Minimum Standards for Behaivoral Health Services in Local Correctional Facilities (HB 1942)

November 1, 2019

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EXECUTIVE SUMMARY

The over-representation of individuals with behavioral health challenged in the criminal justice system is not a new problem or a problem isolated to the Commonwealth of Virginia. Rather, for many years most states have reported having more individuals with behavioral health challenges incarcerated than are reported in national community prevalence rate studies. While nationally there continues to be strong encouragement for the development of criminal justice diversion programs for individuals with serious mental illness who can be more effectively treated in the community, it is recognized that even when the Commonwealth does have robust diversion programs it remains likely that individuals with behavioral health challenges will end up in local/regional jails, as not all cases can/should be diverted. To that end, it is imperative that minimum standards for behavioral health care provided inside the jail be established (bolstered).

During the 2019 General Assembly Session, Delegate Robert Bell sponsored House Bill 1942, which was approved by both chambers and was signed into law on April 3, 2019. HB 1942 amended Virginia Code §53.1-68 (Minimum Standards for local correctional facilities and lock-ups; health inspections, behavioral health services inspections, and personnel). Specifically HB 1942 requires the Board of Corrections to establish minimum standards for behavioral health services in local correctional facilities and procedures for enforcing such minimum standards, with the advice of and guidance from the Commissioner of Behavioral Health and Developmental Services and the State Inspector General. HB 1942 lays out some minimum components, which the standards must address to include at least one unannounced annual inspection of each local correctional facility. Finally, HB 1942 requires that the Chairman of the Board of Corrections to convene a work group to include representatives of sheriffs, superintendents of regional correctional facilities, community services boards, the Department of Behavioral Health and Developmental Services, the Department of Medical Assistance Services, the Virginia Association of Counties, the Virginia Municipal League, and such other stakeholders as the Director shall deem appropriate to determine the cost of implementing the provisions of this act. The work group shall report its findings and conclusions to the Governor and the Chairmen of the House Committee on Appropriations, the House Committee for Courts of Justice, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance, the Senate Committee for Courts of Justice, the Senate Committee on Education and Health, and the Senate Committee on Rehabilitation and Social Services by November 1, 2019. This is the purpose of this report.

The following are the recommendations from the advisory panel to the BOC on the minimum standards for behavioral healthcare in jails:

1. Access to care - Inmates have access to care to meet their mental health needs.

2. Policies & Procedures - The facility has a manual or compilation of policies and defined procedures regarding mental health care services which may be part of larger health care manual.
3. Communication of Inmates' Needs - Communication occurs between the facility administration and treating mental health care professionals regarding inmates' significant mental health needs
4. Mental Health Training for Correctional Officers - A training program established or approved by the responsible health authority in cooperation with the facility administration guides the mental health related training of all correctional officers who work with inmates.
5. Medication Services - Medication services are clinically appropriate and provided in a timely, safe and sufficient manner.
6. Mental Health Screening - Mental health screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met.
7. Mental Health Assessment - All inmates receive mental health screening; inmates with positive screens receive a mental health assessment.
8. Emergency Services - The facility provides 24 hour emergency mental health services.
9. Restrictive Housing - When an inmate is held in restrictive housing, staff monitor his or her mental health.
10. Continuity & Coordination of Health Care During Incarceration - All aspects of health care are coordinated and monitored from admission to discharge.
11. Discharge Planning - Discharge planning is provided for inmates with mental health needs whose release is imminent.
12. Primary Mental Health Services - Mental health services are available for all inmates who suffer from serious mental illness.
13. Suicide Prevention Program - The facility identifies suicidal inmates and intervenes appropriately.
14. Identification & Treatment of Substance Use Disorders – Inmates are screened for substance use disorders & provides treatment based on the individual's needs, amenability to treatment, and availability of resources.
15. Management of Intoxication, Withdrawal, and Overdose – Protocols exist for managing and responding to inmates under the influence, experiencing withdrawal, or showing signs of overdose.

In compliance with the language of HB 1942, the advisory group constructed a self-assessment survey to be filled out by all jails (See Appendix B). The survey inquired about the jails ability to meet the proposed standards and in cases where the jail did not feel they could meet the standard (with current resources) what additional resources or assistance would be needed in order to be able to meet the standards. The overall estimated resource needs of the jails statewide is $42,609,967. In addition the Board of Corrections will need to hire three FTEs in order to conduct the annual inspections of behavioral healthcare services as is now required. The total cost for these three FTEs is estimated to be $273,000.

OVERVIEW OF THE PROBLEM

While the National Institute of Mental Health (NIMH) estimates that approximately 4.2% of adults in the United States suffer from serious mental illness (generally defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities), comparable figures in state prisons and jails are 16 percent and 17 percent, respectively[i]. In Virginia, per the annual Mental Illness in Jails survey conducted by the State Compensation Board, approximately 20 percent of jail inmates have a mental illness, and roughly, 10.42 percent have a serious mental illness[ii]. This data suggests the prevalence rate for serious mental illness in Virginia jails is at least double that of what is found in the community. It should be noted that the reported rate of serious mental illness in Virginia jails is significantly lower than that reported in other states in national research projects. It is unclear whether this is a reflection of the reality in Virginia jails or whether there are other factors effecting the accuracy of reporting. Regardless, the percentage of individuals with SMI in Virginia jails is double that in the community, despite the fact there are no known strong correlations between the existence of serious mental illness and criminal behavior.

Over the past 10 years, Virginia has made considerable strides to better understand how individuals with mental illness flow through local criminal justice systems, where gaps in service exist, and where specific systems and processes could be improved to ensure better coordination and continuity of care. One particular area of concern that has been consistently cited is the need for standards of care provided to individuals with behavioral health disorders who are incarcerated in local and regional jails, which is the focus of this report.

PREVALENCE RATES OF MENTAL ILLNESS IN VIRGINIA JAILS

The Virginia State Compensation Board (SCB) conducts an annual, point in time, survey of all local & regional jails to estimate the number of persons with behavioral health challenges who are incarcerated. The survey is mandated by budget language and DBHDS collaborates with the SCB in the development and refinement of the survey. SCB has conducted the surveys since 2008 thus Virginia has a decade worth of data about the prevalence rates of behavioral health challenges in jails. The survey gathers data on the number of individuals suspected of having any mental illness and those suspected of having a serious mental illness. For the purposes of the survey mental illness is defined as “an individual who has been diagnosed with schizophrenia or a delusional disorder, bi-polar or major depressive, mild depression, an anxiety disorder, posttraumatic stress disorder (PTSD), or any other mental illness as set out by the Diagnostic & Statistical Manual of Mental Disorders (DSM-V), published by the American Psychiatric Association, or those inmates who are suspected of being mentally ill but have received no formal diagnosis.”. For the purposes of the survey, serious mental illness is defined as “A serious mental illness includes diagnoses of schizophrenia/delusional, bi-polar/major depressive or post-traumatic stress disorder”. The survey has undergone multiple revisions to better understand the population and how local and regional jails respond to their needs. Despite the many projects and initiatives that have occurred over the last decade to reduce the rates of incarceration for individuals with behavioral health disorders, the number of individuals reported as having a mental illness continues to grow. Whether this is a result of increased awareness,

more accurate data collection, or an increase in the rates of individuals with behavioral health disorders being sent to jail is unknown. What we do know per the SCB survey is that the numbers are high and continue to rise.

In 2018, nearly 20 percent of inmates incarcerated in Virginia's jails were known or suspected to have any form of mental illness and 10.42 percent were known or suspected of suffering from serious mental illness. Despite a variety of efforts to address the growing number of inmates with behavioral health disorders across Virginia, local and regional jails continue to struggle to provide for the behavioral healthcare needs of individuals placed into their care. Table 1 below highlights the growth (both in terms of overall number of individuals as well as percentage of the jail population) in both the numbers of individuals suspected of having any form of behavioral health challenges and those suspected of having a serious mental illness. It is unclear how much of this "growth" can be attributed to actual increase in the number of individuals with mental illnesses in Virginia jails vs. improved identification of those individuals with mental health challenges. Regardless, the chart bellows shows that a relatively large portion of individuals in jail are suspected of having some form of mental illness.

Table 1: Number of Inmates with Mental Illness by Year

Year	# of Individuals suspected of having any mental illness	% of total jail population suspected of having any mental illness	# of Individuals suspected of having a serious mental illness	% of total jail population suspected of having a serious mental illness
2018	7,852	19.84%	4,124	10.42%
2017	7,451	17.63%	4,036	9.55%
2016	6,554	16.43%	3,355	8.41%
2015	7,054	16.81%	3,302	7.87%
2014	6,787	13.95%	3,649	7.50%
2013	6,346	13.45%	3,553	7.53%
2012	6,322	11.07%	3,043	5.33%

Virginia's jails are ill prepared to respond to the unique needs of individuals with behavioral health disorders. Although some jails have specialized programs and staff, most jails do not due to a lack of funding and resources. A 2014 Review of Mental Health Services in Local and Regional Jails conducted by the Office of the State Inspector General (OSIG) highlighted many of the challenges to include lack of available treatment capacity to address the needs, lack of continuity of care between the community and jail, lack of consistent screening processes, and environmental issues which at times are inconsistent with the treatment needs of individuals in the jails' custody (See Appendix B). The OSIG made many recommendations to address the challenges (some of which have been done) and notably included the establishment/adoption of standards for behavioral health services provided in the jail.

Per the 2018 Mental Illness in Jails report, 1 out of 4 inmates with mental illness is incarcerated on a misdemeanor or ordinance offense. While mental illness itself is not a factor in determining whether to grant an individual bail/bond, unfortunately some of the sequela associated with

serious mental illness (i.e. unemployment, lack of stable housing, lack of community ties) do make individuals with SMI less likely to be granted bond/bail. Despite efforts to create criminal justice diversion programs for these seemingly lower risk offenders, the percentage on inmates with mental illness being held on less serious offenses has remained unchanged.

According to the State Compensation Board's 2018 Mental Illness in Jails report, the total annual cost of mental health treatment across Virginia's Jails was estimated at approximately $21.6 million. This amount is $7 million more than was spent in 2017. The 2018 reports states that 65.52% of the total costs for behavioral health services were funded by the locality, 5.46% funded by the state, 2.29% funded by the federal government, 12.58% by other funding sources, and the breakdown of fund source for the remaining 14.5% of total costs is unknown. Since the majority of funding (65 percent) comes from the locality, regional jails and local jails that serve wealthier localities tend to have more resources than smaller jails serving rural areas. The quality, type, and frequency of mental health treatments and services vary across Virginia's jails. Some jails may have a full time psychiatrist or general practice physician (MD), while others may contract with outside professionals to have services on certain times/days of the week or month. Community Service Boards (CSBs) are the primary behavioral health care providers for Virginia jails, but they are not statutorily obligated to provide behavioral health services beyond pre-screening inmates who may be in need of a temporary detention order (§19.2-169.6).

A REVIEW OF THE ORGANIZATION AND OVERSITE OF JAILS

Unlike other States where a singular entity or authority has control over the operations of its local and regional jails, there is no singular entity with ultimate administrative authority in Virginia. Instead, several state agencies share oversight responsibilities. In 2010, the Research Division of the Department of Criminal Justice Services (DCJS) published a report titled, '*Virginia's Peculiar System of Local and Regional Jails*', which provides an excellent overview of our Commonwealth's local and regional jail oversite system. While the quote to the right is outdated and does not fully reflect the current status of jails, some of the peculiarities still exist and exemplify the challenges. Below are a few excerpts from the DCJS Report[iii]:

- The Board of Corrections (BOC) sets the "standards for the construction, equipment, administration and operation" of jails. The BOC can decertify a jail if the sheriff or jail administrator does not comply with life, health, and safety standards set forth by the BOC within the time allotted, and the Board can begin the process of closing the facility in conjunction with an appropriate circuit court. (p.4)

"The Virginia system is the most peculiar one in the nation. The grounds and buildings are owned by the counties and cities, the jails are operated by the sheriffs and city sergeants, authority is divided between these officials and the county supervisors or town councils and the circuit or corporation courts, and the state pays the cost of keeping the prisoners.
…The State, although paying the bills, has no actual authority over the jails other than the power of inspection and recommendation by the Department of Public Welfare, truly an anomalous situation". - Virginia Legislative Jail Commission, 1937

- The Department of Corrections (DOC) monitors the jails' compliance with BOC standards through monitoring visits, annual inspections, and accreditation and certification audits. Jails must be meet BOC standards to be certified by DOC. (p.4)

- The State Compensation Board (SCB) provides the state portion of operating costs for jails, including salaries and benefits of correctional officers and support staff, costs for certain programs and services, and office expenses. Additionally, the Compensation Board dispenses inmate per diem payments. As part of fulfilling this role, the CB maintains the LIDS database, which tracks persons entering and exiting jails, for the purpose of determining appropriate per diem levels. (p.4)

- The Department of Criminal Justice Services (DCJS) establishes "compulsory minimum entry-level, in-service, and advanced training standards for persons employed as deputy sheriffs and jail officers by local criminal justice agencies." (p.4)

- The Department of Health inspects jails to ensure that the kitchen facilities comply with the state's Food Regulations, and that all areas of the facility comply with BOC standards of facility cleanliness. (p.4)

Although it is not mandatory in Virginia, a number of jails have gone beyond what is minimally required and have become accredited facilities (a recommendation of the 2014 OSIG report). Two national organizations, the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) are the two primary correctional accrediting organizations. Accreditation is achieved by adhering to standards set by the accrediting agency and compliance verification through site visits, interviews, charts and administrative record reviews, and observing how jail medical facilities operate[iv].

THE CURRENT STATUS OF BEHAVIORAL HEALTH CARE STANDARDS IN VIRGINIA JAILS

As stated earlier, minimum standards for mental health care do not currently exist for Virginia's local and regional jails. Unless a jail opts to seek accreditation through a national accrediting agency and agree to adhere to that agency's standards, then most jails simply need to meet the life, health, and safety standards established by the Virginia Board of Corrections. The Virginia Board of Corrections has oversite of 43 life, health, and safety standards and of those standards, only 11 relate either directly or indirectly to incarcerated individuals with behavioral health needs. Below are the 11 standards that relate in some way to incarcerated individuals with behavioral health disorders.

LIFE, HEALTH, SAFETY STANDARD
6VAC15-40-320. Licensed Physician – A licensed physician shall supervise the facility's medical and health care services. Facilities that contract with private medical facilities or vendors shall maintain a current copy of the agreement, unless employed by the facility.

LIFE, HEALTH, SAFETY STANDARD
6VAC15-40-340. **Health Care Provider and Licensing, Certification and Qualification of Health Care Personnel –** Each facility shall have a minimum of one licensed or qualified health care provider who is accessible to inmates a minimum of one time per week. Health care personnel shall meet appropriate and current licensing, certification, or qualification requirements.
6VAC15-40-360. **Twenty-Four Hour Emergency Medical Care -** Written policy, procedure, and practice shall provide 24-hour emergency care medical and mental health care availability.
6VAC15-40-370. **Receiving and Medical Screening of Inmates -** Written policy, procedure, and practice shall provide that receiving and medical screening be performed on all inmates upon admission at the facility. The medical screening shall: 1. Specify screening for current illnesses, health problems and conditions, and past history of communicable diseases; 2. Specify screening for current symptoms regarding the inmate's mental health, dental problems, allergies, present medications, special dietary requirements, and symptoms of venereal disease; 3. Include inquiry into past and present drug and alcohol abuse, mental health status, depression, suicidal tendencies, and skin condition; and 4. For female inmates, include inquiry into possible pregnancy or gynecological problems. 5. All inmates shall receive a tuberculosis (TB) skin test within seven days of admission to the facility.
6VAC15-40-380. **Inmate Access to Medical Services -** Written policy, procedure, and practice shall be developed whereby inmates can be informed, at the time of admission to the facility, of the procedures for gaining access to medical services.
6VAC15-40-400. **Management of Pharmaceuticals -** Written procedures for the management of pharmaceuticals shall be established and approved by the medical authority or pharmacist, if applicable. Written policy, procedure, and practice shall provide for the proper management of pharmaceuticals, including receipt, storage, dispensing and distribution of drugs. These procedures shall be reviewed every12 months by the medical authority or pharmacist. Such reviews shall be documented.
6VAC15-40-420. **Transfer of Summaries of Medical Record** – Medical record summaries shall be transferred to the same facility to which the inmate is being transferred. Required information shall include: vital signs, current medications, current medical/dental problems, mental health screening, mental health problems, TB skin test date and results, special inmate needs/accommodations, pending medical appointments, medical dispositions, overall comments, health care provider/personnel signature and date, and any additional pertinent medical information such as lab work, x-rays, etc.

LIFE, HEALTH, SAFETY STANDARD
6VAC15-40-450. **Suicide Prevention and Intervention Plan –** There shall be a written suicide prevention and intervention plan. These procedures shall be reviewed and documented by an appropriate medical or mental health authority prior to implementation and every three years thereafter. These procedures shall be reviewed every 12 months by staff having contact with inmates. Such reviews shall be documented.
6VAC15-40-1010. **Mental Health Inmates -** Written policy, procedure, and practice shall specify the handling of mental health inmates, including a current agreement to utilize mental health services from either a private contractor or the community services board.
6VAC15-40-1030. **Assessment of Inmates in Disciplinary Detention or Administrative Segregation** –Written policy, procedure, and practice shall require that a documented assessment by medical personnel that shall include a personal interview and medical evaluation of vital signs, is conducted when an inmate remains in disciplinary detention or administrative segregation for 15 days and every 15 days thereafter. If an inmate refuses to be evaluated, such refusal shall be documented.
6VAC15-40-1040. **Staff Training** – The facility shall provide for 24-hour supervision of all inmates by trained personnel.

While the standards do provide some general guidance on how healthcare (to include behavioral healthcare) should be provided, the standards provide very little guidance about the scope of services, robustness of services, and timelines for providing services. As is plainly evident, the existing standards mostly address the existence of policies about services but do not provide any details about compliance indicators. While jails are subject to routine reviews by the BOC/DOC those reviews tend to focus mainly on the safety standards and do not routinely delve into the behavioral health/health standards (partly due to the fact that the DOC accreditation division is staffed with staff who while competent in reviewing jails safety/operational practices often lack the expertise to fully assess the quality of behavioral health services being provided in the jail. HB 1942 addresses these issues by now requiring annual reviews specifically of behavioral health services.

THE DEVELOPMENT OF RECOMMENDED MINIMUM STANDARDS

After passage of HB 1942, the Board of Corrections convened a planning meeting with the Department of Behavioral Health & Developmental Services, and the Office of the State Inspector General. The planning group agreed upon a format for developing the standards, which included input from local and state leaders familiar with behavioral health issues in jails. Participants of the advisory panel represented behavioral health agencies; local jails, regional jails, advocacy groups, DBHDS, OSIG, VADOC, and the BOC (see Appendix A for list of participants). Monthly meetings were scheduled through the Spring/Summer. This advisory group used existing, published best practice standards from the NCCHC and the ACA to guide its work. In the end, the advisory group identified 15 standards for behavioral healthcare, which should be available in all jails within the Commonwealth. The advisory group identified compliance indictors to aid inspectors in identifying whether a particular jail was meeting the intended standard.

Below is a summary of each recommended standard:

Standard #1: ACCESS TO CARE

Inmates shall have access to a minimum level of care to meet their mental health needs/conditions identified through screening/assessment.

Compliance Indicators:

1. The jail administration and the responsible health authority (RHA) identifies and addresses any barriers to inmates receiving health care.

2. The jail/responsible health authority has a sufficient supply of clinical staff to meet the needs of the inmate population either through the provision of on-site services or via contracts with providers.

3. The jail/responsible health authority completes quarterly Continuous Quality Improvement reports addressing the healthcare being provided in the jail.

Standard #2: POLICIES AND PROCEDURES

The facility has a manual or compilation of policies and defined procedures regarding behavioral healthcare services. Specific behavioral health policies may either be free-standing or may be part of larger health care manual.

Compliance Indicators:

1. Behavioral healthcare policies are site specific.

2. Each policy and procedure in the behavioral healthcare manual is reviewed at least annually and revised as necessary under the direction of the responsible health authority (RHA) in conjunction with jail administration. The manual bears the date of the most recent review or revision and, at a minimum, the signatures of the facilities RHA, responsible health care provider, and jail administrator.

3. The manual or compilation is accessible to behavioral healthcare staff as well as correctional staff.

4. All aspects of the standard are addressed by written policy and defined procedures.

Standard #3: COMMUNICATION OF INMATES' NEEDS

Communication occurs between the facility administration and behavioral healthcare professionals regarding inmates' significant behavioral healthcare needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or safety of the institution/staff. Communication is bi-directional and occurs on a regular basis either through planned meetings or impromptu meetings as the need arises.

Compliance Indicators:

1. Correctional staff are advised of inmates' behavioral healthcare needs that may affect housing, work and program assignments, disciplinary measures, and admissions to and transfers from institutions. Such communication is documented.

2. Behavioral healthcare providers and custody staff regularly communicate about the behavioral health needs of inmates.

3. Correctional staff know how to contact behavioral health staff to include communicating with behavioral health staff after-hours.

4. Behavioral health staff demonstrate an understanding of the jail's supervisory hierarchy and know who to call for which types of situations.

5. All aspects of the standard are addressed by written policy and defined procedures.

Standard #4: MENTAL HEALTH TRAINING FOR CORRECTIONAL OFFICERS

A training program established or approved by the responsible health authority in cooperation with the facility administration guides the mental health related training of all correctional officers who work with inmates.

Compliance Indicators.

1. Correctional officers who work with inmates receive mental health related training during their initial academy training and then at least annually thereafter. This training includes, at a minimum:
    a. Recognizing the need for emergency care and intervention during a mental health crisis
    b. Recognizing acute manifestation of intoxication and withdrawal, and adverse reaction to medications
    c. Recognizing signs and symptoms of mental illness
    d. Procedures for suicide prevention
    e. Procedures for appropriate referral of inmates with mental health concerns to staff

2. An outline of the training including course content and length is kept on file.

3. A certification or other evidence of attendance is kept on site for each employee.

4. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their mental health related trainings.

5. More specialized/advanced training is available to those staff who work more closely with inmates with mental health challenges, those who work on specialized mental health units, those who work in medical/health services, and those who because of the nature of their duties are more likely to interact with individuals with mental health challenges.

6. All aspects of the standard are addressed by written policy and defined procedures.

Standard #5. MEDICATION SERVICES

Medication needs are reviewed as part of the intake/screening process. The jail has policies and procedures to guide the timeliness of responding to the medication needs of inmates. In general, for known existing conditions, which without the proper medications, could pose significant risk to health, medications are provided within one day of booking into the jail. For more routine, non-life threatening known conditions for which the inmate was receiving treatment in the community, the jail has policies/procedures to ensure a review is conducted by a healthcare provider within a reasonable time-frame. For conditions newly diagnosed within the jail, the jail has policies and procedures in place to ensure medications are timely acquired based on the doctor's order. Medication services policies in the jail should be consistent with generally accepted medical practices.

Compliance Indicators:

1. Prescription medications are administered or delivered to the patient only on the order of a physician, nurse practitioner, physician's assistant or other legally authorized individual.

2. Medications are delivered in a timely fashion. The facility has a policy identifying the expected time frames from ordering to delivery and a backup plan if the time frames cannot be met.

3. The responsible physician determines prescribing practices in the facility (taking into consider security implications).

4. Medications are prescribed only when clinically indicated.

5. Inmates entering the facility on prescription medication continue to receive the medication in a timely fashion and as prescribed, or acceptable alternative medications are provided as clinically indicated. This process should happen quickly so as to avoid missed medications (which could result in psychiatric decompensation).

6. Policies describe the types of medical conditions which require a more immediate response and those for which a somewhat delayed review by a healthcare professional is appropriate.

7. Policies describe the procedures staff should follow in order to access physician orders and prescriptions both during daytime work hours, weekends, holidays, and afterhours.

8. The ordering clinician is notified of the impending expiration of an order so that the clinician can determine whether the drug administration is to be continued or altered.

9. All aspects of the standard are addressed by written policy and defined procedures.

Standard #6. MENTAL HEALTH SCREENING

Mental health screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met. For those inmates who are unable to be screened upon admission (due to issues to include acute intoxication, non-compliance, etc.) the jail has policies in place to screen such individuals when their condition has changed to the degree they can be successfully screened. The jail has policies in place to manage those inmates who are repeatedly re-admitted to the same jail on the same charges (i.e. weekenders) and policies that address screening for inmates who are transfers from other institutions rather than new admissions.

Compliance Indicators:

1. Intake personnel ensure mental health screening occurs and those that screen positive are referred for further assessment.

2. A mental health screening takes place for all newly admitted inmates as soon as practical.

3. A new screening is not required on weekenders or inmates transferred from one facility to another as long as the results of the initial screening are shared with the receiving facility and there have been no overt changes in the individual's mental status.

4. The mental health screening tool shall be one designated by the Commissioner of DBHDS.

5. The disposition of the inmate (e.g., immediate referral to services, placement in the general population) is appropriate to the findings of the mental health screening and is indicated on the screening form.

6. Mental health screening forms are dated and timed immediately on completion and include the signature and title of the person completing the form.

7. Screening includes identification of prescribed medications.

8. Correctional personnel performing the mental health screen shall be trained in the use of the screening tool and appropriate referral processes.

9. Mental health staff/ mental health provider/designee regularly monitors screenings to determine the effectiveness of this process.

10. All aspects of the standard are addressed by written policy and defined procedures.

Standard #7. MENTAL HEALTH ASSESSMENT

All inmates receive mental health screening; inmates with positive screens receive a mental health assessment.

Compliance Indicators:

1. Within 14 days of a positive result on a mental health screening, a qualified mental health professional, nurse, or licensed mental health professional conducts a preliminary review which includes a face to face meeting with the individual to review their answers on the screening tool (to ensure accuracy), gathers historical information, and reviews current symptoms to determine if a comprehensive assessment is needed.

2. For those individuals who are in acute mental health distress there should be an immediate consultation between correctional staff and the jail provider as to whether immediate intervention is needed. The preliminary review and full assessment should be completed more quickly (within 48 hours).

3. For those individuals who appear suicidal jails should intervene immediately and they should be assessed as soon as practicable.

4. Inmates who appear to have or are suspected of having a serious mental illness based on the results of the preliminary review, have a comprehensive assessment within seven days of the preliminary review.

5. Inmates who have remote histories of mental health treatment but who are currently asymptomatic, are not at increased risk for re-emergence of symptoms and do not

present with any current mental health needs shall receive a full assessment based on the recommendation of the staff member conducting the preliminary review.

6. The comprehensive mental health assessment includes a structured interview with inquiries into:
    a. A history of:
        I. Psychiatric hospitalization and outpatient treatment
        II. Substance use treatment
        III. Detoxification and outpatient treatment
        IV. Suicidal behavior
        V. Self-Injurious behavior
        VI. Violent behavior
        VII. Victimization / traumatic experiences
        VIII. Special education placement
        IX. Cerebral trauma or seizures
        X. Sex offenses
        XI. Gender Dysphoria or Gender Identity issues
    b. The current status of:
        I. Psychotropic medications
        II. Suicidal ideation
        III. Drug or alcohol use and substance use treatment
        IV. Orientation to person, place and time
    c. Emotional response to incarceration.
    d. A history of issues with cognitive impairments, learning disabilities, deficits in adaptive functioning.
    e. History of benefits and entitlements.

7. The health record contains results of the preliminary review and assessment with documentation of referral or initiation of treatment when indicated.

8. Patients who require acute mental health services beyond those available on site are transferred to an appropriate facility.

9. There is a written policy and defined procedures addressing the post admission mental health screening and evaluation process.

Standard #8. EMERGENCY SERVICES

The facility provides 24 hour emergency mental health services.

Compliance Indicators:

1. A written plan includes arrangements for the following, which are carried out when necessary:
    a. Emergency transport of the patient from the facility
    b. Use of an emergency medical vehicle
    c. Use of one or more designated hospital emergency departments or other appropriate facilities
    d. Emergency on call physician or mental health services when the emergency health care facility is not nearby
    e. Security procedures for the immediate transfer of patients for emergency mental health care
    f. Notification to the person legally responsible for the facility

2. A written plan that includes the process and procedure for contacting the responsible CSB to request a pre-admission screening.

3. Procedures for monitoring individuals pending a CSB evaluation for involuntary hospitalization.

4. All aspects of the standard are addressed by written policy and defined procedures.

Standard #9. RESTRICTIVE HOUSING

When an inmate is held in restrictive housing, staff monitor his or her mental health.

Compliance Indicators:

1. Upon notification that an inmate is placed in restrictive housing, a qualified mental health care professional (RN/LPN/QMHP or other health professional that can conduct rounds) reviews the inmates mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation.

    It should be noted that at times placement in restrictive housing may be detrimental to an individual's mental health, however the overall security needs and safety of the individual, other individuals, and staff may necessitate the continued placement in a restrictive housing setting. In such cases, mental health staff shall try to identify strategies to minimize the possible deleterious effects of restrictive housing. Such

review is documented in the health record. The facility strives to house inmates in the least restrictive environment possible (without compromising safety).

2. A mental health professional conducts routine, face to face, rounds on all individuals housed in restrictive housing. The frequency of required rounds is dependent on the level of isolation as well as the individual's pre-existing mental health needs.

    a. Inmates who are in restrictive housing and have limited contact with staff or other inmates are reviewed every day by medical or mental health staff.

    b. Inmates who are allowed periods of recreation or other routine social contact among themselves while being held in restrictive housing are checked weekly by medical or mental health staff.

    c. The frequency of reviews can be adjusted depending on clinical judgment of the mental health professional depending on the person's clinical presentation as long as the rationale for altering the frequency of rounds is justified and documented in the clinical record.

    d. Rounds conducted by mental health professional do not substitute for required checks by correctional officers.

3. Documentation of restrictive housing rounds is made on individual logs or cell cards, or in an inmates health record and includes:

    a. The date and time of the contact.

    b. The signature or initials of the health staff member making the rounds.

4. Any significant mental health findings are documented in the inmates' health record.

5. Medical and mental health staff promptly identify and inform custody officials of inmates who are physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health. The individual's treatment plan is adjusted to address the change in mental status and outline strategies/interventions to aid the individual.

6. All aspects of the standard are addressed by written policy and defined procedures.

Standard #10. CONTINUITY AND COORDINATION OF MENTAL HEALTH CARE DURING INCARCERATION

All aspects of mental health care are coordinated and monitored from admission to discharge.

Compliance Indicators:

1. Clinician orders are evidence based/evidence informed, are consistent with current standards of care, and are implemented in a timely manner.

2. Deviations from standards of practice are clinically justified, documented and shared with the patient.

3. Diagnostic tests, if indicated, and completed and reviewed by the clinician in a timely manner.

4. Treatment plans may be modified as clinically indicated by diagnostic tests and treatment results.

5. Treatment plans, including test results, are shared and discussed with patients.

6. Patients are reviewed by a qualified provider upon return from a hospitalization, urgent care, or emergency department visit to ensure proper implementation of the discharge orders and to arrange appropriate follow up.

7. Recommendations from specialty consultations are reviewed and acted upon by the clinician in a timely manner.

8. If changes in treatment recommendations are clinically indicated, justification for the alternative treatment plan is documented and shared with the patient.

9. Chart reviews are done to ensure that appropriate care is ordered and implemented and that care is coordinated by all health staff including medical, dental, mental health and nursing.

10. The responsible provider determines the frequency and content of periodic health assessments based on protocols promulgated by nationally recognized professional organizations.

11. All aspects of the standard are addressed by written policy and defined procedures.

Standard #11. DISCHARGE PLANNING

Discharge planning is provided for inmates with mental health needs. The frequency and intensity of discharge planning services is dependent on the individual's level of need, the availability of services, having sufficient time to plan, and the individual's willingness to cooperate in the discharge planning process.

Compliance Indicators:

1. For all inmates known or suspected of having any form of mental health disorder, there is access to a list of community mental health resources for which the inmate might be eligible and which might help address their needs. At a minimum this list should include information about the local CSB(s) and procedures for accessing services via same day access. Information about other mental health service providers is provided as available. Information about local support groups/ self-help groups is also provided. Contact information for local offices of Department of Social Services, housing programs, etc. is provided as available.

2. For inmates known or suspected of having a serious mental illness (i.e. psychotic disorders, major affective disorders, and post-traumatic stress disorder) the jail should at a minimum:

    a. Arrange for an intake appointment with the willing provider on the day of release (for individuals who opt for CSB services) and as soon as possible for those opting for private providers.

    b. Arrange for a minimum of a two week supply of current psychotropic medications or scripts for a minimum of two weeks.

    c. Request signed releases of information so that treatment information can be sent to the next behavioral health provider.

    d. For those who are already connected to a provider in the community, facilitate the reconnection to services.

3. For jails that work with CSB's who receive state general funds to support discharge planning, services should include:

    a. Screening and assessment of psychiatric, medical, social services, employment, and residential needs, as well as risk factors, will occur as soon as possible after an individual's admission to jail.

    b. A discharge plan is developed that will address the individual's needs, and include services and interventions that the individual will receive not only in the community upon release from jail, but also those that will begin in the jail

prior to release (such as referrals to psychiatric services, medical services, and treatment programming).

c. Components of the plan include:

- Linkage to a mental health provider in the community (CSB or private provider) that provides psychiatric, therapy, and/or case management services. This includes scheduling an appointment or directing the individual to Same Day Access at the CSB for follow-up services, Linkage to emergency or transitional housing if necessary (i.e., shelter, crisis stabilization, transitional housing).

- Medicaid, GAP, SSDI/SSI application/reinstatement assistance.

- Transportation assistance from the jail to the follow up appointments/providers or discharge placement; as resources are available.

- Linkage to medical providers for treatment of any identified medical conditions.

d. A memorandum of understanding between the CSB and the Jail will outline specific roles and responsibilities in regard to the discharge plan, including the forensic discharge planner position (if available), and the level of participation and financial obligations of all entities in the process of discharge planning.

e. Policies and procedures to ensure communication between jail medical and mental health providers, jail correctional staff, and discharge planning staff occur to note relevant changes in the inmate's mental or physical health, level of risk to self or others, or discharge needs are incorporated into the detailed written discharge plan.

f. For planned discharges, the Jail, or assigned forensic discharge staff person, will:

- Arrange for a minimum of a two week supply of current psychotropic mediations and ideally script for a minimum of two weeks.

- Request signed releases of information so that treatment information can be sent to the next behavioral health provider.

- Make arrangements or referrals for necessary follow up services with community clinicians, including exchange of clinically relevant information (see 2a. mandatory components of discharge plan).

4. All aspects of the standard are addressed by written policy and defined procedures.

Standard #12. PRIMARY MENTAL HEALTH SERVICES

Mental health services are available for all inmates who suffer for serious mental illness. Additional services are provided, as available, to others with less acute, significant mental health needs.

Compliance Indicators:

1. Patients mental health needs are addressed on site or by referral to appropriate alternative providers or facilities. The needs are addressed by a range of mental health services of differing levels and focus, including residential components when indicated.

2. Regardless of facility type or size, primary on site outpatient services include, at a minimum:

    a. Screening, assessment, and referral of inmates with mental health needs.

    b. Crisis intervention services.

    c. Psychotropic medication management, when indicated.

    d. Treatment documentation and follow-up.

    e. Individual counseling or group counseling or peer recovery services or psychosocial/psychoeducational programs to meet any emerging urgent mental health needs.

3. For those inmates who require transfer to an inpatient psychiatric setting (when clinically indicated), written procedures are consistent with Virginia law and are followed and the transfer occurs in a timely manner in cooperation with the accepting facility. Until such transfer can be accomplished the patient is safely housed and adequately monitored daily.

4. Primary mental health services are offered as clinically indicated.

5. A documented attempt is made at least but not limited to every 30 days to attempt to reengage individuals with serious mental illness who while not at risk of harm to self/others have declined treatment.

6. Mental health, medical and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of any of these conditions on each other is adequately addressed.

7. All aspects of the standard are addressed by written policy and defined procedures.

Standard #13. SUICIDE PREVENTION PROGRAM

The facility identifies suicidal inmates and intervenes appropriately.

Compliance Indicators:

1. A suicide prevention program includes the following:

    a. Facility staff utilize evidence based/ evidenced informed processes to identify suicidal inmates immediately initiate precautions.

    b. Suicidal inmates are evaluated promptly by the designated health professional who directs the intervention and ensures follow up as needed.

    c. Acutely suicidal inmates are placed in a specialized cell with specialized clothing/bedding under close observation of staff. The frequency of checks and the degree of restrictions on clothing/bedding/other items is directed by the healthcare professional based on generally accepted standards of practice.

    d. Non-acutely suicidal inmates are monitored on a random schedule with no more than 15 minutes between checks. If however the non-acutely suicidal inmate is placed in an isolation cell with appropriate precautions.

    e. Assessment for need for hospitalization.

2. Key components of a suicide prevention program include the following:

    a. Training – Officers receive annual training on the proper processes for screening for suicidality.

    b. Identification – Officers are instructed on proper methods for screening for the presence/absence of suicide ideation.

    c. Referral – Officers receive annual training on the proper procedures for referring individuals to mental health staff for a comprehensive suicide assessment.

    d. Evaluation – mental health staff utilize evidence based/ evidenced informed methods to assess for suicidal ideation/intent.

    e. Treatment – The jail offers treatment through internal/external mental health providers to address the factors contributing to suicide ideation/intention.

    f. Housing and monitoring – Housing placement takes into consideration the individuals current risk of suicidal ideation/intention and previous history of suicidal gestures.

g. Communication – The jail has processes in place to ensure those with a need to know are aware of inmates who have been placed under suicide precautions to ensure continuity of care and care coordination.

h. Intervention – The jail has policies and procedures which outline the steps staff should take when responding to an inmate who may be suicidal.

i. Notification – The jail has policies and procedures in place to ensure jail administration is aware of all inmates placed on suicide watch/ suicide precautions.

j. Review – All inmates who have been placed on suicide watch/precaution are regularly evaluated by mental health staff to assess the need for ongoing precautions. At a minimum these reviews should occur daily. The review also includes an assessment of whether the inmate requires inpatient psychiatric hospitalization.

k. Debriefing (inmate) – After an individual has been removed from suicide watch a mental health staff member meets with the individual to review those factors which contributed to the individual developing suicide ideation/intention and to review strategies/interventions which might help mitigate future episodes of suicide ideation/intention.

l. Debriefing (staff) – For any staff member who has responded to a suicide attempt, the jail ensures the officer participates in a debriefing to review the incident, gather information to improve jail operations. In addition there is a review to address any secondary trauma the officer might be experiencing as a result of having responded to a traumatic event which could include EAP.

m. Suicide prevention strategies – The jail identifies policies and practices to help prevent inmates from becoming suicidal/ engaging in self injurious behavior to include jail programs, staff trained in crisis de-escalation, peer support activities, etc.

3. The use of other inmates in any way (e.g., companions, suicide prevention aids) is not a substitute for staff supervision.

4. The responsible health authority approves the facilities suicide prevention plan; training curriculum for staff, including development of intake screening for suicide potential and referral protocols, and training for staff conducing the suicide screening at intake.

5. All aspects of the standard are addressed by written policy and defined in procedures.

Standard #14. IDENTIFICATION AND TREATMENT OF SUBSTANCE USE DISORDERS

Inmates are screened for the existence of substance use disorders. For those inmates with substance use disorders, the jail evaluates for acute treatment needs (both behavioral health & medical) and provides treatment based on the individual's needs, amenability to treatment, and availability of treatment programs.

Compliance Indicators:

1. There are written guidelines for the screening, assessment, housing, and management of inmates suspected of having substance use disorders.

2. There is evidence of communication and coordination between medical, behavioral health providers regarding SUD care.

3. Medical conditions associated with SUD (e.g., HIV, liver disease) are recognized and treated.

4. The correctional staff are trained in recognizing the signs/symptoms of alcohol/drug intoxication and withdrawal and what the local procedures to respond to such circumstances.

5. There are on-site individual counseling, group therapy, peer support, or self-help groups for inmates with SUD issues.

6. Inmates with SUD issues have access, upon release, to a list of community mental health resources for which the inmate might be eligible and which might help address their needs.

7. All aspects of the standard are addressed by written policy and defined procedures that define the respective roles of the mental health, substance abuse, and medical staff regarding provision of SUD services.

Standard #15. MANAGEMENT OF INTOXICATION & WITHDRAWAL AND OVERDOSE

Protocols exist for managing and responding to inmates under the influence of alcohol or other drugs and those undergoing withdrawal from alcohol, sedatives or opioids. Detoxification from alcohol, opiates, hypnotics, and other stimulants is conducted under medical supervision in accordance with local, state, and federal laws. When performed at the facility, detoxification is prescribed in accordance with clinical protocols approved by the health authority.

Compliance Indicators:

1. Established protocols are followed for the assessment, monitoring, and management of individuals manifesting symptoms of alcohol and drug intoxication or withdrawal, and overdose.

2. The protocols for intoxication, detoxification, and/or overdose are approved by the responsible physician, are current, and are consistent with national accepted treatment guidelines.

3. Individuals being monitored are housed in a safe location that allows for effective monitoring.

4. Inmates experiencing severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal are transferred immediately to a medical facility upon the recommendation of the jail medical provider or jail protocol.

5. The jail has policies/practices outlining the practice of using overdose reversal medications.

6. Individuals showing signs of intoxication or withdrawal are monitored by qualified health care professionals using recognized standard assessments at appropriate intervals until symptoms have resolved.

7. Detoxification is done under physician supervision.

8. If a pregnant inmate is admitted with opioid dependence or treatment (including methadone and buprenorphine), a qualified clinician is contacted so that the opioid dependence can be assessed and appropriately treated.

9. The facility has a policy that addresses the management of inmates, including pregnant inmates, on methadone, buprenorphine, or similar substances. Inmates entering the facility on such substances have their therapy continued as appropriate, or a plan for appropriate treatment of the methadone withdrawal syndrome is initiated.

10. All aspects of the standard are addressed by written policy and defined procedures.

CROSSWALK OF PROPOSED STANDARDS TO EXISTING STANDARDS

Table 2 below shows how the new proposed standards line-up with existing Board of Corrections Life, Safety, and Health Standards. As is evident, it is recommended that several existing standards be amended to provide more clarity about behavioral healthcare services. In addition, it was recommended that several new standards be created to address recommended minimum standard levels of care.

Table 2: Crosswalk of Proposed Standards to Existing Standards

Proposed Standard	Corresponding Exiting Standard	Comments
1: Access to Care	6VAC15-40-380	
2: Policies & Procedures	6VAC15-40-40	
3: Communication of Inmates' Needs	None	Would need to be a new standard
4: Mental Health Training for Correctional Officers	6VAC 15-40-390	
5: Medication Services	6VAC 15-40-400	Current standard is related to pharmaceuticals in general. Not sure if better to amend or add new standard specific to medications for mental health inmates
6: Mental Health Screening	6VAC 15-40-370	
7: Mental Health Assessment	None	Would need to be a new standard
8: Emergency Services	6VAC 15-40-360	
9: Restrictive Housing	6VAC15-40-1030	
10: Continuity & Coordination of Services	None	Would need to be a new standard
11: Discharge Planning	None	Would need to be a new standard
12: Primary mental health services	None	Would need to be a new standard
13: Suicide Prevention	6 VAC 15-40-450	
14. Identification and Treatment of Substance Use Disorders	6 VAC15-40-370	Needs to be expanded
15. Management of Intoxication, Withdrawal and Overdose	None	Would need to be a new standard

RESOURCE NEEDS TO MEET THE RECOMMENDED BEHAVIORAL HEALTH STANDARDS:

While developing the standards that would be recommended to the Board of Corrections, the advisory group also began to strategize about how to estimate the resource needs of the system to meet the new requirements imposed by HB 1942. The time restrictions imposed by report deadline was a limiting factor in the group's ability to more accurately estimate the true costs of requiring all jails to meet the proposed standards. In general it was recognized that there would likely be two broad categories of expenses: i) the expense to the BOC to conduct the now required annual inspections of jails (and subsequent re-inspections if jails were found to not meet the standards); and ii) the costs to actually bolster the services available in the actual jails to meet

the new standards. The associated costs and the methodology to estimate each cost will be described below:

Board of Corrections Resource Needs

HB 1942 amended Virginia Code §53.1-68 by now including subsection (C) 3 which establishes a requirement that "at least one unannounced annual inspection of each local correctional facility by the Board or its agents to determine compliance with the standards for behavioral health services established pursuant to this subsection and such other announced or unannounced inspections as the Board may deem necessary to ensure compliance with the standards for behavioral health services established pursuant to this subsection". The Board of Corrections currently utilizes staff from the Compliance, Certification, and Accreditation division of the Department of Corrections to conduct the Life, Health, and Safety inspections already required of jails and would likely continue to have the DOC act as its agent with regard to newly promulgated behavioral health standards. It should be noted, however, that current standards only require re-inspections every three years (unless significant deficiencies are found) thus the new requirements established by HB 1942 require much more frequent inspections and the DOC does not have sufficient staff to conduct these more frequent inspections. Additionally, the current inspections focus more on compliance in having particular polices and on the safety of the actual physical jail structures. The Compliance, Certification, and Accreditation division currently does not employ staff with specific behavioral healthcare expertise thus; they currently do not have the expertise necessary to complete the required annual audits. The Board of Corrections in consultation with the Department of Corrections estimated that they could meet the new mandate by hiring three new full time equivalent (FTE) nurses or psychology associates. The statewide average salary for such positions is approximately $70,000 + benefits. In general, the cost of benefits is approximately 30% of the individual's salary. In total, the BOC/DOC would need additional funding of approximately ***$273,000*** to be able to perform the required inspections.

Resource Needs for Jails

Estimating the resource needs of the 58 local and regional jail was an arduous task, especially given the limited timeframe imposed by the November 1, 2019 reporting requirement (although it should be noted that language included in the state budget (**Item #395 #3c (#4))** does task the State Compensation Board and the Department of Criminal Justice Services to report back on the resource needs of meeting the standards by June 30, 2020). The advisory group agreed that having each jail complete a self-assessment as to their status in meeting the proposed standards along with a list of resource needs in order to meet the standards was the most reasonable methodology to use given the constraints. A self-assessment was developed which included the verbatim recommended standards (and compliance indicators) coupled with questions as to whether the jail felt they are/could meet the standard and if not what specific resources would be

needed in order to meet the standard. Realizing it was unlikely that we would receive a 100% response rate, the advisory group agreed that for those jails who failed to respond it would be safest to assume their needs would be similar to the average needs of similarly sized jails. Because the self-assessment was directly tied to the proposed standards, the self-assessment could not be administered until the advisory group finalized its recommendations regarding standards – thus placing further constraints on our ability to accurately estimate the cost of implementing the standards.

The self-assessment survey was sent to all 58 jails on August 12, 2019. Due to time constraints, jails were only provided 3 ½ weeks to respond to the survey. A one-time reminder was sent out to jails encouraging their response. In total, 30 responses were received. Table 3 below summarizes the jails who responded, the size of the jail, and what their estimated resource needs were reported to be. As is evident there is great variability in the reported resource needs. Some jails indicated they were confident they could meet the proposed standards without any new resources whereas others reported large resource needs. The total resource need of the 31 jails who replied to the self-assessment survey was ***$24,078,644***

Table 3: Jail Resource Needs to Meet Proposed Minimum Standards

Jail	TOTAL	Size
Albemarle-Charlottesville Regional Jail	$1,330,000	Large – 250 to 999 bed capacity
Blue Ridge Regional Jail	$1,130,000	Mega- 1000+ bed capacity
Botetourt County Jail	$339,000	Medium – 50-249 bed capacity
Bristol City Jail	$504,000	Medium – 50-249 bed capacity
Chesapeake City Jail	$0	Large – 250 to 999 bed capacity
Chesterfield County Jail	$145,000	Large – 250 to 999 bed capacity
Danville City Jail	$0	Medium – 50-249 bed capacity
Eastern Shore Regional Jail	$0	Medium – 50-249 bed capacity
Fairfax Adult Detention Center	$3,343,000	Mega- 1000+ bed capacity
Fauquier County Jail	$48,000	Medium – 50-249 bed capacity
Gloucester County Jail	$0	Small – 1-49 bed capacity
Hampton Correctional Facility	$723,188	Large – 250 to 999 bed capacity
Meherrin River Regional Jail	$200,000	Large – 250 to 999 bed capacity
Newport News City Jail	$50,000	Large – 250 to 999 bed capacity
Norfolk City Jail	$1,280,000	Mega- 1000+ bed capacity
Northwestern Regional Jail	$0	Large – 250 to 999 bed capacity
Pamunkey Regional Jail	$0	Large – 250 to 999 bed capacity
Piedmont Regional Jail	$625,456	Large – 250 to 999 bed capacity
Pittsylvania County Jail	$0	Small – 1-49 bed capacity
Pr. William/Manassas Regional	$1,508,000	Mega- 1000+ bed capacity
Rappahannock Regional Jail	$0	Mega- 1000+ bed capacity
Richmond City Jail	$0	Mega- 1000+ bed capacity

Roanoke County/Salem Jail	$0	Medium – 50-249 bed capacity
Rockbridge Regional Jail	$2,504,000	Medium – 50-249 bed capacity
RSW Regional Jail	$1,502,000	Large – 250 to 999 bed capacity
Southside Regional Jail	$785,000	Medium – 50-249 bed capacity
Southwest Virginia Regional Jail	$4,165,000	Mega- 1000+ bed capacity
Sussex County Jail	$160,000	Medium – 50-249 bed capacity
Western Tidewater Regional	$3,110,000	Large – 250 to 999 bed capacity
Western Virginia Regional Jail	$627,000	Large – 250 to 999 bed capacity

Table 4 below shows the calculated average resource needs for small, medium, large, and Mega jails. Small is defined as having a bed capacity less than 50, Medium = 50-249, Large = 250-999, and Mega = 1,000 +. Only two small jails responded to the survey and neither noted the need for additional resources. There is some concern that this might not be an accurate representation for all small jails, so to ensure a more accurate estimate the responses from small jails was averaged with the responses from medium jails to establish the estimated need for other small jails.

Table 4: Average Resource Needs of Jails by Size

Jail Size	Projected Resource Needs
Small	$394,545
Medium	$482,222
Large	$692,720
Mega	$1,632,285

Table 5 below shows the jails who did not respond to the survey, their size, and their estimated resource needs. The total resource needs is estimated to be ***$18,531,323***

Table 5: Estimated Jail Resource Needs to Meet Proposed Minimum Standards for Behavioral Healthcare (non-responding jails)

Jail	Size	Estimated Resource Needs
Accomack County Jail	Small	$394,545
Alexandria Detention Center	Large	$692,720
Alleghany/Covington Regional Jail	Medium	$482,222
Arlington County Detention Center	Large	$692,720
Central Virginia Regional Jail	Large	$692,720
Charlotte County Jail	Small	$394,545
Culpeper County Jail	Small	$394,545
Franklin County Jail	Small	$394,545

Hampton Roads Regional Jail	Mega	$1,632,285
Henrico County Jail	Large	$692,720
Henry County Jail	Medium	$482,222
Lancaster County Correctional Facility	Small	$394,545
Loudoun County Jail	Large	$692,720
Martinsville City Jail and Annex	Medium	$482,222
Middle Peninsula Regional Security Center	Medium	$482,222
Middle River Regional Jail	Large	$692,720
Montgomery County Jail	Medium	$482,222
New River Valley Regional Jail	Large	$692,720
Northern Neck Regional Jail	Medium	$482,222
Page County Jail	Small	$394,545
Patrick County Jail	Medium	$482,222
Portsmouth City Jail	Large	$692,720
Riverside Regional Jail	Mega	$1,632,285
Roanoke City Jail	Large	$692,720
Rockingham/Harrisonburg Regional Jail	Medium	$482,222
Southampton County Jail and Annex	Medium	$482,222
Virginia Beach Correctional Center	Mega	$1,632,285
Virginia Peninsula Regional Jail	Large	$692,720

With regard to which standards were reported to require the infusion of the most resources, it was difficult to tell given differing response approaches from the jails. Some jails tended to request the majority of services in Access to Care and then note the resources infused here would enable them to meet other standards. Fairly uniformly, jails reported the proposed standards for Medication Services and Identification & Treatment of Substance Use Disorders would require a significant infusion of resources.

The total estimated costs to put resources in all jails is calculated by combining the costs outlines in Table 1 with those outlined in Table 3. The total estimated resource needs across the Commonwealth total ***$42,609,967***.

DISCUSSION/CONCLUSIONS

Jails across the Commonwealth and across the country are designed to serve a public safety role in society. Their role is to incapacitate the individual by restricting his/her access to engage in criminal activities, to act as a deterrent for future criminal activities (for the individual and for society), to provide a means for retribution to society for the crimes committed, and to the degree possible provide for the rehabilitation of the individual so as to mitigate risk for future criminal

behavior. Over time, the United States (and Virginia) has seen an increase in the number of individuals with behavioral health challenges incarcerated in jails. While the existence of a behavioral health disorder is not a factor, which can or should necessarily preclude incarceration (and the above mentioned functions of incarceration), clearly if incarcerated the existence of a behavioral health condition does pose unique challenges for the jail in managing the inmate and addressing his/her needs. Failing to provide for the mental health needs of inmates undermines the core functions of incarceration. Releasing inmates with serious mental illness without having provided treatment and without solid aftercare plans places the individual and the community at heightened risk. In essence, providing good clinical treatment not only is the right thing to do, it is good public safety practice.

This report articulates the 15 minimum standards for behavioral health care for jails. It should be stressed these are minimum standards and jails/communities should strive not only to meet these standards but also to exceed them. The workgroup included descriptive "performance indicators" so that there could be some uniformity/common understanding as to how to measure compliance with these standards. While some jails report, via a self-assessment, that they are well poised to meet the new standards (when adopted) a large number of jails reported needing an infusion of significant resources in order to meet the standards. In addition, the Board of Corrections also needs an infusion of resources so that it can perform its oversight function. Localities are already funding a majority of the behavioral health services being provided in jails. There is some concern whether localities can allocate the necessary funds to enable their local/regional jail to meet the proposed standards. It seems prudent for the Commonwealth to convene a policy team to decide the Commonwealth's obligation for the provision of behavioral health services in jails.

It should also be remembered that while the cost to fund the resource needs is very large, it pales in comparison to the potential negative consequences of not providing individuals the treatment they need. Additionally, national research has shown that providing adequate behavioral health treatment to incarcerated individuals can decrease their rates of re-arrest, their rates of emergency room visits (when released), and their use of other high dollar services. The advisory group encourages the funding of the BOC and jails so that Virginia is seen as a leader in the provision of behavioral healthcare services to this very vulnerable population. The Commonwealth may benefit from engaging national experts in justice re-investment to see if there are creative ways to fund the behavioral healthcare services. These experts might also aid in estimating the cost savings/ cost avoidance which could be realized and re-invested into the system by implementing these standards.

Appendix A:

ADVISORY GROUP PARTICIPANTS

First Name	Last Name	Organization
Ms. Janet	Areson	Virginia Municipal League
Ms. Katie	Boyle	Virginia Association of Counties
Ms. Jana	Braswell	Department of Behavioral Health and Developmental Services - OFS
Mr. Bruce	Cruser	Mental Health America of VA
Mr. Keith	Davies	Office of the State Inspector General
Ms. Robyn	DeSocio	State Compensation Board
Ms. Beth	Dugan	Prince William CSB
Ms. Leslie	Egen	Department of Criminal Justice Services
Mr. Emmanuel	Fontenot	Department of Corrections
Dr. Olivia	Garland	Virginia Board of Corrections
Ms. Melissa	Gibson	DisAbility Law Center
Mr. Jeff	Hefty	VML/VACO
Ms. Angie	Hicks	VA Beach CSB
Ms. Kari	Jackson	State Compensation Board
Ms. Kemba	Jennings	Virginia Board of Corrections
Sup. Martin	Kumer	Albemarle-Charlottesville Regional Jail
Maj. Mandy	Lambert	Prince William County Jail
Dr. Denise	Malone	Department of Corrections
Dr. Heather	Masters	Virginia Board of Corrections
Sheriff Gabe	Morgan	Newport News Sheriff's Office
Ms. Karen	Nicely	Virginia Board of Corrections
Mr. Robert	Payne	Virginia Department of Health
Sheriff Lane	Perry	Henry County Sheriff
Sup. Bobby	Russell	Virginia Association of Regional Jails
Dr. Mike	Schaefer	Department of Behavioral Health and Developmental Services - OFS
Ms. Christine	Schein	Department of Behavioral Health and Developmental Services - OFS
Ms. Aileen	Smith	VA Beach CSB
Ms. Tamara	Starnes	Blue Ridge CSB
Sheriff Kenneth	Stolle	Virginia Beach Sheriff's Office
Sheriff Michael	Taylor	Pittsylvania County Sheriff's Office
Sup Timothy	Trent	Virginia Association of Regional Jails
Sheriff Darrell	Warren	Gloucester Sheriff's Office
Mr. Andy	Warriner	Department of Criminal Justice Services
Ms. Leslie	Weisman	Arlington CSB

APPENDIX B:

Self Assessment Survey

Virginia's Behavioral Health Standards for Local and Regional Jails
2019 Fiscal Impact Survey

Date: _____ **Name of Jail:** _____

Your Jail's Region (select one):
☐ Central
☐ Western
☐ Eastern

Size of your Jail:
☐ Mega - 1,000+ bed capacity
☐ Large - 250 to 999 bed capacity
☐ Medium – 50 to 249 bed capacity
☐ Small - 1 to 49 capacity

Contact Information:
Name/Title: _____
Email: _____
Phone Number: _____

Standard #1: ACCESS TO CARE Inmates have access to care to meet their mental health needs (or conditions) as listed in the minimal health standards for jails.
Compliance Indicators The responsible health authority (RHA) identifies and addresses any barriers to inmates receiving health care.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
1 = not confident at all, 2 = slightly confident, 3 = somewhat confident, 4 = confident, and 5 = very confident

In order to be **VERY CONFIDENT**, please indicate the resources your jail would require:

Do you need more **clinical staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
_____
Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
_____

Do you need more **security staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
_____
Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
_____

Do you need more **administrative staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
_____
Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
_____

List any other resources needed (i.e. training, information technology services, technical assistance, etc.)
_____
_____

Please provide any additional cost: _____

Standard #2: POLICIES AND PROCEDURES
The facility has a manual or compilation of policies and defined procedures regarding mental health care services which may be part of larger health care manual. *Note: Private contractors must adhere to, and remain in compliance with the standards set forth for local/regional jails*

Compliance Indicators

5. Mental Health care policies are site specific.
6. Each policy and procedure in the mental health care manual is reviewed at least annually and revised as necessary under the direction of the responsible health authority (RHA). The manual bears the date of the most recent review or revision and, at a minimum, the signatures of the facilities RHA and responsible physician.
7. The manual or compilation is accessible to mental health staff.
8. All aspects of the standard are addressed by written policy and defined procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
1 = not confident at all, 2 = slightly confident, 3 = somewhat confident, 4 = confident, and 5 = very confident

In order to be **VERY CONFIDENT**, please list any resources needed (i.e. training, information technology services, technical assistance, etc.): _____

Please provide a gross estimate cost: _____

Standard #3: COMMUNICATION OF PATIENTS NEEDS
Communication occurs between the facility administration and treating mental health care professionals regarding inmates' significant mental health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or safety of the institution/staff. Communication is bi-directional and occurs on a regular basis either through planned meetings or impromptu meetings as the need arises.

Compliance Indicators

6. Correctional staff are advised of inmates' mental health needs that may affect housing, work and program assignments; disciplinary measures; and admissions to and transfers from institutions. Such communication is documented.
7. Mental health providers and custody staff regularly communicate about the mental health needs of inmates.
8. All aspects of the standard are addressed by written policy and defined procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
1 = not confident at all, 2 = slightly confident, 3 = somewhat confident, 4 = confident, and 5 = very confident

In order to be **VERY CONFIDENT**, please list any resources needed (i.e. training, information technology services, technical assistance, etc.): _____

Please provide a gross estimate cost: _____

Standard #4: MENTAL HEALTH TRAINING FOR CORRECTIONAL OFFICERS

A training program established or approved by the responsible health authority in cooperation with the facility administration guides the mental health related training of all correctional officers who work with inmates.

Compliance Indicators

7. Correctional officers who work with inmates receive mental health related training at least ever year. This training includes, at a minimum:
    f. Recognizing the need for emergency care and intervention during a mental health crisis
    g. Recognizing acute manifestation of intoxication and withdrawal, and adverse reaction to medications
    h. Recognizing signs and symptoms of mental illness
    i. Procedures for suicide prevention
    j. Procedures for appropriate referral of inmates with mental health concerns to staff
8. An outline of the training including course content and length is kept on file.
9. A certification or other evidence of attendance is kept on site for each employee.
10. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their mental health related trainings.
11. All aspects of the standard are addressed by written policy and defined procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?

1 = not confident at all, 2 = slightly confident, 3 = somewhat confident, 4 = confident, and 5 = very confident

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Please provide a gross estimate cost: _____

Standard #5. MEDICATION SERVICES

Medication services are clinically appropriate and provided in a timely, safe and sufficient manner - within 48hrs (unless there is data/evidence to suggest a more timely intervention is needed) there will have been an evaluation of the situation either by nurse, PA, etc. to develop a medication plan which could include referral to a physician and prescriptions (as indicated).

Compliance Indicators

10. Prescription medications are administered or delivered to the patient only on the order of a physician, nurse practitioner, physician's assistant or other legally authorized individual.
11. Medications are delivered in a timely fashion. The facility has a policy identifying the expected time frames from ordering to delivery and a backup plan if the time frames cannot be met.
12. The responsible physician determines prescribing practices in the facility (consider security implications).
13. Medications are prescribed only when clinically indicated.
14. Inmates entering the facility on prescription medication continue to receive the medication in a timely fashion and as prescribed, or acceptable alternative medications are provided as clinically indicated. This process should happen quickly so as to avoid missed medications (which could result in psychiatric decompensation).
15. The ordering clinician is notified of the impending expiration of an order so that the clinician can determine whether the drug administration is to be continued or altered.
16. All aspects of the standard are addressed by written policy and defined procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?

1 = not confident at all, 2 = slightly confident, 3 = somewhat confident, 4 = confident, and 5 = very confident

In order to be **VERY CONFIDENT**, please indicate the resources your jail would require:

Do you need more **clinical staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
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Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
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Do you need more **security staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
_____
Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
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Do you need more **administrative staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
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Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
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List any other resources needed (i.e. training, information technology services, technical assistance, etc.)
_____
_____

Please provide any additional cost: _____

Standard #6 MENTAL HEALTH SCREENING Mental health screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met.
Compliance Indicators 11. Intake personnel ensure mental health screening occurs and those that screen positive are referred for further assessment. 12. A mental health screening takes place for all inmates as soon as possible. 13. The mental health screening tool shall be one designated by the Commissioner of DBHDS. 14. The disposition of the inmate (e.g., immediate referral to services, placement in the general population) is appropriate to the findings of the mental health screening and is indicated on the screening form. 15. Mental health screening forms are dated and timed immediately on completion and include the signature and title of the person completing the form. 16. Screening includes identification of prescribed medications. 17. Correctional personnel performing the mental health screen shall be trained in the use of the screening tool and appropriate referral processes. 18. Mental health staff/ mental health provider/designee regularly monitors screenings to determine the effectiveness of this process. 19. All aspects of the standard are addressed by written policy and defined procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
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Please provide a gross estimate cost: _____

Standard #7. MENTAL HEALTH ASSESSMENT
All inmates receive mental health screening; inmates with positive screens receive a mental health assessment.

Compliance Indicators

10. Within 14 days of admission to the correctional system, a qualified mental health professional or mental health staff conducts an assessment on those inmates scoring positive on the initial mental health screen. Those individuals who are in acute mental health distress should be seen more quickly (within 48 hours). Those individuals who appear suicidal should be assessed immediately.
11. The mental health assessment includes a structured interview with inquiries into:
    - f. A history of:
        - XII. Psychiatric hospitalization and outpatient treatment
        - XIII. Substance use treatment
        - XIV. Detoxification and outpatient treatment
        - XV. Suicidal behavior
        - XVI. Self-Injurious Behavior
        - XVII. Violent behavior
        - XVIII. Victimization / traumatic experiences
        - XIX. Special education placement
        - XX. Cerebral trauma or seizures
        - XXI. Sex offenses
        - XXII. Gender Dysphoria or Gender Identity issues.
    - g. The current status of:
        - V. Psychotropic medications
        - VI. Suicidal ideation
        - VII. Drug or alcohol use and substance use treatment
        - VIII. Orientation to person, place and time
    - h. Emotional response to incarceration
    - i. A history of issues with cognitive impairments, learning disabilities, deficits in adaptive functioning.
    - j. History of benefits and entitlements
12. The health record contains results of the assessment with documentation of referral or initiation of treatment when indicated.
13. Patients who require acute mental health services beyond those available on site are transferred to an appropriate facility.
14. There is a written policy and defined procedures addressing the postadmission mental health screening and evaluation process.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
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Do you need more **clinical staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
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Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
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Describe the number of hours or type of resources needed:
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Please provide a gross estimate cost (based on prevailing salaries, cost of services, etc.):
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Do you need more **administrative staff**? ☐ Yes ☐ No
Describe the number of hours or type of resources needed:
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List any other resources needed (i.e. training, information technology services, technical assistance, etc.)
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Please provide any additional cost: _____

Standard #8. EMERGENCY SERVICES The facility provides 24 hour emergency mental health services.
Compliance Indicators 5. A written plan includes arrangements for the following, which are carried out when necessary: g. Emergency transport of the patient from the facility h. Use of an emergency medical vehicle i. Use of one or more designated hospital emergency departments or other appropriate facilities j. Emergency on call physician or mental health services when the emergency health care facility is not nearby k. Security procedures for the immediate transfer of patients for emergency mental health care l. Notification to the person legally responsible for the facility 6. A written plan that includes the process and procedure for contacting the responsible CSB to request a pre-admission screening (documentation of agreement to plan). 7. All aspects of the standard are addressed by written policy and defined procedures.
Status/ Barriers to Implementation: Most jails are likely already meeting this standard. No known new resources needed to implement this standard.

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Describe the number of hours or type of resources needed:
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List any other resources needed (i.e. training, information technology services, technical assistance, etc.)
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Please provide any additional cost: _____

Standard #9. RESTRICTIVE HOUSING When an inmate is held in restrictive housing, staff monitor his or her mental health
Compliance Indicators 1. Upon notification that an inmate is placed in restrictive housing, a qualified mental health care professional (RN/LPN/QMHP or other health professional can conduct rounds) reviews the inmates mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation. It should be noted that at times placement in restrictive housing may be detrimental to an individual's mental health the overall security needs and safety of the individual, other individuals, and staff may necessitate the continued placement in a restrictive housing setting. In such cases, mental health staff shall try to identify strategies to minimize the deleterious effects of restrictive housing. Such review is documented in the health record. 2. The mental health professionals monitoring of an inmate in restrictive housing is based on the degree of isolation: e. Inmates who are in restrictive housing and have limited contact with staff or other inmates are monitored every day by medical or mental health staff f. Inmates who are allowed periods of recreation or other routine social contact among themselves while being held in restrictive housing are checked weekly by medical or mental health staff **Depending on clinical judgment the frequency of contacts could be altered. Evaluation by mental health professional does not substitute for required checks by correctional officers. 3. Documentation of restrictive housing rounds is made on individual logs or cell cards, or in an inmates health record and includes: c. The date and time of the contact d. The signature or initials of the health staff member making the rounds 4. Any significant mental health findings are documented in the inmates' health record. 5. Medical and mental health staff promptly identify and inform custody officials of inmates who are physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health. 6. All aspects of the standard are addressed by written policy and defined procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
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Do you need more **administrative staff**? ☐ Yes ☐ No

Describe the number of hours or type of resources needed:
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List any other resources needed (i.e. training, information technology services, technical assistance, etc.)
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Please provide any additional cost: _____

Standard #10. CONTINUITY AND COORDINATION OF HEALTH CARE DURING INCARCERATION
All aspects of health care are coordinated and monitored from admission to discharge.

Compliance Indicators

12. Clinician orders are evidence based/evidence informed, are consistent with current standards of care, and are implemented in a timely manner.
13. Deviations from standards of practice are clinically justified, documented and shared with the patient.
14. Diagnostic tests, if indicated, and completed and reviewed by the clinician in a timely manner.
15. Treatment plans may be modified as clinically indicated by diagnostic tests and treatment results.
16. Treatment plans, including test results, are shared and discussed with patients.
17. Patients are reviewed by a qualified provider upon return from a hospitalization, urgent care, or emergency department visit to ensure proper implementation of the discharge orders and to arrange appropriate follow up.
18. Recommendations from specialty consultations are reviewed and acted upon by the clinician in a timely manner.
19. If changes in treatment recommendations are clinically indicated, justification for the alternative treatment plan is documented and shared with the patient.
20. Chart reviews are done to assure that appropriate care is ordered and implemented and that care is coordinated by all health staff including medical, dental, mental health and nursing.
21. The responsible provider determines the frequency and content of periodic health assessments based on protocols promulgated by nationally recognized professional organizations.
22. All aspects of the standard are addressed by written policy and defined procedures.

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Standard #11. DISCHARGE PLANNING
Discharge planning is provided for inmates with mental health needs whose release is imminent.

Compliance Indicators

5. For planned discharges, the provider:
    e. Arrange for a minimum of a two week supply of current psychotropic mediations and ideally script for a minimum of two weeks.
    f. Request signed releases of information so that treatment information can be sent to the next behavioral health provider (template of ideal MOU for information exchange – BAA. Include signing privacy notice).
    g. For inmates with serious medical or mental health needs, make arrangements or referrals for follow up services with community clinicians, including exchange of clinically relevant information. SMI is more complicated and requires cross agency, multiagency intervention and resources. Discharge planning services should follow the best standards from DBHDS prior report. Consideration should be given to making forensic patients a priority population for services. With Same Day Access this should be partly addressed by significantly reducing the wait time for a mental health assessment by the CSB in the community.
6. All aspects of the standard are addressed by written policy and defined procedures.

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Standard #12. PRIMARY MENTAL HEALTH SERVICES
Mental health services are available for all inmates who need services.

Compliance Indicators

8. Patients mental health needs are addressed on site or by referral to appropriate alternative facilities. They are addressed by a range of mental health services of differing levels and focus, including residential components when indicated.
9. Regardless of facility type or size, basic on site outpatient services include, at a minimum:
    f. Identification and referral of inmates with mental health needs
    g. Crisis intervention services
    h. Psychotropic medication management, when indicated
    i. Treatment documentation and follow-up

    When available:
    j. Individual counseling, group counseling and psychosocial/psychoeducational programs
10. Those who require transfer to an inpatient psychiatric setting is clinically indicated, required procedures are followed and the transfer occurs in a timely manner. Until such transfer can be accomplished the patient is safely housed and adequately monitored daily.
11. Basic mental health services are offered as clinically indicated.
12. An attempt is made every 30 days to reengage individuals with a serious mental illness who have declined treatment.
13. Mental health, medical and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of any of these conditions on each other is adequately addressed.
14. All aspects of the standard are addressed by written policy and defined procedures.

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Please provide any additional cost: _____

Standard #13. SUICIDE PREVENTION PROGRAM
The facility identifies suicidal inmates and intervenes appropriately.

Compliance Indicators

6. A suicide prevention program includes the following:
    - f. Facility staff identify suicidal inmates and immediately initiate precautions
    - g. Suicidal inmates are evaluated promptly by the designated health professional who directs the intervention and assures follow up as needed
    - h. Acutely suicidal inmates are placed on constant observation
    - i. Non-acutely suicidal inmates are monitored on a random schedule with no more than 15 minutes between checks. If however the non-acutely suicidal inmate is placed in an isolation cell constant observation is required
7. Key components of a suicide prevention program include the following:
    - n. Training
    - o. Identification
    - p. Referral
    - q. Evaluation
    - r. Treatment
    - s. Housing and monitoring
    - t. Communication
    - u. Intervention
    - v. Notification
    - w. Review
    - x. Debriefing
8. The use of other inmates in any way (e.g., companions, suicide prevention aids) is not a substitute for staff supervision.
9. When an inmate is taken off suicide precautions an assessment is completed to determine if they remain at elevated future risk and if so then a plan is implemented to monitor and manage the ongoing risk.
10. The responsible health authority approves the facilities suicide prevention plan; training curriculum for staff, including development of intake screening for suicide potential and referral protocols, and training for staff conducing the suicide screening at intake.
11. All aspects of the standard are addressed by written policy and defined in procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
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In order to be **VERY CONFIDENT**, please indicate the resources your jail would require:

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Describe the number of hours or type of resources needed:
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Do you need more **administrative staff**? ☐ Yes ☐ No
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List any other resources needed (i.e. training, information technology services, technical assistance, etc.)
_____
_____

Please provide any additional cost: _____

Standard #14. IDENTIFICATION AND TREATMENT OF SUBSTANCE USE DISORDERS
Inmates are screened for the existence of substance use disorders. For those inmates with substance use disorders, the jail evaluates for acute treatment needs (both behavioral health & medical) and provides treatment based on the individual's needs, amenability to treatment, and availability of treatment programs.

Compliance Indicators:

8. There are written guidelines for the screening, assessment, housing, and management of inmates suspected of having substance use disorders.
9. There is evidence of communication and coordination between medical, behavioral health providers regarding SUD care.
10. Medical conditions associated with SUD (e.g., HIV, liver disease) are recognized and treated.
11. The correctional staff are trained in recognizing the signs/symptoms of alcohol/drug intoxication and withdrawal and what the local procedures to respond to such circumstances.
12. There are on-site individual counseling, group therapy, peer support, or self-help groups for inmates with SUD issues.
13. Inmates with SUD issues have access, upon release, to a list of community mental health resources for which the inmate might be eligible and which might help address their needs.
14. All aspects of the standard are addressed by written policy and defined procedures that define the respective roles of the mental health, substance abuse, and medical staff regarding provision of SUD services.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
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Describe the number of hours or type of resources needed:
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Standard #15. MANAGEMENT OF INTOXICATION & WITHDRAWAL AND OVERDOSE
Protocols exist for managing and responding to inmates under the influence of alcohol or other drugs and those undergoing withdrawal from alcohol, sedatives or opioids. Detoxification from alcohol, opiates, hypnotics, and other stimulants is conducted under medical supervision in accordance with local, state, and federal laws. When performed at the facility, detoxification is prescribed in accordance with clinical protocols approved by the health authority.

Compliance Indicators:

11. Established protocols are followed for the assessment, monitoring, and management of individuals manifesting symptoms of alcohol and drug intoxication or withdrawal, and overdose.
12. The protocols for intoxication, detoxification, and/or overdose are approved by the responsible physician, are current, and are consistent with national accepted treatment guidelines.
13. Individuals being monitored are housed in a safe location that allows for effective monitoring.
14. Inmates experiencing severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal are transferred immediately to a medical facility upon the recommendation of the jail medical provider or jail protocol.
15. The jail has policies/practices outlining the practice of using overdose reversal medications.
16. Individuals showing signs of intoxication or withdrawal are monitored by qualified health care professionals using recognized standard assessments at appropriate intervals until symptoms have resolved.
17. Detoxification is done under physician supervision.
18. If a pregnant inmate is admitted with opioid dependence or treatment (including methadone and buprenorphine), a qualified clinician is contacted so that the opioid dependence can be assessed and appropriately treated.
19. The facility has a policy that addresses the management of inmates, including pregnant inmates, on methadone, buprenorphine, or similar substances. Inmates entering the facility on such substances have their therapy continued as appropriate, or a plan for appropriate treatment of the methadone withdrawal syndrome is initiated.
20. All aspects of the standard are addressed by written policy and defined procedures.

Please consider the Standard listed above. How confident are you that your jail is currently meeting this standard?
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List any other resources needed (i.e. training, information technology services, technical assistance, etc.)
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Please provide any additional cost: _____

[i] Substance Abuse and Mental Health Services Administration. Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide. (SMA)-16-4998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

[ii] Virginia State Compensation Board, 2018 Mental Illness in Jails Report. Accessible at: http://www.scb.virginia.gov/docs/2018mentalhealthreport.pdf

[iii] https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/research/virginias-peculiar-system-local-and-regional-jails.pdf

[iv] See: Jails Inadvertent Health Care Providers: accessible at: http://www.pewtrusts.org/~/media/assets/2018/01/sfh_jails_inadvertent_health_care_providers.pdf