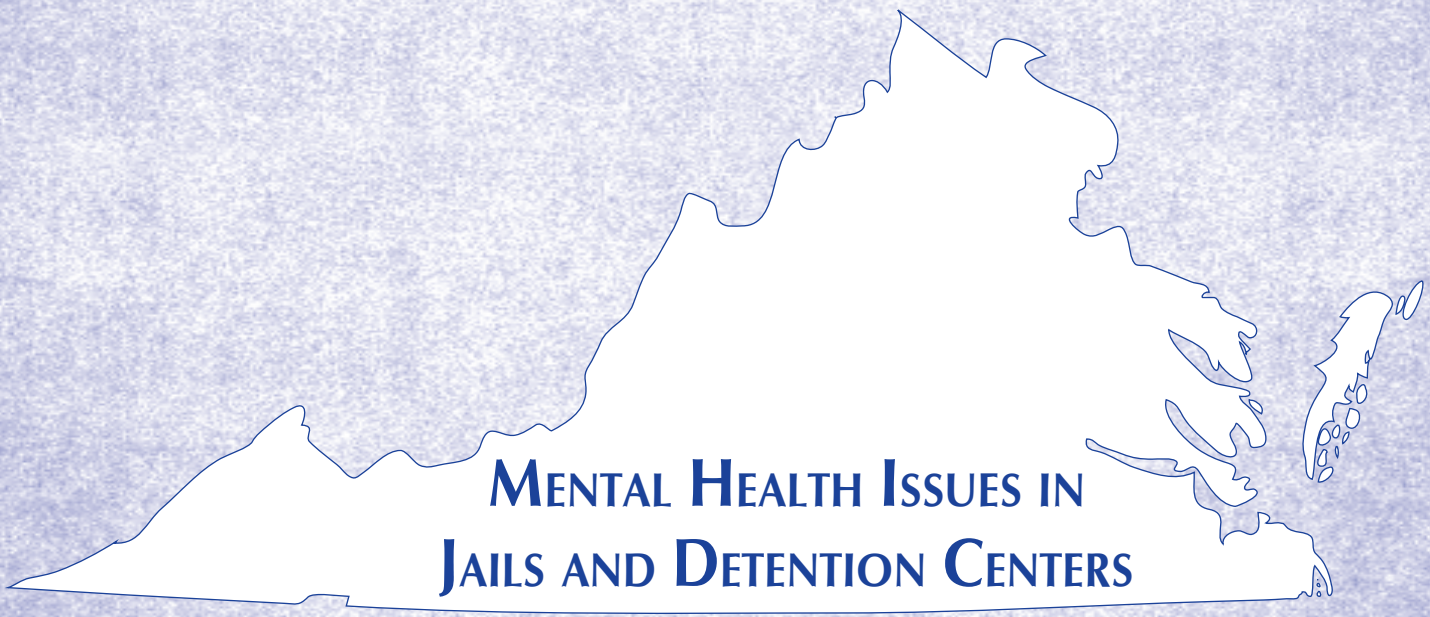
Blueprints for Change: Criminal Justice Policy Issues in Virginia



Mental Health Issues in Jails and Detention Centers

Virginia Department of Criminal Justice Services
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The Department of Criminal Justice Services (DCJS) is the state criminal justice planning agency in Virginia and is responsible for administering state and federal funds dedicated to improving state and local criminal justice practices, preventing crime and delinquency, and ensuring services to crime victims.

In its role as a planning agency, the Department convened six policy sessions over a two day period in August, 2006. The facilitated sessions explored six different leading edge criminal justice issues, chosen by the Department. Each three-hour session brought together a multidisciplinary group of executive-level participants who were selected because of their knowledge of the issue and their ability to advance the discussion of public policy related to the issue.

The discussions in these sessions, and the recommendations that emerged, are recorded in these policy papers.

In publishing these papers, DCJS hopes that they will stimulate further discussions by state and local decision makers and will provide useful guidance for making substantive statutory change where necessary, as well as for decisions on funding, and policy and program development.

The 2006 Blueprints for Change: Criminal Justice Policy Issues in Virginia documents are:

• Disproportionate Minority Contact (DMC) with the Juvenile Justice System •

• Domestic Violence, Protective Orders, and Firearms • Drug Enforcement Status in Virginia •

• Enhancing Virginia's Campus Security and Safety • Mental Health Issues in Jails and Detention Centers •

• Regional Crime Information Sharing Networks •

For additional information on theses documents, please visit the
Department of Criminal Justice Services website at: www.dcjs.virginia.gov/blueprints

Mental Health Issues in Jails and Detention Centers

Over the last 40 years the Commonwealth of Virginia has transferred the responsibility for the deinstitutionalized state patient from the state to the local units of government, without supplying adequate funding for needed behavioral healthcare services locally.

There is no standardized training for local elected government officials to help them understand how to work with and render the needed behavioral healthcare services for their mentally ill citizens. Mentally ill citizens who are behaving in a criminal manner frequently end up in the jail or detention center, rather than in a behavioral health care facility. There are even reports of youth being placed in detention in order to get them access to mental health services.

Many jails and juvenile detention centers in the Commonwealth do not have standard treatment services for the mentally ill or substance abusing offenders in their custody. These facilities are not designed for, nor funded to provide adequate behavioral health care services to local offenders in need. The present funding from private, federal, state, and local sources has been inadequate to meet the needs of the mentally ill who are placed in these local facilities.

Through various grant opportunities and the provision of some state funds over the last few years, a number of juvenile detention centers are now able to provide mental health services, but those funded through grants are time-limited. The crisis intervention and mental health services provided in detention facilities are now seen as critical to the operations of the facilities. There is a need to determine how to sustain and expand these services, and to identify whose responsibility it is to do so.

The following basic policy questions were discussed at the Blueprints for Change meeting in Charlottesville on August 28, 2006. It is clear that these (and other similar questions) need to be answered and policies developed before the jails and juvenile detention centers in Virginia can begin to appropriately handle the increasing numbers of mentally ill and substance abusing individuals placed in their custody.

The Blueprints Policy Workgroup for this topic was comprised of specialists in behavioral health and corrections, professionals who work with adults and juveniles, academics and practitioners, all with a significant interest and concern for the mentally ill who end up in the justice system and in our correctional facilities.

Policy/Research Questions

1. Should Virginia design a standard system to divert mentally ill (including substance users and abusers) individuals to more appropriate DMHMRSAS facilities or CSB/Behavioral Health Authorities at the local level?
2. Should Virginia jails and juvenile detention centers be pragmatic, understand that “relief is not in sight,” and begin to establish a capacity to effectively address the service needs of the mentally ill population?
3. How can Virginia better pay for services needed to meet the legally required treatment needs of the mentally ill person who enters a jail or juvenile detention center?
4. Who should provide treatment? Where? With what source of funds?
5. How can Virginia determine what the required basic/minimum service needs are for the mentally ill already incarcerated in jails or juvenile detention centers?

Discussion

Initial discussion included a brief history on jails and detention centers and the lack of MH services in jails. Jails and detention centers are not primarily designed to deliver Mental Health services to inmates. It was also pointed out and discussed that when the Supreme Court ruled that correctional facilities need to render services for the mentally ill the Court did not define the type of services that should be offered.

A presentation on the "Forensics Special Populations Work Group Recommendations," reflecting many years of work done by experts in the MH field, was followed by discussion of Virginia's status on the development of mental health services for the severely mental ill in jails and detention centers. The Policy Workgroup received and reviewed draft data and information that looked at the number of mentally ill in jails and juvenile detention centers. There was a higher percentage of mentally ill identified in the juvenile detention centers (37%=350 persons) than the jails (16%=4,006), but there were more than 10 times more adults in raw numbers. This jail data may be understated due to the fact that jail staff are not trained to screen and refer mentally ill inmates. They are simply hired to classify offenders by security levels and background. Some of the jails have special funding and can identify the mentally ill or those with co-occurring disorders (MI/SA), but this is estimated to be the case at just 10 of the 78 jails in Virginia. A study, recently released by the Bureau of Justice Statistics (BJS), suggests that understatement of the numbers of mentally ill offenders in local jails may be a reflection of the fact that jails count, as mentally ill, only those who have previously been identified as mentally ill and, more specifically, those who are prescribed psychotropic medication. The BJS study "sampled" jails and used inmate self-report to arrive at a figure suggesting that closer to half of all jail inmates have mental health concerns. Many mental health problems (e.g. acute or chronic depression) would not be readily apparent to staff in a jail environment.

The Policy Workgroup learned of a special study being done at Hampton Roads Regional Jail to get more accurate data on this specialty unit that houses some 600 mentally ill offenders who are on special medication.

The treatment services available in the community are inadequate to meet the needs of the mentally ill consumer who is already in the criminal justice system. As one of the participants stated, it has been this way for over 30 years. There seems to be little improvement at the community level due to a lack of resources.

The discussion highlighted the fact that, since the beginning of deinstitutionalization, there has been little money to follow the consumer who needs treatment. This is the case in both the juvenile and adult systems. Many private facilities that used to accept these patients have now closed their doors. There are very limited numbers of psychiatric beds left in the private sector for this often indigent, often under-insured or uninsured population. Nearly all of these services have closed their doors to indigent or uninsured psychiatric patients.

The Policy Workgroup discussions focused on two major matters. The first, very simply stated, is that there is a need for more discussion of this topic in cross-disciplinary groups like the Blueprints opportunity. Such discussions raise consciousness about the issue, build consensus on approaches to address the concerns of the mentally ill in the justice system, allow for the development of coalitions and partnerships, and, importantly, help us realize that behavioral health goals are not at odds with justice system goals – we all want to do the right thing in the most effective manner.

The second matter, a much broader discussion, is that there are a number of strategies that must be discussed and, as appropriate, developed so that we may begin taking concerted action steps and not just continue to voice concerns.

Among the possible actions discussed were:

Multidisciplinary planning and policy groups, like the Blueprints Workgroup, ought to be formally established. One of the primary goals of such a work group would be to design a system that keeps adults and juveniles with mental illness out of the criminal justice system and reduces the need for the criminal justice system to become involved in providing MH treatment. One such "prevention model" would be a managed care model for keeping non-violent mentally ill persons in the community, but not over-utilizing services.

Research needs to be done on the potential for setting up a model that allows funding to follow the mentally ill consumer. It is important to decide how much funding is needed to allow jail administrators or superintendents to contract for the MH services needed.

Regional mental health service institutes could be established, similar to the Northern Virginia MH Center, that are designed as "soft facilities" to work with the nonviolent mentally ill clients that are presently being sent to jails or detention centers. These could be co-located with the regional jails, but would not be designed like jails or detention centers. The structure of this new regional system could be similar to the regional jail system, but the institutes would not be correctional facilities. There are presently around 4,000 offenders who could be better served in one of these facilities rather than in the jail system.

Residential and day treatment facilities need to be developed throughout the state to meet the treatment needs of the mentally ill in the community so that when a judge has to sentence a mentally ill person they have community alternatives to jails or detention centers.

Virginia needs to develop a special hybrid diagnostic model that keeps people out of jails or detention centers – a model which considers both the nature of the crime and the level of mental illness of the person who committed the crime. This model must have a screening process that would measure and acknowledge any strong risk of criminality. It should also provide a measure of stability but would not be a mental health assessment. There is also a need to assess the responsiveness of these individuals to treatment, to assist in placement decisions. Currently, there is no standardization of these types of measures. Because detention centers are required to screen for mental health issues, their screening differs somewhat from those of the jails. However, screening for mental health concerns alone is not enough. Criminal risk and responsiveness to treatment should also be measured.

Communities must have sound/stable funding to make appropriate treatment services available to assist mentally ill offenders with recovery and reintegration to society upon release. Prisoner reentry policies and procedures need to be strengthened and expanded to include offenders in jails and detention centers. Residential services with treatment support and follow-up are not readily available. Community level treatment service systems cannot now meet the needs of the mentally ill returning from jails and detention centers. And, the concept of recovery in the mental health field needs to be supported and developed in Virginia.

Cross training should be enhanced and structured to meet gaps in service knowledge in many areas related to the treatment of the mentally ill in the criminal justice system.

The continuing discussion made it clear that the Commonwealth's approach to handling so many of the mentally ill (adults and juveniles) through the justice system is not just a problem for the jails and juvenile detention centers. Chief Justice Hassell and Dr. Bonnie of UVA have established a commission to study the constitutional rights to treatment in this environment and the impact of these populations on the judicial system. Judges, especially Juvenile Court judges, understand that they are sometimes sentencing people to jail or detention to ensure they have some access to treatment, not because the punishment "fits the crime" and the offender. Prosecutors realize that dockets could be reduced and more time and resources could be focused on "bad" people if alternatives were available for the diversion of "sick" people. Law enforcement clearly understands, as evidenced by increasing interest in and efforts to establish crisis intervention skills

and programs, that the mentally ill individual must be addressed to limit the potential for harm to himself or others and that mental illness is distinctly different from criminality.

More research must be done to document the level and nature of the impact of the mentally ill on the justice system. More policy discussions, across disciplines, should be conducted to "raise consciousness" about these issues and to build common ground and common goals. It was also suggested that this group meet again to further consider the many issues that were surfaced and, given time constraints, only superficially addressed.

The group discussed the next steps that are needed. While time did not allow a highly structured process to identify and prioritize the most important concerns and the most appropriate action steps, a number of conclusions and recommendations could be readily extracted from the discussion.

Conclusions and Recommendations

1. This Mental Health (MH) Work Group (or a group or groups like it) should address treatment issues both in jails and detention centers on an ongoing basis. Create an infrastructure for this MH Work Group to examine and identify any additional people who should be on the work group. Then, identify the MH/SA services needed for these facilities, how they are currently funded, and how they could be funded in the future.
2. Establish this work group with representatives from across secretariats. Participants could be identified by initial work group (8/28/06). The MH Work Group needs to be expanded with representatives from the judiciary, Commonwealth Attorneys, Chiefs of Police, and Sheriffs to increase opportunities for discussion, planning, and collaboration.
3. It is important to recognize the similarity of concerns and overlap with "re-entry." Reentry services are especially needed for this population, not just mental health intervention.
4. It is essential that the criminal justice system establish improved, universal screening to better and more expeditiously identify the mentally ill population. Screening, by trained and competent screeners, should occur when an individual first enters a jail or detention center. While there is an effective screening instrument in place for juveniles, an appropriate instrument needs to be identified for adult offenders. While this could add significantly to their workload, pretrial programs are well placed to conduct simple screenings and to suggest further assessment when so indicated. It would be necessary to support the expansion of pretrial programs so that pretrial services are available to all courts/all local adult detention facilities. It would be of value to connect the local pretrial programs to jails, electronically, so pretrial screenings and information can be accessed by jails.
5. More intervention must be supported in jails and detention centers at the community level.
6. It would be of value to experiment with "softer" facility that is a hybrid of criminal justice detention and mental health intervention.
7. There is a significant need for cross training similar to the Gains model of training.
8. There is a clear need for regional, community-based, mental health facilities.
9. The Jail Services Team Model has shown clear merit and value. Additional teams should be established to provide regional services.
10. DMRMHSAS could develop a proposal to assemble a training group for model program dissemination.

11. It will remain important to "track the money" to see how much goes into mental health services.
12. Policy choices, not growth in crime rates, have driven the growth of adult and juvenile correctional populations. Similarly, policy choices will drive the size and nature of any additional behavioral health programming. We must pay attention to resources when seeking to put policy recommendations in place. And, we must develop policies that neither over-state the size of the mentally ill population in our jails and detention centers, nor under-serve them.
13. Organizational change consultants who have the expertise to examine the existing jail and detention center systems could be of great help in the design and implementation of any new initiatives for the mentally ill and those with co-occurring disorders.
14. There should be a system in place to identify which of the inmates being admitted to jail or detention are clients of the local CSBs. The Chesterfield CSB, for example, checks daily to see which of their clients have been admitted to jail.
15. Consideration should be given to advancing legislation to enable jail administrators or superintendents to send inmates in need of services to MH beds without requiring jail officer supervision. (This may be needed for detention centers also.)
16. We must continue to provide cross-training opportunities for mental health, jail, detention, and court services/probation staff.
17. We must all understand that a more effective system would invest substantially in prevention – to keep those with behavioral health issues out of jails and detention centers in the first place.

The Department of Criminal Justice Services can:

- support the continuing examination of concerns with facility-based services to the mentally ill.
- support the growth of reentry services with special attention paid to the needs of those with behavioral health problems.
- work with local pretrial programs to identify and utilize a simple screening instrument to identify and refer for services those with mental illness and co-occurring disorders.
- track and pursue federal funds to support new initiatives on behalf of this population.
- continue to provide funds for programs that address substance abuse (and co-occurring disorders).
- continue to support cross-training initiatives.

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