COMMONWEALTH of VIRGINIA

Department of Criminal Justice Services

Shannon Dion
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October 24, 2018

The Honorable Ralph Northam
Governor of Virginia
Patrick Henry Building
1111 East Broad Street
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The Honorable Brian J. Moran
Secretary of Public Safety and Homeland Security
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

The Honorable Daniel Carey
Secretary of Health and Human Resources
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee
Pocahontas Building, 14th Floor
900 East Main Street
Richmond, VA 23219

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee
Pocahontas Building, 14th Floor
900 East Main Street
Richmond, VA 23219

The Honorable S. Chris Jones
Chairman, House Appropriations Committee
Pocahontas Building, 14th Floor
900 East Main Street
Richmond, VA 23219

Re: Report on the Evaluation of the Jail Mental Health Pilot Programs

Dear Sirs:

Pursuant to the 2016 Appropriations Act (2016 Virginia Acts of Assembly, Chapter 780, Item 398 J.1-6), the Department of Criminal Justice Services (DCJS) provided grant funding for the establishment of six jail-based pilot programs to provide services to mentally ill inmates. In consultation with the Department of Behavioral Health and Developmental Services (DBHDS), DCJS evaluated the implementation and effectiveness of the pilot programs. Enclosed please find a report of the evaluation of the pilot programs.

Please contact me with any questions. Staff at the department are available should you wish to discuss this report or the work of the pilot programs.

Sincerely,

Shannon Dion

Shannon Dion

Attachment

c: Dr. S. Hughes Melton, Commissioner, DBHDS
Dr. Michael Schaefer, Assistant Commissioner of Forensic Services, DBHDS

Evaluation of the Jail Mental Health Pilot Programs

Virginia Department of Criminal Justice Services
1100 Bank Street, Richmond, Virginia 23219
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October 2018

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PREFACE

The 2016 Appropriations Act (2016 Virginia Acts of Assembly, Chapter 780, Item 398 J.1-6) directed the Virginia Department of Criminal Justice Services (DCJS) to establish pilot programs to provide services to mentally ill inmates, and evaluate the implementation and effectiveness of the pilot programs. The language reads:

> 1. The Department of Criminal Justice Services shall solicit proposals from local or regional jails to establish pilot programs to provide services to mentally ill inmates, or to provide pre-incarceration crisis intervention services to prevent mentally ill offenders from entering jails. The Department of Criminal Justice Services shall evaluate the proposals in consultation with the Department of Behavioral Health and Developmental Services and the Compensation Board, and shall report a list of up to six recommended pilot sites to the Secretary of Public Safety and Homeland Security and the Chairmen of the House Appropriations and Senate Finance Committees no later than September 15, 2016.
>
> 2. In its solicitation for proposals, the Department of Criminal Justice Services shall require submissions to include proposed actions to address the following minimum conditions and criteria:
>
> a. Use of mental health screening and assessment instruments designated by the Department of Behavioral Health and Developmental Services;
> b. Provision of services to all mentally ill inmates in the designated pilot program, whether state or local responsible;
> c. Use of a collaborative partnership among local agencies and officials, including community services boards, local community corrections and pre-trial services agencies, local law enforcement agencies, attorneys for the Commonwealth, public defenders, courts, non-profit organizations, and other stakeholders;
> d. Establishment of a crisis intervention team or plans to establish such a team;
> e. Training for jail staff in dealing with mentally ill inmates;
> f. Provision of a continuum of services;
> g. Use of evidence-based programs and services; and,
> h. Funding necessary to provide services including, but not limited to: mental health treatment services, behavioral health services, case managers to provide discharge planning for individuals, re-entry services, and transportation services.
>
> 3. The funding for each pilot program shall supplement, not supplant, existing local spending on these services.
>
> 4. In evaluating proposals and recommending pilot sites, the Department of Criminal Justice Services, in consultation with the Department of Behavioral Health and Developmental Services and the Compensation Board, shall at minimum give consideration to the following factors:
>
> a. The readiness of the local or regional jail to undertake the proposed pilot program;

b. The proposed shares of cost to be funded by the Commonwealth, localities, or other sources, respectively;
c. The need for such a program demonstrated by the local or regional jail;
d. The demonstrated collaborative relationship between the jail and community mental health treatment providers and other stakeholders; and,
e. To the extent feasible, ensuring the recommendation of pilot sites representing both rural and urban settings.

5. Included in the appropriation for this Item is $1,000,000 the first year and $2,500,000 the second year from the general fund to be awarded to local or regional jails to support the proposals recommended pursuant to the report required by Paragraph J.1. of this Item. The funding for each pilot program shall be effective for pilot programs starting as of January 1, 2017.

6. The Department of Criminal Justice Services, in consultation with the Department of Behavioral Health and Developmental Services, shall evaluate the implementation and effectiveness of the pilot programs and report to the Governor; the Secretaries of Health and Human Resources and Public Safety and Homeland Security, and the Chairmen of the House Appropriations Committee and the Senate Finance Committee by October 15, 2017, for grants awarded in the first year, and by October 15, 2018, for all grants.

INTRODUCTION

The high incidence of mental illness among inmates in local jails has long been recognized as a serious problem. A 2017 report from the Bureau of Justice Statistics found that, nationally, 26% of jail inmates exhibited signs of "serious mental distress." In Virginia, the State Compensation Board's *Mental Illness in Jails Report 2017* stated that 18% of inmates held in Virginia's local jails were known or suspected to have a mental illness.

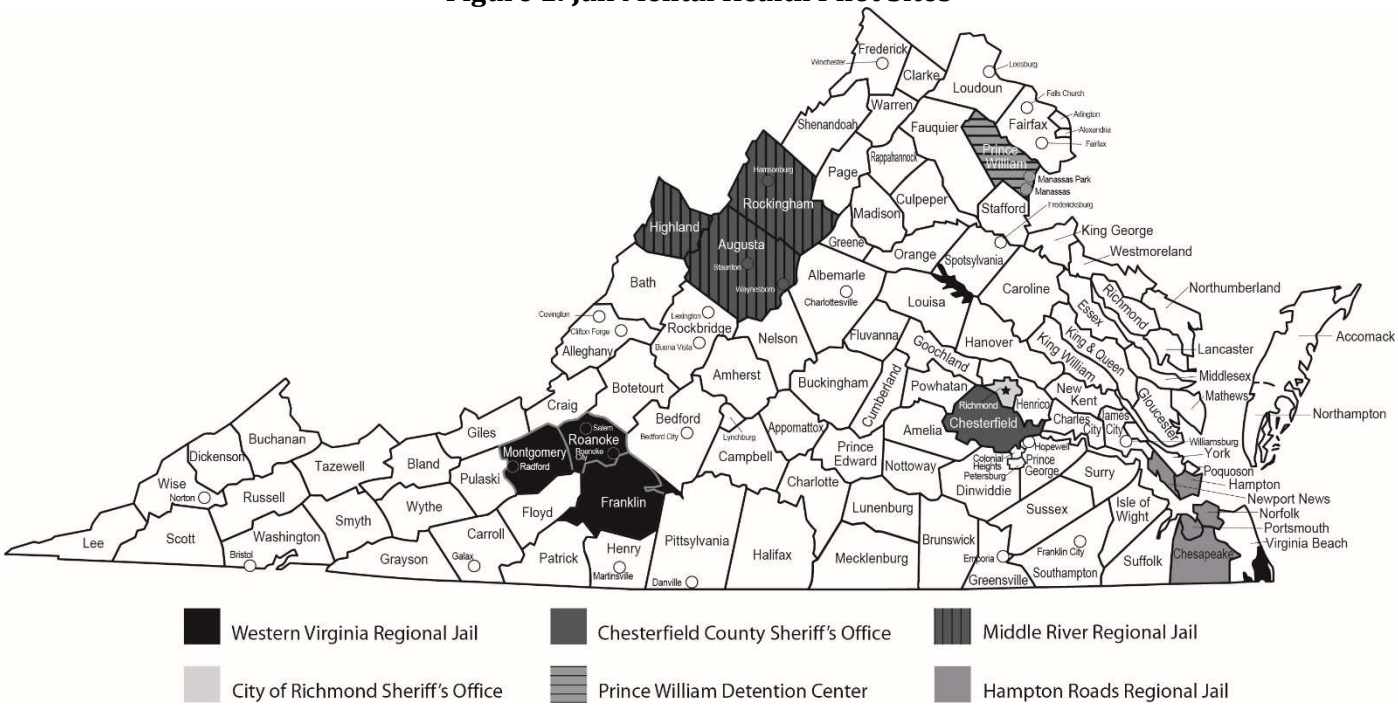
To address this problem, the 2016 Appropriations Act established the Jail Mental Health Pilot Program, an 18-month grant program to provide a continuum of behavioral health services to inmates incarcerated and released to the community. In July 2016, 19 Virginia local and regional jails submitted concept papers to DCJS describing their proposed mental health pilot program and funding budget. In December 2016, the Criminal Justice Services Board awarded grants of $1 million for FY17 and $2.5 million for FY18 to six of these jails: the Chesterfield County Sheriff's Office, Hampton Roads Regional Jail, Middle River Regional Jail, Prince William Adult Detention Center, Richmond City Sheriff's Office, and Western Virginia Regional Jail (see Table 1 and Figure 1).

Table 1: Jail Mental Health Pilot Programs and Award Amounts

Selected Pilot Site	Funding Awarded FY 17–18
Chesterfield County Sheriff's Office	$416,281
Hampton Roads Regional Jail	$939,435
Middle River Regional Jail	$536,384
Prince William-Manassas Regional Adult Detention Center	$410,898
Richmond City Sheriff's Office	$670,813
Western Virginia Regional Jail	$526,185

This evaluation covers the period funded by these grants (January 1, 2017— June 30, 2018) and focuses on the lessons learned that can be applied should Virginia decide to implement similar mental and behavioral health services in other jails. The aim was to identify which approaches to delivering these services appeared to be the most promising and the most challenging.

Figure 1: Jail Mental Health Pilot Sites



DATA COLLECTION AND EVALUATION METHODOLOGY

Data Collection

To assess how the jail pilot sites implemented and delivered services under this program, each jail was required to submit quarterly qualitative data about their accomplishments, challenges, and program updates, as well as quantitative performance measures, on the following broad activities:

- Mental health screenings and assessments provided to inmates admitted to the jail
- Mental health treatment plans and treatment services provided to inmates in the jail
- Measures of jail safety for inmates and jail staff
- Aftercare services provided to assist inmates released from the jail

DCJS staff also conducted interviews with staff from each of the jails during the program to collect more in-depth data on program implementation and performance.

Data Analysis

The findings presented in this report focus mainly on aspects of the pilot programs that were reported and could be appropriately analyzed for all six jails combined. More detailed data was reported by each of the individual jails to provide additional insight into its implementation achievements, and is available from DCJS. Appendices A–F provide an abbreviated two-page summary of information obtained for each of the six jails.

Baseline data on the numbers and types of services that inmates in the six jails were receiving prior to the start of the pilot program was not available. Therefore, data presented in this report focuses on changes observed over the 18-months from the start of the project period (January 1, 2017) through the end of the project period (June 30, 2018). Furthermore, the numeric measures of services provided to inmates exclude the first three months of the project (January–March 2017), because this period consisted of administrative start-up activities rather than service provision. Thus, the numeric measures of services provided to inmates in this report cover a 15-month period (April 2017–June 2018). Data are generally reported in three-month quarterly intervals, although because the program covers 15 months (five 3-month periods) the final reporting period is referred to as the fifth "quarter."

Because each of the six jail pilot sites worked with a unique inmate population (in terms of number of inmates, average length of stay, and prior experience with mental health services), staff at each site designed their program to meet the needs of their jail population. As a result, although all of the jails reported the same basic performance measures data to DCJS, there are also differences in the data reported by each of the jails.

SUMMARY OF EVALUATION FINDINGS

The jail mental health pilot project demonstrated that providing targeted, dedicated, and carefully-considered funding for jail mental health services produced measurable improvements in identifying inmates with mental and behavioral health needs, in developing treatment plans and delivering services to these inmates, and in providing post-release services to aid their transition into the community.

The 18-month pilot project also demonstrated that integrating mental health services in a jail environment can be a complex, lengthy and challenging process. Jails were not designed to be mental health facilities, and historically jail personnel have been trained on the custodial control of inmates, not the treatment of mental health patients. Similarly, procedures for delivering mental health services were designed for clinical and treatment settings, not for jails. Finally, mental health providers are not typically trained on providing services to inmates within the confines of a jail environment. This is not to say that jails should not be providing these services. Rather, much of what was learned—and what may be helpful for future jail mental health efforts—involves understanding and facilitating the blending of two different roles: correctional supervision and mental health provision.

Achievements Common to All Six Jails

A number of achievements were identified across the six jails over the 18-month pilot program, using both quantitative data and qualitative information collected from each site.

Quantitative Data

The jails increased the percentage of inmates that received a mental health screening after being booked into the jail. During the first quarter of the program, 69% of these inmates were screened; by the fifth quarter of the program, 84% were screened. The jails also reduced the longest amount of time that inmates had to wait to be screened following booking. During the first quarter of the program, 10% of inmates had to wait 72 hours or more to be screened; by the fifth quarter of the program, only 3% had to wait this long. Reducing the amount of time between booking and screening was essential to allow staff to identify mentally ill inmates before they were released, transferred, or bonded and provide them with needed services.

The jails also increased the percentage of inmates who received a full mental health assessment after screening positive for mental illness. During the first quarter of the program, only 13% of positive screened inmates received a full mental health assessment; by the fifth quarter, 70% of these inmates received a full assessment. Additionally, the jails reduced the amount of time that inmates had to wait between screening and receiving an assessment. During the second quarter of the program (first quarter data was unavailable due to start-up times), 87% of the inmates that screened positive had to wait more than one-to-two weeks to be assessed; by the fifth quarter of the program, only 10% of these inmates had to wait that long.

Data on inmates with a treatment plan developed showed mixed results. The percentage of inmates with a plan developed increased slightly from 86% in the first quarter to 88% in the third quarter, but then dropped to only 64% in the fifth quarter. It is unclear why this drop occurred, but the jails indicated that it may be related to turnover among mental health staff at the jails.

Mental health treatment services provided to inmates by the jails increased for all types of therapy provided. Total one-on-one therapy hours provided increased from 183 hours in the first quarter to

445 hours in the fifth quarter. Total group therapy hours increased from 392 hours in the first quarter to 980 hours in fifth quarter. The total amount of "other" therapy hours provided increased from 100 in the first quarter to 575 in the fifth quarter.

The jails also increased the number of released program participants that received aftercare services to help improve their transition back into the community. Overall, the jails increased the number of inmates that received seven types of aftercare services from the first quarter to the fifth quarter of the program.

Data on jail safety measures over the course of the program showed mixed results. The number of reported injuries to jail staff and to inmates (to others and to self) declined from the first quarter of the program to the fifth quarter. However, other measures, including numbers of acute crises, inmates placed in restrictive housing, and behavioral infractions, increased during this period. These increases likely occurred because the program provided an increased number of mental health staff who were trained to detect and report these occurrences.

Qualitative Data

Written quarterly reports and interviews also identified achievements common across the participating jails. Although not numerical measures, these sources provided insights into program aspects not anticipated when the numeric performance measures were devised.

In these sources, jails repeatedly emphasized the benefits having funding to hire highly qualified staff dedicated to identifying and addressing inmate mental health needs. During the program, all of the jails combined reported hiring a total of 18 additional staff, including seven reentry specialists or case managers, three peer support specialists, three consultant licensed clinicians, two licensed clinicians, two psychiatric services consultants, and one community case manager. Sites reported that previously they had to place the demands for addressing inmate mental health needs on only one or a few staff members.

Jails also emphasized the benefits of funding to provide training to staff, with major types of mental health training including Mental Health 101, Mental Health in Corrections, Crisis Intervention Team training, certified peer counselor training, Dialectical Behavior Therapy training, and Officer Training: An Introduction to Intellectual and Developmental Disabilities: Support and Communication Strategies.

Achievements identified across participating sites also occurred within the structure and operation of the actual programs. Specifically, they implemented new evidence-based curricula taught by specialists in the jails. Some participants told staff members that these programs were beyond any they had previously experienced. Some sites also used grant funding to create special housing pods so that program participants could live apart from the general inmate population and receive specialized care.

The final set of achievements identified in quarterly reports and site interviews pertained to aftercare and reentry elements of the pilot program. The grant funding helped jails increase collaborative relationships with community service providers and stakeholders, which was essential in improving the reentry process for released individuals. This in turn allowed the jails to increase the numbers of released inmates receiving aftercare services including making appointments, and obtaining housing, transportation, medication, and employment opportunities. Some officials also credited the aftercare performance measures for encouraging them to contact

and follow-up with released participants, which helped them learn more about the intricacies of the reentry process.

Challenges Common to all Six Jails

Staffing was a challenge at all of the sites. Jail officials continually stressed the difficulties they faced in hiring qualified mental health staff for positions that were funded on a year-to-year basis. It was especially difficult to hire reentry specialists. Jails frequently noted that they felt they could have done a better job attracting qualified individuals if they were able to offer a two-year position, rather than a 12 or 18-month position.

Frequent turnover among program staff was also an issue across all of the sites. These staffing issues affected all areas of the pilot program, from identifying and assessing mentally ill inmates to delivering services inside and beyond the jail, as well as in collecting and reporting performance data. When decreases in quarterly measures of services provided to inmates were reported, jail staff frequently attributed these drops to gaps created by staff turnover, and not as a result of the programs themselves.

The lengthy implementation process was also a frequent focus of jail officials. They stressed that even well-resourced jails should anticipate a lengthy implementation process for a program of this nature. The length of the implementation process was influenced by an array of factors, including the need to get various approvals from local governing agencies and unexpected delays in hiring due to local government policies and practices, and difficulty in attracting candidates. Officials also stressed that merging the activities of staff members from mental health and criminal justice backgrounds was sometimes difficult. It sometimes took time to merge these different cultures and get them working jointly toward the major goals of each program.

Jail officials also stressed the inherent challenges of dealing with a transient jail population. Officials described examples of when they were moving an inmate from the screening to the assessment stage, and the inmate was then bonded out of jail before the assessment could be conducted or a treatment plan could be developed. Likewise, it was difficult to create treatment plans focused on providing a continuum of care when individuals could be unexpectedly released, transferred, or bonded. This also made it difficult for jail staff to maintain working groups when there was frequent turnover within the program population.

Various challenges were also cited related to the reentry and aftercare elements of the program. Jail officials often highlighted the difficulty and time-consuming nature of case management. However, this was essential for officials to create relationships with program participants and improve reentry efforts. Officials also frequently highlighted the practical challenges faced when providing reentry services. These challenges included difficulty finding affordable housing for released inmates, difficulty ensuring medication compliance for released inmates, and difficulty collecting performance data for aftercare services, and difficulty following up with released inmates.

Although increasing and improving collaborative relationships with community agencies was an achievement for the programs, it was not without its challenges. This difficulty was particularly noted for sites that worked with multiple Community Services Boards (CSBs). They specifically stated that CSBs have unique ways of operating, which can make coordination with multiple CSBs difficult.

LESSONS LEARNED AND RECOMMENDATIONS

Based on the achievements and the challenges identified in this evaluation, the following lessons learned and recommendations are provided. Because the jails examined in this report served as pilot programs for delivering mental health services, the findings focus on the lessons learned that can be applied, should Virginia implement similar programs in other jails. The evaluation did not aim to categorize the findings from these jails as "successes" or "failures." Instead, the aim was to identify which approaches to delivering mental health services appeared the most promising and which appeared to be the most challenging.

Implementation and Staffing

Recommendation 1:
Future jail mental health programs should emphasize the use of professional standards, evidence-based practices, and standards and guidelines shown to produce the best outcomes. At the same time, they should also recognize that jails will need the flexibility to develop programs that respond to their unique circumstances. Virginia should continue to avoid a strict, one-size-fits-all approach when designing jail mental health program goals and requirements.

Each pilot site was able to implement additional, enhanced mental health services for inmates entering the jail. Each of the six jails, having different populations, resources, and programmatic approaches, also encountered unique implementation issues and experienced unique achievements and challenges.

Recommendation 2:
Future jail mental health program planning and funding should recognize and account for the sometimes lengthy process needed to implement these services.

Each pilot site was able to implement most of the goals it established at the beginning of its program. However, each jail also required considerable time to reach full implementation of the program due to the complexities of establishing mental health services in jails. These complexities included lengthy administrative start-up issues, time required to recruit, hire and train staff, and time required to establish relationships with community aftercare providers. Implementing programs could take from six to nine months to complete.

Recommendation 3:
Future jail mental health program planning and funding should address identifying ways to entice mental and behavioral health workers to provide services in jails. This program demonstrated that hiring and retaining these workers was a major challenge due to funding levels, funding stability, and the unique issues with working in a jail setting.

Each pilot site was eventually able to recruit and hire qualified mental and behavioral health staff, but this was a major challenge. Most jails took longer than expected to hire these staff. Reasons for difficulties obtaining these staff included: unwillingness to accept positions that are only temporarily funded through grants; salary levels offered were not competitive with other employers; not wanting to work within the restrictions of a jail environment; and the difficulty of finding employees living in, or willing to work in, isolated areas where some of the jails are located. Conducting exit interviews with staff that are hired, but then leave the jails, could help provide information to help address this issue.

Additionally, frequent turnover among the mental and behavioral health staff was a recurring problem. Jails often reported that these staff would leave, in some cases only shortly after they were hired. This contributed to delays in implementation and gaps in providing services.

Recommendation 4:
Future jail mental health program planning and funding should emphasize the need to provide both mental/behavioral health staff and jail staff with the types of training needed to provide mental health services to inmates.

This project demonstrated that hiring additional staff alone is not enough; the jails stressed that having staff properly trained in understanding and providing mental health services was a key benefit of the program. Each pilot site was able to provide both existing jail staff and newly-hired mental health staff with various types of training on mental health topics and service delivery. This training was provided by multiple sources, and the jails emphasized the benefits of having adequately trained staff to deliver these services.

Recommendation 5:
Future planning for jail mental health programs should include a review of the obstacles to providing aftercare services noted in this report, and identify strategies for addressing these obstacles.

Each pilot site was able, to varying degrees, to provide released inmates with aftercare services such as medication, transportation, housing, and assistance with job placement and obtaining health and social benefits. However, many of the jails also faced challenges in locating and securing these services for inmates. These challenges included a general lack of providers for these services (especially in rural areas); high costs for housing; housing providers hesitant to accept or maintain offenders; and service providers not being available when inmates were released.

Programming

Recommendation 7:
Future jail mental health programs should consider the criteria they establish for inmate program participation.

This project demonstrated that improved program selection criteria might reduce challenges encountered later in the programs, such as inmates who refuse to provide mental health history information, who do not actively participate in programming, or who become problems to aftercare providers. The selection criteria should also consider identifying inmates who are most likely to be removed from the jail before they can obtain the benefits of the programs. This would allow jail staff to focus their time and resources on inmates that are most likely to remain in the programs.

The criteria jails established for selecting inmates to participate in their jail mental health programs varied across the jails, and included gender, prior criminal convictions, drug use, sentence length, etc. These criteria influenced the types of programming provided and the achievements and challenges the jails experienced.

Recommendation 8:

Consider reviewing the process used to select the instruments used for inmate mental health screening and assessment. Alternatively, consider reviewing the process used to train staff on use of the current instruments.

Some jail staff reported that the screening and assessment instruments were difficult to use. Other jails reported that they decided to add additional elements to the designated screening tools.

Performance Measurement

Recommendation 9:

Future jail mental health programs should be sure that data definitions and collection procedures are clearly understood by all program staff responsible for collecting and reporting data. Some jails reported difficulty collecting and reporting the data. Although standardized data collection procedures are necessary, assessment data collected from jails must also be flexible and account for differences among jail programs.

Assessing the results of jail mental health programs requires collecting data to identify whether the programs are implemented correctly and whether they are achieving their intended outcomes. This pilot program evaluation identified lessons learned that could improve data collection and evaluation if similar programs are implemented in the future. This is especially relevant given that many jails did not have baseline data to compare results with, and each jail developed unique programs with different goals and objectives, making it even more difficult to collect, analyze and evaluate the data across the programs.

Recommendation 10:

Information and lessons learned from current and future jail mental health programs should be maintained and made available statewide so that other jails considering their own mental health programs can benefit from the lessons learned from previous programs.

This project demonstrated that each jail had different experiences, achievements and challenges implementing their programs. Making this information readily available would allow jails statewide to build on the experience of other jails that have already done this.

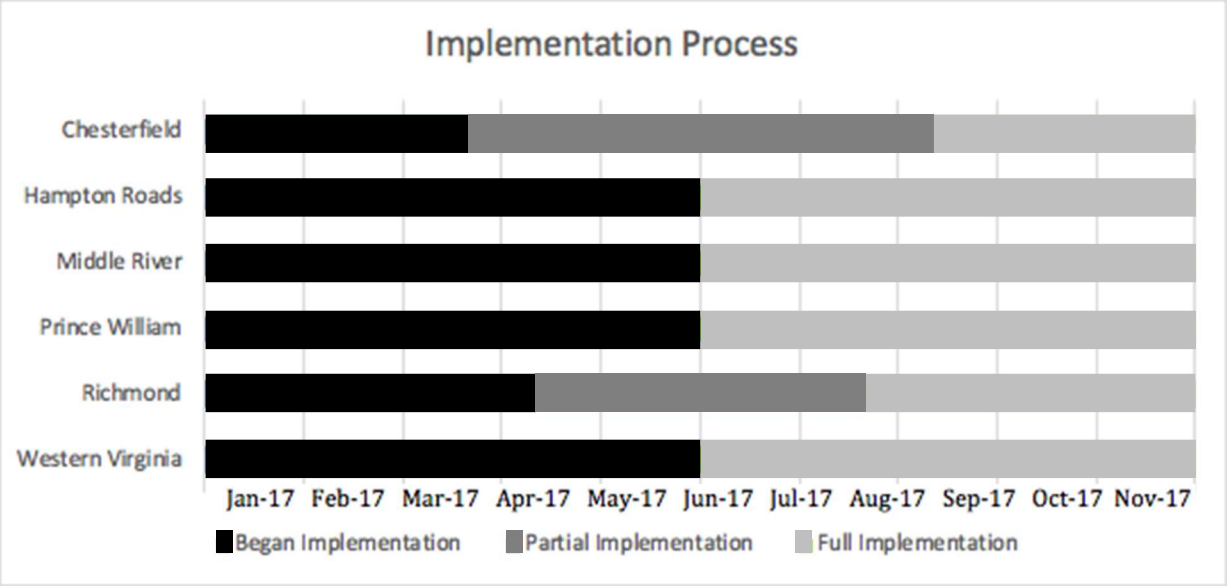
SPECIFIC PROJECT FINDINGS

Implementation

Funding to implement the pilot program at each of the six jails became available on January 1, 2017. However, the time required for the jails to develop details of their programs, train existing staff and hire new (primarily mental and behavioral health) staff, and establish relationships with community-based aftercare service providers delayed full implementation of the programs until months later—ranging from May to September of 2017. As a result, none of the six jails were able to expend all of the first-year grant funds during the grant period. Much of the delay in spending the available funding was due to the time it took to recruit and hire staff, which was the largest single program expense for each jail. Thus, one of the early lessons learned from this pilot project is that funding periods for such programs should recognize that considerable time may be required for sites to expend their start-up funding.

Figure 2 shows the range of time it took for each of the six jails to begin program implementation, achieve partial implementation, and achieve full implementation.

Figure 2: Pilot Project Implementation Times for Each Jail



Program Staffing

A significant portion of the funding awarded to each site was used to improve staffing levels of mental health professionals in the jails. These individuals were hired to help each pilot site better identify mentally ill inmates in the screening and assessment process, create a treatment plan tailored to the needs of each inmate, provide services to these inmates in the jails, and improve community reintegration following release by connecting these inmates with important community resources.

Prior to the implementation of the pilot program, each site was already providing various types of mental health services, but the grant funding allowed each jail to increase and enhance the staffing dedicated to addressing mental health needs. Jail officials cited both the increase in staffing and the

increase in highly educated and highly trained staff, as a major reason why they were able to increase their ability to provide mentally ill inmates a continuum of care from booking through their release.

All of the jails noted that recruiting and hiring qualified mental health professionals was a challenge. These challenges are not unique to the jails. In a presentation to the Senate Finance Committee-Health and Human Resources Subcommittee on January 15, 2018, the Department of Behavioral Health and Developmental Services (DBHDS) explained that CSBs and state hospitals have also faced significant turnover challenges. The presentation noted that CSBs are losing case managers to health plans.

Compounding the already existing workforce challenges for qualified mental health professionals was the unique nature of grant-funded positions in a correctional setting. Some jails noted the challenges of hiring or retaining staff for only one year with no assurance of future funding.

Site officials frequently expressed frustrations at how often employees left crucial positions soon after being hired. This was especially detrimental to smaller programs that only had a few individuals dedicated to this program. For example, some sites had only one individual dedicated to aftercare services, including both developing the aftercare plan and following up on the implementation of the plan. If that employee left that position at any point during the pilot program, the site struggled to continue providing those aftercare services while also trying to hire a qualified candidate for the position. The high level of turnover among staff also reduced the ability of some jails to collect and report the performance data needed to assess the programs.

Jail officials stated anecdotally that if they had been able to assure and advertise for at least two years of funding, they probably would have had more success filling these key roles.

Criteria for Including Inmates in Program for All Six Jails

Each site began the pilot program with different goals for the inmate population it served, and these goals were used to establish criteria for inmates to be included in each site's program. These varied criteria determined the inmate population eligible for program participation at different stages in the process, from screening and assessment to treatment planning and post-release services.

Five of the six jail sites included all inmates booked into the jail, even before screening, as potential program participants. One site considered only female inmates for program participation. Other exceptions existed in other sites; for example, inmates serving nonconsecutive weekend sentences ("weekenders") were not eligible for participation at some sites.

Once individuals were screened using a mental health screening tool, all inmates that screened positive for a mental illness were potential program participants. At this point, approaches to potential program participation among the jails began to diverge. Some sites aimed to conduct a full mental health assessment of all inmates who screened positive. Eligibility to participate was then determined based on the assessment results and other information such as the individual's charge and expected length of stay. Other sites took into consideration exclusion criteria, such as the type of charge, before determining whether or not to conduct an assessment. These jails regarded the assessments as lengthy and work-intensive, and thus wanted to assess only those potential participants that met all other inclusion criteria. All of the sites operated voluntary programs, i.e., all inmates could reject an offer to participate in the program even if they met all of the criteria for participation. Table 2 shows the similarities and differences of the criteria for inclusion across all six sites.

Table 2: Criteria for Participation in Jail Mental Health Pilot Programs

	Mental Illness (not necessarily SMI)	Serious Mental Illness	Long Length of Stay	Cognitive Ability Level Consideration	Behavior Concerns	Violent/Sexual Charge Excludes Participation	Male	Female	Inmate Can Voluntarily Refuse Participation	Staff Discretion
Chesterfield	X						X	X	X	
Hampton Roads		X	X			X	X	X	X	X
Middle River		X			X		X	X	X	X
Prince William	X							X	X	X
Richmond		X	X	X	X	X	X	X	X	X
Western Virginia	X						X	X	X	X

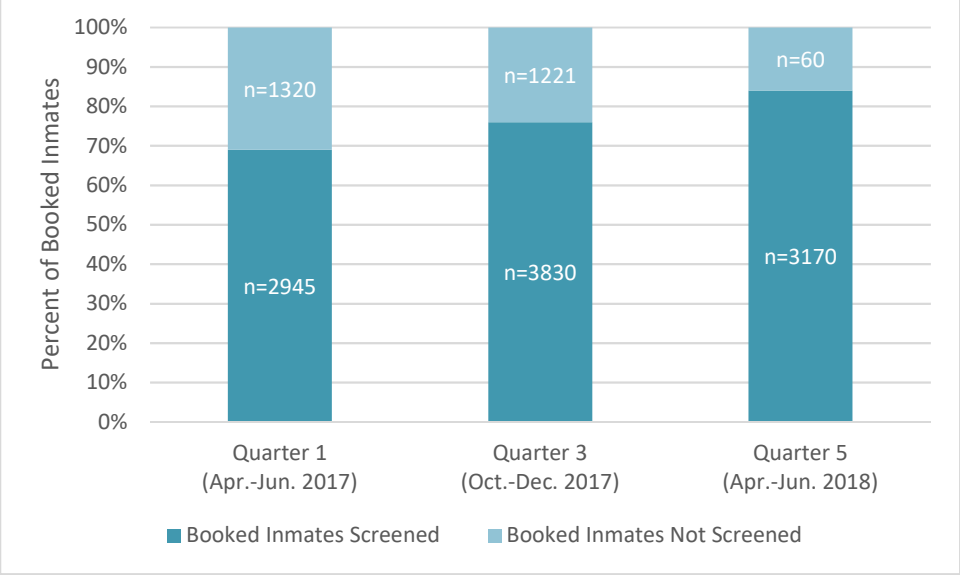
Mental Health Screening

The first set of performance measures for the pilot program aimed to assess each site's ability to conduct mental health screenings of booked inmates, the time-frame in which those screenings were conducted, and the results of those screenings.

All six sites used the Brief Jail Mental Health Screen (BJMHS) or the Correctional Mental Health Screen for Women (CMHS-W) as their screening tools. These instruments were designated by DBHDS as the screening tools that should be used by each jail. Some sites added supplemental questions to the screening tools, but this was not done uniformly across all six sites.

A major achievement of the pilot program was an increase in the percentage of inmates booked into the jails that received an initial mental health screening. Figure 3 shows the percentage of booked inmates screened and not screened during the first, third, and fifth quarters of the 18-month grant period.

Figure 3: Percentage of Booked Inmates Receiving Mental Health Screening

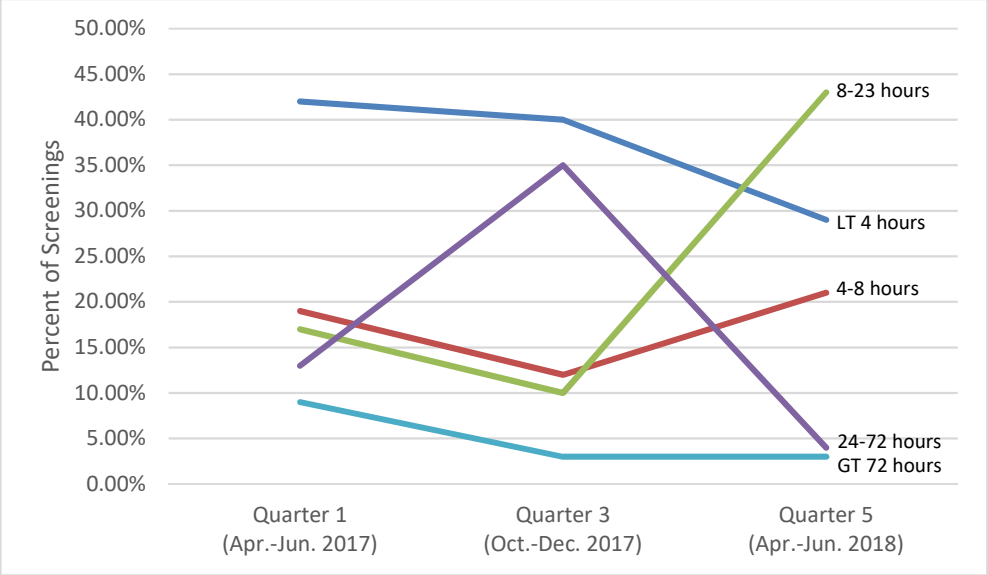


As can be seen, during the first quarter of the program, 69% of the inmates booked into the jail received a mental health screening. However, this increased to 76% of inmates screened in the third quarter and 84% of inmates screened in the fifth quarter.

Despite this increase, 16% of inmates booked into the jails were still not screened during the fifth quarter. Common reasons cited for this were that inmates were being bonded out of jail before they could be screened, were released to pre-trial programs before screening, were intoxicated and unable to answer screening questions, or refused to answer the screening questions.

Another achievement of the pilot program was the overall ability for the jails to administer the screenings in a shorter timeframe after booking. By the fifth quarter of the program, 93% of screenings were conducted within the first 23 hours of booking. Figure 4 shows the percentage of all screenings that took place within different time frames of booking for the first, third, and fifth quarters of the grant period.

Figure 4: Time from Jail Admission to Mental Health Screening



As can be seen, over the project period the jails reduced the longest periods of time that inmates had to wait to be screened following booking. During the first quarter of the program, almost 10% of inmates had to wait 72 hours or more to be screened, but by the fifth quarter of the program this had been reduced to 3% of the inmates. Similarly, during the first quarter of the program, 13% of inmates had to wait 24–72 hours to be screened, but by the fifth quarter only 4% of the inmates had to wait this long.

Although the longest periods of time until mental health screening declined, the percentage of inmates screened in less than four hours after admission also decreased, from 43% in the first quarter to 28% in the fifth quarter. It is unclear why this occurred. However, in totality the overall time to conduct screenings decreased, and reducing the amount of time between booking and screening was essential to ensure that staff was able to identify mentally ill inmates before they were released, transferred, or bonded and provide them with needed services.

Mental Health Assessment

When inmates screened positive for a potential mental illness, they were then given a full assessment to determine if they actually had a mental illness, identify the type of illness, and determine the severity of the illness. The results of the assessment helped staff members determine if the individual met their criteria for program participation, and helped staff develop a treatment plan tailored to the specific needs of that individual.

As previously stated, some sites aimed to fully assess all inmates that screened positive while others only conducted assessments of individuals that met all other criteria for program inclusion. This decision, in turn, affected how the assessments results were used. For example, the sites that only allowed individuals with a serious mental illness (SMI) to participate had a higher threshold for participation based on the assessment results than those that did not establish SMI as a requirement for participation. Specific details about how the criteria for program inclusion impacted assessments at each site can be found in the case study reports in the appendices.

While all six sites used the same screening tools designed by DBHDS, the jails had flexibility in selecting the assessment tools they used. Table 3 shows the similarities and differences in these assessment tools used across all six sites.

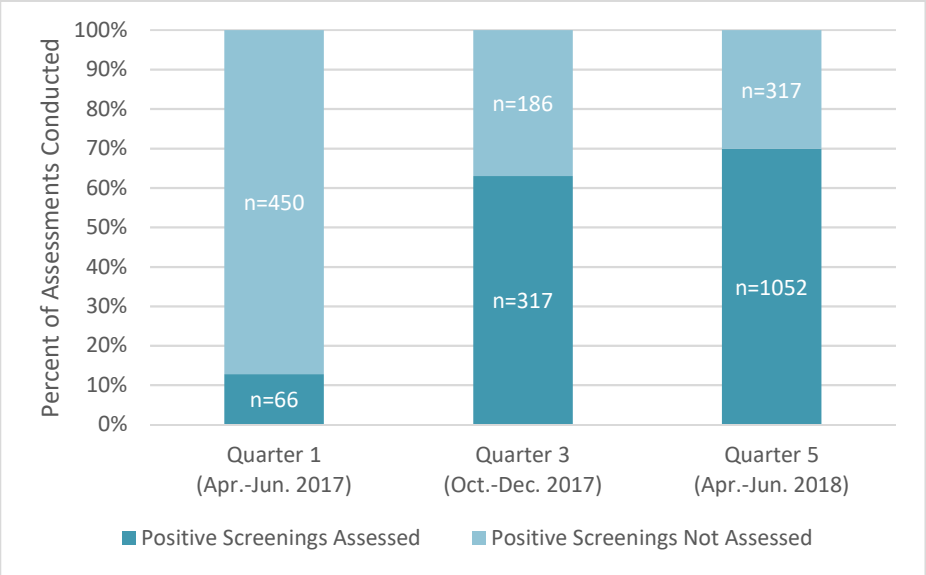
Table 3: Types of Mental Health Assessment Tools Used by Jail Mental Health Pilot Sites

	Psychosocial Assessment	Designed by University	Designed by National Organization	Designed by Staff	Administered to Only Program Participants	Administered to All Positive Screenings
Chesterfield	X			X		X
Hampton Roads			X			
Middle River	X					X
Prince William	X	X				
Richmond	X			X	X	
Western Virginia	X			X		X

Despite the different assessment approaches used by the six sites, some analyses of performance measures could be made across all of the sites. The first is the percentage of individuals screened positive that received a full assessment. This measure is important because, if the goal was to provide more and better services to mentally ill inmates, conducting more assessments was essential to identifying all booked individuals that had some type of mental illness. The results of this analysis must be approached with caution since all of the sites did not perform assessments uniformly. For example, sites that considered criteria for program participation *before* determining who to assess had a narrower population of interest than sites that conducted assessments on all positive screened individuals.

Figure 5 shows the percentage of individuals that were screened positive and received a full assessment across all six sites during the first, third, and fifth quarters of the grant period.

Figure 5: Percentage of Positive Screened Inmates Receiving Full Mental Health Assessments

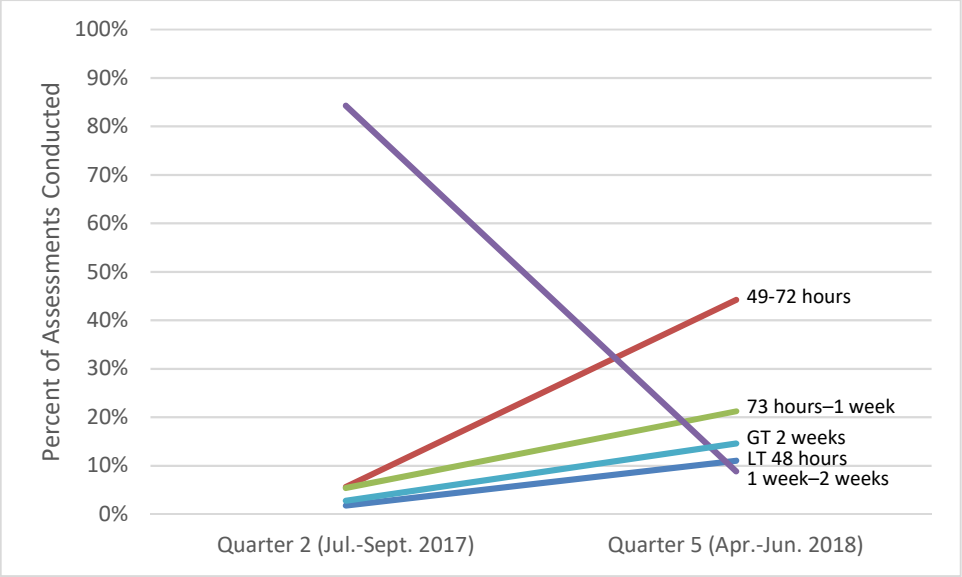


As can be seen, only 13% of positive screened inmates received a full mental health assessment during the first quarter of the program. However, by the third quarter 63% percent of these inmates received a full assessment, and by the fifth quarter 70% received a full assessment.

Although there was a large increase in assessments performed by the fifth quarter, 23% of positive screened inmates still did not receive an assessment. Common reasons cited for this included inmates refusing the assessment and inmates being transferred, bonded, or released from jail before the assessment could be conducted.

Not only did the percentage of inmates receiving a full assessment increase during the pilot program, but the time that it took from when an inmate was screened to when the assessment was performed decreased. Figure 6 shows, for all of the pilot site jails combined, the amount of time that elapsed between when an inmate received an initial mental health screening and then received a full mental health assessment. The starting point for this comparison is the second quarter of the program, because not all jails were able to track this data during the first quarter.

Figure 6: Time Between Mental Health Screening and Mental Health Assessment



As can be seen, the percentage of times until assessment that took one-to-two weeks fell sharply, from 87% in the second quarter to less than 10% in the fifth quarter. Over the same period, the percentage of times that assessments were done in less than 72 hours increased from 8% to 56%. Overall, the pilot program allowed jails to considerably reduce the time it took to provide inmates with a full mental health assessment.

There was considerable variation between the six jails in the change in elapsed times between screenings and assessments. Over the course of the programs, some jails did not see constant declines in the elapsed time, but instead saw fluctuations from one quarter to another. Some of these fluctuations were due to factors such as turnover in staff available to conduct the screenings and assessments.

Treatment Services

Inmates screened for and assessed to have a mental illness, and who met other program criteria, were offered participation in the mental health program. Inmates deciding to participate were then provided an array of treatment services while incarcerated. Each jail operated their program differently to serve their unique population, and each defined the term "program" based on their particular circumstances.

The commonly offered treatment services across all six sites could be broadly defined as either mental health services while in jail or aftercare preparation services. Jail staff provided program participants with treatment planning, case management services, medication management, evidence-based curriculum, cognitive behavioral therapy, peer support specialists, and an array of other unique services while incarcerated. Table 4 summarizes the treatment services offered by all of the sites.

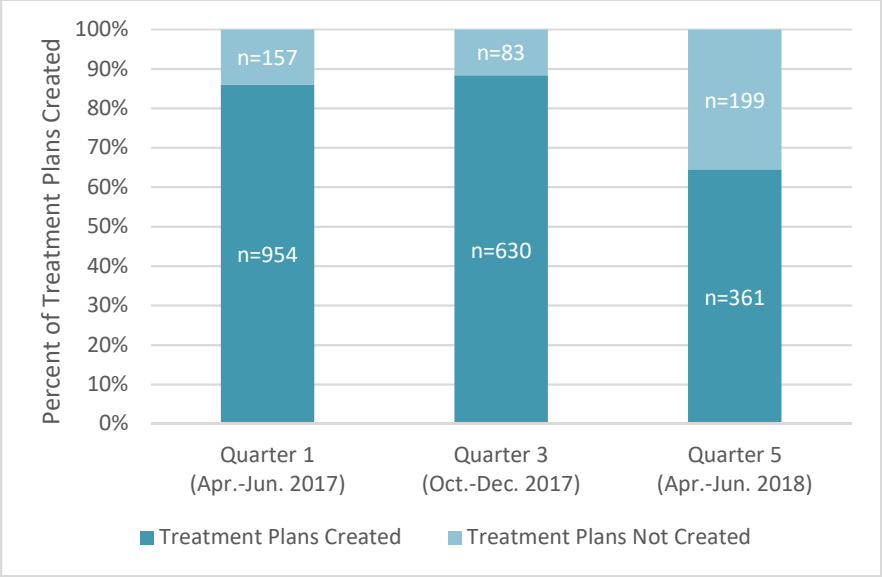
Table 4: Mental Health and Aftercare Services Offered by Pilot Sites

Mental Health Services While in Jail	Aftercare Preparation Services
For Inmates:	***For Inmates:***
Case Management	Case Management
Individual Counseling	Release Planning
Moral Recognition Therapy	Medication Management
Group Therapy	Housing Assistance
Stress Management	Job Placement Assistance
Medication Management	Direct Connection to CSB
Job Training Programs	Transportation Assistance
Certified Peer Support Training	Healthcare/Disability Benefits Assistance
For Staff:	***For Staff:***
Mental Health Training	Increased Collaboration with Community Agencies
Mental Health First Aid Training	Training in Release Planning

Two primary performance measures were used to capture the achievements and/or challenges the jails faced in providing treatment services to program participants: the percentage of inmates with a treatment plan developed, and the number of therapy hours offered during each quarter of the grant period.

Figure 7 shows the percentage of eligible inmates that had a treatment plan developed in the first, third, and fifth quarters of the grant period.

Figure 7: Percentage of Eligible Inmates That Had a Treatment Plan Developed



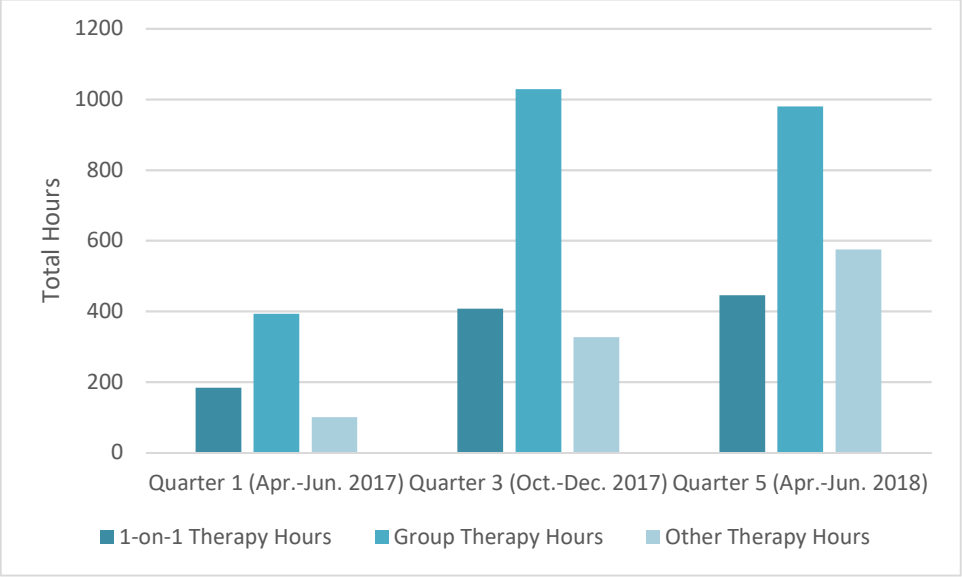
As can be seen, the percentage of eligible inmates that had a treatment plan developed increased slightly from 86% in the first quarter to 88% in the third quarter, but then dropped to only 64% in the fifth quarter. It is unclear why this drop occurred, but interviews with jail staff indicate that it is partially due to high turnover rates for some of the mental health staff hired under the grant. Hiring these additional staff—especially skilled staff capable of doing assessments and developing treatment plans—produced an initial increase in developing treatment plans. However, when these

staff later left the jails, the ability to provide these services dropped until replacements could be hired.

The second set of performance measures used to gauge the impact of grant funding on in-jail services provided were the number of therapy hours offered during each quarter of the grant period.

Figure 8 shows the total amount of one-on-one, group, and other therapy hours provided to program participants during the first, third, and fifth quarters of the grant.

Figure 8: Total Hours of Therapy Provided by Mental Health Pilot Programs



As can be seen, the numbers of hours of all types of therapy provided increased over the course of the program. Total one-on-one therapy hours provided increased from 183 hours in the first quarter to 407 and 445 hours in the third and fifth quarters, respectively. The total number of group therapy hours provided increased from 392 hours in the first quarter to 1029 and 980 hours in the third and fifth quarters, respectively. The total amount of 'other' therapy hours provided increased from 100 in the first quarter to 327 and 575 in the third and fifth quarters, respectively. The increase in therapy hours provided is attributed to the overall increase in the number of qualified mental health staff hired at each site using the grant funding.

Jail Safety

It was anticipated that the mental health program could improve the overall safety of participating jails, and performance measures were designed to identify such changes, including the number of behavioral health related incidents causing injuries to staff, other inmates, or self, the number of inmates placed in restrictive housing due to a documented behavioral health related incident, the number of inmates that experienced an acute crisis resulting in jail employee intervention due to a behavioral health related incident, the number of behavioral infractions due to a behavioral health related incident, and the number of temporary detention orders (TDOs).

Most of the jail safety measures showed an increase in incidents from the first quarter to the fifth quarter. There were overall increases in the rate of acute crises, participants placed in restrictive

housing, and behavioral infractions. Overall total injuries to staff, other inmates, and to self, declined over the program period. The rate of TDOs remained relatively stable over the course of the project.

Although at first these increases would appear to be a negative finding, it is possible (and indeed likely) that they indicate another benefit of the program. The funding allowed the jails to hire additional mental health staff who are specifically trained to detect, identify and record inmate behaviors that are related to mental and behavioral health. Furthermore, some jails established a separate living pod for program participants, where it would have been much easier to identify any of the safety issues that occurred among the participants. Finally, as part of the program, all jails were specifically asked to detect and report on these measures.

It is therefore likely that these reported increases are due to better detection and reporting of these incidents, rather than an increase in the number of actual incidents. A longer-term follow-up would be needed to determine if jail safety measures actually show later improvements based on the mental health services provided under these programs.

Collaborative Partnerships Developed by all Six Jails

Establishing collaborative partnerships with service providers in the community was a major goal of the pilot program, especially for providing services to inmates following release from jail. While each of the sites had already established some collaborative partnerships with community agencies prior to the pilot program, the grant funding allowed each site to improve and enhance these partnerships. These increased and improved partnerships had a direct impact on the aftercare services provided across the sites.

Aftercare

Aftercare services were a critical element of the pilot program at all six jails. Funding at each site was dedicated to helping released inmates who were receiving services in the jail continue to access essential services in the community. It was anticipated that creating a bridge from the jail to services within the community would contribute to a successful reentry for released inmates.

The increased funding created by this grant improved the continuum of care for mentally ill inmates at all six pilot sites. All of the jails improved their ability to deliver aftercare services by hiring staff members dedicated primarily or solely to post-release transitions and improving the bridges to community resources for each released participant. Jail staff noted in interviews that, prior to the grant, they often did not have the capacity to do anything other than give inmates instructions on what they should do when released and hope that they followed these instructions. The hiring of reentry staff enabled them to monitor the scheduling and attendance of community appointments and the use of available resources.

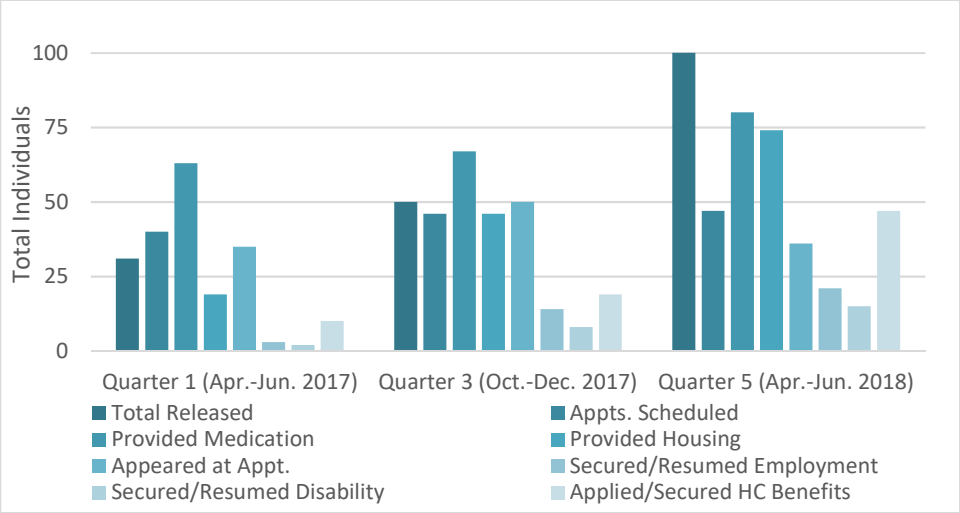
Nevertheless, the aftercare element of the pilot program was often the most difficult to implement. It was also the most difficult to monitor for data collection purposes, because released inmates were difficult to track. Jail staff often had to rely on community agencies to provide data on when released inmates appeared at appointments, or secured housing, employment, other benefits, etc.

Since most of the sites were not fully implemented until June 2017 or later, it was not until late 2017 before participants could move far enough through the program to be released into the aftercare portion of the project.

Figure 9 shows, for the first, third and fifth quarters of the program, the total numbers of program participants released, the total with community appointments scheduled prior to release, the total

that appeared at that appointment, the total provided with medication, the total provided with housing, the total that secured/resumed employment, the total that secured/resumed disability benefits, and the total that secured/resumed health care benefits.

Figure 9: Aftercare Services Provided by Mental Health Pilot Programs



For all seven types of aftercare services provided, the number of inmates receiving these services increased over the course of the program. Between the first and fifth quarters, the number of inmates provided medications following release increased by 27%, the number appearing at appointments increased by 3%, the number securing or resuming disability payments increased by 650%, the number with appointments scheduled increased by 18%, the number provided with housing increased by 289%, the number securing or resuming employment increased by 600%, and the number that applied for or secured health care benefits increased by 370%.

In the long term, the hope is that by providing more of these types of mental health and aftercare services, inmates will be more successful reentering the community.

CONCLUSION

This project demonstrated that with dedicated funding for mental health, jails were able to more quickly identify inmates that have a mental illness, and provide much needed clinical, case management, and aftercare services. Each of the six pilot programs employed different types of services and crafted the programs to meet the localized needs of individual jails. While this approach served the needs of the individual jails and provided valuable lessons on implementation of programs, the different goals and objectives made it challenging to develop recommendations on which approaches and practices work best. Without the benefit of consistent across-the-board baseline data prior to the implementation of the pilots, the programs require additional operating time to provide comprehensive information on which approaches and practices will enhance mental and behavioral health services in jails. A continuing assessment of jail mental health programs will build the information necessary to make these improvements.

APPENDIX A: CHESTERFIELD COUNTY JAIL PROFILE

Total of $416,281 awarded in FY 2018 — Total of $292,132 awarded in FY 2019

Site Goals Listed by Chesterfield County Sheriff's Office

- Increase clinical, case management, and reentry services for inmates with mental illness
- Hire a senior clinician and a reentry coordinator

Services Offered Under the Grant by Chesterfield County Sheriff's Office

Mental Health Services While in Jail	**Aftercare Preparation Services**
For Inmates:	***For Inmates:***
Case Management	Case Management
Individual Counseling	Release Planning
Moral Recognition Therapy	Medication Management
Group Therapy	Housing Assistance
Stress Management	Job Placement Assistance
Medication Management	CSB Appointments
Job Training Programs	Governor's Access Plan (GAP) Referrals
Certified Peer Support Specialist	Healthcare/Disability Benefits Assistance
Certified Peer Counselor Training	IOP (aftercare intensive outpatient)
Seeking Safety (cognitive behavioral therapy)	
For Staff:	***For Staff:***
Mental Health 101 Training	Increased Collaboration with Community Agencies
Varied Staff Training	Training in Release Planning

Implementation Process

Chesterfield County Sherriff's Office (CCSO) began implementing aspects of their program on April 1, 2017. On July 1, 2017, CCSO hired their reentry coordinator. The reentry coordinator began providing services on September 1, 2017, which is the date when staff considered their program fully operational and new services were provided. Officials noted that they were already providing mental health services in April 2017, using infrastructure that was already in place prior to the grant. The new funding helped them improve and enhance the delivery of these services.

Program Design

Chesterfield staff established criteria for program participation that determined which inmates would be eligible for treatment services. At the outset of the pilot program, Chesterfield staff only considered seriously mental ill (SMI) inmates eligible for program participation. Staff softened this criterion as the program evolved and began providing services to inmates whose illnesses did not rise to the threshold of SMI. Participation in treatment services was voluntary.

Overall Achievements

The data gathered from Chesterfield County identified various program achievements during the 18-month pilot program. The numerical data showed that Chesterfield staff decreased the percentage of admitted inmates not screened, and increased the percentage of inmate screenings conducted within 24 hours of intake. Staff improved the percentage of inmates assessed within 48 hours of the initial screening. Chesterfield used grant resources to hire qualified mental health professionals to provide an increased amount of treatment service hours to mentally ill inmates. Regarding jail safety, Chesterfield staff reported very few incidents related to mental health. Lastly,

Chesterfield staff increased the number of released individuals that were provided aftercare services during the grant period.

The quarterly report and interview data, which allowed site staff to mention what they considered important factors not captured by the numeric data, or emphasize certain findings in the numeric data, also indicated achievements.

This data focused upon the jail's ability to use grant funding to hire essential mental health staff members. They also improved their program by adding screenings tools into their automated system so that booking staff could conduct the screenings during the intake process. A staff member encapsulated their achievements well by stating, "It was simpl[y] that I wanted to reach more people and out of those that were seen, about one-third had diagnosis of mental illness. Now more are being identified and help can be provided to them. I took a two-prong approach—get people seen and give them treatment while they are here. But this does no good without aftercare. They often leave and come back because they go out and lose [their] job, insurance, etc. and they come back to jail. My mission is continuity of care."

Overall Challenges

The numeric, quarterly reports, and interview data also identified challenges faced by the jail while implementing the pilot program, although there was inconsistent reporting of performance measures. The collected quantitative data indicated that the total number of inmates that screened positive but were not assessed increased in later stages of the grant period. The total number of treatment plans developed in the first quarter of the program was the highest amount created.

There were also a number of challenges identified in the qualitative information collected. Chesterfield staff stressed that despite the increase in staffing under the grant, they still needed more mental health staff members to bridge the gaps in the reentry process. Also, the implementation process was long and often delayed by local jurisdictional issues, which made it difficult to begin hiring and providing services under the grant. Staff also struggled to find affordable housing in Chesterfield County for released inmates. This difficulty was especially notable for female inmates released, especially those with children. They also struggled to find housing providers that would rent to ex-offenders.

The short average length of stay of Chesterfield's inmate population created a number of challenges for them. They had difficulty starting and maintaining therapeutic groups within the jail. Reentry provided challenges as staff faced difficulties planning for reentry, coordinating with community agencies, follow-up with released inmates, and collecting aftercare data with the transient inmate population.

APPENDIX B: PRINCE WILLIAM-MANASSAS REGIONAL ADULT DETENTION CENTER PROFILE

Total of $410,898 awarded in FY 2018 — Total of $311,416 awarded in FY 2019

Site Goals Listed by Prince William-Manassas Regional Adult Detention Center

- Provide mental health services to female inmates
- Incorporate clinical personnel and consultants to provide clinical services and case management services for inmates with mental illness
- Provide group and individual services for inmates with mental illness
- Hire a clinical reentry coordinator and a case manager

Services Offered Under the Grant by Prince William-Manassas Regional Adult Detention Center

Mental Health Services While in Jail	**Aftercare Preparation Services**
For Inmates:	***For Inmates:***
Case Management	Case Management
Individual Counseling	Release Planning
Group Therapy	Medication Management
Recovery In a Supportive Environment (RISE)	Housing Assistance
Dialectical Behavior Therapy (DBT)	Job Placement Assistance
Medication Management	CSB Appointments
	Healthcare/Disability Benefits Assistance
For Staff:	***For Staff:***
Mental Health First Aid Training	Increased Collaboration with Community Agencies
Varied Staff Training	Training in Release Planning

Implementation Process

Prince William hired two mental health specialists on July 1, 2017. These individuals were essential for their program to operate effectively and their start date was considered the full implementation date. Prince William staff offered some services prior to the grant; however, this is when they began providing new and enhanced services to the target population. One of the newly hired specialists focused on the therapeutic elements of the program, while the other specialized in reentry services. The therapeutic specialist remained in that position throughout the duration of the program. There was frequent turnover, however, in the reentry specialist position. Hiring a qualified reentry specialist that remained in this position was a challenge throughout the pilot program.

Program Design

Prince William staff created program participation criteria that dictated which inmates were eligible for treatment services. The main delineating criterion was that only female inmates were eligible for participation. The inmate's diagnosis did not have to reach the threshold of seriously mentally ill (SMI) to be eligible for participation. All program participation was voluntary.

Overall Achievements

A number of achievements were identified at Prince William over the 18-month pilot program. These achievements were seen in both the quantitative data and qualitative information. The quantitative data collected indicated that nearly all female inmates booked over the 18-month grant period were screened. Most screenings took place within the first four hours of intake as the grant

progressed. Also, staff was able to reduce the percentage of assessments conducted between one to two weeks after the initial screening. Staff also significantly increased the total treatment hours offered in the latter stages of the grant period. The jail saw a decreasing amount of incidents affecting jail safety.

Some achievements were also identified in the quarterly written reports and the interview data, which allowed site staff to mention what they considered to be important factors not captured by the numeric data, or to emphasize certain findings contained in the numeric data.

During the pilot program, staff was able to implement cognitive based programing to help inmates regulate emotions, improve medication management and crisis stabilization, develop evidence-based courses, and adopt a new assessment tool. They also improved employee training.

Prince William staff described a number of achievements in their reentry services. Staff emphasized that the grant funding helped them increase and improve collaborative relationships between the pilot site, stakeholders, and service providers. This helped them improve the transition from incarceration to bed placements in local community agencies or other housing options. They also improved follow-up discharge planning services with the local community services board and implemented *Supportive Transition After Release* program, which provided supportive assistance to participants per their individualized service plans.

Overall Challenges

The numeric, quarterly report and interview data also identified challenges faced by the jail while implementing the pilot program. Many assessments took place over one week after the initial screening was conducted. Also, the total treatment plans developed peaked during the third quarters before decreasing the following quarters.

There were also a number of challenges identified in the qualitative information. These challenges included: a lack of a uniform database for data collection, implementation delays that limited first quarter services provided, issues with how to treat unique populations like weekenders, and strategic communication barriers between agency divisions on role diffusion. There was also an array of challenges noted regarding barriers to screening, which included: male versions of screening tool being conducted by mistake, inmates rebooked and re-released within 24 hours due to an error, inmates not screened due to psychotic presentations at intake, and intoxication.

Program staff also highlighted challenges faced with staffing. Staff shortages made it difficult to devote enough time to grant programming and timely completion of assessments. Assessments and counseling sessions were often rescheduled to attend to needs outside of the pilot program. The inherent turnover of inmate populations also made it difficult to execute a complete treatment plan.

APPENDIX C: HAMPTON ROADS REGIONAL JAIL PROFILE

Total of $939,435 awarded in FY 2018 — Total of $600,008 awarded in FY 2019

Site Goals Listed by Hampton Roads Regional Jail

- Develop and implement discharge planning for inmates with serious mental illness
- Implement clinical assessments and counseling for inmates with serious mental illness
- Implement coordination of care planning with five surrounding community services boards
- Hire a program coordinator, program administrator, clinical therapist, case manager, and peer support specialist

Services Offered Under the Grant by Hampton Roads Regional Jail

Mental Health Services While in Jail	**Aftercare Preparation Services**
For Inmates:	***For Inmates:***
Case Management	CORE Program (Community Oriented Re-Entry Program)
Individual and Group Therapy	Case and Medication Management
Cognitive behavioral therapies	Release Planning
Medication Management	Housing and Job Placement Assistance
Job Training Programs	CSB Appointments
Certified Peer Support Specialist/Training	Healthcare/Disability Benefits Assistance
For Staff:	***For Staff:***
CIT Training	Increased Community-Agency Collaboration
Mental Health First Aid	Training in Release Planning

Implementation Dates

Hampton Roads Regional Jail (HRRJ) considered their program fully implemented in September 2017, when all of their case managers were hired. They hired a case manager for each locality that they service, which includes Chesapeake, Hampton, Newport News, Norfolk, and Portsmouth. HRRJ began providing various services immediately at the beginning of the grant and preemptively established community relationships in anticipation of the approved grant funding.

Program Design

Hampton Roads used the program participation criteria to divide inmates into two different groups. The first criteria determined which inmates were eligible for in-jail treatment planning and services. All inmates who screened positive were eligible for a treatment plan and services while incarcerated. The second set of criteria determined which inmates were eligible for discharge services. HRRJ coined their discharge services the CORE program. For an inmate to qualify for the CORE program, they must have been classified as seriously mentally ill (SMI) according to the full assessment. Inmates charged with a violent or sexual offense or given a lengthy sentence were excluded from CORE programming eligibility, even if they were deemed SMI. Mental health staff then used a subjective approach to determine which inmates with a SMI would be a good fit for the CORE program.

Overall Achievements

A number of achievements were identified at Hampton Roads during the pilot program. The numerical data showed that nearly all inmates booked were screened, and the time between booking and screening improved from initially occurring within 24–72 hours of booking to nearly all screenings occurring within 8–23 hours in the final quarter. Staff also increased the rate of positive screenings that received full assessments. There was an increase in the number of in-jail treatment plans created each quarter. Also, the total amount of treatment therapy hours increased over course of the pilot program.

Regarding jail safety, the number of injuries, the number of inmates placed in restrictive housing, behavioral infractions, and the number of TDOs decreased over the course of the pilot program. Regarding aftercare services, nearly all of the released individuals that participated in the CORE program had community appointments established prior to release and were provided with medication.

Some achievements were also indicated in the quarterly written reports and interview data, which allowed site staff to mention what they considered important factors not captured by the numeric data, or to emphasize certain findings contained in the numeric data. Respondents indicated that grant funding helped them hire an array of essential personnel and provide staff with mental health training. They felt strongly that officers and staff increased their ability to identify individuals that required a higher level of care. They also increased their ability to assist participants with medication and housing needs upon release. Staff also noted that the aftercare measures encouraged them to follow-up with released participants.

Overall Challenges

The numeric, quarterly reports and interview data also identified challenges to implementing the pilot program. The numeric data indicated that the total number of treatment plans developed decreased each quarter, while the total amount of acute crises increased over time. Regarding aftercare, few CORE participants were provided housing assistance, appeared at their community health appointment, secured/resumed employment, secured/resumed disability benefits, and applied for/resumed health insurance benefits later in the grant period.

There were also challenges identified in the quarterly reports and interviews. Most challenges highlighted by Hampton Roads staff involved reentry issues. Staff described difficulties linking released inmates to mental health services. This was challenging due to communication breakdowns and lack of information sharing between mental health services providers and program staff. There was also a lack of reliable transportation to schedule appointments upon release. The transient nature of jail populations also made aftercare planning, follow-up, and data collection challenging.

Staff members faced other challenges as well. There were unexpected delays in hiring due to city hiring practices. They also struggled to find training for CORE staff members and operate certain classes due to low attendance rate, lengthy/multiple weekly class times required, limited staffing, and limited class space. Also, inmates were constantly being removed or marked ineligible to attend classes by classifications, due to individuals' criminal history, current charges, and/or involvement in incidents in the housing pods. Hampton Roads also faced the unique challenge of working with four different community service boards (CSBs). Grant staff had to speak four "CSB languages," which led to frequent meetings to address miscommunications.

APPENDIX D: WESTERN VIRGINIA REGIONAL JAIL PROFILE

Total of $526,185 awarded in FY 2018 — Total of $400,005 awarded in FY 2019

Site Goals Listed by the Western Virginia Regional Jail

- Provide evidence-based therapy groups such as cognitive based programming
- Use peer support specialists to bridge gaps and advocate for inmates as they transition
- Hire a program coordinator, reentry specialist, licensed clinician, and three peer support specialists

Services Offered Under the Grant by the Western Virginia Regional Jail

Mental Health Services While in Jail	**Aftercare Preparation Services**
For Inmates:	***For Inmates:***
Case Management	Case Management
Individual Counseling	Release Planning
Group Therapy	Medication Management
Medication Management	CSB Appointments
Seeking Safety, Mental Health 101 and *DBT* (cognitive behavioral therapy)	Job Placement and Housing Assistance
	Healthcare/Disability Benefits Assistance
For Staff:	***For Staff:***
Mental Health 101 Training	Increased Collaboration with Community Agencies
Varied Staff Training	Training in Release Planning

Implementation Process

Western Virginia Regional Jail (WVRJ) considered May 1, 2017 their full implementation date. This is the date on which WVRJ began delivering services, all key individuals involved in the pilot program were hired, and everybody in the special needs housing pod were trained. Program staff also began running groups and offering curriculum to program participants on this date.

Program Design

Western Virginia designed an inclusive set of program participation criteria that made services available to a large population of booked inmates. When inmates were screened and assessed positive for a mental illness, their name was sent to pilot program staff. The inmate's mental health diagnosis did not have to reach the threshold of seriously mentally ill (SMI) to be considered for program participation. Mental health staff then went through the list of positively screened and assessed inmates and determined which inmates should receive treatment services based on their diagnosis. Inmates that staff determined would benefit from treatment services were offered program participation. Inmates could also participate in the pilot program if they volunteered. WVRJ staff debated whether they should make their criteria even more inclusive because many inmates who went through the in-jail programming asked to go through the program a second time. One mental health staff member interviewed stated that their participants said they had received various types of treatment services previously, but this was their most positive and effective experience.

Overall Achievements

A number of achievements were identified at Western Virginia over the 18-month pilot program. The numeric data indicated that all inmates booked were screened within four to eight hours of intake throughout the program. Staff also increased the percentage of positively screened individuals that were fully assessed. Staff members provided a large number of group therapy and peer support hours over the grant period. The site reported very few safety incidents related to mental health throughout the program. Regarding aftercare, staff provided medication consistently to released program participants throughout the program. Site staff improved their ability to provide housing assistance and employment opportunities to released program participants over the course of the grant as well.

Some achievements were also identified in the quarterly written reports and interview data, which allowed site staff to mention what they considered important factors not captured by the numeric data, or to emphasize certain findings contained in the numeric data.

Staff described inmates "begging" to go through the program a second time despite not being incentivized to go through the program again. They also stated that the number of behavioral incidents plummeted, and in-class participants told staff that they did not want to get in trouble because they do not want to get kicked out of the program. Participants told staff members that the curriculum was different than anything they had ever participated in. Staff noted that the curriculum seemed to be what participants were "holding [onto] tightly." Until the implementation of this program, treatment focused upon changing people, places, and things, which staff noted is cliché. Staff expressed that these individuals would have changed the people, places, and things in their life if it were that easy. This new program helped participants work to change their learned behaviors because most of these individuals "can't go live in a nice neighborhood with a good job and they will be confronted with [the] same stressors as before and this gives them a different manner to approach those things." The Project Director also reported multiple positive calls from local judicial officials about the program. The Program Coordinator and Project Director were asked to speak at regional meetings due to feedback they received about the offender population and service providers.

Overall Challenges

The numeric, quarterly reports and interview data also identified challenges faced by the jail while implementing the pilot program. The total number of treatment plans developed decreased over the course of the grant. Few one-on-one therapy hours were provided throughout the pilot program. It also appeared that staff members had difficulties establishing appointments with community agencies and assuring that these individuals appeared at their first community appointments.

Some challenges were also identified in the written quarterly reports and interviews. Western Virginia staff described difficulties adjusting security staff to new programming. They also ran into classroom management issues (i.e. noise, distractions, etc.). They also faced difficulties finding housing for released offenders, especially in rural areas.

APPENDIX E: MIDDLE RIVER REGIONAL JAIL PROFILE

Total of $536,384 awarded in FY 2018 — Total of $304,766 awarded in FY 2019

Site Goals Listed by the Middle River Regional Jail

- Enhance the delivery of mental health services to all inmates
- Create a therapeutic pod for inmates with serious mental illness
- Improve and expand initial psychiatric screening through telemedicine
- Hire two full-time clinicians and two reentry case managers

Services Offered Under the Grant by the Middle River Regional Jail

Mental Health Services While in Jail	**Aftercare Preparation Services**
For Inmates:	***For Inmates:***
Case Management	Case Management
Individual and Group Therapy	Release Planning
Occupational Therapy Program using graduate student volunteers from Mary Baldwin College	Medication Management
Skill Building Programs and Education	Healthcare/Disability Benefits Assistance
Stress and Medication Management	Job Placement and Housing Assistance
Job Training Programs	CSB Appointments
Art and Recreational Therapy	*Strength in Peers Program*
For Staff:	***For Staff:***
Officer Training	Increased Collaboration with Community Agencies
Varied Staff Training	Training in Release Planning

Implementation Process

Middle River Regional Jail (MRRJ) began its hiring process on January 1, 2017. MRRJ immediately met their goal of hiring two full-time clinicians on staff because they already had one full-time and one part-time clinician on staff. Grant funding gave them the ability to convert the part-time position into a full-time position. MRRJ began providing services on May 15, 2017.

Program Design

Middle River designed their criteria for program participation to use a mix of objectivity and subjectivity. To be eligible for participation, an inmate must have been diagnosed with a serious mental illness (SMI) and/or been unable to cope in other jail housing settings. Inmates were disqualified from program participation if staff thought that their behavior would be disruptive to other inmates in the special needs pod. Program participation was voluntary.

Overall Achievements

A number of achievements were reported at MRRJ over the 18-month pilot program. The numeric data showed that all inmates positively screened in the later stages of the grant received the full assessment, and staff members consistently assessed a high percentage of all positively screened inmates. Staff was able to consistently conduct screenings within eight hours of booking and most assessments within 72 hours of the initial screening. Very few behavioral related incidents causing injuries and TDOs occurred during the pilot program. Nearly all released program participants had community-based appointments made prior to release, were provided medication, appeared at their scheduled community meeting, and secured/resumed employment.

Some achievements were also indicated in the quarterly written reports and interview data, which allowed site staff to mention what they considered important factors not captured by the numeric data, or to emphasize certain findings contained in the numeric data.

Staff members stated that case managers developed good relationships with program participants, created plans tailored to their specific needs, and took the time necessary to help with each individual's challenges. They conducted weekly follow-up discussions and released participants often voluntarily reached out to case managers to inform them of their success and challenges. Program staff described the work of the case managers as taking released participants "by the hand and walking them through their first 30 days when they are out." Program staff stated without this grant funding, they would have to return to their previous method of handing the released individuals a stack of paper with information and hoping that they took advantage of the community services.

Overall Challenges

The numeric, quarterly report and interview data also identified challenges faced by MRRJ while implementing the pilot program. The percentage of booked inmates that were screened and total treatment plants developed decreased in the later stages of the grant period. The total number of inmates placed in restrictive housing and experiencing an acute crisis both peaked in the fourth quarter, and they had a much higher total number of behavioral-related injuries to self than staff and other inmates. Also, few released program participants were provided with housing assistance, secured/resumed disability benefits, or applied for/secured health insurance benefits.

There were also a number of challenges identified in the written quarterly reports and interviews. Most of these challenges were related to the reentry and aftercare elements of the. Program staff described a lack of suitable permanent housing because there was extremely limited availability and lots of competition for safe, affordable, stable housing. These housing difficulties were also partly influenced by "bridges burned" by previously-released individuals, which sometimes limited future housing opportunities for inmates released after these incidents.

The other highlighted challenges focused on difficulties that straddled both the in-jail and reentry elements of the pilot program. Program staff expressed frequent difficulties with assuring that participants were complying with their medication plans. They also noted that case management was time-consuming and building rapport with individuals took time. Staff members also expressed frustrations with the implementation process that created funding delays and hindered an efficient process at the outset of the program.

APPENDIX F: RICHMOND CITY SHERIFF'S OFFICE PROFILE

Total of $670,813 awarded in FY 2018 — Total of $466,673 awarded in FY 2019

Site Goals Listed by the Richmond City Sherriff's Office

- Develop a separate housing unit for inmates receiving mental health treatment services
- Implement cognitive based programing
- Focus resources on higher need and lower functioning inmates with mental illness
- Hire a program coordinator, licensed clinician, reentry specialist, and a community case manager

Services Offered Under the Grant by the Richmond City Sherriff's Office

Mental Health Services While in Jail	**Aftercare Preparation Services**
For Inmates:	***For Inmates:***
Clinical Case Management	Case Management
Individual and Group Counseling	Release Planning and CSB Appointments
Crisis Intervention	Medication Management
Pro-Social groups—writing/ narrative exercises	Housing and Job Placement Assistance
Stress Management and Recreational Therapy	Healthcare/Disability Benefits Assistance
Recreational Therapy	*Strength in Peers Program*
Psychoeducation/IMR and Peer-led discussion groups *Occupational Therapy Program* and Art Therapy	Connected with community to provide increased education, exposure, and activities to program participants.
For Staff:	***For Staff:***
Staff trainings	Increased Collaboration with Community Agencies

Implementation Process

Richmond City Sheriff's Office (RCSO) began staffing the pilot program in May 2017. The site was fully staffed on June 12, 2017 and the first program participant was admitted into the program on July 24, 2017. The first formal group treatment session began on September 7, 2017. On this date, all essential staff members were hired, trained, and in place, inmates were participating in the program, and formal group sessions were initiated.

Program Design

Richmond staff implemented several tiers of criteria for program participation. An inmate had to be in the facility for at least 90 days before the staff began reviewing their case. Staff members then reviewed each inmate diagnosed with a serious mental illness (SMI) to determine if they were had high cognitive functioning to assure that they could participate in high-level programming.

The next tier involved a legal and behavioral element. Inmates with a recent violent or sexual offense and/or a primary diagnosis of substance abuse were ineligible, as were inmates confirmed to be transferring to Department of Corrections. Inmates also could have no recent or pending institutional infractions for behavior or disciplinary issues. The last elements of the criteria were subjective. Richmond staff determined if the inmate was motivated to participate and engage in programming before they were offered participation. Staff members also looked at inmates on a case-by-case basis to determine if they would succeed in the program despite not meeting all the aforementioned criteria.

Overall Achievements

A number of achievements were identified at RCSO over 18-month pilot program in the quantitative data and qualitative information collected. The quantitative data indicated that staff provided an array of treatment hours in a diverse set of services. Staff members also increased the total amount of inmates provided with aftercare services over the duration of the grant period.

Some achievements were also indicated in the quarterly written reports and interview data, which allowed site staff to mention what they considered important factors not captured by the numeric data, or to emphasize certain findings contained in the numeric data.

All program participants were able to be housed in a dedicated special needs pod, where they were able to participate in weekly therapeutic and life skills groups, as well as individual therapy and case management services. Mental health staff also developed and implemented curriculum for yoga, meditation, mindfulness, and assisted inmates with tutoring for General Education Development (GED) testing. Jail clinicians initiated discussions for assistance with a local yoga studio owner, local artist with creative involvement in corrections, local domestic violence expert, local storyteller and writing teacher, and local health and wellness educators.

Richmond staff implemented a financial assistance system for released participants that included housing for up to 90 days and medication assistance. They also provided transportation assistance to and from appointments and assisted individuals with obtaining entitlement program benefits. Staff improved the bridge from release to services by providing immediate basic needs at the time of their release, including hygiene packs, transportation support (i.e. bus tickets), housing assistance, clothing, and food vouchers. They also created immediate contact with Richmond Behavioral Health Authority or Offender Aid and Restoration of Richmond within 24–48 hours of their release. Richmond staff also began to collaborate with the Richmond City Justice Center education department to discuss options for education support and development, and testing was scheduled for participants.

Overall Challenges

The numeric, quarterly reports and interview data also identified challenges faced by the jail while implementing the pilot program. The numeric data showed that the total screenings and assessments conducted, and treatment plans created peaked in the early stages of the grant, and screenings took place 72 hours or later after booking. Also, the total number of inmates not screened peaked in the fourth quarter. All assessments conducted in the late stage of the grant period took place one week or later after the initial screening.

There were also a number of challenges identified in the qualitative information collected. Program staff expressed frustrations with how the transient nature of the jail population made aftercare planning, follow-up, and data collection challenging. This disrupted admission planning for the program, which directly affected their ability to fill the special needs housing pod to capacity. They also described continued challenges in aftercare due to a lack of suitable permanent housing for released program participants. In addition, they had turnover in four positions during the pilot program, each of which directly affected their ability to operate their program effectively.