services Board (CSB) staff to assess and provide mental health services, while others rely on the completion of a twelve question mental health assessment without dedicated Qualified Mental Health Professional (QMHP) staff to follow-up, but the jails reported that 70% of SR offenders serving the entirety of their sentence in the jails were diagnosed as, were suspected to have or self-reported a SMI.

Lastly, there is a high rate of recidivism for SR offenders with mental health diagnoses who serve their sentences completely in jails. Without the DOC having knowledge of which SR offenders in jails is diagnosed with a SMI, the DOC works with jails to bring offenders needing specialized treatment into facilities at a more expedited rate to ensure they receive necessary care.

In order to address the inconsistencies surrounding the collection of data, assessment of SR offenders in jails diagnosed with a SMI and treatment, DOC offers the following recommendations:

- Increase the number of District Mental Health Clinicians within the DOC, which will allow for better assessment, diagnoses, treatment and continuity of care regardless of whether the SR offender with a SMI is transferring to a DOC facility, discharging directly from the jail, or continuing with DOC Probation and Parole supervision.
- Implement electronic health records that can "talk" across the continuum of care, and (including the jails, prisons, CSBs, probation offices, state hospitals and Veteran's Administration) could streamline diagnosis and treatment options, greatly boosting efficacy of the system as a whole.
- Allow additional resources to be available for individuals with MH issues upon release from jails and prisons. For example, Discharge Assistance Planning (DAP) funds are used for housing, mental health care, medication, and transportation but can only be accessed by psychiatric hospitalization at DBHDS. Governor's Assistance Program (GAP) is only available after CSB screening. It has been very beneficial to have DOC offenders prioritized for Supplemental Security Income (SSI) benefits screenings, but this is not available to the jails. Lastly, if Medicaid were suspended instead of revoked, less high risk-high need offenders would be back in communities with few or no visible means of self-support.
- Standardize the application and utilization of mental health services within jails, to include trauma informed care strategies and practices, and focus on case management.
- Standardize the methods for the MH assessment for all local jails, regional jails and the DOC to reduce reliance on self-reporting and determine which offenders have been or should be diagnosed with a SMI in a consistent manner.

- Determine criteria as to which offenders should be prioritized for treatment or movement, such as amount of time remaining to serve, severity of SMI, and treatment options available at the jail.

Background

The Department of Corrections shall evaluate potential options to reduce the number of state-responsible inmates with serious mental illness who serve the entirety of their state-responsible sentences in, and are released directly from, local and regional jails. In its evaluation, and using the definition of serious mental illness in accordance with the American Correctional Association, the Department shall give consideration to (i) the number of state-responsible inmates identified by jail staff with serious mental illness held in regional jails, the jails in which they are held, their diagnostic category as delineated in the DSM-V, the length of their state-responsible sentence and the type of their offense, and whether they were assigned to a DBHDS facility from the jail for evaluation; (ii) which among these offenders should be prioritized for transfer to a state correctional facility; (iii) the current inmate population with serious mental illness held in state correctional facilities, their diagnosis and the acuity of their symptoms, and the length of their sentence and the type of their offenses; (iv) the facilities and services currently provided for the treatment of inmates with serious mental illness held in state correctional facilities; and, (v) what additional capital and operating resources would be needed by the Department to facilitate a reduction in the number of state-responsible inmates with serious mental illness serving the entirety of their sentence in local and regional jails. The Department shall provide the results of its evaluation to the Chairmen of the House Appropriations and Senate Finance Committees no later than October 15, 2018.

Methodology

The biggest challenge to evaluating seriously mentally ill offender needs in the 28 Regional and 31 Local Jails in Virginia is that DOC does not have access to mental health data for SR in Virginia's regional and local jails. Additionally, there is no consistency with the degree of mental health assessments completed at each jail—every jail operates independently and the DOC has no oversight or access to data. To bridge that gap for the purposes of this study, the Compensation Board offered to include additional questions to their annual "Mental Illness in Jails" survey, conducted each year with a "snapshot" survey taken in June of each year. In particular, an additional question addressed whether time to serve for SR offenders is greater than or less than two years, as offenders with less than two years to serve and have no serious medical or mental health issues tend to serve their time in a jail. Additionally, the jails reported on the commitments for evaluation at a DBHDS facility.

To provide data on DOC mental health populations, historical DOC reports were utilized, along with current information on offenders identified as meeting the American Correctional Association definition of seriously mentally ill (SMI), mostly culled from the paper mental health records of those identified as meeting the criteria for SMI. DOC currently does not have electronic health records so mental health data is not readily available in existing data sources. The DOC Statistical Analysis and Forecast Unit was able to extract data on DOC inmates, to the extent possible without electronic health records, to address sentence and offense questions for those with data markers for SMI based on their mental health code in VACORIS, the offender management system used by the DOC. DOC identified 811 seriously mentally ill offenders (SMI) in its incarcerated population on May 31, 2018. Qualified Mental Health Professionals (QHMPs) from DOC facilities provided diagnoses for these 811 SMI offenders (up to 5 diagnoses could be recorded per offender).

Mental Health, Jails, and Recidivism

The November 2017 "DOC Recidivism" report, issued by the DOC Statistical Analysis and Forecast Unit, revealed that in fiscal years 2010-2013, the recidivism rate for offenders with known mental health impairment increased significantly more than the recidivism rate for offenders with no known mental health impairment. Specifically, three-year recidivism rates for mental health offenders were: 28.5% (2010), 30.2% (2011); 31.0% (2012), and

30.9% (2013). For non-mental health offenders, the recidivism rates were: 21.4% (2010); 21.1% (2011); 21.3% (2012); and 20.1% (2013).

Not only are the rates of recidivism for SMI offenders appreciably higher than non-SMI offenders, but the cost of incarceration ($27,000) is significantly higher than the cost of treatment. [1]

According to Dr. Denise Malone, DOC Chief of Mental Health Services: "The "revolving door" between incarceration and the street for offenders with mental health issues is propelled largely by untreated mental illness and co-occurring substance abuse disorders among returning citizens. As predicted, the decreased availability of hospital and training center beds without a congruent increase in community services has increased the 'criminalization' of the mentally ill in Virginia. In brief, offenders with mental illness who are stabilized while incarcerated by programming, monitoring, structured settings, and medications will require increased support, services, and structure far beyond what they are receiving now. Without these services in place, returning citizens with mental illness are not able to maintain the level of functioning required for successful transition back into their communities."

Mental Health Offenders in Jails

The Virginia Compensation Board jail study data from 2017 confirmed that the majority of crimes perpetrated by individuals with mental illness were nonviolent. (Note: We do not have data on length of sentence for individuals with mental illness from the jails, as this is not currently tracked.) This Virginia data is congruent with national research that confirms individuals with mental illness are far more likely to be the victims than the perpetrators of violence (Desmarais, Van Dorn, Johnson, Grimm, Douglas and Swartz, 2014[2] : Choe, Teplin, & Abram, 2008[3]; Desmarais & Shipman, 2016[4].) Contrary to current cultural lore, age (under 24) and gender (males) are far more powerful predictors of violence than having a mental health diagnosis. Furthermore, Desmarais and Shipman (2016) documented that three risk factors are predictive of violence for individuals with or without mental illness—usage of alcohol, if the person has engaged in violence over the previous six months, and if the person has been a victim of violence in the last six months. This research confirms that if we can serve individuals with mental illness in the least restrictive, safest environments possible we can prevent or interrupt a problematic behavioral chain of events by offering more diversionary and treatment-oriented approaches and settings. In comparison with the VA jail sample, the offenses committed by 81% of the DOC SMI sample were violent offenses, including Rape/Sexual Assault (18%), Robbery (15%), Property/Public Order (15%), Assault (14%), First Degree Homicide (14%), and drug offenses (5%.) Length of sentences range from under two years to 321 years (mean=22.7 years, median=15.0.)

Jails vary widely in application and utilization of MH services. Some have their own MH staff but the SCB data found that most rely on CSB's, where quality and quantity of services vary widely. One commonality evident in the 2017 SCB survey data was that offenders who come into jails and prisons have documented increases in anxiety and depression. The recent multidisciplinary jail workgroup chaired by DBHDS wrote standards for increasing consistency and quality of care for the jails, but the jails and CSB's are not currently mandated to follow these guidelines. The diagnosis and current functioning will drive the treatment modality and frequency needed, but by focusing solely on "Serious Mental Illness," only five diagnoses receive a focus (Bipolar or major depressive disorder, dysthymic disorder, anxiety disorder, Post-traumatic stress disorder, Schizophrenia or schizoaffective disorder.) It is necessary to keep in context that any mental illness can become serious. There is no data from the

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[1] DOC Budget Office, Division of Administration, Presentation to House Appropriations Committee, January 27, 2016

[2] "Community Violence Perpetration and Victimization among Adults with Mental Illnesses." American Journal of Public Health, 2014 December: 104(12).

[3] "Perpetration of Violence, Violent Victimization, and Severe Mental Illness: Balancing Public Health Concerns." Psychiatric Services, February 2008, Vol. 59, Number 2.

[4] "Researchers ID Risk Factors that Predict Violence in Adults with Mental Illness." NC State News, March 1, 2016.

jail survey about acuity beyond the statement that 21 offenders in jail went to a state hospital in FY2018, which would be indicative of more acute symptoms and corresponding decrement in functioning.

Findings

SR Offenders in Local/Regional Jails with Serious Mental Illness

In fiscal year 2017, there were 2,568 offenders diagnosed with mental illness who were released from DOC custody to community supervision. This number represents 20% of the total releases (12,539), but this percentage only includes offenders who were assigned mental health codes (i.e., indicating minimal, mild, moderate, or severe impairment) in VACORIS at some point during incarceration in a DOC facility. However, the majority of SR offenders on community supervision either spend their entire incarceration in local or regional jails or are sentenced directly to probation from court. Since there is an increasing number of SR offenders who serve all of their incarceration time in the jails, it is difficult to capture precise data about the numbers of "jail-only" offenders who have mental illness. In FY2017 there were 5,623 SR offenders who spent their term of incarceration in a jail. Only 2,659 of these offenders had at least one previous term of incarceration in a DOC facility, leaving 3,736 who did not have a mental health code in VACORIS.

According to the State Compensation Board's 2018 "Mental Illness in Jails" survey, jail staff reported that 1,459 State Responsible (SR) offenders in local/regional jails in June 2018 were Seriously Mentally Ill (SMI), which comprises 20% of the total number of SR offenders in these jails. More than two-thirds of these 1,459 SR SMI offenders in jails were male (1,004 or 69%) and 455 offenders were female (31%). While the 1,004 male SR SMI offenders comprised 16% of the total number of male SR offenders in jails, the 455 female SR SMI offenders comprised more than one-half of the total number of female SR offender in jails (58%).

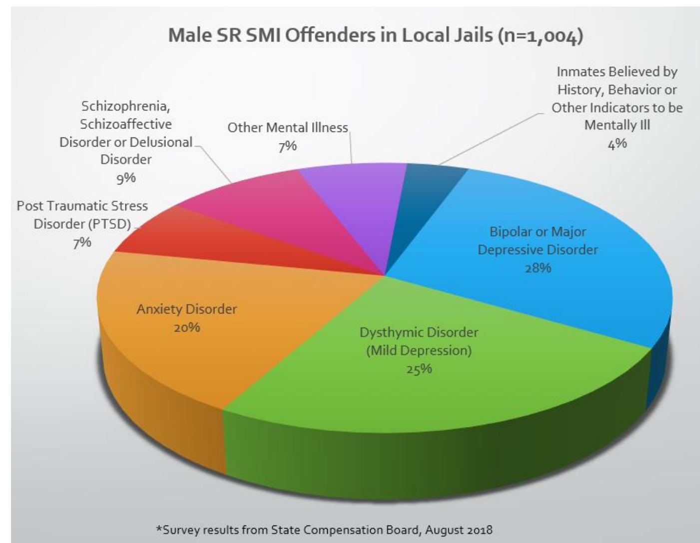
SR SMI offenders were incarcerated in jails across the Commonwealth; however, more than one-half of these offenders (52%) were located in six jails: Chesapeake City Jail (21%); Southwest Virginia Regional Jail (10%); Western Virginia Regional Jail (6%); Virginia Beach Correctional Center (6%); Blue Ridge Regional Jail (5%); and Page County Jail (4%). More than one-half of the male SR SMI offenders (52%) were also located in six jails: Chesapeake City Jail (22%); Southwest Virginia Regional Jail (9%); Virginia Beach Correctional Center (6%); Page County Jail (6%); Western Virginia Regional Jail (5%); and Arlington County Detention Facility (5%). The female SR SMI population followed a geographic distribution similar to the males, and more than one-half these offenders were located in just five jails: Chesapeake City Jail (20%); Southwest Virginia Regional Jail (12%); Western Virginia Regional Jail (9%); Blue Ridge Regional Jail (6%); and Virginia Beach Correctional Center (4%). The table on the following page has a complete listing of jail reported SR SMI offenders by gender and location.

SR SMI Offenders in Local/Regional Jails by Gender and Location - June 2018

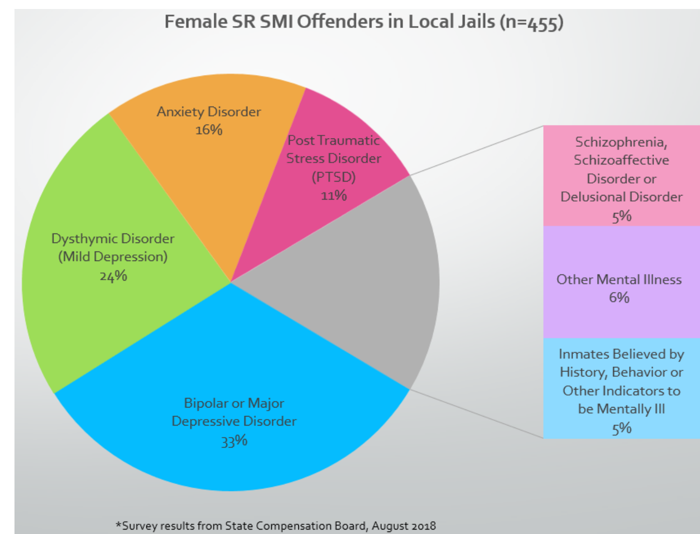
Local/Regional Jail	Males			Females			Total SR SMI	
	#	% of Male SMI	% of Total	#	% of Female SMI	% of Total	#	% of Total
Accomack County Jail	8	0.8%	0.5%	0	0.0%	0.0%	8	0.5%
Albemarle-Charlottesville Regional Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Alexandria Detention Center	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Alleghany County Regional Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Arlington County Detention Facility	46	4.6%	3.2%	8	1.8%	0.5%	54	3.7%
Blue Ridge Regional Jail	38	3.8%	2.6%	29	6.4%	2.0%	67	4.6%
Botetourt County Jail	7	0.7%	0.5%	2	0.4%	0.1%	9	0.6%
Bristol City Jail	8	0.8%	0.5%	5	1.1%	0.3%	13	0.9%
Central Virginia Regional Jail	24	2.4%	1.6%	7	1.5%	0.5%	31	2.1%
Charlotte County Jail	7	0.7%	0.5%	6	1.3%	0.4%	13	0.9%
Chesapeake City Jail	217	21.6%	14.9%	93	20.4%	6.4%	310	21.2%
Chesterfield County Jail	1	0.1%	0.1%	1	0.2%	0.1%	2	0.1%
Culpeper County Adult Detention Center	2	0.2%	0.1%	2	0.4%	0.1%	4	0.3%
Danville Adult Detention Center	1	0.1%	0.1%	0	0.0%	0.0%	1	0.1%
Danville City Jail	1	0.1%	0.1%	5	1.1%	0.3%	6	0.4%
Eastern Shore Regional Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Fairfax Adult Detention Center	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Fauquier County Jail	1	0.1%	0.1%	3	0.7%	0.2%	4	0.3%
Franklin County Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Gloucester County Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Hampton Correctional Facility	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Hampton Roads Regional Jail	33	3.3%	2.3%	12	2.6%	0.8%	45	3.1%
Henrico County Jail	7	0.7%	0.5%	6	1.3%	0.4%	13	0.9%
Henry County Jail	15	1.5%	1.0%	9	2.0%	0.6%	24	1.6%
Lancaster Correctional Center	0	0.0%	0.0%	1	0.2%	0.1%	1	0.1%
Loudoun County Adult Detention Center	2	0.2%	0.1%	2	0.4%	0.1%	4	0.3%
Martinsville City Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Meherrin River Regional Jail	8	0.8%	0.5%	4	0.9%	0.3%	12	0.8%
Middle Peninsula Regional Jail	5	0.5%	0.3%	1	0.2%	0.1%	6	0.4%
Middle River Regional Jail	16	1.6%	1.1%	15	3.3%	1.0%	31	2.1%
Montgomery County Jail	26	2.6%	1.8%	6	1.3%	0.4%	32	2.2%
New River Regional Jail	10	1.0%	0.7%	4	0.9%	0.3%	14	1.0%
Newport News City Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Norfolk City Jail	19	1.9%	1.3%	1	0.2%	0.1%	20	1.4%
Northern Neck Regional Jail	29	2.9%	2.0%	10	2.2%	0.7%	39	2.7%
Northwestern Regional Jail	19	1.9%	1.3%	12	2.6%	0.8%	31	2.1%
Page County Jail	60	6.0%	4.1%	0	0.0%	0.0%	60	4.1%
Pamunkey Regional Jail	7	0.7%	0.5%	1	0.2%	0.1%	8	0.5%
Patrick County Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Piedmont Regional Jail	8	0.8%	0.5%	2	0.4%	0.1%	10	0.7%
Pittsylvania County Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Portsmouth City Jail	5	0.5%	0.3%	1	0.2%	0.1%	6	0.4%
Prince William/Manassas Regional Jail	30	3.0%	2.1%	15	3.3%	1.0%	45	3.1%
Rappahannock Regional Jail	4	0.4%	0.3%	3	0.7%	0.2%	7	0.5%
Richmond City Jail	33	3.3%	2.3%	16	3.5%	1.1%	49	3.4%
Riverside Regional Jail	29	2.9%	2.0%	10	2.2%	0.7%	39	2.7%
Roanoke City Jail	24	2.4%	1.6%	10	2.2%	0.7%	34	2.3%
Roanoke County/Salem Jail	13	1.3%	0.9%	19	4.2%	1.3%	32	2.2%
Rockbridge Regional Jail	10	1.0%	0.7%	1	0.2%	0.1%	11	0.8%
Rockingham-Harrisonburg Regional Jail	3	0.3%	0.2%	1	0.2%	0.1%	4	0.3%
RSW Regional Jail	8	0.8%	0.5%	8	1.8%	0.5%	16	1.1%
Southampton County Jail	2	0.2%	0.1%	0	0.0%	0.0%	2	0.1%
Southside Regional Jail	1	0.1%	0.1%	1	0.2%	0.1%	2	0.1%
Southwest Virginia Regional Jail	92	9.2%	6.3%	56	12.3%	3.8%	148	10.1%
Sussex County Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Virginia Beach Correctional Center	62	6.2%	4.2%	20	4.4%	1.4%	82	5.6%
Virginia Peninsula Regional Jail	17	1.7%	1.2%	8	1.8%	0.5%	25	1.7%
Western Tidewater Regional Jail	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%
Western Virginia Regional Jail	46	4.6%	3.2%	39	8.6%	2.7%	85	5.8%
Total SR SMI Offenders in Jails	**1,004**		**68.8%**	**455**		**31.2%**	**1,459**	

SOURCE: State Compensation Board's 2018 "Mental Illness in Jails" survey

As reported in the "Mental Health in Jails" survey, more than one-quarter of the male SR SMI offenders in local/regional jails are reported to have Bipolar or Major Depressive Disorder (28%), one-quarter are reported to have Dysthymic Disorder (Mild Depression), and one-fifth are reported to have Anxiety Disorder.



One-third of the female SR SMI offenders in local/regional jails are reported to have Bipolar or Major Depressive Disorder, almost one-quarter are reported to have Dysthymic Disorder (Mild Depression), and 16% are reported to have Anxiety Disorder.



We were unable to ascertain what constituted "other types of treatment" available in the jail as documented by the SCB survey so it is difficult to make programmatic recommendations. The greatest percentages of "treatment" were broadly listed as "individual counseling" and "other individual or group MH treatment" at 34% each, as compared to 22% of group substance abuse and 10% group counseling. Providers are increasing in cost and becoming harder to find given the current shortage of health care professionals. If other forensic settings in addition to state prisons offered basic groups in symptom management, illness education, coping with trauma, and stress management/coping skills with a focus on building an individual's resilience, this would surely be more cost-effective in the long term than having people return to hospitalization and/or incarceration.

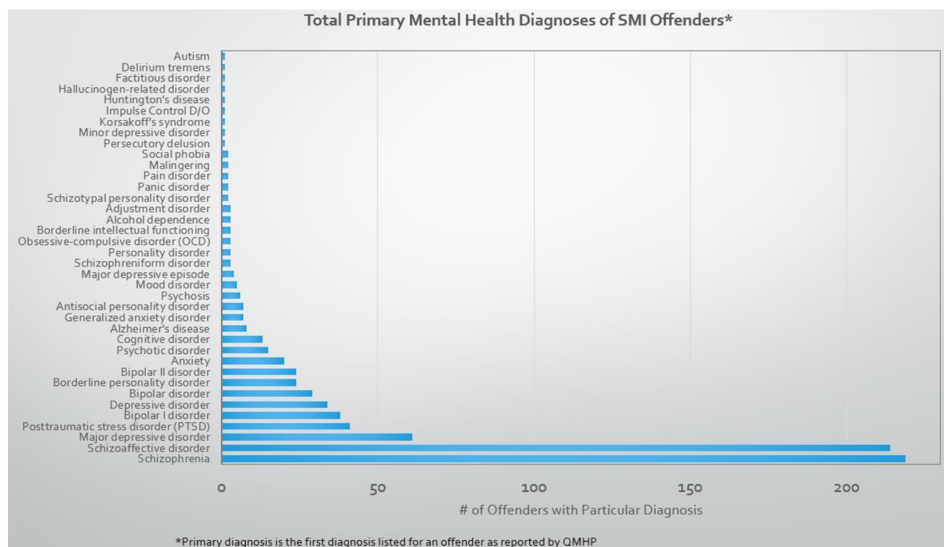
The combination of individual cognitive-behavioral workbooks and groups would be within the range of most jails to provide with some additional staffing, such as treatment officers and QMHP's. In accordance with standards of clinical practice and to best utilize available resources, the MH staff at DOC institutions offer group sessions such as

Seeking Safety, Advanced Anger Management, Trauma Resolution, Coping with Stress, Interpersonal Effectiveness Skills, Houses of Healing, Mind over Mood, Emotional Regulation Skills, Distress Tolerance Skills, Mindfulness Skills, and Symptom Management.

SR Offenders with Serious Mental Illness in DOC Facilities

Among the 29,953 offenders incarcerated in DOC facilities on May 31, 2018, 28% had a mental health diagnosis; however, the use of only five specific diagnostic categories as "Seriously Mentally Ill" decreases these numbers to 811 offenders (3%) as being defined as seriously mentally ill (SMI). These SMI offenders were predominately Male (94%); this gender breakdown is similar to the gender breakdown of the DOC facility population as a whole (92% Male). On average, these SMI offenders were 43.5 years old (median=42.0). Thirteen percent of the SMI population was under 30 years of age while one-third was 50 years old or older.

The 811 SMI offenders' diagnoses encompassed 38 types, from adjustment disorders to social phobia. The five most prevalent diagnoses were schizophrenia, schizoaffective disorder, major depressive disorder, PTSD, and Bipolar I. The chart below shows the number of offenders with each particular diagnosis:



Of the 811 SMI offenders in DOC facilities:

- 65% of those diagnosed with schizophrenia were either moderately (MH3) or severely impaired (MH4)[5]
- 62% of those diagnosed with schizoaffective disorder were listed as substantially impaired (MHS2) and 35% were listed as MH3
- 75% of those diagnosed with major depressive disorder were listed as MHS2
- 90% of those diagnosed with PTSD were listed as MHS2
- 72% of those diagnosed with Bipolar I disorder were listed as MHS2

Of the 811 SMI offenders in DOC facilities, 119 offenders were serving Single Life, Multiple Life, or Three Strikes sentences. The remaining 692 SMI offenders were serving a total imposed sentence ranging from a low of just under two years (22.0 months) to a high of 321 years (mean=22.7 years; median=15.0). A substantial majority of these offenders (81%) were convicted of a violent most serious offense (MSO), while 15% were convicted of a Property/Public Order MSO and 5% were convicted of Drug MSO. The most prevalent MSOs were Rape/Sexual Assault (18%), Robbery (15%), and Assault and First Degree Homicide, each at 14%.

[5] See Appendix A for a complete list of mental health code definitions.

Mental Health Services Provided to SMI Offenders in DOC Facilities

DOC Mental Health Services must serve all offenders, and by offering a continuum of care the agency is able to stabilize offenders and keep them at baseline functioning, which may prevent them from decompensation. To maintain compliance with standards of the American Correctional Association (ACA), current clinical standards of practice, and the *Code of Virginia*, there are 151 Qualified Mental Health Professionals assigned to all 26 DOC major institutions who offer core mental health services, including biopsychosocial intake, screening, assessment, monitoring, crisis management, groups, brief solution-focused individual treatment sessions, responding to offender requests, and consultation. Services may vary from site to site, depending on offender's needs, level of functioning, and available resources. Psychiatric services, including medication management, are also available.

Most mental health services are available on an outpatient basis within DOC facilities. Offenders with mental disorders are housed within the least restrictive available setting consistent with clinical, medical and security needs. DOC currently has 548 total licensed mental health beds, including 90 inpatient beds at Marion Correctional Treatment Center and 22 beds at Fluvanna Correctional Center for Women for offenders who currently meet "commitment status" and are committed by a Circuit Court for treatment in accordance with Code of Virginia §53.1-40.2. Offenders who require less structure than the inpatient beds, but more services than are available in general population settings, may be referred to one of the 436 beds in six Residential Treatment Mental Health Units, also licensed by DBHDS. Male offenders are referred to Powhatan Mental Health Unit (MHU), Greensville MHU, Greensville Residential Treatment Unit (RTU) or Marion Correctional Treatment Center Residential Program. The Sex Offender Residential Treatment Program (SORT) is located at Greensville. Female offenders in need of residential treatment are referred to Fluvanna MHU.

Psychiatric Services

Approximately 20% of the DOC offender population requires psychotropic medication management. A continuum of services has been developed within the DOC, both to meet the needs of offenders while incarcerated, and to assist in planning for their release from the Department and successful transition to the community.

Outpatient psychiatric services are available to offenders in all major institutions. Psychiatric services for each institution are determined by the population number and composition, the severity of psychiatric illness in that population and the additional resources and programs available at that institution.

Upon initial evaluation, the psychiatrist spends sufficient time with the offender to make a thorough mental health assessment. The psychiatrist also answers the offender's questions regarding possible diagnoses, treatment and medication options, and possible effects. In providing mental health services, the psychiatrist recognizes that offenders being evaluated may be experiencing a variety of emotional problems or mental disorders. The psychiatrist also recognizes that some offenders seek medications for personal gain, not related to any objective signs of mental disorder.

Medications and treatment are ordered based on clinical need and not in response to an offender's request, desire, or demand. At a minimum, an offender who receives psychiatric services will have a diagnosable psychiatric disorder per the most current edition of the "Diagnostic and Statistical Manual of Mental Disorders". When prescribing medications, the psychiatrist monitors effects of such medications on a regular basis, and continues the prescription(s) only as long as deemed necessary. Medications should be discontinued as soon as considered appropriate. Long-term use of medications to address adjustment or situational problems is discouraged.

DOC continues to develop psychiatric services and recently expanded to provide psychiatric care to the Community Corrections Alternative Programs and began a Bridge Clinic to provide some limited services to recently released offenders still under supervision by the DOC. The newest initiative is a pilot program for Medication Assisted Treatment for Opioid Addiction.

DOC MH Services to Reduce SMI in Restrictive Housing

Secure Diversionary Treatment Program (SDTP)

Additionally, there are 119 beds at three facilities in the DOC currently devoted to the Secure Diversionary Treatment Program (SDTP) initiative. The purpose of the Secure Diversionary Treatment Program at Wallens Ridge State Prison, Marion Correctional Treatment Center, and River North Correctional Center is to:

- Show a significant reduction in the use of Segregation for SMI offenders.
- Provide SMI offenders with successful self-management of daily activities within a facility.
- Increase the level of treatment services available for those confined in correctional facilities.
- Increase the level of interactions of SMI offenders with CCIT certified staff.
- Maintain public safety while providing more intensive programming to restrictive housing offenders assessed as SMI.

The SDTP initiative is informed by research including Cognitive Behavioral programming, evidence-based practices, Dialectical Behavioral Therapy, Social Skills Training, Stages of Change, Motivational Interviewing, and Systems Theory. Additionally, Correctional Officers as well as non-custody staff are trained in evidence-based Interactive Journaling, C-CIT, Mental Health First Aid, and Trauma Informed Care.

Shared Allied Management (SAM) Living Units

The purpose of the Shared Allied Management (SAM) Pods is to improve the efficient delivery of correctional services to high need populations by making them available in a single general population housing unit with an allied management team of staff. The offenders assigned to these units have mental health diagnoses that results in management challenges, a medical condition requiring frequent attention by nursing staff, or are offenders who are vulnerable to predation. Offenders in these groups tend to cycle in and out of Restrictive Housing and licensed mental health units.

With the implementation of these mission-driven SAM Units, the number of beds available for the placement of "at-risk" offenders in general populations has been increased across 10 institutions statewide for a total of 648 beds, located at Sussex I State Prison, Sussex II State Prison, Greensville Correctional Center, Nottoway Correctional Center, Buckingham Correctional Center, Pocahontas Correctional Center, Augusta Correctional Center, Green Rock Correctional Center, Wallens Ridge State Prison, and Red Onion State Prison. Multiple programming options are provided in these mission-driven units according to the needs of the offenders housed in them.

DOC MH Services in Community Corrections

At the end of June 2017, there were a total of 64,701 probationers and parolees on DOC supervision, including offenders released from DOC prisons, released from jails, and sentenced to probation from court. Twenty percent of these offenders (12,539) had mental health codes in VACORIS from previous DOC QMHP assessments. This group includes those with severe mental disorders (e.g., Schizophrenia, Bipolar Disorder); less severe mental disorders (e.g., depression, anxiety); substance abuse issues; co-occurring mental disorder and substance abuse; and histories of sexual offending.

Despite the large number of SR offenders on community supervision, a remarkably small number of QMHPs have provided mental health services in Community Corrections. Prior to 2017, there were a total of only 5 full-time mental health staff in Community Corrections specifically designated to work with the 43 Probation and Parole Districts and 5 Detention and Diversion Centers. The staffing consisted of one Mental Health Clinical Supervisor (MHCS), three Regional Mental Health Clinicians (RMHCs), one full-time Mental Health Clinician assigned to Chesterfield Women's Detention & Diversion Center (CWDDC), with the latter position created in 2010.

In the context of the Risk-Need-Responsivity model, a ratio of five professional staff to nearly 13,000 offenders on community supervision with mental health needs does not adequately address the higher risk of recidivism associated with mentally ill offenders who are more likely to have repeated involvement with the criminal justice system. The transitional period from incarceration to the community is often the most difficult for offenders. The majority of these offenders, who were not released from DOC facilities, have not had the benefit of receiving consistent mental health services or the concerted re-entry planning that occurs in DOC facilities. Subsequently, this large group of offenders faces even greater obstacles to receiving necessary mental health interventions in the community.

The pre-2016 data clearly demonstrated that the DOC needed additional mental health clinicians to facilitate reentry and continuity of mental health services to increase the likelihood of success for probationers and parolees with mental health issues. Specifically, there was a need for clinicians who could: 1) facilitate the process of connecting offenders to community mental health resources, including Community Services Boards (CSBs), hospitals, residential treatment facilities, and private providers; and 2) provide training, consultation, and support for Probation Officers in the Districts to enhance their ability to appropriately supervise probationers with mental illness.

In 2016, the DOC received funding for 20 full-time District Mental Health Clinician positions (6 approved for FY 2017 and 14 approved for FY 2018). Thanks to a tremendous effort by the Regional Mental Health Clinicians and Community Mental Health Supervisor, all 20 of the District Mental Health Clinician (DMHC) positions were filled between December 2016 and August 2017. Another important development in 2017 was the transition of the Detention and Diversion centers to the umbrella of the Community Corrections Alternative Program (CCAP). Previously, offenders were not accepted into detention or diversion centers if they were prescribed psychotropic medication. Under CCAP, offenders who are stable on psychotropic medications included on the DOC's accepted formulary are not precluded from acceptance into this very beneficial form of alternative sentencing.

The Mental Health Services staff in Community Corrections is now comprised of the following positions: One Mental Health Clinical Supervisor (MHCS); three Regional Mental Health Clinicians (Central, Eastern, Western); a Mental Health Clinician at CWDDC; and twenty District Mental Health Clinicians distributed among the 43 Probation & Parole Districts and four Men's Detention and Diversion Centers (CCAP facilities). There are also two full-time Mental Health Specialists assigned to two of the largest P&P Districts (Richmond and Roanoke). These positions were established during a pilot project in 2004 and these staff work closely and in coordination with the Community Mental Health staff.

The addition of the new positions has expanded the role of the Regional Mental Health Clinicians (RMHCs) to being full time supervisors of their respective District Mental Health Clinicians (DMHCs) in each region. The Community Mental Health staff is now enhanced with the ability to provide a much more intensive focus on each of the Districts and CCAP facilities than was possible with only one mental health clinician serving each region. The DMHCs will serve as an essential resource for Probation Officers who supervise mental health offenders. Their range of professional activities include, but are not limited to, the duties listed below:

- Consultation and training with Probation Officers who supervise probationers with mental health issues
- Collaboration with regional and local jails to ensure re-entry planning and continuity of mental health services for State Responsible probationers
- Collaboration and training with DOC Facility QMHPs to assist in re-entry planning and ensuring continuity of mental health services for probationers releasing from these facilities
- Mental health screening of probationers and potential CCAP participants to determine mental health needs and make supervision recommendations to DOC staff

- Collaboration with CSBs and other treatment providers and resources in the community to ensure continuity of mental health services for probationers
- Providing brief interventions to probationers to ensure maintenance of mental stability until longer-term treatment interventions are in place

The initiative to increase the Community Mental Health Staff's focus on jail offenders to address the disproportionate recidivism rate for "jail-only" offenders began in October 2017. A first step was to redefine the categories for collecting monthly quality assurance data to clearly demonstrate this concerted effort. The following is a summary of services provided by the Community Corrections MHS staff from November 1, 2017 through June 30, 2018. All data reported represents the number of contacts unless otherwise specified.

Direct Mental Health Contacts (including referrals for MH screenings, assessments, diagnostic clarification, or treatment recommendations; short-term interventions or monitoring)	Number of Contacts
• DOC facility offenders	1293
• Jail or court offenders	2344
Intensive Treatment Intervention (emergent cases)	
• DOC facility offenders	197
• Jail or court offenders	332
• Release planning for MH offenders	1770
• Mental Health Groups	243
Case Consultations/Meetings	
• Regional MH Clinicians	1323
• District MH Clinicians	2868
• Probation Officers	6610
• Institutional/Other DOC staff	1398
• Local & Regional Jail staff	1061
• Community Services Boards (CSBs)	1226
• Other, including state hospitals, private providers, Community Release Placements (CRPs), DJJ	926
• Re-Entry Councils or other re-entry focused meetings	313
• Mental Health Trainings provided	64
• Other Professional Meetings/Committees	715

DOC Recommendations for Resources Needed to Facilitate a Reduction in SR SMI Offenders in Local/Regional Jails

- DOC is experiencing significant, positive results from their increase in community service providers. Increasing capacity to allow for assignment of District Mental Health Clinician to each probation office and CCAP facility would result in 24 additional Qualified Mental Health Providers (QMHP) community positions assigned to DOC. These QMHPs could then complete a formal MH screening in the jail for SR offenders and act as consultant and liaison for the SR offenders prior to and during that all-important time of transition back to the community. This would greatly decrease the percentage of individuals in jails who are merely "suspected of having MH issues" and would ensure that resources were applied to the maximum benefit. The jails would have to provide requests for positions in order to provide additional screening, assessments, and services in accordance with the Jail Mental Health Standards issued by DBHDS.

- Having an electronic health record that could "talk" across the continuum of care, including the jails, prisons, CSB's, probation offices, state hospitals and Veteran's Administration could streamline diagnosis

and treatment options, greatly boosting efficacy of the system as a whole. Clinicians could then ascertain which treatments had been effective for a certain consumer.

- Resources upon release continue to be a problem for high risk, high needs returning citizens. Providing additional resources to address this need would decrease arrests and violations which stem from “subsistence crimes” where the returning citizen simply does not have the basic necessities available when he/she arrives on the street and resorts to criminal activity to house, feed, and clothe him/herself. There are funding streams available to the community, which are problematic for offenders to access. For example, Discharge Assistance Planning (DAP) funds for assistance with housing, medication, mental health services and transportation were available to jails and prisons are only accessed through the hospital/CSB gatekeepers. Governor’s Assistance Plan (GAP) funding for medical and mental health services are only available after a CSB screening. If Disability Determination Services (DDS, a division of the Department of Aging and Rehabilitative Services) would allow jails to have the same “priority status” that prisons do through our interagency MOU, more offenders would leave with disability funding in place. Currently, DDS gives releasing DOC offenders priority status in benefit determination process, which can shorten the waiting period for up to 1-2 years.

  Suspending Medicaid while incarcerated would help both the jail and prison populations in reinstating benefits upon release on a timely basis. Whether GAP, DAP, SSI, and/or Medicaid recipients, these individuals are all on the same continuum of care, needing engagement from CSB and other community resources. To increase successful application for these benefits for offenders, additional staffing for both jails and DOC would be needed; however, timing of the application and approval process for short sentences would still be an issue.

- Embracing court ordered outpatient treatment and diversionary programs for individuals whose MH status repeatedly results in criminal justice involvement.

- In 2017, 46 VA jail sites reported doing some sort of “case management” although this was neither quantified nor defined. DOC has increased its amount of case management, including synergistic work by counselors, problematic release department staff, and district mental health clinicians. Given the increase in percentage of SR individuals coming from the jails who recidivate, providing adequate case management would be a cost-effective choice of intervention.

- Jails currently vary widely in policies and practices regarding the amount of medication provided upon release. It has been beneficial for DOC offenders to leave with 30 days’ worth of medications, and another 30-day prescription for backup when clinically warranted. It can take more than 2-3 months to get into rotation with a CSB or private provider. As a system, although giving out medication costs the jails more initially, it will be significantly less expensive for the system as a whole.

- Increasing incorporation of trauma informed care strategies and practices by Virginia Courts, CSBs, and jails. There is a high percentage of justice-involved individuals for whom a history of trauma has either aggravated MH issues, or may be misdiagnosed if the system is not astute at recognizing and managing these issues. Staff from multiple disciplines can serve as trainers across the state to increase staff knowledge and skills of trauma informed strategies and practices.

- Last year, there was a pilot program and corresponding study about the efficacy of “residential units” for individuals with MH issues in VA jails. Without analyzing the results of that study, and comparing it to outcomes of prison and hospital residential units, it is impossible to know if this is a cost effective use of

funds or not. However, it does allow an agency to focus services when individuals who are medically and mentally vulnerable are housed together in specialty pods. However, without the proper resources and supports, these can become "clinical cul-de-sacs" where individuals can be housed instead of treated.

- To prevent MH offenders from additional involvement in the justice system, expansion of drop off centers, outpatient programs, Crisis Intervention Training (CIT) officers/staff, and diversion settings can all reduce the number of mentally ill who find their way into the jails.

- Specialized housing is needed for returning citizens who are high on the risk and needs spectrum, with particular issues such as substance abuse, neuro-cognitive disorders, traumatic brain injury, complicated medical profiles, and/or history of sex offenses. When these individuals are released, procuring appropriate housing becomes a fiscal and logistical hardship.

- At this juncture, given available data, capital resources are not warranted as a recommendation for improving outcomes for SR SMI offenders serving their sentences in jails. Providing more QMHPs and treatment officers can be expensive initially, although there is a significant cost saving when recidivism is decreased or prevented. Specialized housing in the jail needs to be studied carefully and comprehensively before implemented, and if it is not properly staffed with clinical professionals it becomes a quagmire for those housed there. Until we have data about the true incidence and acuity of offenders with mental health issues in the jails, it would be wise to instead invest in what we already know to be effective, which is the community QMHP's through DOC.

Appendix A – DOC Mental Health Code Definitions

MH1 – Minimal Impairment (6% of offenders incarcerated in DOC facilities)
The offender does not currently require mental health treatment but has a history of self-injurious behavior, suicidal gestures or attempts, or mental health treatment within the past two years; the offender is not prescribed psychotropic medication and can function satisfactorily in a general population setting

MH2 – Mild Impairment (20% of offenders incarcerated in DOC facilities)
The offender must have a documented significant DSM diagnosis or diagnosis of a personality disorder with symptoms that are usually mild to moderate but stable; the individual can typically function satisfactorily in a general population setting for extended periods; monitoring by a QMHP may be necessary; the offender may be prescribed psychotropic medication

MHS2 – Substantial Impairment (2% of offenders incarcerated in DOC facilities)
The offender must have a documented significant DSM diagnosis that meets SMI criteria which requires monitoring by a QMHP and may require medication intervention

MH3 – Moderate Impairment (<1% of offenders incarcerated in DOC facilities)
The offender has an on-going mental disorder and may be chronically unstable; the offender typically cannot function in the general population for extended periods of time and requires on-going mental health monitoring or mental health monitoring and treatment; the offender may be prescribed psychotropic medication

MH4 – Severe Impairment (<1% of offenders incarcerated in DOC facilities)
The offender is seriously mentally ill and is considered to be a danger to self or to others or may be substantially unable to care for self; the offender may be prescribed psychotropic medication