REPORT OF THE COMMITTEE
OF THE JOINT COMMISSION ON BEHAVIORAL HEALTH CARE, VIRGINIA STATE CRIME COMMISSION AND THE VIRGINIA COMMISSION YOUTH

Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 25

COMMONWEALTH OF VIRGINIA
RICHMOND
2002

Members of the Committee

Senator Stephen H. Martin, *Chairman*
Delegate Glenn M. Weatherholtz, *Vice-Chairman*
Senator R. Edward Houck
Senator Janet D. Howell
Delegate David B. Albo
Delegate John H. Rust, Jr.
Delegate Robert Tata
Gary L. Close, Attorney for the Commonwealth, Culpeper County
William G. Petty, Attorney for the Commonwealth, City of Lynchburg

Staff

Division of Legislative Services
Nancy L. Roberts, *Section Manager*
Amy Marschean, *Senior Staff Attorney*
Gayle N. Vergara, *Senior Research Associate*
Iris A. Kincaid, *Operations Staff Assistant*
Heather K. Butros, *Editor*

Virginia State Crime Commission
Kim Echelberger, *Acting Executive Director*

Virginia Commission on Youth
Amy Atkinson, *Executive Director*
Joyce Garner, *Executive Assistant*
Leah Hamaker, *Policy Analyst*
Georgia S. Hamilton, *Policy Intern*
Kristi Wright, *Senior Policy Analyst*

Senate of Virginia
John McE. Garrett, *Deputy Clerk*

Commonwealth of Virginia

GENERAL ASSEMBLY
RICHMOND

May 1, 2002

TO: The Honorable Mark R. Warner, Governor
and
The General Assembly of Virginia

We are pleased to transmit to you the final report of the study authorized by Senate Joint Resolution 440 (2001), Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders. The purpose of this study was to examine the current system and make recommendations concerning mental health and substance abuse treatment services delivered to and needed by adult and juvenile offenders at the state and local levels.

This study represents precedent-setting collaboration among the Joint Commission on Behavioral Health Care, the Virginia Commission on Youth and the Virginia State Crime Commission on issues of mutual concern. In light of the current budgetary situation, we believe our recommendations are realistic and lay the groundwork for future action.

We wish to express our appreciation to the many individuals who shared their time and expertise to assist us in our work. We particularly commend the strong cooperation that occurred among consumers, family members, advocates and the criminal justice and mental health and substance abuse treatment professionals in collecting data and formulating creative ideas. Due to the complexity of the issues, the 2002 Session of the General Assembly continued the study for two additional years and we look forward to the continued assistance of these individuals.

Respectfully submitted,

Senator Stephen H. Martin, *Chairman*
Delegate Glenn M. Weatherholtz, *Vice-Chairman*
Senator R. Edward Houck
Senator Janet D. Howell
Delegate David B. Albo
Delegate John H. Rust, Jr.
Delegate Robert Tata
Gary L. Close, Attorney for the Commonwealth,
Culpeper County
William G. Petty, Attorney for the Commonwealth,
City of Lynchburg

TABLE OF CONTENTS

I. Executive Summary 1

II. Introduction 5
- A. Organization of the Report 6
- B. Background 7
- C. Virginia's Legal Obligations 8
- D. Related Virginia Studies 9
- E. Innovative Programs 10

III. Mental Health and Substance Abuse Treatment Services for Adult Offenders 15
- A. Overview of the Adult Criminal Justice System 15
- B. Mental Health Treatment Services for Adult Offenders 16
- C. Substance Abuse Treatment Services for Adult Offenders 20
- D. Local and Regional Jail Survey Results 22
  - 1. Mental Health Treatment Services 23
  - 2. Substance Abuse Treatment Services 23
  - 3. Service Coordination 24
  - 4. Recommended Changes or Additional Services 25
- E. Probation and Parole Survey Results 26
  - 1. Mental Health Treatment Services 26
  - 2. Substance Abuse Treatment Services 27
  - 3. Service Coordination 27
  - 4. Recommended Changes or Additional Services 29
- F. Findings and Recommendations 30
  - 1. Interagency Collaboration 30
  - 2. Capacity 31
  - 3. Clinical Guidelines 32
  - 4. Cross Training 32
  - 5. Data Collection, Evaluation and Information Sharing 33

IV. Mental Health and Substance Abuse Treatment Services for Juvenile Offenders 35
- A. Overview of the Juvenile Justice System 35
  - 1. Services for Nonstate Wards 35
  - 2. Services for State Wards 37
  - 3. Transitional Services 38
- B. Virginia's Juvenile Justice Process 38
- C. Mental Health Treatment Services for Juvenile Offenders 41
  - 1. Treatment Needs of Juveniles 41
  - 2. Services Offered by the Department of Juvenile Justice 42
  - 3. Locally Operated Mental Health Services 44

D. Substance Abuse Treatment Services for Juvenile Offenders 46
1. Treatment Needs of Juveniles 46
2. Services Offered by the Department of Juvenile Justice 47
3. Locally Operated Substance Abuse Services 48
E. Mental Health and Substance Abuse Treatment Funding Sources 49
1. Virginia Juvenile Community Crime Control Act (VJCCCA) 49
2. Substance Abuse Reduction Effort (SABRE) 50
3. Comprehensive Services Act 50
F. Interagency Collaboration 52
G. Data Collection, Evaluation and Information Sharing 52
H. Survey Results 53
1. Mental Health Treatment Needs 54
a. Juveniles in Need of Services 54
b. Screening and Assessment 54
c. Wait Time for First Mental Health Appointment 55
d. Level of Mental Health Services Received 56
2. Substance Abuse Treatment Needs 56
a. Juveniles in Need of Services 56
b. Screening and Assessment 57
c. Wait Time for First Substance Abuse Treatment Appointment 58
d. Level of Substance Abuse Treatment Services Received 58
3. Barriers to Treatment 59
4. Service Coordination for Juvenile Detainees 59
I. Findings and Recommendations 60
1. Interagency Collaboration 60
2. Capacity 60
3. Clinical Guidelines 63
4. Cross Training 63
5. Data Collection, Evaluation and Training 64

V. Conclusion and Final Recommendation 65

VI. References 66

VII. Appendix 71
A. Senate Joint Resolution 440 (2001)
B. Legislation and Budget Amendments As Proposed to the 2002 Session of the General Assembly
C. Committee Survey Questionnaires
1. Local and Regional Jail Survey
2. Probation and Parole Survey
3. Local and Regional Detention Home Survey
4. Court Service Unit Survey

D. Virginia's Legal Obligations to Offenders with Mental Illness or Substance Abuse Disorders
E. Virginia's Mental Health Professional Shortage Areas
F. Memorandum on Mental Health Courts--Council of State Governments Staff
G. SJR 440 Committee Meeting Notes
H. Work Group Membership

I. EXECUTIVE SUMMARY

"The United States currently has more mentally ill men and women in jails and prisons than in all state hospitals combined," wrote Chris Sigurdson (2000) in an article published by the American Correctional Association. However, national research indicates that fewer than 50 percent of men and women with severe mental illnesses receive mental health treatment while they are incarcerated and fewer than 25 percent of inmates with more moderate forms of mental illness receive mental health services.

In its 2000 annual report to Congress, the Coalition for Juvenile Justice estimated that 50 percent to 75 percent of young people in the criminal justice system nationwide suffer from mental illness. Thirty-six percent of the parents surveyed by the Coalition said their children were in the criminal justice system because they could not get needed help outside the system.

The National GAINS Center (1997) estimates that sixty-three percent of jail detainees have a mental illness or a substance abuse disorder; five percent have both. Among state and federal prisoners, an estimated 57 percent have a mental or substance abuse disorder and approximately 13 percent of prisoners have both a serious mental illness and a co-occurring substance abuse disorder.

Offenders with mental illness are often jailed for relatively minor offenses, such as vagrancy, trespassing, disorderly conduct, alcohol-related charges, or failing to pay for a meal. The Center on Crime, Communities and Culture (1996) asserts that, "When it is mental illness and not criminal intent that underlies a petty criminal act, treatment in mental health programs is demonstrably more effective at reducing recidivism than a sentence to jail."

Against this background, the 2001 Session of the General Assembly directed the Joint Commission on Behavioral Health Care, the Virginia Commission on Youth and the Virginia State Crime Commission to examine treatment options for offenders who have mental illness or substance abuse disorders (SJR 440, Senator R. Edward Houck). As outlined in SJR 440, the study was to include mental health and substance abuse services delivered to and needed by adult and juvenile offenders at the state and local levels. Specifically, the Commissions were directed to review the:

- Incidence of mental illness and substance abuse among offenders;
- Current system for delivering mental health and substance abuse services, including assessment, treatment, post-release, and follow-up;
- Model treatment programs for offenders;
- Costs and benefits of private versus public delivery of treatment services;
- Need for specialized training of local law enforcement and court personnel; and
- Funding, sources of funding and legislation required to ensure adequate assessment and treatment services.

To address such a comprehensive mandate, each of the Commissions appointed members to serve on a special study committee. Senator Stephen H. Martin was elected Chairman and Delegate Glenn M. Weatherholtz was elected Vice-Chairman. Other members included Senator R. Edward Houck; Senator Janet D. Howell; Delegate David B. Albo; Delegate John H. Rust, Jr.; Delegate Robert Tata; Gary L. Close, Attorney for the Commonwealth, Culpeper County; and William G. Petty, Attorney for the Commonwealth, City of Lynchburg.

The Committee met six times, sent out questionnaires and held two public hearings to receive testimony and hear presentations from consumers, family members, advocates, criminal justice professionals, treatment providers, academic faculty and other experts. The Committee also maintained a website to facilitate the exchange of information, where interested persons were able to download agendas, presentations, meeting summaries, and a decision matrix that described the options being considered. The decision matrix was available for public comment from October 17 until November 9, 2001. A work group composed of consumer, family, advocacy, local government, defense attorney, mental health treatment, substance abuse treatment, and criminal justice representatives assisted with identifying issues, collecting data, and developing solutions.

The Committee wishes to express its gratitude to the numerous dedicated consumers, family members, advocates, criminal justice professionals, treatment providers, attorneys, academic faculty, local government officials and others who contributed to the Committee's deliberations and final work products. Their cooperation, candor, and innovative thinking were remarkable and greatly appreciated.

Recognizing the current budgetary situation, most of the Committee's recommendations were designed to lay the groundwork for future action: maintaining funds that are appropriated in the current biennium budget; gathering information about unmet needs; fostering interagency collaboration and planning; establishing minimum clinical guidelines; and providing a framework for information sharing and evaluating the effectiveness of existing programs. This Executive Summary highlights the Committee's key findings and recommendations.

Interagency Collaboration. Clearly defined responsibilities for serving adult and juvenile offenders with mental illness and interagency collaboration do not exist in many communities across the Commonwealth. Moreover, there does not appear to be a consensus as to whether the responsibility for providing treatment services should reside with the criminal justice system or the mental health treatment system. The Committee recommended that the General Assembly establish an interagency work group under the leadership of the Committee to develop a screening-assessment-treatment model for offender groups with mental health needs. The work group would be asked to make recommendations concerning the statutory assignment of responsibility for providing needed treatment services; a regional planning process to foster state and local interagency collaboration; model memoranda of agreement that detail responsibilities for services, information exchange, and cross training of staff; and a framework to pilot the memoranda and evaluate the results. In addition, the Committee recommended that the Office of the Secretary of the Supreme Court be requested to examine the feasibility of designing and implementing a model court order that addresses mental health needs of offenders.

Capacity. Virginia communities lack sufficient capacity, including the availability of acute psychiatric care, to treat offenders with mental illness and substance abuse disorders while they are incarcerated and when they are released from state correctional facilities, jails or detention homes. Moreover, lack of a comprehensive and systemic approach to funding these services has resulted in inequitable access to care across Virginia. The Committee recommended that the General Assembly (i) direct the Department of Criminal Justice Services (DCJS), in collaboration with other stakeholder agencies and groups, to identify the unmet need for mental health and substance abuse treatment services for adult offenders and to develop a comprehensive plan, including the necessary resources and funding sources for covering the increasing costs of providing existing services and to fill service gaps; (ii) direct the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services to make recommendations to the Committee concerning access to psychiatric care for jail inmates and to ensure an adequate supply of acute psychiatric beds for children and adolescents; (iii) direct the Department of Medical Assistance Services to examine ways to provide immediate access to Medicaid

to eligible offenders when they are released from prisons or jails; (iv) direct the Department of Corrections to recommend ways to ensure the appropriate management of medications for offenders when they are released from state correctional facilities; (v) direct the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Department of Juvenile Justice (DJJ) to identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate number of residential and acute psychiatric beds for the treatment of juvenile offenders; (vi) continue the funding for the "Keep Our Kids At Home" (KOKAH) project, which has demonstrated success at reducing inpatient hospitalization; (vii) include juvenile offenders in the plan being developed as a result of Item 323K in the current biennium budget to provide and improve access by children to mental health, substance abuse and mental retardation services; (viii) continue the funding for recruitment and retention of psychiatrists in medically underserved areas, which is currently $500,000 each year; (ix) appropriate $50,000 to expand the National Health Service Corp--Virginia Loan Repayment Program to include mental health professionals; and (x) explore ways to expand the use of telepsychiatry in underserved areas.

Clinical Guidelines. The Commonwealth has not developed clinical guidelines for jails or detention homes to ensure an adequate level of mental health services for people who are incarcerated. The Committee recommended that the General Assembly direct the State Board of Corrections, the State Mental Health, Mental Retardation and Substance Abuse Services Board and the Board of Juvenile Justice as appropriate to develop minimum guidelines for the provision of mental health and substance abuse treatment services in jails and detention homes and a plan, including the necessary fiscal and staff resources, for meeting the guidelines.

Training. Cross training for balancing therapeutic goals with security needs and public safety is needed for law enforcement, judges, jail and detention staff, and community treatment staff. The Committee recommended that DMHMRSAS be requested to develop and make recommendations for implementing a curriculum for cross training law-enforcement officers, judges, jail and detention staff, and community treatment staff in security and treatment.

Data Collection, Evaluation and Information Sharing. No comprehensive mechanism exists to systematically collect complete and accurate data on treatment services provided to and needed by adult and juvenile offenders or to evaluate the effectiveness of the services. The Committee recommended that the General Assembly (i) request the Secretary of Public Safety, in conjunction with other Cabinet Secretaries, to develop a plan, including the estimated cost, for the collection of data on treatment services provided to and needed by state-responsible adult and juvenile offenders and for the evaluation of the effectiveness of treatment services; (ii) continue the funding for intensive substance abuse treatment services in jails for the next biennium and direct DMHMRSAS to conduct comprehensive process and outcome evaluation of therapeutic communities in local jails; and (iii) direct the Virginia Commission on Youth to coordinate the collection and dissemination of information on effective treatment modalities and practices.

Continuation of the Study. The Committee brought together members of the Joint Commission on Behavioral Health Care, the Virginia State Crime Commission and the Virginia Commission on Youth to apply their individual expertise to the study of issues related to adult and juvenile offenders with mental illness and substance abuse disorders. During their deliberations, the members collected a great deal of information and acquired additional expertise, both individually and collectively, on issues that cross the boundaries between the criminal justice system and mental health and substance abuse treatment systems. The members of the Committee would like to use the expertise that they have acquired to track the activities that they set in motion, provide legislative oversight to the interagency group that will develop a screening-assessment-treatment model for offender groups with mental health

needs and continue their research into programs that will prevent persons with mental illness and substance abuse disorders from entering the criminal justice system in the first place. The Committee's final recommendation is to continue the study of treatment options for offenders with mental illness or substance abuse disorders and to include the Secretaries of Public Safety and Health and Human Resources in their deliberations.

II. INTRODUCTION

Senate Joint Resolution 440 (2001), introduced by Senator R. Edward Houck, directed the Joint Commission on Behavioral Health Care, in conjunction with the Virginia State Crime Commission and the Virginia Commission on Youth, to study treatment options for persons involved in the criminal justice system who have mental illness or substance abuse disorders. The scope of the study included mental health and substance abuse services delivered and needed at the state and local levels to adult and juvenile offenders. The Commissions were directed to include the following areas in their review:

- Incidence of mental illness and substance abuse among offenders;
- Current system for delivering mental health and substance abuse services, including assessment, treatment, post-release, and follow-up;
- Model treatment programs for offenders;
- Costs and benefits of private versus public delivery of treatment services;
- Need for specialized training of local law enforcement and court personnel; and
- Funding, sources of funding and legislation required to ensure adequate assessment and treatment services.

Each of the Commissions appointed members to serve on the joint study committee. Senator Stephen H. Martin was elected Chairman and Delegate Glenn M. Weatherholtz was elected Vice-Chairman.

From the Joint Commission on Behavioral Health Care
Senator Stephen H. Martin, *Chairman*
Senator R. Edward Houck*
Delegate John H. Rust, Jr.
Delegate Glenn M. Weatherholtz, *Vice-Chairman*
From the Virginia State Crime Commission
Senator Janet D. Howell
Delegate David B. Albo
William G. Petty, Attorney for the Commonwealth, City of Lynchburg
From the Virginia Commission on Youth
Delegate Robert Tata
Gary L. Close, Attorney for the Commonwealth, Culpeper County

* Senator Houck also served as a member from the Virginia Commission on Youth.

The Committee met six times and held two public hearings to receive testimony and hear presentations from consumers, family members, advocates, criminal justice professionals, treatment providers, academic faculty and other experts. The Committee also applied for and received technical assistance from the Bazelon Center for Mental Health Law, located in Washington, D.C. In addition, questionnaires were sent to 75 local and regional jails, 42 probation and parole districts, 22 juvenile detention homes and 35 court service units to gain a better understanding of current mental health and substance abuse treatment services and the need for improvement. The Committee also maintained a website to facilitate the exchange of information, where interested persons were able to download agendas, presentations, meeting summaries, and the decision matrix (**http://dls.state.va.us/groups/sjr440/welcome.htm**). The decision matrix, which described the findings and options being considered by the committee, was available for public comment from October 17 until November 9, 2001.

The Division of Legislative Services, the Virginia State Crime Commission, and the Virginia Commission on Youth provided staff to the Committee. In addition, a work group composed of consumer, family, advocacy, local government, defense attorney, mental health, substance abuse treatment, and criminal justice representatives met several times to help identify issues, assist with data collection, and recommend solutions. A list of the work group members is included in the Appendix. SJR 440 required the Committee to provide an interim report to the Senate Committee on Finance and the House Committee on Appropriations and to make final recommendations to the Governor and the 2002 Session of the General Assembly.

The Committee wishes to express its gratitude to the numerous dedicated consumers, family members, advocates, criminal justice professionals, treatment providers, attorneys, academic faculty, local government officials and others who contributed to the Committee's deliberations and final work products. Their cooperation, candor, and innovative thinking were remarkable and greatly appreciated.

A. ORGANIZATION OF THE REPORT

The report is organized into five chapters, references and an appendix:

(I) Executive Summary
- Summarizes the findings and recommendations.

(II) Introduction
- Describes background information, including the authority for the study, Committee process, indicators of the problem, Virginia's legal obligations, related studies, and information about innovative programs.

(III) Mental Health and Substance Abuse Treatment Services for Adult Offenders
- Provides an overview of the state and local criminal justice systems for adult offenders; describes mental health and substance abuse treatment services available to adult offenders; summarizes jail and probation and parole survey results; and describes the findings and recommendations related to adult offenders.

(IV) Mental Health and Substance Abuse Treatment Services for Juvenile Offenders
- Provides an overview of the state and local criminal justice systems for juvenile offenders; describes mental health and substance treatment services available to juvenile offenders; summarizes detention home and court service unit survey results; and describes the findings and recommendations related to juvenile offenders.

(V) Conclusion and Final Recommendation
- Describes future issues that the General Assembly might wish to consider and recommends continuation of the study.

(VI) References

(VII) Appendix
- Provides supporting documents and information.

B. BACKGROUND

"The United States currently has more mentally ill men and women in jails and prisons than in all state hospitals combined," according to a recent article published by the American Correctional Association (Sigurdson, 2000). However, national research indicates that fewer than 50 percent of men and women with severe mental illnesses receive mental health treatment while they are incarcerated and fewer than 25 percent of inmates with more moderate forms of mental illness receive mental health services (Sigurdson).

In its 2000 annual report to Congress, the Coalition for Juvenile Justice estimated that 50 percent to 75 percent of young people in the criminal justice system nationwide suffer from mental illness. Thirty-six percent of the parents surveyed by the Coalition said their children were in the criminal justice system because they could not get needed help outside the system. Twenty percent of the parents relinquished custody of their children to get services (Coalition for Juvenile Justice, 2000).

The National GAINS Center estimates that approximately seven percent of jail inmates suffer from acute and serious mental illness at booking and approximately one-third of jail inmates are dependent on alcohol or other drugs. Fifty percent of jail inmates have other, less serious mental disorders, such as chronic depression, anxiety disorders, and antisocial personality disorders. In total, 63 percent of jail detainees have a mental illness or a substance abuse disorder; five percent have both. Among state and federal prisoners, an estimated 57 percent have a mental or substance abuse disorder and approximately 13 percent of prisoners have both a serious mental illness and a co-occurring substance abuse disorder (The National GAINS Center, 1997).

In 1998, the U.S. Department of Justice reported that 283,800 mentally ill offenders were incarcerated in the Nation's prisons and jails. Their survey data indicated that 16 percent of state prisoners, seven percent of federal inmates and 16 percent of local jail inmates reported either a mental condition or at least an overnight stay in a mental hospital at some point in their lives. Another 547,800 individuals, or 16 percent of all probationers, reported a mental condition or an overnight stay in a mental hospital (Ditton, 1999).

The Department of Justice found that 60 percent of prisoners with mental illness reported receiving some form of treatment; among jail inmates with mental illness, only 41 percent reported receiving some form of mental health services. Approximately 56 percent of probationers reported receiving treatment, the most common forms being counseling or therapy, medication, or an overnight stay in a mental hospital or treatment facility (Ditton, 1999).

Offenders with mental illness are often jailed for relatively minor offenses, such as vagrancy, trespassing, disorderly conduct, alcohol-related charges, or failing to pay for a meal. "When it is mental illness and not criminal intent that underlies a petty criminal act, treatment in mental health programs is demonstrably more effective at reducing recidivism than a sentence to jail" (Center on Crime, Communities and Culture, 1996).

A brief filed in support of the plaintiffs in *Brad H., et al. v. the City of New York, et al.* (2000) asserted that "the criminal justice system has replaced the mental health system as the primary mental health provider in the United States." The brief asserts that when inmates, who have been receiving mental health services while they are incarcerated, are released from jail or prison, they are typically sent into the communities without any form of discharge planning. Discharge planning would include a temporary supply of medication, follow-up appointments to continue therapy, and assistance in obtaining housing and other public services. Without discharge planning, the inmates are unlikely to

obtain needed mental health care and are likely to be reincarcerated in a short period of time (Brad et al.).

The Criminal Justice/Mental Health Consensus Project, under the auspices of the Council of State Governments, reports that individuals with severe mental illness or substance abuse disorders who commit nonviolent crimes are often swept into the criminal justice system and repeatedly recycled through the courts and correctional facilities. Moreover, health care providers or criminal justice officials may fail to recognize that a defendant or an offender has a mental illness and a substance abuse problem; therefore, they may try unsuccessfully to treat one or the other condition in isolation. Front-line police officers and corrections officers often lack the resources to deal adequately with individuals with mental illness. Finally, prosecutors and judges may not be trained to impose appropriate conditions of pretrial release, probation, or incarceration on defendants or offenders who have a mental illness or a substance abuse disorder or both (Pretrial Services Resource Center, 2001).

Both the numbers and the costs of arresting and incarcerating persons with mental illness and substance abuse disorders have increased over the past years, placing additional strain on state and local budgets. A team of researchers in California estimated that the fiscal impact of housing persons with mental illness in the California criminal justice system is $1.7 billion per year (Izumi, Schiller, and Hayward, 1996).

On a systems level, criminal justice and mental health/substance abuse treatment constituencies at the state and local levels rarely think collectively about potential policies, programs and legislation to address the problems. Some Virginia localities are notable exceptions. However, dissemination of information about model programs has been slow and resources have been limited for new initiatives.

C. VIRGINIA'S LEGAL OBLIGATIONS

Federal and Virginia laws afford certain key rights to incarcerated persons with mental illness or substance abuse disorders. The Eighth Amendment prohibition against "cruel and unusual punishment" requires that anyone in custody suffering from a mental illness be given medical treatment for any serious illness. However, the mandatory care is limited to considerations for cost, time, and medical necessity. Several courts have identified components of a "minimally adequate" mental health care delivery system, including (i) a systematic program for screening and assessing inmates to identify those in need or mental health care; (ii) a treatment program that involves more than segregation and close supervision of inmates; (iii) employment of a sufficient number of trained mental health professionals; (iv) maintenance of accurate, complete and confidential mental health treatment records; (v) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (vi) a basic program to identify, treat, and supervise inmates at risk for suicide. Educational, vocational or rehabilitative services for a substance abuse disorder, however, are not guaranteed under the Eighth Amendment (Wallace, 2001).

The Fourteenth Amendment "due process" clause provides a procedural safeguard protecting an inmate/prisoner's "liberty interest." When a prisoner is diagnosed with either a mental illness or substance abuse disorder requiring a detrimental change in his "liberty interest," the Fourteenth Amendment requires either an adversarial hearing or an evidentiary hearing (Wallace, 2001).

Under the provisions of the federal Americans with Disabilities Act of 1990 (ADA), a jail or prison cannot exclude an inmate from participating in a benefit or service because of his mental illness or substance abuse disorder. In addition, there seems to be a growing body of precedent recognizing that the ADA prohibits discrimination based on a person's particular disability (Wallace, 2001).

Virginia law closely tracks the minimum requirements of federal law, including "medically necessary" treatment, and goes beyond by requiring treatment for certain offenders with substance abuse disorders (Wallace, 2001). A full explanation of Virginia's legal obligations is included in the Appendix.

D. RELATED VIRGINIA STUDIES

In 1994, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) found that "Arrests for public intoxication account for 15 percent of all arrests in the Commonwealth... Chronic public inebriates clog the mental health system in addition to jail and other community systems... Public inebriate centers and social detoxification facilities are cost effective measures to divert public inebriates from Virginia's jails" (pp.12-13). The Department made several recommendations, including a study of the civil commitment of individuals with primary substance abuse to state mental health facilities and funding to expand and develop public inebriate centers and social detoxification facilities.

Also in 1994, the Joint Legislative Audit and Review Commission (JLARC) found that the Department of Corrections "[had] not fully developed a system of comprehensive mental health care." Although JLARC determined that the Department provided quality mental health treatment for male inmates at Marion Correctional Treatment Center, acute care for women was less available and treatment was inconsistent among facilities for the same level of care. JLARC also found that the Department of Corrections "[lacked] adequate mechanisms to ensure cost-effectiveness" of mental health treatment (pp. IV, 25). Problems were noted with bed utilization, the use of psychologists to perform routine administrative tasks, the lack of a distinct mental health budget and excessive costs of a contract for mental health treatment at one sheltered care unit. To address the problems, JLARC recommended implementation of a quality assurance process, including the use of expertise from DMHMRSAS in setting standards and coordinating post-release services with community services boards.

A 1994 interagency study of the mental health needs of youths in the Virginia Juvenile Justice system focused on youths in 17 detention homes in Virginia. Among the important findings were that eight to 10 percent of youths in detention homes had serious mental health problems that required immediate attention and that only 14 percent were receiving the mental health services they required. In addition, another 39 percent of the youths did not need immediate intervention but would require mental health services as part of their continuing association with the juvenile justice system. "Neither the Community Services Boards nor the secure detention homes, have sufficient fiscal and staff resources, staff training and system response mechanisms to address the needs of these youths uniformly and adequately," (Virginia Policy Design Team, 1994, p. 5).

In 1995, JLARC analyzed the consequences of overcrowding in local jails, particularly on the health and safety of inmates. JLARC found that selected jail standards and oversight by the Department of Corrections needed to be strengthened. For example, the medical screening standard was found to be too broad and the medical screening forms used in some jails were found to be inadequate. Five of 21 medical screening forms did not include questions about inmates' potential suicide behavior; and several forms only contained one or two general questions about mental health status, such as, "Is your mental condition ok?" (p. 39). JLARC also found that a suicide prevention standard needed to be promulgated and that staff needed to receive training in suicide prevention.

A 1999 evaluation of the drug treatment court program in the Twenty-Third Judicial Circuit of Virginia (County of Roanoke, City of Roanoke, City of Salem, and the Town of Vinton) concluded that

the program had demonstrated a high rate of graduation and low rates of post-program convictions among graduates. In addition, the contractual cost of the program at $1,813 per participant per year is substantially less than the cost of incarceration (Shoemaker, 1999).

In October 2000, the Department of Planning and Budget assessed the evaluation mechanisms at the Indian Creek Correctional Center. The Indian Creek Correctional Center is a medium security correctional facility that opened in 1993 in Chesapeake, Virginia, and operates as a residential substance abuse treatment facility. The Department of Planning and Budget concluded that Indian Creek does not have the resources to evaluate its therapeutic community and, as a result, quantitative evidence about the inmates' progress does not exist.

The Interagency Drug Offender Screening and Assessment Committee (2001a) indicated that a "substantial portion of offenders entering the criminal justice system in Virginia have substance abuse problems related to drugs or alcohol" (pp. 2-3). Screening and assessment results indicated that 85.5 percent of adult felons, 95 percent of adult misdemeanants screened by the Virginia Alcohol Safety Action Programs, 65.6 percent of adult misdemeanants screened by local community-based probation programs, and 32.9 percent of juvenile offenders need substance abuse treatment.

The Department of Criminal Justice Services (2001) reported that national evaluations of drug court programs and the evaluation of the Twenty-Third Judicial Circuit Drug Court in Virginia have demonstrated cost effectiveness and positive results in terms of successful program participation and recidivism reduction. Virginia operates eight drug court programs, including two juvenile drug courts in Richmond and Fredericksburg. Four other courts, including one juvenile court, have received federal funding to plan drug court programs. The report made recommendations concerning future funding of drug court programs and administrative oversight.

The 2000 Session of the General Assembly directed the Virginia Commission on Youth to study children and youths with serious emotional disturbance requiring out-of-home placement. The Commission's interim report (2001) estimated that at least 2,228 children with serious emotional disturbance are in need of out-of-home placement. Residential treatment and therapeutic foster care were the services most often recommended but not received. The most commonly cited reasons were lack of funds, service unavailable, uncooperative family, and uncooperative child.

E. INNOVATIVE PROGRAMS

A common feature of emerging strategies to address the needs of offenders with mental illness or substance abuse disorders is collaboration across systems. Collaboration can include coordinated strategic planning, multiagency budget submissions, comprehensive screening and assessment, cross training of staff, team approaches to assessment and case management, and establishing connections that are critical to aftercare following release (Eastern Kentucky University, 2001).

Programs for Adult Offenders. Henrico Area Mental Health and Retardation Services provides a comprehensive array of mental health and substance abuse services in the two-site Henrico County jail system. Based on strong cooperation between jail administrators and community services board staff, intensive training in therapeutic communication and mental health intervention is provided to jail staff; a strong emphasis is placed on discharge planning; and psychiatric consultation, medication management, crisis intervention, on-site screening and assessment, dedicated treatment areas, outreach substance abuse treatment programs, mental health group treatment, and a 36-bed therapeutic community are included (Kellogg, 2001).

The Fairfax County, Virginia, jail has deputies who are specially trained in mental health issues and provides a written policy that involves mental health providers in classification decisions related to diagnostic and treatment services as well as other classification determinations. The Alexandria jail has eight full-time licensed or certified clinical staff, on-site emergency mental health and substance abuse assessment and crisis intervention services, on-site psychiatry consultation and medication monitoring, 24-hour critical care treatment area for inmates with serious mental illness, therapeutic community for offenders with substance abuse disorders, dedicated treatment areas, and psychotropic medications provided by the community services board (Kellogg, 2001).

Having specific positions responsible for handling crisis intervention and short-term treatment appears to be an effective means of managing and supervising mentally disoriented persons. The rate of officer injury rates during mental illness events decreased almost six-fold after the start of the Memphis crisis intervention team program. The Roanoke County, Virginia, Police Department implemented crisis intervention training based on the Memphis model in November 2000. Police officers are trained in the recognition of symptoms of mental illness and substance abuse, pharmacology, crisis intervention and anger management. The primary goal is to assist persons in crisis, reduce the level of violence that can be associated with crisis intervention and direct the consumer to an appropriate level of care with a health care professional (Kincaid, 2001).

Albuquerque, New Mexico, adopted the Memphis model, but also conducts follow-ups with individuals in their homes. Albuquerque initiated a program to link people at the pretrial level with community services. Forty percent of the people who previously were held in jail have been diverted and only six percent have been rearrested, none for violent crimes (Thompson, 2001). Crisis intervention can be provided by specialists, as in sites in Summit County, Ohio, and Shelby County, Tennessee, or in teams, as in Jefferson County, Kentucky. Whatever the method, the primary goals are to assess, stabilize as quickly as possible, house appropriately, and provide direct mental health services (Steadman and Veysey, 1997).

Project Link in Monroe County, New York, features a mobile treatment team with elements of the assertive community treatment model, a forensic psychiatrist, a dual diagnosis treatment residence, and culturally competent staff. Yearly jail days dropped from 107 to 46 per person; yearly hospital stays decreased from 115.9 to 7.4 days; the average number of arrests per person declined considerably; and no assaults, suicide attempts, or other reportable incidents occurred among the clientele (Thompson, 2001).

Hampshire County, Massachusetts, provides case management services to every jail inmate. Inmate treatment needs are assessed at intake and the case manager then provides individual counseling, meets with the family, and makes appropriate referrals (Steadman and Veysey, 1997).

The Thresholds Jail Program in Chicago's Cook County Jail, which provides long- and short-term aftercare services, found that jail time decreased 82.2 percent for the first 30 clients to complete one year of the program, resulting in a savings of $157,640 to the jail. In addition, the number of hospitalizations decreased 85.5 percent, resulting in savings of $916,000 to Illinois state hospitals (Thompson, 2001).

The Georgia Department of Human Resources and the Department of Corrections operate a Treatment and Aftercare for Probationers and Parolees pilot project that focuses on former inmates with mental illness, mental retardation, or substance abuse problems (Kellogg, 2001).

Programs for Juvenile Offenders. "Wraparound Milwaukee" is a comprehensive, community-based system of care for both delinquent and nondelinquent youths with serious emotional needs and their families. Treatment plans, which can include formal and informal services, are individualized and family-driven. Care coordinators operate with very small caseloads to allow for the personal contact needed to work with youths with complex needs. The approach, called "no wrong door," allows a young person and his family to receive supportive mental health services from any point of contact including schools, religious institutions, recreation programs, public health facilities, and law-enforcement agencies. The program also includes a mobile crisis team, a 250-member provider network delivering 80 different services, and family advocacy components. Child welfare, mental health, and juvenile justice agencies pay a case rate based on the number of youths they serve and these funds are supplemented by Medicaid, insurance and Supplemental Security Income payments. After all the funds are pooled and decategorized, the project can use the funds to cover any service that the families need. Since the program was initiated, recidivism rates for a variety of offenses have declined and significant improvement has occurred in the participants' functioning at home, school and in the community (Eastern Kentucky University, 2001).

The Northern Virginia Juvenile Detention Home located in Alexandria, Virginia, has a consulting psychiatrist, full-time registered nurse, full-time clinical social worker, and full-time recreational therapist on staff. They offer group and individual counseling as well as access to Alexandria community services board services (Kellogg, 2001).

The Crater Juvenile Corrections Program in Petersburg, Virginia, employs three full-time therapists, each with an average caseload of 15 youths. In addition, a board-certified child psychiatrist provides psychiatric evaluations and medication checks. Therapists provide on-site crisis intervention assessments, individual counseling, group counseling, case management, and a weekly parent education support group (Kellogg, 2001).

The Virginia Beach Community Services Board Multisystemic Therapy Program is an intensive family and community-based treatment program that addresses the multiple causes of serious anti-social behavior in juvenile offenders. Therapists provide formal assessments, individual and family counseling, parenting education, emergency services, case management, post-discharge monitoring, and consultations with school, court service unit and other agency personnel (Kellogg, 2001).

"Project Hope" is a Rhode Island statewide initiative that serves youths with co-occurring mental health and juvenile justice needs who are being released from the Rhode Island Training School for Youth. A majority of the youths also have a history of substance abuse prior to incarceration. Project Hope forms strong links with an array of community providers, including health care, substance abuse treatment, educational/vocational services, domestic violence and abuse support groups, recreational programs, and day care services (Eastern Kentucky University, 2001).

New York State uses mobile mental health treatment teams to provide and coordinate mental health services to youth under criminal justice supervision. The teams are stationed in the facilities and programs on a regular basis, averaging four days per week. Since staff outside the facility clinically supervises the team members, the staff is able to avoid becoming immersed in behavior control and institutional administrative issues. Since initiation of the mobile teams, placements in state-operated inpatient facilities have decreased from 75 to 12 per year. In addition, the relationship between the mental health system and the juvenile justice system has improved significantly, leading to mutual understanding and shared responsibility for problems and solutions (Eastern Kentucky University, 2001).

Discharge Planning. The consensus among the American Psychiatric Association, the American Association for Correctional Psychology, and the National Commission on Correctional Health Care is that timely and effective discharge planning is an essential element of adequate mental health treatment and the continuity of care (Brad H., et al. v. The City of New York, et al., 2000). The American Psychiatric Association (2000) defines discharge planning in a prison or jail setting as "all procedures through which each inmate in need of mental heath care at the time of release...is linked with appropriate community agencies capable of providing ongoing treatment..." (p. 46). Because discharges or transfers may occur on short notice, the American Psychiatric Association recommends that discharge planning be a part of the initial treatment plan.

In Ohio, community linkage representatives meet with inmates diagnosed with mental illness before they are released and refer the inmates to appropriate community providers. The jail systems in Cook County, Illinois, and Nassau County, New York, are also providing similar discharge planning services. Discharge planning is provided for every individual in the Fairfax County jail. The Offender Aid and Restoration Program links jail detainees with mental health, transportation and housing services upon release. One important feature of the Fairfax program is that detainees work with the same professional staff person from intake through discharge (Steadman and Veysey, 1997).

Diversion Programs. Court liaison and diversion programs have been effective in some jurisdictions. Hillsborough County, Florida, established a pre-booking diversion program, which incorporates a crisis center to which police can bring criminal offenders who are suspected of having serious mental illness. In Clearwater, Florida, a court liaison goes to the jail to identify candidates for civil commitment and mental health treatment as opposed to the criminal justice route. In Shelby County, Tennessee, all the involved parties, particularly the community mental health providers, sheriff's department, and the jail's medical department sign a multi-agency memorandum of agreement.

Fairfax County uses a mobile crisis unit, which is a home visit team for those who are unable or unwilling to go to a mental health center. The purpose of the unit is to divert inmates with mental illness from jail through working with the family, the police, and the courts. Members of the unit also train officers and magistrates in mental health issues. A court liaison program in Fairfax County is built into the screening process and is provided by magistrates on a 24-hour basis in consultation with pretrial services staff (Kellogg, 2001).

The Ohio Department of Mental Health recently awarded 13 diversion grants to counties to provide mental health linkage and treatment as an alternative to incarceration in local jails for nonviolent offenders. Grants have been used to establish crisis intervention teams, diversion teams, court liaison programs, and outreach programs (Kellogg, 2001).

Marion County, Indiana, initiated the Psychiatric Assertive Identification and Referral (PAIR) diversion program in July 1996. Defendants with serious mental illness can be recommended for diversion from jail to community-based treatment by almost anyone, including a jail screener, public defender, prosecutor, judge, case manager, therapist, or family member. Upon obtaining a written treatment plan from a mental health provider and securing prosecutor approval, a willing defendant is placed on PAIR at his next court date. If the defendant successfully completes the PAIR diversion, the case will be remanded to the court of origin for dismissal of all charges. The arrest remains on the defendant's criminal history, but disposition will indicate that the case was dismissed.

Mental Health Courts. In some areas, strong support has been developing for mental health courts, which have "their genesis in the concept of specialty courts and the idea of therapeutic jurisprudence." While mental health courts share some common characteristics, they may differ in

administration and practice. In fact, some argue that "almost any special effort by the courts to better address the needs of persons with serious mental illness who engage with the criminal justice system can qualify as a mental health court by current standards" (Steadman, Brown and Davidson, 2001, p. 457). Jefferson County, Kentucky, for example, operates a post-booking diversion program, whose purpose is to provide community-based mental health services as an alternative to incarceration for adjudicated offenders with chronic mental illness. Detainees are required to commit to a two-year treatment program and failure to comply with the treatment program can result in a specified jail term (Steadman and Veysey, 1997).

Broward County, Florida, established the first mental health court in 1997, followed by the establishment of mental health courts in at least 11 other jurisdictions. America's Enforcement and Mental Health Project Act, which was signed into law in November 2000, authorizes the creation of up to 100 mental health courts and $10 million a year for four years for their maintenance (Diana Dunker, Memorandum, August 23, 2001). The U.S. Department of Justice published the first comprehensive description of the four most visible mental health courts in April 2000. A comprehensive outcome evaluation of the effectiveness of mental health courts is underway in Broward County and King County (Seattle), Washington, but the results are not yet available. A memorandum on mental health courts prepared for the Committee by the staff of the Council of State Governments is included in the Appendix.

III. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES FOR ADULT OFFENDERS

A. OVERVIEW OF THE ADULT CRIMINAL JUSTICE SYSTEM

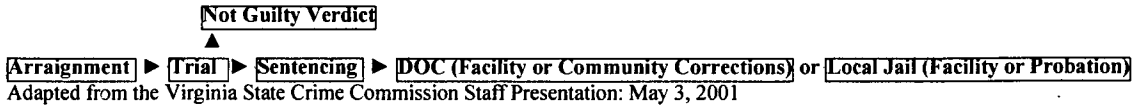
More than 100,000 adults are involved in Virginia's criminal justice system each year. The criminal justice process occurs in two phases: Arrest/Pretrial and Trial/Post-Trial. The specific criminal procedure may vary according to the charge and the jurisdiction, but the following paragraphs describe the most common elements and sequence of events.

The Arrest/Pretrial Phase (Chart 1) begins with entry into the system: a crime is observed and reported, a suspect is identified, an investigation is conducted and an arrest is made. A charged suspect is taken before a magistrate (or judge), who informs the accused of the charges and decides whether there is probable cause to detain the individual. If the charge is a felony, the suspect may be detained in jail or released on bond pending the preliminary hearing in general district court. The purpose of the preliminary hearing is to determine if there is probable cause to believe that the suspect committed a crime within the jurisdiction of the court. If the judge finds probable cause, the case may be bound over to a grand jury. A grand jury hears evidence against the suspect presented by the prosecutor and decides if there is sufficient evidence to cause the suspect to be brought to trial. If the grand jury finds sufficient evidence, it submits an indictment (true bill), which is a written statement of the essential facts of the offense charged against the suspect.

Once the indictment has been returned, phase two begins. The suspect is scheduled for an arraignment, where he is informed of the charges, advised of the rights of criminal defendants and asked to enter a plea to the charges. If the suspect pleads not guilty or not guilty by reason of insanity, a date is set for the trial in circuit court. The trial results in acquittal or conviction on the original charges or on lesser offenses.

Chart 1
Arrest/Pretrial Phase

Trial/Post-Trial Phase



Adapted from the Virginia State Crime Commission Staff Presentation: May 3, 2001

After conviction, sentencing is imposed. Sentencing can include incarceration in a Department of Corrections (DOC) facility or a local or regional jail or probation, which allows the offender to remain at liberty but subject to certain conditions and restrictions such as drug testing and treatment. Adult offenders may become the responsibility of the state or local correctional systems or some combination of both systems. (For a misdemeanor charge, the process is abbreviated. The magistrate determines probable cause and a trial date is set for general district court. Conviction of the charges results in sentencing to a local or regional jail or a local post trial unit.)

Adult defendants who are sentenced to a year or more in a state facility or with a state probation unit are referred to as state-responsible offenders and are supervised by state correctional staffs. Some state-responsible offenders are housed in local and regional jails under contract to the Department of

Corrections. Adult defendants who are sentenced to 365 days or less in jail or with local post-trial units are referred to as local-responsible offenders and are supervised by local correctional staffs. Mental health and substance abuse treatment services, where they exist, may be provided in varying degrees by correctional facility staff, state mental health facilities, community services boards, private providers or some combination of public and private providers.

The state-responsible inmate population (in prisons and jails) increased by 87 percent between 1991 and 2001, from 17,734 in fiscal year 1991 to 33,109 at the end of fiscal year 2001, representing an increase of 15,375 offenders or a seven percent average annual increase of 1,538 offenders (Aronhalt, 2001, p.13).

In 2001, the average local-responsible jail population was 15,356 inmates. From fiscal year 1998 through 2001, the average annual increase in the jail daily population was six percent. The total jail population averaged over 12 months in 2001 was 20,895 inmates, including local-responsible inmates, state-responsible inmates under contract with DOC, federal contract prisoners, and a few juveniles. Local-responsible inmates accounted for an average of 73 percent of the total fiscal year 2001 jail population (Aronhalt, 2001, pp. 13, 24).

DOC operates 28 major institutions, 15 field units and six work centers. In addition, DOC operates the following community corrections programs: 42 probation/parole districts; seven probation/parole sub-offices; 10 day reporting centers; six diversion centers; five detention centers; and one intensive treatment center (boot camp). In addition to approximately 33,000 inmates, almost 40,000 offenders are under active state probation and parole supervision (DOC, 2001b). DOC was appropriated $824 million in fiscal year 2001: $661.2 million for institutions; $90.7 million for community corrections; $33.5 million for correctional enterprises; and $38.6 million for central agency activities.

Seventy-five local and regional jails are operated and supervised by local sheriffs or regional jail superintendents. With operating and capital cost of $459,315,894 in fiscal year 2000, local and regional jails accounted for 66 percent of the total inmate days in the Commonwealth. The 13 largest facilities account for 53 percent of the Commonwealth's total jail funding and 53 percent of the inmate days (Compensation Board, 2001). In addition to more than 15,000 local-responsible jail inmates, 12,526 defendants were placed under local pretrial supervision in fiscal year 2000; on June 30, 2000, more than 16,000 offenders were under active local community-based probation supervision (Department of Criminal Justice Services, 2000a).

B. MENTAL HEALTH TREATMENT SERVICES FOR ADULT OFFENDERS

State-Responsible Offenders. The Department of Corrections (DOC) mission statement for mental health services reads: "The mission of the mental health services program within the Department of Corrections is to provide assessment and treatment services to inmates, and consultation, training and educational services related to mental health issues to correctional staff. Mental health services providers follow professional and ethical standards of practice, and sound correctional principles" (Department of Corrections, 2001b).

DOC estimates that approximately 10 percent of the inmate population in state prisons require some level of mental health services. DOC has developed a continuum of services (acute, residential and outpatient) that is intended to meet the needs of inmates while they are incarcerated and to assist in planning for an inmate's release. Mental health classification codes ("severe impairment" to "no mental health services needs") are assigned by clinical staff at initial intake, reviewed at least annually, and reviewed again when the inmate is ready for release. Evaluations are based on interviews, record review and psychological testing (Department of Corrections, 2001b).

State mental health facilities provide competency and emergency-related services to the offender population. Services include evaluation of competency to stand trial, evaluation of criminal responsibility, emergency inpatient treatment prior to trial, treatment to restore competency to stand trial, emergency treatment after conviction and prior to sentencing, and emergency treatment post-sentence and prior to transfer to the Department of Corrections. In fiscal year 2000, approximately 25 percent of the patients in state mental health facilities were admitted from courts and jails or juvenile detention centers for treatment or evaluation (Kellogg, 2001).

DOC focuses its treatment services on AXIS I disorders, which include diagnoses of major depression, schizophrenia, and substance abuse. Aggregated data are not available; but DOC analyzed a spot sample, which showed that out of a population of 923 inmates at Red Onion State Prison, Virginia's maximum security facility, 629 (68 percent) had an Axis I diagnosis. Of the 629 inmates, 431 had a substance abuse diagnosis and 217 were dually diagnosed with Axis I mental illness and substance abuse. "Novel" or atypical antipsychotic medications (Clozaril, Risperdal, Seroquel, and Zyprexa) are available to inmates at an annual cost (Table 1) of approximately $1.25 million per year (Department of Corrections, 2001b).

Table 1
Novel Antipsychotic Medications Available Within the Department of Corrections

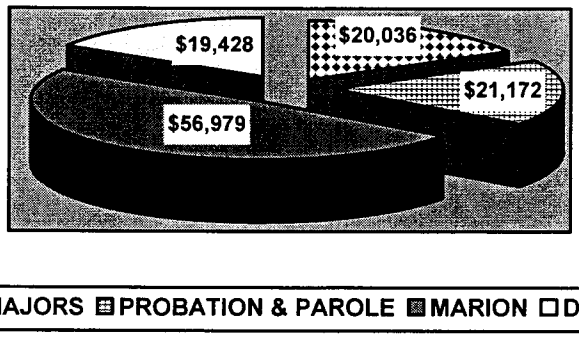
Medication	Inmates/Month	$/Inmates/Month	$/DOC/Year
Clorizaril	8	$447	$49,942
Risperdal	115	$235	$323,839
Seroquel	24	$264	$75,997
Zyprexa	154	$434	$801,675

Department of Corrections Presentation to the SJR 440 Committee: May 31, 2001

Acute care mental health services are provided to the most seriously mentally ill at Marion Correctional Treatment Center (140 male beds) and Fluvanna Correctional Center for Women (40 beds), both of which are licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Inmates who are acutely mentally ill must go through a judicial commitment procedure before they can be transferred to an acute care unit. In addition, a court order may be sought to treat the inmate over his/her objection if commitment criteria are met. An offender cannot be treated over his objection unless a court order has been obtained (Department of Corrections, 2001b).

DOC employs 119 full-time mental health staff in 28 institutions/centers, including 96 psychologists and six psychiatrists. In addition, 18 contract psychiatrists are available in 19 institutions for four to 20 hours per week; all mental health services at Sussex I, Sussex II and Fluvanna institutions are privatized. The "typical" mental health staffing, excluding acute care units at Marion and Fluvanna, is one psychologist for every 250 general population inmates and eight hours of contract psychiatric services per week. Acute care staffing (120 beds) at Marion Correctional Treatment Center is four full-time psychiatrists, four full-time psychologists, four full-time clinical social workers, and 24-hour nursing. The average cost per inmate receiving mental health services at the Marion Correctional Treatment Center (acute care) is $56,979 per year, compared to the average cost per inmate in general population of $19,428 per year (Chart 2).

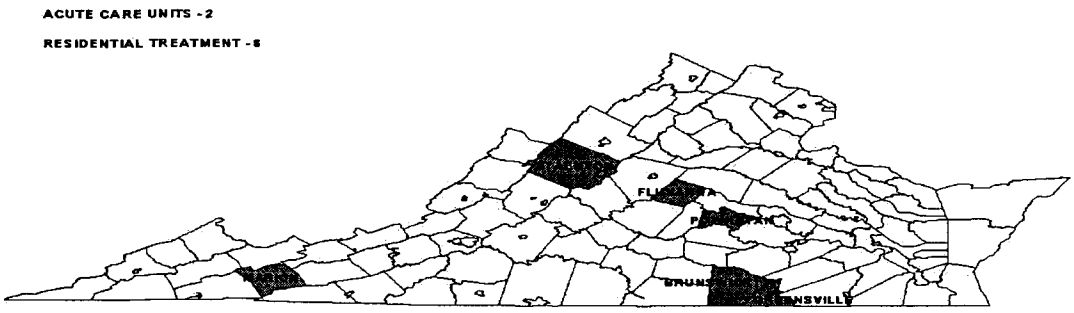
Chart 2
Department of Corrections
Annual Cost Per Offender
Receiving Mental Health Services (6-30-00)



Six residential treatment mental health units are located at Brunswick (60 beds, expanding to 94), Fluvanna (129 beds), Greensville (80 beds), Marion (47 beds), Powhatan (12 beds), and Staunton (49 beds). These units provide services in a structured and more intensive setting to inmates who have mental disorders but do not require acute care services. The inmates are treated in the segregated units and returned to the general population setting if possible. The unit at Brunswick will offer services for inmates who are dually diagnosed with both a mental disorder and a substance abuse disorder after its expansion. The Department of Mental Health, Mental Retardation and Substance Abuse Services licenses all of the residential treatment units (Department of Corrections, 2001b).

Chart 3

DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES



DOC Presentation to SJR 440 Committee: May 31, 2001

Outpatient mental health services are provided to inmates at every DOC institution with qualified mental health professionals. Services include therapy, assessment and evaluation, crisis intervention, consultation, psycho-educational groups, and medications. Psychiatric services are available at all major facilities. Crisis intervention and assessment services are provided as needed to inmates assigned to field units (Department of Corrections, 2001b).

Offenders receiving mental health services are evaluated by a qualified mental health professional prior to release. A discharge summary is forwarded to the offender's probation and parole district and DOC mental health clinical supervisor. DOC relies exclusively on community services boards for post-release services. The first appointment with the community services board typically occurs six weeks after release (Department of Corrections, 2001b).

According to DOC, at least 18 percent of the individuals under state probation and parole supervision have significant mental health problems. Fifteen percent of men and 25 percent of women may have concurrent mental illness and substance abuse disorders. Probation and parole districts typically rely on community services boards for services; however, gaps in service exist. In almost every instance, demand exceeds the ability of community services boards to provide services. In every community, consumers, including offenders, experience waiting lists for services (Department of Corrections, 2001b).

The Committee heard testimony that service availability is not uniform and that critical needs exist in transition services when the inmate is released from a state facility, including: (i) identifying and developing transition resources; (ii) providing mental health specialists for each probation and parole district; (iii) providing regional mental health professionals for probation and parole districts; (iv) developing specialized case loads; (v) creating family programs; (vi) providing day treatment centers; (vii) providing housing; (ix) providing services for offenders with a history of violence; and (x) providing services for offenders who have multiple diagnoses. The Committee also heard testimony that collaborative planning and joint training of criminal justice and treatment staff are needed; a system is needed to match services to facilities based on mission and needs of the offender population; the effectiveness of programs and services need to be evaluated; and information management systems are needed to track and monitor diagnostic information and medication use (Department of Corrections, 2001b).

Local Offenders. While the level of need for mental health treatment among local inmates is at least equal to the level of need in state prisons, funding, treatment services, and staffing are often significantly less in local and regional jails. The Virginia Sheriffs' Association reported to the Committee that reductions in allocations and staffing pressures created by new responsibilities mean fewer resources for services other than those needed to maintain public safety. The Sheriffs' Association recently entered into an agreement with a medical insurance provider that reportedly has resulted in significant cost savings to jails that participate in the program (Virginia Sheriffs' Association, 2001).

In response a survey conducted by this committee, more than half of the jails estimated that from 16 to 50 percent of their inmates need mental health services. However, much of this need is not being met. Almost 25 percent of responders said that individual counseling and medication management are unavailable; more than 60 percent do not offer group counseling; and almost 40 percent do not provide case management. Sixty percent of the responders rely on community services boards to provide mental health services and 30 percent use a private contract or some combination of public and private providers.

Local jails have indicated that a lack of treatment options, limited access to acute psychiatric care, lack of appropriate facilities for housing inmates with mental illness and lack of appropriate training in mental health issues for correctional officers are recurring problems (Virginia Sheriffs' Association, 2001). A survey by the DMHMRSAS, in conjunction with the Virginia Sheriffs' Association, indicated that the unmet need for mental health services in local jails is approximately $20 million per year. Over a six-month period from November 1 through April 30, 2001, community services boards that responded to the survey reported that mental health services were provided to 4,226 inmates in local and regional jails. However, approximately 4,092 inmates did not receive needed mental health services (Kellogg, 2001).

When an inmate is released from local or regional jail, several problems can prevent a smooth, effective transition to community care. The referral system may be inadequate, resulting in a failed link

to the community services board case management. The offender may not have received appropriate psychiatric care, including atypical antipsychotics, while he was incarcerated due to lack of resources. Moreover, the offender might be released with only a few days' supply of medication and may not seek help until a petty crime is committed and the cycle repeats itself (Virginia Association of Community Services Boards, 2001).

C. SUBSTANCE ABUSE TREATMENT SERVICES FOR ADULT OFFENDERS

State-Responsible Offenders. Approximately 80 percent of the inmate population have a history of substance abuse associated with criminality. Funding for prison substance abuse treatment, aided by the Substance Abuse Reduction Effort (SABRE) initiative, grew 31 percent from $430,000 in 1995 to $3.75 million in 2001 (Department of Corrections, 2001a).

The 1998 and 1999 Sessions of the Virginia General Assembly passed legislation that requires many offenders to undergo screening and assessment for substance abuse problems related to drugs or alcohol. Defendants convicted of a felony or Class 1 drug-related misdemeanor are screened and, if the screening indicates a need, assessed for substance abuse (§§ 18.2-251.01 and 19.2-299.2 of the *Code of Virginia*). For adult felons, screening and assessment occur prior to sentencing through probation and parole districts; for adult misdemeanants, screening and assessment occur after sentencing through local Alcohol and Safety Action Programs or local community-based probation programs. Virginia's system for identifying, sanctioning and treating drug-involved offenders consists of screening and assessment, community-based services for probationers, institutional-based services for inmates, transitional services for inmates being released to the community, and community-based services for newly released offenders.

Prison facilities at securities levels one through five offer substance abuse educational programs that are based on a standard curriculum that was developed by the Department's certified substance abuse counselors and is delivered by case management counselors. There are currently 2,900 treatment slots devoted to substance abuse educational programs. In addition, 137 treatment slots are available in eight correctional facilities for substance abuse counseling groups. Case management counselors in addition to their other duties deliver programming (Department of Corrections, 2001a).

Therapeutic Communities, which are long-term treatment programs lasting from 12 to 48 months, are available in eight correctional facilities: Indian Creek Correctional Center--850 beds (Chesapeake); Botetourt Correctional Unit #25--325 beds (Troutville); Staunton Correctional Center--49 beds (Staunton); Greensville Work Center--68 (Jarrett); Pocahontas Correctional Unit #13--130 beds (Chesterfield); Virginia Correctional Center for Women--130 beds (Goochland); Brunswick Work Center--100 beds (Lawrenceville); Fluvanna Correctional Center for Women--112 beds (Troy). Inmates are accepted into Therapeutic Communities near the end of their sentences to optimize the effects as they are being prepared for release. However, with space to serve only seven percent of the inmates in need, some Therapeutic Communities have waiting lists. The final phase of the program occurs in the community, either as a transitional Therapeutic Community or as Post-Release Supervision (Department of Corrections, 2001a).

Despite the advances in substance abuse treatment for offenders through recent initiatives, the Committee heard testimony that a number of gaps exist in the substance abuse treatment continuum. Many are similar to the gaps in mental health services: no uniformity in service availability statewide; limited availability of day treatment programs; no family programs; bed shortage for detoxification, residential/in-patient services, halfway houses, and recovery houses; limited availability of aftercare/relapse prevention, post-residential, intensive outpatient, outpatient or prison programs; no

residential programs for violent offenders; no system for matching offenders to programs; no integrated communication system across programs/agencies; no links between drug treatment and vocational training and job placement; and few programs for dually diagnosed offenders (Department of Corrections, 2001b).

Local Offenders. Class 1 misdemeanor drug offenders who are ordered to supervision by a community-based probation program or participation in a local alcohol safety action program are required to receive a substance abuse screening, and assessment if indicated, as part of their sentence. However, the level of substance abuse treatment in local jails varies by locality. In a few localities, the local government has decided to fund substance abuse treatment services in the local jails. For example, the Committee heard testimony that Henrico County uses primarily local funds to operate a Therapeutic Community, which can accommodate up to 36 inmates for substance abuse treatment. A panel of participants in the Therapeutic Community, Project Fresh Start, told the Committee about their positive experiences. Other inmates completed a five-question written questionnaire on which one inmate wrote, "It gives me a chance to do something positive for myself as well as society. I am not just 'doing time', then return to the streets to continue my actions. It lets me take a look a what I've done, why I've done it, and can do to keep from doing it again." Another inmate wrote, [The worst thing about being in Project Fresh Start is] "I had to find it in jail."

Through the Substance Abuse Prevention and Treatment block grant, DMHMRSAS funds one substance abuse case manager in each community services board to identify cases and provide assessments and counseling. Nine community services boards receive funds totaling $1.1 million ($225,000 state general funds appropriated to the Department of Mental Health, Mental Retardation and Substance Abuse Services; $194,692 appropriated to DCJS; and $700,000 in Intensive Drug Enforcement Jurisdictions Fund appropriated to the Department of Criminal Justice Services) to provide intensive substance abuse treatment services in jails (Petersburg, Roanoke County, Roanoke City, Virginia Beach, Norfolk, Fairfax, Hampton, Martinsville, and the Middle Peninsula-Northern Neck areas). These programs, modeled after offender-based Therapeutic Communities, have a total capacity of 211 beds and the average length of stay is between 90 and 180 days; approximately 400 to 600 inmates per year participate in these programs (Kellogg, 2001).

In addition, many community services boards provide substance abuse services to the offender population through local initiatives and through nine adult drug courts. Drug courts combine strict, frequent supervision by probation staff over a 12 to 18 month period, with intensive drug treatment by clinicians and close judicial monitoring by the court. The following localities currently operate drug courts: Richmond; Roanoke/Salem/Roanoke County; Charlottesville/Albemarle; Chesterfield/Colonial Heights; Fredericksburg/Stafford/Spotsylvania/ King George; Norfolk; Virginia Beach; Newport News; and Portsmouth. Twenty localities are reported to be in various stages of planning to establish or expand a drug court (Kellogg, 2001).

Analysis of data from the Performance and Outcome Measurement System by DMHMRSAS indicated that consumers who were court ordered to receive treatment were more likely to report a reduction in the use of drugs (53.8 percent) than consumers who sought treatment voluntarily (32.3 percent). Moreover, consumers who completed treatment reported fewer arrests (1.2 percent) than those who were discharged for noncompliance or against professional advice (20.7 percent) or those who were discharged for some other reason (17.6 percent) (Department of Mental Health, Mental Retardation and Substance Abuse Services, 2002).

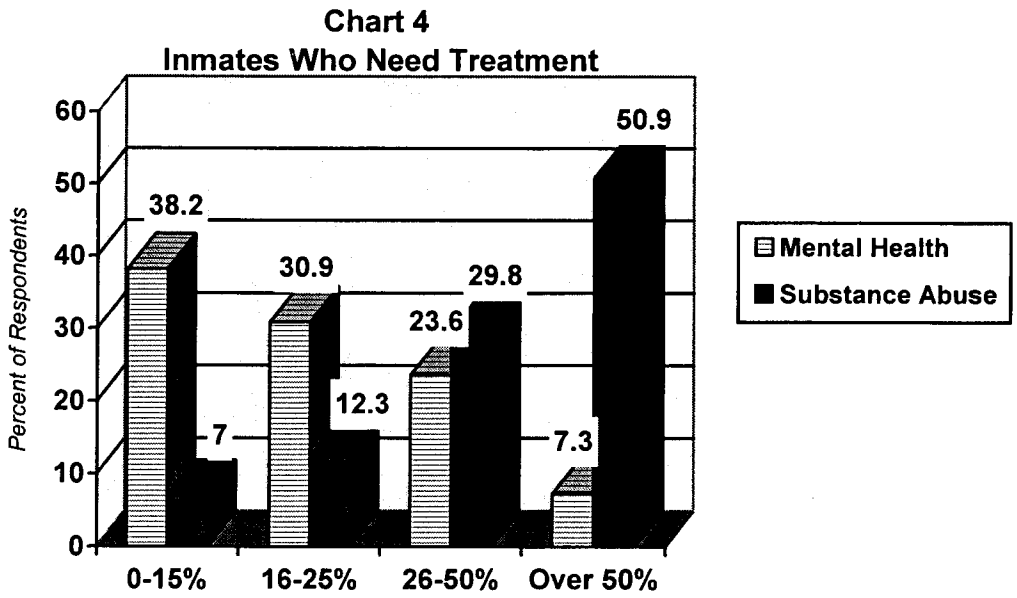
In testimony to the Committee, representatives from the community services boards stated that an offender with severe substance abuse treatment needs who is released from jail with no mechanism in

place for transitional case management might "drop out of sight," at least until he commits another crime. Close and continuous coordination between the community services board, the probation officer or case manager, preferably beginning while the offender is still incarcerated, is necessary to ensure that services are provided. The reality is that once a person is released from a local jail, he competes with all other needs funded by community services boards. In addition, if the offender is released without probation or parole supervision, he may not seek or accept treatment (Virginia Association of Community Services Boards, 2001).

According to the Virginia Sheriffs' Association, "substance abuse treatment for inmates is an important concern affecting a significant number of incarcerated inmates in local jails, and should be addressed" (Virginia Sheriffs' Association). More than 80 percent of the jails that responded to a survey by this committee indicated that greater than 25 percent of inmates need substance abuse treatment. The jails also said that treatment space, consistent assessments, a continuum of services, discharge planning and more drug courts were needed. A survey by DMHMRSAS indicated that the unmet need for substance abuse treatment in local and regional jails is approximately $34 million per year. Over a six-month period from November 1 through April 30, 2001, community services boards that responded to the survey reported that substance abuse treatment services were provided to 5,369 inmates in local and regional jails. However, approximately 6,124 inmates did not receive needed substance abuse treatment services (Kellogg, 2001).

D. LOCAL AND REGIONAL JAIL SURVEY RESULTS

The Committee sent questionnaires to 75 local sheriffs and regional jail superintendents to gain a better understanding of the scope of current services in local jails for inmates with mental illness or substance abuse disorders and the need for additional services. (Copies of the questionnaires are included in the Appendix). Sixty responses (80 percent) were returned. More than 80 percent of the responders said that 25 percent or more of the inmates need substance abuse treatment. Nearly 62 percent of the responders believe that at least 16 percent of the inmates need mental health treatment.



Survey Results: Percent Who Need Treatment

1. Mental Health Treatment Services

- Responder estimates of the percentage of inmates who need mental health services:
  0-15% (38.2%) 16-25% (30.9%) 26-50% (23.6%) Over 50% (7.3%)
- 96.7% of the responders indicated that mental health services are available in their jails.
- Mental health services are provided by:
  CSB (60%) Private Contract (10%) Combination (20%)
  Jail Staff (1.7 %) Other or NA (8.3%)
- 96.7% indicated that inmates are screened for mental health needs when they are admitted.
- 80.4% indicated that they use a standardized screening instrument.
- 96.6% conduct a mental health needs assessment if indicated by the screening.
- 42.2 % use a standardized assessment instrument.
- 77.4% indicated that males wait less than one day for emergency treatment; 20.8% indicated that the average wait is one to two days; and 1.9% indicated a 3- to 5-day wait.
- 76.6% indicated that females wait less than one day for emergency treatment; 19.1 % indicated that the average wait is one to two days; 2.1% indicated a 3- to 5-day wait; and 2.1% indicated a wait of more than 10 days.

Table 2
Availability of Mental Health Treatment Services in Jails

Service	Males--Yes	Males--No	Females--Yes	Females--No
Emergency	**100%**	**0**	**98.1%**	**1.9%**
Case Management	**62.7%**	**37.3%**	**61.1%**	**38.9%**
Group Counseling	**35.6%**	**64.4%**	**41.5%**	**58.5%**
Individual Counseling	**76.3%**	**23.7%**	**75.9%**	**24.1%**
Medication Management	**76.3%**	**23.7%**	**77.8%**	**22.2%**

- Forty-two (73.7%) responders indicated that they experienced problems handling persons who require acute psychiatric care. Of those who experienced problems, 19 indicated problems accessing hospital beds, because inmates did not meet the criteria for admission, beds were not available, or the time to process the admission was burdensome; nine indicated a lack of space or staff to house inmates with mental illness or both.

2. Substance Abuse Treatment Services

- Responder estimates of the percentage of inmates who need substance abuse treatment:
  0-15% (7%) 16-25% (12.3%) 26-50% (29.8%) Over 50% (50.9%)
- 93.3% indicated that substance abuse treatment services are available in their jails.
- Substance abuse treatment services are provided by:
  CSB (72.2%) Private Contract (9.3%) Jail Staff (7.4%)
  Combination (11.1%)
- 86.7% indicated that inmates are screened for substance abuse when they are admitted.
- 66.7% indicated that a standardized screening instrument is used.
- 84% conduct a substance abuse assessment if indicated by the screening.
- 41.2% use a standardized substance abuse assessment instrument.

- 71.1% indicated that male inmates wait less than one day for emergency treatment; 21.1% indicated that the average wait is one to two days; 5.3% indicated a 3 to 5 day wait; and 2.6% indicated a wait of more than 10 days. (Only 63% of the responders answered this question).
- 69.7% indicated that female inmates wait less than one day for emergency treatment; 24% wait 1 to 2 days; 3% wait 3 to 5 days; and 3% wait more than 10 days. (Only 55% of the responders answered this question).

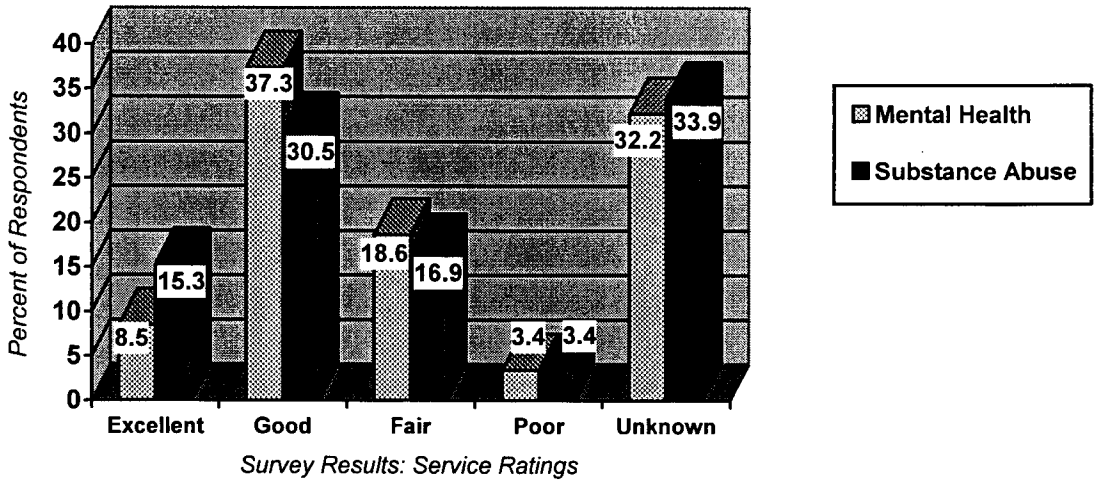
Table 3
Availability of Substance Abuse Treatment Services in Jails

Services	Male--Yes	Male--No	Female--Yes	Female--No
Emergency	**77.2%**	**21.1%**	**73.6%**	**24.5%**
Case Management	**52.6%**	**43.9%**	**51.9%**	**44.2%**
Group Counseling	**70.2%**	**26.3%**	**73.6%**	**22.6%**
Individual Counseling	**66.7%**	**29.8%**	**64.2%**	**32.1%**
Medication Management	**50.9%**	**45.6%**	**49.1%**	**47.2%**

3. Service Coordination

- 59.6% of the responders always contact the CSB when an inmate who may need services is admitted; 38.6% indicated that the CSB is contacted sometimes; 1.8 percent indicated that the CSB is never contacted.
- 59.3% indicated that a plan for services to be delivered in the community is developed when the inmate is released; 39% indicated that no plan is developed.
- 70% of the respondents indicated that requiring the court order to include a release plan would be beneficial.
- Respondents indicated that the average wait for the first mental health appointment in the community was:
  0-10 days (22%) 11-30 days (16.9%) 31-60 days (3.4%)
  Over 60 days (3.4%) Unknown (54.2%)
- Respondents indicated that the average wait for the first substance abuse treatment appointment in the community was:
  0-10 days (23.7%) 11-30 days (16.9%) 31-60 days (1.7%)
  Over 60 days (1.7%) Unknown (55.9%)
- 66% of respondents indicated that the relationship between community agencies and the jail was excellent or good; 34.1% indicated that the relationship was fair or poor.
- 8.3% of the respondents rated the level of mental health services available in the community as excellent; 36.7 % rated the services as good; 18.3% rated the level of services as fair; 3.3 % rated the services as poor; and 31.7% indicated the level of service was unknown.
- 15.3% of the respondents rated the level of substance abuse treatment services available in the community as excellent; 30.5% percent rated the services as good; 16.9 % rated the services as fair; 3.4% rated the level of services as poor; and 33.9 percent indicated the level of service was unknown.

Chart 5
Jail Ratings of Community Services



4. Recommended Changes or Additional Services

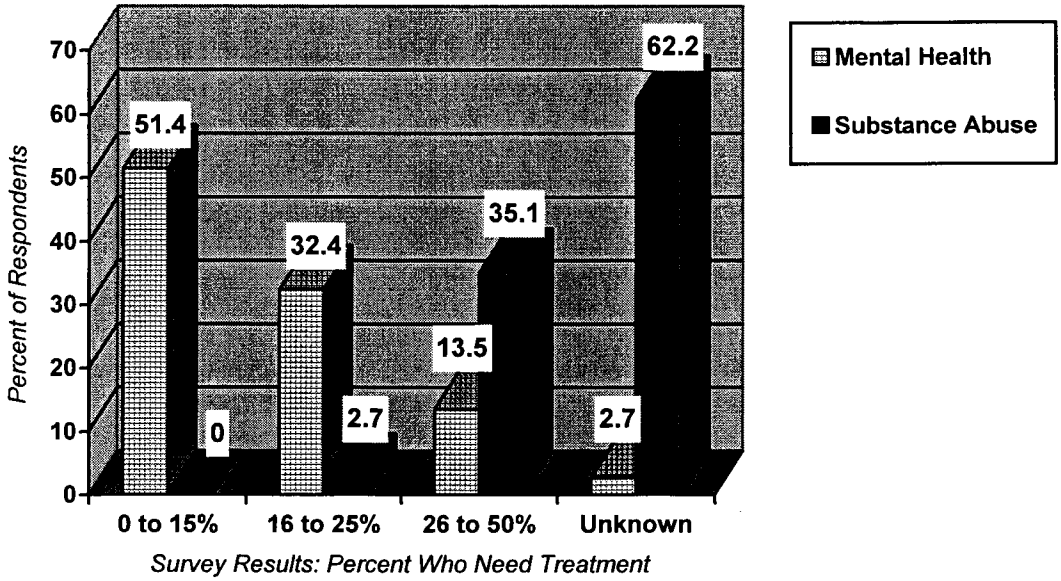
Forty-three responses to the final question on the survey were received: "What changes or additional services in your jail or in the community would ensure a higher level of identification and treatment to inmates and former inmates who have mental health or substance abuse treatment needs?"

- Twenty-six indicated a need for additional staff to provide mental health and substance abuse services.
- Ten jails related a need for more services provided by CSBs. For example, two jails want CSBs to continue services to their clients if they become incarcerated. Another jail wants incarcerated persons to be a designated priority for CSBs. One jail cited a "critical need for mental health services beyond the emergency response level"; another cited the need for more on-site evaluations and treatment by CSB staff; two indicated a need for case management; and another indicated the need for "quicker follow-up" with community agencies when an inmate is released.
- Three jails cited a need for staff training.
- The need for better access to medications (including court-ordered medication), hospital beds, and housing was mentioned.
- The need to restore funding for the "Public Inebriate Program," which provides services for persons with dual diagnoses of substance abuse and mental illness, also was mentioned.
- Treatment space in the jails, regional cooperation, consistent assessments, service continuum, discharge planning, drug courts, and mental health courts were all cited as potential improvements.

E. PROBATION AND PAROLE SURVEY RESULTS

The Committee sent a questionnaire to 42 Probation and Parole Districts to gain a better understanding of the scope of current services and the need for additional services in local communities. Responses were received from 37 (88%) of the districts. Almost 46 percent of the responders believe that at least 16 percent of their caseloads need mental health treatment. One hundred percent of the responders believe that at least 16 percent of their caseloads need substance abuse services (Chart 6).

Chart 6
Offenders Under Probation and Parole Supervision Who Need Treatment



1. Mental Health Treatment Services

- Responder estimates of their caseload that need mental health services:
  0-15% (51.4%) 16-25% (32.4%) 26-50% (13.5%) Unknown (2.7%)
- 38.9% reported that offenders are not screened for mental health needs when they are released from the correctional facility; 25% reported that offenders are screened for mental health treatment needs, usually by the CSB, when they are released from the correctional facility; 33.3% indicated that offenders are screened at the correctional facility.
- In those districts that reported screening availability, assessments are also conducted, usually by the CSB, when the screening indicates potential mental health problems; only four districts indicated that a standardized assessment instrument is used.
- 43.2% of the responders indicated that they do not receive a mental health treatment history when an offender is released from a correctional facility; 37.8% do receive a treatment history; 18.9% indicated that they sometimes receive a treatment history.
- 61.5% indicated that the treatment history is adequate; 38.5% indicate that the treatment history is not adequate.
- Probation and Parole District staffs do not provide mental health services.
- 97.3% reported that community services board (CSB) provide mental health services.

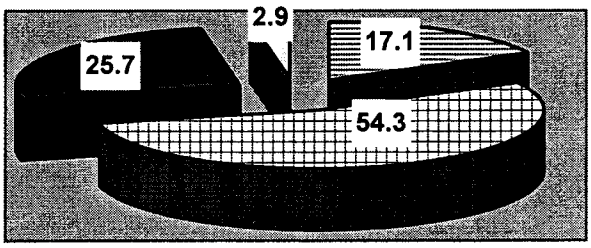
2. Substance Abuse Treatment Services

- Responder estimates of the percentage of their caseload that need substance abuse treatment: 0-15% (0) 16-25% (2.7%) 26-50% (35.1%) Over 50% (62.2%)
- 67.6% of the responders reported that offenders are screened for substance abuse when they are released from the correctional facility; 16.2% indicated that offenders are not screened; 13.5% reported that offenders are screened at the correctional facility.
- 85.2% indicated that a standardized screening instrument is used.
- In those districts that screen, 92.9% conduct an assessment if the screening indicates potential mental health problems; 85.7% use a standardized assessment instrument.
- 55.6% of the assessments are conducted by Probation and Parole staff; 14.8% by CSB staff; and 29.6% by some combination.
- 62.2% of the responders indicated that they do not receive a substance abuse treatment history when an offender is released is released from a correctional facility; 29.7% do receive a substance abuse treatment history; 8.1 sometimes receive a treatment history.
- 47.6% indicated that the treatment history is adequate; 47.6% indicate that the treatment history is not adequate; 4.8% were unknown.
- 43.2% of the Probation and Parole Districts reported that their staff provides substance abuse treatment services; 56.8% do not.
- 97.2% of the responders indicated that CSBs provide substance abuse assessment and treatment.

3. Service Coordination

- 54.1% of the responders indicated that offenders receive a discharge plan from the correctional facility; 29.7% indicated that offenders do not receive a discharge plan; 13.5% indicated that offenders sometimes receive a discharge plan.
- 63.3% said that the Probation Officer oversees the discharge plan.
- 75% of the responders said that offenders receive a temporary supply of prescription medications or a back-up prescription if needed when they are released from a correctional facility; 16.6% said that offenders sometimes or never received a temporary supply of prescription medications.
- The temporary supply of prescription medications is intended to last: 5-10 days (28.1%) 11-30 days (59.4%) Unknown (12.5%)

Chart 7
Probation and Parole
Average Wait for Mental Health Treatment

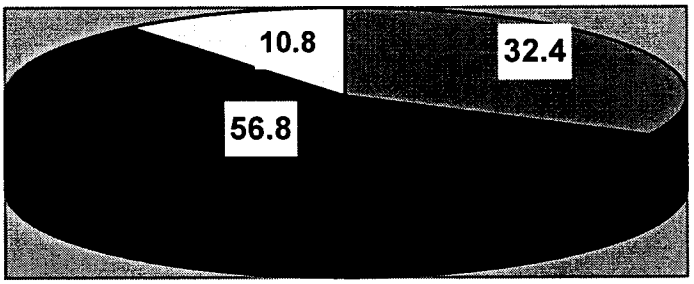


Survey Results:

0 to 10 days | 11 to 30 days | 31 to 60 days | Over 60 days

- The average wait for the first appointment to receive mental health services in the community is:
  0-10 days (17.1%) 11-30 days (54.3%) 31-60 days (25.7%) Over 60 days (2.9%)
- The average wait for the first appointment to receive substance abuse treatment services in the community is:
  0-10 days (32.4%) 11-30 days (56.8%) 31-60 days (10.8%)

Chart 8
Probation and Parole
Average Wait for Substance Abuse Treatment

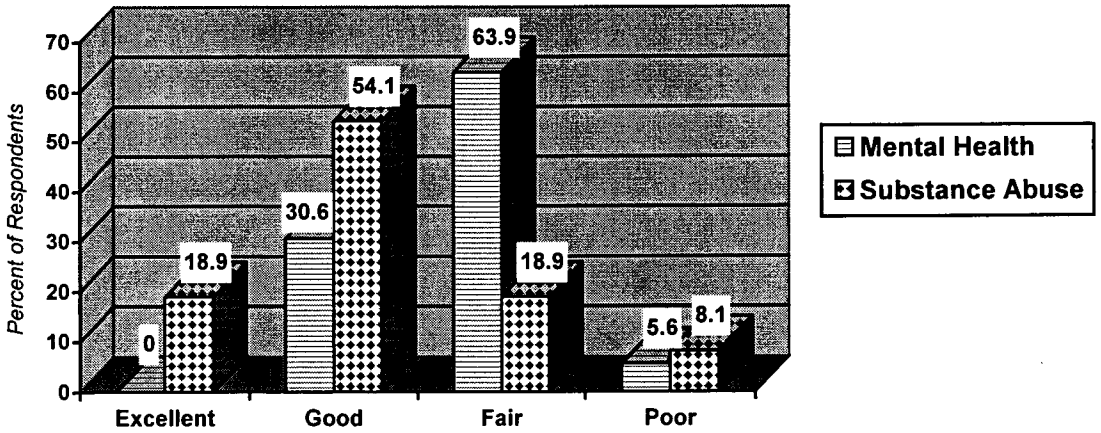


Survey Results:

0 to 10 days | 11 to 30 days | 31 to 60 days

- 69.5% of responders describe the level of mental health services available to offenders as fair or poor; 30.6 % of responders describe the level of mental health services available to offenders as good.

Chart 9
Probation and Parole
Community Services Ratings



Survey Results: Service Ratings

- 27% of responders describe the level of substance abuse services available to offenders as fair or poor; 73% of responders describe the level of substance abuse services available to offenders as excellent or good.

4. Recommended Changes or Additional Services

- Fourteen districts mentioned the need for housing and residential services, including halfway houses and residential services for offenders who have mental illness, substance abuse disorders, and dual diagnoses.
- Nine districts mentioned the need for more inpatient and outpatient services for dual-diagnosed offenders.
- Five districts cited the need for additional services for sex offenders.
- Two districts reported the need for better information from correctional institutions about offenders' history of mental illness.
- At least one district mentioned the need for specific services: assessment, crisis intervention, intensive treatment, day support, medication management, mental health and substance abuse outpatient treatment and detoxification facilities.
- At least one district also cited the need for additional staff, transportation, and smoother transition from incarceration to community.

F. FINDINGS AND RECOMMENDATIONS--ADULT OFFENDERS

Finding 1: Interagency Collaboration. *Formal state and local interagency collaboration, which is necessary to plan integrated, comprehensive service delivery systems for adult offenders with mental illness, is not available in all communities. Interagency responsibilities for serving adult offenders with mental illness in local jails and local pre-trial service and community-based probation programs often are not clearly defined. Jails and community services boards frequently lack coordination in the areas of pre-release planning, communications and continuity of care that are necessary to assure rapid connections to community services upon release. Moreover, a consensus does not appear to exist as to whether the responsibility for the provision of services should reside with the criminal justice system or the mental health treatment system. The Interagency Drug Offender Screening and Assessment and the SABRE initiatives have promoted interagency cooperation toward improving the integration of substance abuse identification and treatment within the criminal justice system. However, similar statewide initiatives have not been targeted to offenders with mental illness.*

Recommendation 1: Establish an interagency work group under the leadership of the Committee to develop a screening-assessment-treatment model for offender groups with mental health needs. The work group should identify or develop:

- Consensus concerning the statutory assignment of responsibility for providing treatment services to offenders with mental illness or substance abuse disorders;
- A regional planning process to foster state and local interagency collaboration;
- A defined continuum of care;
- Model memoranda of agreement that detail responsibilities of the treatment provider and the purchasing agency and provisions for exchange of information, cross training for staff, confidentiality and payment terms; and
- A framework to pilot the memoranda and evaluate the results.

The Committee's membership should be expanded to include the Secretaries of Health and Human Resources and Public Safety as ex officio members. The work group should consist of the following entities:

- Department of Criminal Justice Services;
- Department of Corrections;
- Department of Mental Health, Mental Retardation, and Substance Abuse Services;
- Department of Social Services;
- Virginia Association of Community Services Boards;
- Community Criminal Justice Boards;
- Virginia Sheriffs' Association; and
- Regional Jails Association.

Recommendation 2: Request that the Office of the Executive Secretary of the Supreme Court work with the Department of Criminal Justice Services, the Department of Corrections, Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Virginia Association of Community Services Boards, Community Criminal Justice Boards, the Virginia Sheriffs' Association, and the Regional Jails Association to examine the feasibility of designing and implementing a model court order that addresses mental health services.

Finding 2: Capacity. *Many communities lack sufficient capacity to treat offenders with mental illness and substance abuse disorders while they are incarcerated and when they are released from state correctional facilities and local or regional jails. Lack of a comprehensive and systemic approach to funding these services has resulted in inequitable access to care across Virginia. The Department of Corrections indicated that additional clinical support is needed in Probation and Parole Districts. Forty-two (73.7 percent) of the local and regional jails that responded to a survey from this committee indicated problems dealing with persons who require acute psychiatric care: 19 respondents indicated problems accessing hospital beds, because inmates did not meet the criteria for admission, hospital beds were not available, or the time to process the admission was burdensome; and nine respondents indicated lack of space and staff to house inmates with mental illness. Community services boards that responded to a survey by the Department of Mental Health, Mental Retardation and Substance Abuse Services indicated that their expenses for mental health and substance abuse services provided or contracted for in jails is approximately $6 million per year. The community services boards estimated that the cost of meeting the unmet need for mental health and substance abuse services in local jails is approximately $34 million per year.*

Recommendation 3: By budget amendment, direct the Department of Criminal Justice Services, in collaboration with the Department of Corrections, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Virginia Association of Community Services Boards, Community Criminal Justice Boards, the Virginia Sheriffs' Association, and the Regional Jails Association, to identify the unmet need for mental health and substance abuse treatment services for offenders and develop a comprehensive plan, including the necessary resources and funding sources, for covering the increasing costs of providing existing services and to fill service gaps.

Recommendation 4: By budget amendment, direct the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, in consultation with the Department of Corrections, Virginia Sheriffs' Association, the Regional Jails Association, and the Virginia Association of Community Services Boards, to make recommendations to this committee concerning access to psychiatric care for jail inmates, including the availability of inpatient beds, judicially ordered treatment and atypical antipsychotic medications. The recommendations should include consideration for use of existing state facilities (Department of Corrections and Department of Mental Health, Mental Retardation and Substance Abuse Services) and designated sections of regional jails.

Recommendation 5: By budget amendment, direct the Department of Criminal Justice Services, Department of Medical Assistance Services, Department of Corrections, and Department of Mental Health, Mental Retardation and Substance Abuse Services to examine opportunities to leverage nongeneral funds to meet the unmet need for services.

Recommendation 6: Direct the Department of Medical Assistance Services, in conjunction with the Department of Corrections and the Department of Juvenile Justice, to examine ways to provide immediate access to Medicaid for eligible offenders when they are released from prisons or jails.

Recommendation 7: Direct the Department of Corrections and the Department of Mental Health, Mental Retardation and Substance Abuse Services to recommend ways to ensure the appropriate management of medications for offenders when they are released from state correctional facilities, including development of a memorandum of agreement to ensure the continuity of care.

Fifty localities in Virginia have been designated as Mental Health Professional Shortage Areas. The 2000-2002 biennium budget includes $500,000 each year for the recruitment and retention of psychiatrists in medically underserved areas. Eleven residents are currently enrolled in the program; six will graduate in 2002.

Recommendation 8: Continue the current funding level ($500,000 each year) for recruitment and retention of psychiatrists.

Recommendation 9: Request that the Department of Mental Health, Mental Retardation and Substance Abuse Services explore the expanded use of telepsychiatry for underserved areas.

Finding 3: Clinical Guidelines. *The Commonwealth has not developed clinical guidelines for local and regional jails to ensure an adequate level of mental health services. Guidelines are especially needed in the areas of assessments to determine the presence of any mental illness or substance abuse disorder and the most appropriate service disposition for specific offenders; diversion services for nonviolent offenders; treatment services provided in jails; and post-release treatment services, including specialized services such as supervised living programs. Uniform screening and assessments for mental illness are not available in many local jails. Eighty percent of the jails that responded to the Committee's questionnaire indicated that standardized screening instruments were used for mental health, but only 42.2 percent use standardized assessment instruments. Almost 70 percent use standardized screening instruments for substance abuse, but only 41.2 percent use standardized assessment instruments. In many cases, local inmates lack access to adequate mental health and substance abuse treatment services, including psychiatrists, acute psychiatric inpatient beds and atypical antipsychotic medications. Discharge plans are not routinely developed and oversight responsibilities are not routinely assigned when offenders with mental illness or substance abuse disorders are released from local jails. Of those jails responding to the Committee's survey, 40 percent indicated that no discharge plans are developed when the inmate is released.*

Recommendation 10: By budget amendment, direct the State Board of Corrections and the State Mental Health, Mental Retardation and Substance Abuse Services Board, in consultation with the Virginia Sheriffs' Association, the Regional Jails Association, and the Virginia Association of Community Services Boards, to develop (i) minimum guidelines for the provision of mental health and substance abuse treatment services in local and regional jails that reflect an adequate continuum of services, including the availability of atypical antipsychotic medications; and (ii) a plan, including the necessary fiscal and staff resources, for meeting the guidelines. The State Board of Corrections and the State Mental Health, Mental Retardation and Substance Abuse Services Board shall report their findings and recommendations to this committee by September 30, 2002.

Finding 4: Cross Training. *Cross training for balancing therapeutic goals with security needs and public safety is needed for law enforcement, judges, jail staff, and community treatment staff. The concept of training specific law-enforcement officers to interact with suspects who have mental illness began in Memphis, Tennessee, and has since been replicated in other communities, including Albuquerque, New Mexico, and Roanoke County, Virginia. The Virginia Police Chiefs Foundation recently developed an intensive four-day training seminar for police officers on crisis intervention with persons with mental illness.*

Recommendation 11: Request that the Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with the Office of the Executive Secretary of the Supreme Court and the Department of Criminal Justice Services, develop and make recommendations for implementing a curriculum for cross training law-enforcement officers, judges, jail staff, and community treatment staff in security and treatment, including philosophy, confidentiality, judicially ordered treatment, medication management, records management, and treatment and security services reference guides.

Finding 5: Data Collection, Evaluation and Information Sharing. *No comprehensive mechanism exists to systematically collect complete and accurate data on treatment services provided to and needed by adult offenders, or to evaluate the effectiveness of the services.*

Recommendation 12: Request that the Secretary of Public Safety, in conjunction with the Secretary of Health and Human Resources and the Secretary of Administration, develop a plan, including the estimated cost, for the collection of data on treatment services provided to and needed by state-responsible offenders and for the evaluation of the effectiveness of treatment services.

Nine community services boards receive funds totaling $1,119,692 from a combination of sources in fiscal year 2002 to provide intensive substance abuse treatment services in local jails. Although these programs are patterned after a national model for offender-based therapeutic communities, evaluation data are not available to determine the success of the programs in Virginia jails. The programs are located in Petersburg, Roanoke County, Roanoke City, Virginia Beach, Norfolk, Fairfax, Hampton, Martinsville, and Middle Peninsula-Northern Neck areas. The sources of funds are: DMHMRSAS - $225,000 (general fund); DCJS - $194,692 (general fund) and 700,000 (nongeneral fund).

Recommendation 13: Continue the funding for intensive substance abuse treatment services for the next biennium and direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to issue a Request-for-Proposals to conduct a comprehensive process and outcome evaluation of therapeutic communities in local jails.

State agencies and treatment providers need better ways of sharing "best practices" information with each other.

Recommendation 14: Request that the Department of Mental Health, Mental Retardation and Substance Abuse Services, in consultation with federal, state and local experts, explore ways to communicate "best practice" information among treatment providers.

IV. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES FOR JUVENILE OFFENDERS

A. OVERVIEW OF THE JUVENILE JUSTICE SYSTEM

The Virginia Department of Juvenile Justice (DJJ) provides a continuum of services that are designed to hold juveniles accountable for their actions and rehabilitate youth who have committed status and delinquent offenses in Virginia. The agency offers statewide programming in "the areas of prevention, intervention, restriction, and reformation of youth" (Department of Juvenile Justice, 2001a). The Department's mission is to protect the public through a balanced approach of comprehensive services that prevent and reduce juvenile crime through partnerships with local organizations while providing the opportunity for delinquent youth to become responsible and productive citizens (Department of Juvenile Justice, 2001a).

DJJ primarily interacts with juveniles alleged to have committed a delinquent act. The definition of a delinquent act is (i) an act designated a crime under the law of this Commonwealth, or an ordinance of any city, county, town or service district, or under federal law, (ii) a violation of § 18.2-308.7, or (iii) a violation of a court order as provided for in § 16.1-292, but shall not include an act other than a violation of § 18.2-308.7, which is otherwise lawful, but is designated a crime only if committed by a child (Va. Code Annotated, § 16.1-228, 2001). DJJ also interacts with children who are in need of supervision (CHINSup), children in need of services (CHINS), and children who are abused, neglected, or lacking proper parental care (Department of Criminal Justice Services, 2000b).

DJJ supports community programs and services, supervision and case management for committed juveniles as well as services for juveniles who are not committed to but are exposed to the system (DJJ, Juvenile Justice Process, 2002). DJJ oversees 32 Juvenile & Domestic Relations District Court Service Units (CSUs), a Reception & Diagnostic Center, seven Juvenile Correctional Centers (JCCs), and three halfway houses. Virginia also has three CSUs that function as locally operated, independent Court Service Units. Additionally, DJJ provides partial financial support through block grant funding for 22 secure detention facilities. The agency also contracts for one private halfway house. Partial funding also is provided to 43 Offices on Youth, which provide prevention and intervention services to 53 localities (Department of Criminal Justice Services, 2000b).

Juvenile justice services are organized at both the state and local level in Virginia and DJJ oversees these services at both levels. These services are divided into two categories, services for nonstate wards and services for state wards.

1. Services for Nonstate Wards

The Division of Community Programs within DJJ coordinates the services for nonstate wards. Nonstate wards are those juveniles who enter the system when delinquent offenses are carried out but are not committed to DJJ. These juveniles are released to their parents or guardians or detained by DJJ while appropriate sanctions or services are selected. The programs that fall under this division include:

- Court Service Units;
- Offices on Youth;
- Community-funded programs and services;
- Detention services; and
- Alternatives to commitment (Department of Juvenile Justice, 2001h).

Offices on Youth, detention services and community funded programs and services are operated by local agencies to target the particular needs of the youth within the community. The Court Services Units, with the exception of three locally operated units, are operated by DJJ. Alternatives to commitment are operated by private vendors under contract to DJJ.

Court Service Units (CSUs). The Commonwealth operates 32 CSUs that serve as the center of the statewide juvenile justice process. Additionally, three CSUs are locally operated. These entities are responsible for performing juvenile intakes, investigations and reports, domestic relations services, custody investigations, and probation/parole supervision. At the CSU, it is determined whether a petition should be filed with the Juvenile & Domestic Relations Court or if any alternative action is necessary. Alternative actions may include diversion and referral to other available community resources.

Intake--considered the first step in the juvenile justice process--occurs 24 hours a day at each of the CSUs. The role of intake is to determine how a juvenile's case will be handled. Factors considered include the nature of the complaint or charge and whether the complaint or charge is serious or violent in nature. Based on information gathered, a determination is made whether a petition should be filed with the juvenile court and, if so, whether the juvenile should be released to the parents or detained pending a court hearing (Department of Juvenile Justice, 2001h). The juvenile may be diverted out of the court system completely.

Social histories make up the majority of the reports that the CSU personnel complete (Department of Juvenile Justice, 2001l, p. 8). Other reports are completed by the CSU that also provide the basis for developing appropriate services for the juvenile and the family. Social histories are prepared in:

> any case involving a child, who has been adjudicated, subject to the jurisdiction of the juvenile and domestic relations district court or circuit court, and the court, before final disposition thereof, may require an investigation, which (i) shall include a drug screening and (ii) may include the physical, mental and social conditions, including an assessment of any affiliation with a youth gang as defined in § 16.1-299.2, and personality of the child and the facts and circumstances surrounding the violation of law (Va. Code Ann., § 16.1-273, 2001).

The CSUs also supervise juvenile probation and parole. Probation supervision is one of the most frequently used dispositions for juveniles found guilty of a charge. Virginia's juvenile probation and parole focus on community protection, accountability and competency development (Department of Juvenile Justice, 2001l, p. 8).

Offices on Youth. The Offices on Youth are local agencies funded through grants from DJJ. The primary objective of these agencies is to "coordinate and cooperate with other local child service agencies to assess needs and plan services for youth and families" (Department of Juvenile Justice, 2001g). Currently, the local Offices on Youth are the only agencies within DJJ that are designed specifically to coordinate prevention efforts. The activities coordinated by the Offices on Youth are intended to reduce the number of youth who enter the juvenile justice system, and typically target high-risk behaviors such as substance abuse and school truancy. Minimum standards governing the operation of the local Offices on Youth exist in regulation. The role of the Offices, pursuant to § 66-26 of the Code of Virginia, is to develop and supervise delinquency prevention and youth development programs in order that better services and coordination of services are provided to children. Office on Youth programs address various risk factors that juveniles exhibit and develop policies to prevent juvenile delinquency by promoting affirmative youth development.

Community-Funded Programs and Services. There are a number of community-based programs designed to promote optimal prevention, treatment, and rehabilitation efforts. Such services may include residential facilities, such as group homes and crisis shelter care, as well as individual and family counseling. There are also programs in many communities that provide assessment and treatment for specific populations such as sex offenders, youth with mental illness, and chemically dependent youth. The Virginia Juvenile Community Crime Control Act (VJCCCA) (§ 16.1-309.2 et seq. of the Code of Virginia) funds some of these programs.

The VJCCCA provides localities with state resources to help establish a local community-based system of services that corresponds to the youth's offense and treatment needs (Virginia's Three-Year Plan, 2000). DJJ provides assistance to localities by developing and implementing plans under the VJCCCA, both for nonresidential and residential placements. The VJCCCA is discussed in greater detail in Section E of this chapter.

Detention Services. Localities or multi-jurisdictional commissions operate 22 local and regional detention homes. DJJ provides support in the form of capital construction and up to 50 percent of operating costs, with the exception of one state-operated facility that is adjacent to the Culpeper Juvenile Correctional Facility. These facilities provide short-term care for juveniles who require secure custody before and during the process of disposition or placement. Youth in detention centers are not considered to be in the custody of DJJ. However, detention facilities may also accept post-dispositional delinquents whom the court has given a lesser period of confinement than those youths typically placed in Juvenile Correctional Centers. Treatment services in post-dispositional delinquents are coordinated by the detention homes, the family and local agencies and are designed to specifically meet the needs of each juvenile.

Alternatives to Commitment. The Division of Community Programs also offers alternatives to commitment, such as boot camps and day treatment programs. The Boot Camp, Camp Kenbridge, is located in Lunenberg County and is a privately operated facility. Camp Kenbridge houses 100 juveniles and serves as an intermediate sanction for a Juvenile & Domestic Relations District Court (Department of Juvenile Justice, 2001e, p. 8). This placement is reserved for nonviolent offenders who have never been committed to a Juvenile Correctional Center. There also are two-day treatment programs available in private facilities in the Tidewater area. These programs provide specific, marine-based skill development and educational services in a structured day school environment.

2. Services for State Wards

DJJ is the primary provider of services for state wards. When a judge determines that placement in a community program or probation is not appropriate for a juvenile offender, the juvenile is committed to DJJ. Committed juveniles are not to be below the age of 10 and must be adjudicated on a delinquency charge (Department of Criminal Justice Services, 2000b). Juveniles committed to the custody of DJJ typically receive residential placements in one of three types of facilities:

- Juvenile Correctional Centers;
- Privately contracted residential facilities; or
- Halfway houses.

Juvenile Correctional Centers. There are seven Juvenile Correctional Centers operated by DJJ. These facilities provide programs to "address the treatment, disciplinary, medical, and recreational needs of the juveniles." (Department of Juvenile Justice, 2001i). These centers offer targeted programs

designed to address certain behaviors such as substance abuse or sexual offenses and treat various conditions such as developmental and behavior disorders. In addition, DJJ operates the Reception and Diagnostic Center, which serves as the intake facility for all juveniles committed to the custody of DJJ. The Center provides secure confinement for all juveniles for approximately 30 days while they are being evaluated to determine treatment needs and appropriate placement. In 2001, these facilities had a bed capacity of 1,243 (Department of Juvenile Justice, 2001l, p. 12).

Privately Contracted Residential Facilities. Two privately owned facilities in Virginia have contracted with DJJ to provide supplemental beds and treatment services for state wards. The Tidewater Environmental Institute in Norfolk and the Virginia Wilderness Institute in Grundy offer residential care and treatment programs for juveniles committed to DJJ. By contracting with private providers, DJJ has given juvenile offenders additional treatment options while supplementing the available number of correctional center beds.

3. Transitional Services

DJJ also oversees services for juveniles released from Juvenile Correctional Centers or private placements to aid the parole officers in facilitating a smooth transition from incarceration to community living. Halfway house and parole services are offered by DJJ to provide assistance in the juveniles' shift back to the community. Services offered to juveniles include relapse prevention, substance abuse treatment, instruction on independent living skills, home-based counseling and vocational education.

Halfway Houses. Four halfway houses are available to state wards in Virginia. Three of these facilities are state-owned, and one is operated by a private agency. These facilities provide residential services to juveniles that require a transition from Juvenile Correctional Centers back into the community. The goal of these programs is to promote adjustment and reduce the risk of recidivism. DJJ purchases services for offenders that facilitate the shift from incarceration to community living. These services include counseling, programs that teach independent living skills, substance abuse treatment, sex offender treatment, relapse prevention, educational services and employability programs (Department of Juvenile Justice, 2001l, p. 14).

Parole Services. DJJ also oversees the provision of parole services to juveniles released from the Juvenile Correctional Centers. These services assist juveniles in their transition to the community. They may include family and individual counseling, referral to community services, vocational services, or specialized educational services.

B. VIRGINIA'S JUVENILE JUSTICE PROCESS

A youth becomes involved in the juvenile justice system when he/she commits a status or delinquent offense that is reported to one of the Commonwealth's 35 local Court Service Units (CSUs) by the police, the victim, or another citizen (Department of Juvenile Justice, 2001d). At that time, the juvenile is typically brought to the CSU and the intake process is initiated. Juvenile intake is considered the first step in the juvenile justice system. There are 35 CSUs located across the Commonwealth that serve as the center of this process. Intake officers are available 24 hours a day to receive, review, and process all complaints made regarding juvenile criminal activity. Intake functions are mandated by the Code of Virginia (Va. Code Annotated, § 16.1-260, 2001).

Once an offense is reported to the local CSU, the intake officer makes a determination as to whether a petition should be filed with the Juvenile & Domestic Relations District Court. The officer has the discretion to divert some of the cases from the adjudication process, based on the nature of the

offense and the circumstances surrounding the event (Department of Juvenile Justice, 2001f). A number of juveniles in Virginia are diverted to community-based programs that are designed to address their individual needs, such as individual or family counseling. Other juveniles are required to perform some type of community service to make amends for their offense. Localities also provide resources such as crisis shelter care, community youth homes, and family-oriented group homes to youths in need of community residential care (Department of Juvenile Justice, 2000a).

The cases that are not diverted are forwarded to the local Juvenile & Domestic Relations District Court for adjudication. Once it is decided that a case will move forward to court, the intake officer decides whether the juvenile should be released to parents or detained pending a court hearing. This decision is based on multiple factors including the juvenile's risk to the community or self and the risk of absconding (Va. Code Annotated § 16.1-248, 2001). If the decision is made to detain the juvenile, a hearing must be held by the Court within 72 hours to determine if further detention is necessary. If the juvenile remains in detention, the adjudicatory hearing must occur within 21 days.

If applicable, the case then proceeds to a preliminary hearing. This hearing is used to determine whether the case has enough merit to carry it to trial. The court also addresses issues such as competency, subpoenas and witnesses, as well as any transfers or waivers.

A juvenile's case may be transferred to circuit court at this stage if it meets certain statutory requirements (Va. Code Annotated, § 16.1-269.1, 2001). Specifically, a juvenile must be 14 years of age or older at the time of the alleged offense, and must be charged with an offense that would be a felony if committed by an adult. If a transfer hearing is initiated, the court must then determine whether it should retain jurisdiction over the juvenile. This decision is made after the court considers characteristics of the offender such as age, maturity (mental, emotional, and physical), criminal record, and the extent of any mental retardation or illness. In making the decision, the court also considers factors such as the seriousness and number of alleged offenses committed by the juvenile, and the appropriateness and availability of services and dispositional alternatives in both systems.

If the court does not find probable cause at the preliminary hearing, the case is dismissed. However, if probable cause is established, the case moves forward to the adjudicatory hearing, where a judge determines innocence or guilt. If a guilty verdict is returned, the court may initiate a social history investigation. This investigation examines the juvenile's court history, contacts with other agencies, family background, physical, mental and social circumstances and includes a drug screening. Once this information is collected, the court uses it to determine which dispositional sanctions and services are most appropriate for the juvenile and the family. Available dispositions include warnings, reprimands, fines, or conditional dispositions such as probation, participation in the CSU programs, referral to local services or facilities, referral to other agencies, private placement (through the Comprehensive Services Act), boot camp, or commitment to DJJ. A custodial commitment to DJJ is typically the last resort, and is used only for those juveniles whose "[d]elinquent behavior, criminal offense histories, and treatment histories make it impossible to place [them] in foster homes, non-secure facilities, or with their own families." (Department of Juvenile Justice, 2001i). The criteria for commitment of a juvenile are provided in § 16.1-278.8 in the Code of Virginia (2001).

If the court decides to commit a juvenile to DJJ, he is sent to the Reception and Diagnostic Center (RDC) to begin the intake process. The RDC conducts psychological, educational, social and medical evaluations for committed juveniles. Based on the results of these evaluations, DJJ classifies treatment services into mandatory, recommended, and ancillary treatment objectives. The RDC evaluates each committed juvenile by reviewing his social and offense history, educational assessment, psychological assessment, any other assessments, physical assessments as well as substance abuse

screenings (Department of Juvenile Justice, 2001j). The juvenile is then placed in a correctional center or a privately operated residential facility. Table 1 lists the facilities and the population capacity (Department of Juvenile Justice, 2001b).

Table 1
Juvenile Correctional Facilities
2001 Population Capacity

State-owned Facilities (DJJ, Agency Overview, 2001, p. 12).	**Beds**
Reception and Diagnostic Center	166
Barrett Juvenile Correctional Center	98
Beaumont Juvenile Correctional Center	322
Bon Air Juvenile Correctional Center	280
Culpeper Juvenile Correctional Center	112
Hanover Juvenile Correctional Center	154
Natural Bridge Juvenile Correctional Center	71
Oak Ridge Juvenile Correctional Center	40
Total State-owned Beds	**1,243**

Contracted Private Providers (DJJ, Programs and Facilities, 2002).	**Beds**
Tidewater Environmental Institute (Associated Marine Institute)	17
Virginia Wilderness Institute (Associated Marine Institute)	32
Total Private Provider Beds	**49**

A juvenile who is placed in one of the seven Juvenile Correctional Centers after being evaluated for services needs and appropriate placement generally receives educational, crisis intervention, counseling, and case management services. Juveniles also may receive treatment and service specialization for issues such as substance abuse, anger control, mental health, and sex offending. Vocational training is offered through the Youth Industries program, which is an enterprise initiative that "provides youth with long-term commitments job skills training in areas such as bindery work, culinary art, offset duplicating machine operating, silk-screening, printing, electrical wiring and horticulture" (Department of Juvenile Justice, 2001j).

Each of the centers offers specific rehabilitative and treatment programs. Most facilities offer substance abuse and anger management programs. Three facilities also offer sex offender treatment services; two offer college-bound and SAT testing programs. In addition, certain facilities are designated for the treatment of specific populations. For example, the Barrett facility offers intensive substance abuse treatment for "chemically dependent juveniles of all ages with less serious committing offenses." (Department of Juvenile Justice, 2001i). Oak Ridge facility serves male offenders with developmental disabilities and severe behavior disorders, using a behavioral "token economy" program to facilitate treatment and management efforts.

Once juveniles complete the commitment period, they are placed on parole and are provided with transition services by the Court Service Units. For some juveniles, 24-hour residential care and treatment services are necessary prior to release into the community. For these juveniles, halfway houses are available to provide these services. Once the parole period and the transition services are completed,

they are discharged from the system. DJJ utilizes an integrated approach in treating juveniles and emphasizes accountability in its programs. Strategies are also employed that reduce the risk of recidivism.

According to statistics published by DJJ, in 1999, 1,616 youth were committed to Virginia's Juvenile Correctional Centers. Of this number, 89 percent were males and 11 percent were females. There were fewer African American juveniles (59 percent) committed to the system in 1999 than in 1993 (65 percent), compared to Caucasian juveniles who show the reverse trend. Caucasian juveniles comprised 37 percent of the total committed youth in 1999, compared to 32 percent in 1993. About three percent of committed juveniles were of other races or ethnic groups, e.g., Hispanic. The average age of the juveniles at commitment has remained stable, ranging from 15.6 years to 15.8 years (McGarvey, E.L. & Waite, D., 2000).

C. MENTAL HEALTH TREATMENT SERVICES FOR JUVENILE OFFENDERS

Families may turn to the juvenile justice system as a last resort, in hopes that their child will be able to access the needed services. According to a national report released by the National Alliance for the Mentally Ill, 36 percent of respondents to a nationwide survey of families who have children with severe mental illnesses said that their children were in the juvenile justice system because of the unavailability of mental health care services (National Alliance for the Mentally Ill, 1999). Of additional concern is the fact that risk factors related to behavior problems, such as substance abuse, delinquency, teenage pregnancy, truancy, and violence, show a significant overlap. For example, "early and persistent antisocial behavior" in the school setting may be a sign of behavior problems in a number of areas (Redding, 2001). Risk factors tend to have an interactive effect. That is, one single factor is not usually a cause, but rather multiple factors working together can create problem behavior. Other overlapping risk factors include:

- Extreme economic deprivation;
- Family management problems;
- Family conflict;
- Academic failure beginning in elementary school;
- Friends who engage in the behavior; and
- Early initiation of the problem behavior. (Redding, 2001).

Effective intervention programs typically address multiple risk factors, involve comprehensive services that are individualized and family and child-centered, and would ideally be delivered in a natural setting in collaboration with the family. Furthermore, providers who demonstrate skill, persistence, and a strong sense of accountability are considered to be in the best position to deliver these interventions.

1. Treatment Needs of Juveniles

Estimates provided by both state and local juvenile justice facilities suggest that juvenile offenders have significant mental health treatment needs. A recent study showed that more than 40 percent of males and almost 60 percent of females in detention homes were in need of mental health services; more than seven percent of males and more than 15 percent of females had urgent mental health treatment needs (Redding, 2001). Overall, very few of the local detention homes or the CSU intake officers conduct uniform screening and assessments for mental illness. Furthermore, once

screened, the facilities may not be able to serve the juveniles due to the limited availability and capacity of treatment programs.

Juveniles whose mental health disorders are severe or whose conditions deteriorate while in detention sometimes need the security and services provided by inpatient psychiatric hospitalization. However, mental health providers have repeatedly cited the diminishing numbers of public inpatient psychiatric beds as a significant barrier to child and adolescent treatment efforts (Hays-Smith, 2001). Detention officials are all too often faced with the situation in which an inpatient bed cannot be found, while they continue to have responsibility for the juvenile's well-being and care. In addition to fewer inpatient beds, additional barriers are factors such as fewer beds for children (11 years and younger) and the complex and often inadequate funding that is available to support the juvenile's hospitalization.

A study by Dr. Richard Redding of the Institute of Law, Psychiatry, and Public Policy at the University of Virginia sheds light on some of the difficulties juvenile offenders may confront in accessing mental health services. He interviewed juvenile justice professionals in Virginia and asked them to identify 10 key barriers to meeting the mental health needs of juvenile offenders (Redding, 2001). The responses are provided in the list that follows.

Barriers to Meeting the Mental Health Needs of Juvenile Offenders Cited by Virginia Juvenile Justice Professionals

- Lack of a guiding philosophy for serving juvenile offenders;
- Juvenile justice system used as a "dumping ground" for juveniles with mental health problems;
- Undiagnosed learning problems;
- Lack of early intervention, leading to an escalation of delinquent behaviors;
- Need for greater parental involvement in, and accountability for, their child's treatment and rehabilitation;
- Need for detention and community-based treatment;
- Need for improved interagency collaboration and integrated comprehensive service delivery systems;
- More local services needed for special populations of juveniles - insufficient advocacy for court-involved juveniles, post-adjudication;
- Inadequate funding to localities to serve juvenile offenders; and
- Legal confidentiality impediments to interagency records sharing and development of integrated data systems.

2. Services Offered by the Department of Juvenile Justice

Each year, a significant number of juveniles with mental health problems enter the juvenile justice system. DJJ assesses juveniles as they enter the system to ascertain their needs and what services are to be provided.

Many of the juveniles with mental health disorders also have problems with substance abuse. Also, many do not receive services until they enter the juvenile justice system although they may have been more appropriately treated in a community-based setting.

Pre-Disposition/Court Service Units. DJJ does not have a system for the routine collection of information about the mental health needs of all juveniles who come before the court. However, a court may order mental examinations of juveniles if the judge determines that this is necessary (Va. Code Annotated, § 16.1-275, 2001). If the family cannot pay for the court-ordered examination, DJJ must absorb the cost (§ 16.1-275, 2001). DJJ expenditures for court-ordered mental health evaluations have increased from $218,486 in fiscal year 1998 to $364,213 in fiscal year 2001 (Department of Juvenile Justice, 2001e).

Juvenile Correctional Centers (JCCs). Juvenile Correctional Centers serve approximately 1,200 to 1,300 juveniles per year. The number of commitments has decreased from 1,735 in fiscal year 1996 to 1,456 in fiscal year 2000 (Department of Juvenile Justice, 2001e). The trend continues in fiscal year 2001, with an expected decrease to 1,250 commitments.

All juveniles committed to the DJJ are assessed at the Reception and Diagnostic Center. During this time, each juvenile is assessed by a caseworker who updates his social history and coordinates the assessment process (McGarvey, E.L. & Waite, D., 2000). Psychological assessments may include intelligence testing, mental status, personality assessment, alcohol and drug questionnaire/interview, and referrals for psychiatric consultation. DJJ reports that more than 60 percent of males and more than 71 percent of females left the Center with a designated mental health treatment need in fiscal year 2000 (Department of Juvenile Justice, 2001e). The overall percentage of committed juveniles needing mental health treatment increased from 33.6 percent in 1993 to 61.7 percent in 2000. Approximately 50 percent of the committed juveniles had a history of taking psychotropic medication prior to admission to the juvenile system, and more than 20 percent of males and females had had a prior psychiatric hospitalization. It was also found in fiscal year 2000 that almost four percent of the males (three per month) met the criteria for a psychotic disorder.

Once a need is identified, DJJ Behavioral Services Unit provides mental health and sex offender treatment services in the juvenile correctional centers. Representatives from DJJ report that the Behavioral Services Unit is adequately staffed, and that the total mental health budget is $3.5 million for the seven juvenile correctional centers and the reception and diagnostic center (Department of Juvenile Justice, 2001e).

Detention Homes. Detention home admissions grew from 16,000 in fiscal year 1996 to more than 22,000 in fiscal year 2000 (Department of Juvenile Justice, 2001e). The average daily detention home population currently exceeds capacity, but additional expansions are planned for the next several years (Department of Juvenile Justice, 2001e). The average length of stay in a detention home is 18 days (Department of Juvenile Justice, 2001k).

A recent study showed that more than 40 percent of males and almost 60 percent of females in detention homes need mental health services, and more than seven percent of males and more than 15 percent of females had urgent mental health treatment needs (Redding, 2001). However, while all detention facilities are reported to provide some form of mental health services, many offer very limited forms of treatment. Of the 22 detention homes, 18 offer assessment services, eight offer medication management, seven offer medication assessment, and six offer group counseling (Department of Juvenile Justice, 2001e). Furthermore, only half of the homes provide specific discharge planning for mental health. The services that are available are currently funded through a combination of detention home budgets, community services boards and grant funds.

The lack of uniform standards for the evaluation and treatment of juvenile offenders negatively impacts the availability and quality of treatment. DJJ's regulations require that staff at each secure detention facility "ascertain the resident's need for a mental health assessment and if staff determine that a mental health assessment is needed, it shall take place within 24 hours of such determination" (Va. Code Annotated, § 16.1-248.2, 2001). The Code of Virginia then places responsibility for conducting this assessment on the local CSBs (Va. Code Annotated, § 16.1-248.2). The CSB is then compensated from funds appropriated to DJJ for this purpose. DJJ is responsible for developing criteria and a compensation plan for these assessments (Va. Code Annotated, § 16.1-248.2). However, regulations do not give the detention homes basic guidelines for conducting screenings or assessments. Furthermore,

uniform clinical guidelines for mental health treatment services to be provided in Virginia detention homes do not exist for pre-dispositional detention. Moreover, discharge plans are not routinely developed and oversight responsibilities are not routinely assigned when juvenile offenders with mental illness or substance abuse disorders are released from detention homes.

In order to further document the availability of mental health and substance abuse services, DMHMRSAS conducted a survey of CSBs for the period of November 30, 2000, through April 30, 2001, to determine the number of juveniles who received or needed services in detention centers during that period. CSBs reported that the most frequently received forms of mental health services were case management and outpatient services (Kellogg, July 2001). They also reported that the services for which there was the greatest need were outpatient and emergency services. The survey results reported that, overall, there were more than 1,000 juveniles in detention centers for which a need for mental health services was identified but for which treatment was not provided.

Post-Disposition. Section 16.1-294 of the Code of Virginia directs DJJ to provide a continuum of residential and nonresidential mental health services to juveniles under parole supervision. In fiscal year 2000, the average daily population of juveniles on parole was 1,039 juveniles (Department of Juvenile Justice, 2000b). These juveniles received individual, group, and family counseling under the auspices of this program.

3. Locally Operated Mental Health Services

In many communities, community-based mental health services available to juvenile offenders are limited by a lack of resources that can be used to purchase the service or an absence of the service within the community. These gaps leave many juveniles' needs unmet, and place increased stress upon existing services. The lack of service availability exists at all stages and affects juveniles in local detention homes, juveniles released from a JCC or a local detention home, and juveniles whose disposition requires participation in these services. Sometimes the lack of services contributes to a juvenile being held longer in secure detention while waiting for needed services, such as substance abuse treatment or mental health counseling (Department of Juvenile Justice, 2001c).

For many communities, the availability of treatment is significantly affected by a shortage of qualified mental health service providers. Fifty Virginia localities have received the federal designation of Mental Health Shortage Provider Area, which is based on the ratio of mental health professionals to the population of the community (Bureau of Primary Health Care, 2002). Furthermore, particular deficiencies exist for professionals who specialize in children's services, an area which often requires specialized knowledge (Hays-Smith, 2001). Efforts are currently being made to recruit more qualified professionals to shortage areas; however, juveniles in need of treatment in many communities may find it extremely difficult to gain access to necessary mental health service providers such as child psychiatrists.

Community Service Boards (CSBs). Community Service Boards provide comprehensive mental health, mental retardation and substance abuse services for people of all ages and are designed to be the entry point into publicly provided services. CSBs support the efforts of schools, DJJ, social service agencies, law-enforcement agencies, and courts. The Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) provides funding to the 40 CSBs across the Commonwealth, on a matching basis, to enable them to provide these services. Other major funding comes from the localities and federal sources. In 2000, CSBs served an unduplicated count of approximately 195,000 clients (Burruss, 2001).

When CSBs were established, one of the focal points at that time was a client being released from state psychiatric facilities and training centers. Yet, over the years, the need for services has surpassed the resources to provide those services in the CSB system.

By law, CSBs are required to provide emergency services (evaluations and pre-screening for hospitalization) and case management services (Va. Code Ann. § 37.1-194, 2001). The CSBs also provide services to evaluate, and maintain a juvenile's competency to stand trial, evaluations of criminal responsibility, and evaluations for waivers of juvenile court jurisdiction (Kellogg, 2001). DMHMRSAS contracts with a private provider to provide restoration to competency services for juveniles.

Each CSB provides emergency and case management services to children. All 40 CSBs also provide outpatient services to at least one or more children age 0-17. However, the availability of other services varies by region.

In some areas of the Commonwealth, the CSB is the only mental health service provider to children. For these children, gaps in service availability within the CSBs can have a significant impact on the success of treatment efforts. Funding streams for these services include: Medicaid, private health insurance, the Comprehensive Services Act (CSA) or other outside funds.

Continuum of Care. Representatives from the Virginia Association of Community Services Boards have called for the development of a statewide comprehensive service system for children that includes those treatments listed, as well as crisis intervention services, case management, outpatient services, vocational training, and intensive community-based residential treatment (Hays-Smith, 2001). This system of care, if developed, could serve to provide early interventions to prevent children and adolescents from becoming involved in the juvenile justice system and could provide ongoing, seamless treatment for these children and adolescents. However, services of this type would require a specific funding stream that could be used to establish the infrastructure (Hays-Smith, 2001).

Unlike individuals in the adult services system, many children do not receive their primary mental health, mental retardation and substance abuse services from a community services board. Other sources of service might be public education, social services, juvenile justice, and private providers. For children who receive services from several different agencies, coordination is often difficult. A comprehensive public or private case management system has been cited as a necessary component of child and adolescent services. This would more nearly ensure that treatment efforts are individualized, comprehensive, and non-duplicative (Hays-Smith, 2001).

State Mental Health Services. Juveniles with severe mental health problems may require the services of psychiatric hospitals. Over the past two decades, the focus of mental health services in Virginia, for both adults and children, has moved toward community-based services and away from state institutions. There are certain advantages to community-based treatment including maintaining the opportunity for family interaction, the importance of having the juvenile remain in the home and the flexibility in coordinating aftercare services (Child and Family Services Council, 1999). However, there is a continuing need for psychiatric hospitalization as a component of a local array of care.

State Mental Health Facilities. State mental health facilities also provide services to the juvenile offender population. These services may include evaluations of competency to stand trial, emergency inpatient treatment prior to trial, treatment to restore competency to stand trial, and emergency treatment after conviction, both pre- and post-sentencing (Kellogg, 2001).

Currently, 64 inpatient beds are available for juveniles in state mental health facilities. This number represents a reduction of 108 beds since 1992 (Redding, 1999). This dramatic decrease in the availability of state psychiatric beds for juveniles reflects the philosophy that residential placements should be replaced with community services. However, the limited number of state psychiatric beds may substantially influence a juvenile's access to emergency psychiatric treatment. During a five-day period in March 2001, the Commonwealth Center for Children & Adolescents, formerly known as DeJarnette Center, an acute care, mental health facility for children and adolescents, was unable to assist in the placement of 35 children, age 5 to 17, in any psychiatric hospital in Virginia. This limitation in the availability of psychiatric beds has likely had a significant impact on the treatment efforts for juvenile offenders with immediate mental health needs.

D. SUBSTANCE ABUSE TREATMENT SERVICES FOR JUVENILE OFFENDERS

Many of the juveniles in the juvenile justice system have substance abuse disorders. Substance abuse presents concerns for juvenile offenders because of the long-term risk of addiction, its association with other health disorders, and its relationship to delinquency and misconduct. Research indicates that more than 50 percent of detained adolescents experience problems with drug and alcohol abuse and depression (Redding, 1999). Furthermore, substance abuse is the single strongest risk factor for juvenile involvement in violent activities (Redding, 1999). Consequently, the substance abuse treatment needs of these juvenile offenders must be addressed if efforts at rehabilitation are to be effective.

1. Treatment Needs of Juveniles

Prompt evaluation of juveniles after intake is crucial in detecting whether the juvenile has a substance abuse problem. This also helps to ensure that an appropriate substance abuse treatment plan is implemented. Factors to be considered in developing effective substance abuse treatment plans are knowledge of the juvenile's drug abuse patterns, knowledge of any other separate mental illnesses, and knowledge of other social factors (Lexcen and Redding, 2000).

Treatment for adolescent substance abuse may include inpatient programs, outpatient programs, multisystemic therapy, adventure-based residential programs, and behavioral family therapy (Lexcen and Redding, 2000). Identifying special needs and referring families to programs that address them, such as educational and vocational assistance, may also help families receive support from a variety of community resources.

Treatment for substance abuse in juvenile offenders may be complicated by a lack of available resources. For example, the limitations of treatment services in detention facilities may hinder the treatment of juveniles (Lexcen and Redding, 2000). This is also a problem for juveniles that are committed to DJJ. Another problem is treatment dropout for families of substance abusing or dependent juvenile offenders. Strategies for improving completion rates include earlier acceptance into treatment programs, higher levels of involvement with treatment providers, and concrete program planning.

2. Services Offered by the Department of Juvenile Justice

Court Service Units. Juvenile felons, certain misdemeanants and first-time drug offenders are required to undergo a substance abuse screening and, if necessary, a follow-up assessment, to identify an offender's substance abuse problems and treatment needs (Va. Code Annotated §§ 16.1-273, 16.1-278.8:01, 2001). This initial screening takes place within the CSUs, followed by a more detailed assessment, if indicated, by qualified personnel using standard, validated instruments. The screening and assessment instruments are specifically designed for use with adolescents and include the following: the Substance Abuse Subtle Screening Inventory (SASSI); the Child and Adolescent Functional Assessment Scale (CAFAS); and the Adolescent Problem Severity Index (APSI). Screening and assessment instruments, as well as the qualified and certified staff to administer them in each CSU, are funded through a combination of state general funds ($950,000), federal grants ($1.1 million), and the Drug Offender Assessment Fund ($300,000) (Department of Juvenile Justice, 2001e).

Post-Disposition. From June 2000 through May 2001, 8,888 SASSI screenings and 2,549 assessments, using APSI or CAFAS, were completed for juveniles under the supervision of the CSUs (Department of Juvenile Justice, 2001e). Thirty-four percent of the juveniles were identified as moderate to high risk for substance abuse. Alcohol and marijuana were the drugs used most frequently, and the age of first use for a large majority was under age 14. Significant numbers use alcohol or marijuana on a daily basis and about 30 percent use the drugs up to eight times per month. In addition, 72 percent of the juveniles who were assessed on the CAFAS test had a severe or moderate impairment from abuse of substances.

If the findings of the assessment indicate that the juvenile has a substance abuse problem, the court may take several actions. The juvenile may be ordered to enroll in nonresidential community services such as substance abuse education, individual, group, and family counseling, intensive outpatient programs, and relapse prevention programs (Department of Juvenile Justice, 2001e). If the juvenile is committed to DJJ, the court may incorporate mandatory substance abuse treatment into his disposition as part of the parole services used to transition him back into the community. In fiscal year 2001, all of the substance abuse services provided to juveniles under parole supervision were funded by the SABRE program, which will be discussed later in this section.

Juvenile Correctional Centers (JCCs). As previously discussed, all youths committed to DJJ are assessed at the Reception and Diagnostic Center (RDC). As a part of these assessments, a substance abuse screening is performed. Substance abuse assessments conducted in the Juvenile Correctional Centers indicate that more than 35 percent of females and almost 40 percent of males exhibit a high probability for alcohol and drug dependence (Department of Juvenile Justice, 2001e). In 1998, 33 percent of youth incarcerated in state facilities exhibited a severe level of substance abuse.

The JCCs currently provide substance abuse services in several forms: individual, group, and family therapy are available, as well as individual substance abuse education and prescriptive services. Treatment services typically last eight weeks and are designed to increase the juveniles' awareness of the consequences of substance use and to enhance their motivation to change their behavior. Prescriptive services are offered on a 12-week cycle and are intended to provide relapse and recidivism prevention. There are also two therapeutic community residential programs provided: one for males at the Barrett Juvenile Correctional Center, and one for females at the Bon Air Juvenile Correctional Center. Individual, substance abuse education and prescriptive services are available at all other JCCs (Department of Juvenile Justice, 2001e).

Barrett Juvenile Correctional Center provides services through a contract with the Gateway Foundation to provide a minimum six-month substance abuse program. A therapeutic community setting approach is utilized, and Barrett is currently in its fifth year of the contract. In fiscal year 2000, Barrett served 295 youths (Department of Juvenile Justice, 2001e). Bon Air JCC offers residential services funded through the U.S. Department of Justice, Office of Justice Programs, Residential Substance Abuse Treatment (RSAT) Grant Program. During calendar year 2000, Bon Air served 44 females. The third year of the grant commenced on July 1, 2001. Substance abuse education services also are available for those females not meeting RSAT program requirements (Department of Juvenile Justice, 2001e).

Despite these services, significant waiting lists for prescriptive and substance abuse education services exist at the other facilities, with 142 juveniles on a waiting list for services system-wide (Department of Juvenile Justice, 2001e). Moreover, the treatment services provided at Barrett and Bon Air have a limited combined capacity of 124. The availability of services is further limited because DJJ lacks an adequate number of certified substance abuse counselors. Shortages of substance abuse counselors exist at Beaumont, Hanover, Culpeper, and Bon Air, although approximately 50 percent of the juveniles in these facilities have a diagnosed substance abuse treatment need.

3. Locally Operated Substance Abuse Services

Community-based substance abuse services are critical in the continuum of treatment options for juvenile offenders. Just as there are a number of advantages to mental health services offered in the community, similar advantages exist for community-based substance abuse treatment.

Juveniles who have been released from a JCC, who are held in detention or who live at home but have been court ordered to receive services use these community-based substance abuse services. DJJ coordinates with community-based programs to facilitate the treatment process and to help juveniles become and remain drug- and alcohol-free. The ultimate goal is to rehabilitate juveniles so they avoid delinquent behavior and court involvement. Services for substance abuse offered in the community may include substance abuse assessments, urinalysis, breathalyzer tests, case management, education, counseling, and intensive treatment (residential or nonresidential) (Department of Juvenile Justice, 2001b).

For juveniles who have been released from a JCC, community-based services can supplement the efforts begun in the institution. The value of treatment efforts within institutions can be lost without strong community supports, making community-based services key in the juvenile's transition back to the community following incarceration.

Detention Homes. DJJ reports that 17 of the 22 detention homes offer substance abuse services (Department of Juvenile Justice, 2001e). Of these 17 facilities, eight offer assessment, and six facilities provide group counseling, individual counseling, and education. Only eight facilities provide specific discharge planning for substance abuse services.

A survey of CSBs conducted by DMHMRSAS regarding the number of juveniles who received or needed mental health and substance abuse services in detention centers indicated that there were more than 1,600 juvenile offenders in need of some form of substance abuse services who were not receiving them (Kellogg, 2001). Similarly, a DMHMRSAS study of juvenile detainees in two detention homes, Norfolk and Rappahannock, indicated that more than 82 percent reported using both alcohol and drugs during their lifetimes (Department of Mental Health, Mental Retardation and Substance Abuse Services,

1999b). More than one-half of the juveniles met the criteria for needing substance abuse treatment, but most were not receiving treatment at the time of arrest.

Community Services Boards. In fiscal year 2001, $561,215 general funds were allocated to five CSBs to provide substance abuse treatment services in juvenile detention centers. The five CSBs include: Hampton-Newport News, District 19 (Petersburg), Henrico Area, Fairfax-Falls Church, and Rappahannock Area (Fredericksburg) (DMHMRSAS, 1999b). The services provided by these CSBs include assessment and evaluation, case identification, crisis stabilization, and linkage to community programs after release. In addition, some CSBs have established independent programs to provide substance abuse services to offender populations through joint initiatives with juvenile detention centers.

Juvenile Drug Treatment Courts. Juvenile Drug Treatment Courts combine intensive substance abuse treatment and probation supervision, while relying on the court's authority to mandate the juvenile's compliance. There are currently two juvenile drug treatment court programs: City of Richmond and the City of Fredericksburg, in conjunction with the Counties of Stafford, Spotsylvania, and King George. With the expiration of federal funding, their continuation depends on funding from DJJ and the localities. Two additional programs are in the planning stages in the Cities of Newport News and Charlottesville.

E. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT FUNDING SOURCES

Funding for substance abuse and mental health services in the juvenile justice system comes from resources such as the VJCCCA, SABRE, the CSA, DMHMRSAS, and DJJ. Funding resources may also include local dollars, federal and state grants, private insurance and sliding scale fees.

Despite the existence of several funding streams, the availability of treatment services for juvenile offenders is often impacted by a lack of resources. Many of these funding streams have strict criteria and regulations that limit their availability to certain services or populations. For example, federal requirements terminate Medicaid eligibility for juveniles once they enter a correctional facility. This is especially problematic for juveniles who are placed in detention who need to continue taking medication or who need hospitalization. The Medicaid benefits available to them prior to their detainment are terminated, placing the responsibility of the cost to provide the services fully on the locality.

These various funding restrictions make the seamless provision of coordinated services especially difficult. The most obvious result is the lack of money to pay for a juvenile to receive a particular service. However, when service providers are unable to have their service adequately supported, many feel they have few options but to omit that service or relocate to a region that has the demand and resources to support their practice. As previously discussed, some regions of Virginia have been more negatively impacted than others and are now designated mental health provider shortage areas.

1. Virginia Juvenile Community Crime Control Act (VJCCCA)

The Virginia General Assembly enacted the VJCCCA effective January 1, 1996. The purpose of the VJCCCA is to ensure the imposition of appropriate and just sanctions and to make the most efficient use of correctional resources for those juveniles (Va. Code Annotated, § 16.1-309.2, 2001).

Local plans are developed by each participating locality in consultation with the juvenile court judge and the director of the local CSU. The Board of Juvenile Justice approves plans. Current

legislation proposes to forge a connection between the VJCCCA and CSA planning efforts (Va. Code Annotated, § 16.1-309.2, 2001).

Funding for the VJCCCA has grown from $11.1 million in fiscal year 1996 to almost $30 million in fiscal year 2002 (Va. Code Annotated, § 16.1-309.2, 2001). Each locality prepares a plan based on court data and an assessment of the need for services and programs. Most of the VJCCCA placements are nonresidential. In fiscal year 2000, the VJCCCA served 20,742 youths. Of the 7,203 youths released from a VJCCCA program or service, nearly 57 percent had no new juvenile intakes or adult arrests after release. In fiscal year 2000, only 5.2 percent (1,938) placements were for substance abuse assessment and treatment and 2.8 percent (1,054) placements were for mental health assessments. Two percent ($928,092) of VJCCCA funding was used for substance abuse assessment and treatment and 0.2 percent ($73,538) was used for mental health assessments. The largest categories of expenditures for the VJCCCA consist of residential placements, outreach detention and electronic monitoring.

2. Substance Abuse Reduction Effort (SABRE)

The SABRE program, applicable to juveniles and adults, went into effect on July 1, 2000. The intent of the program is to reduce criminal recidivism through an integrated system of substance abuse treatment services and criminal justice sanctions. The program's efforts have focused on changes to correctional policies to emphasize alcohol and drug testing and treatment, as well as close community supervision and treatment services. The mandatory treatment component is intended to promote "changes in habits of addiction and abuse" (Substance Abuse Reduction Effort, 2001). SABRE legislation requires every first-time juvenile drug offender to undergo alcohol and drug testing and subsequent treatment based on the results of the screening and assessment (Va. Code Annotated §§ 16.1-278.8:01, 278.8, -273, 2001). More than $14 million has been earmarked for the treatment component of this program. The appropriation for juvenile offenders for fiscal year 2002 is $2.34 million (Department of Juvenile Justice, 2001e).

The SABRE program also calls for a "seamless system of substance abuse service delivery" that "provides effective treatment services in all domains of correctional control...balanced by continued treatment in the community" (Interagency Drug Offender Screening and Assessment Committee, 2001b). In response, communities have initiated several programs to promote substance abuse treatment efforts. For example, the Blue Ridge Behavioral Health Authority (BRBHA), located in Roanoke, has collaborated with the Court Service Unit to use SABRE money to provide an array of substance abuse treatment, excluding residential treatment (Hays-Smith, 2001). BRBHA offers an integrated and comprehensive system of prevention and services for families of youth that suffer from mental health issues, mental retardation and substance use. Collaborative efforts include coordination with families and other existing community institutions to optimize all treatment options and resources.

3. Comprehensive Services Act

The Comprehensive Services Act (CSA), enacted in 1992 and implemented in 1993, is a focal point for many of the services provided for and to children and families at risk (Department of Criminal Justice Services, 2000b). Services may be provided prior, during or after a juvenile's involvement with the juvenile justice system. The intention of the CSA was to create a community-based service system that centered on the family and the child to better address the needs of troubled and at-risk youth and their families.

Originally, CSA pooled funds from nine previously existing funding streams that were used to purchase residential and nonresidential services for children but additional appropriations have been added since the inception of CSA (Department of Criminal Justice Services, 2000b). The State Executive Council, charged with overseeing the management of these funds, is composed of the agency heads of the major child-servicing agencies. The Office of Comprehensive Services is empowered by the Council to administer CSA.

At the local level, a Community Policy and Management Team (CPMT) receives and administers funds and develops policies that determine how funds will be utilized for eligible children in the local community (Department of Criminal Justice Services, 2000b). The CPMT is also responsible for program implementation and oversight. Also at the local level, there is at least one Family Assessment and Planning Team (FAPT) that reviews cases, compiles individual case plans, and has case management responsibilities (Department of Criminal Justice Services, 2000b). FAPTs are appointed by and make recommendations to the CPMT.

Two classifications of children may be served by the CSA, mandated and nonmandated. Children mandated to receive services include those in foster care, at risk of being placed in a foster home (foster care prevention services) or special education students eligible for private tuition assistance. Nonmandated children generally include juvenile offenders or children referred by the mental health system (local CSB) (Virginia Commission on Youth, 2002, p. 23).

This distinction is critical because this mandate includes a requirement for sum sufficient funding for the services needed by a mandated child, which means that state and local governments are required to appropriate sufficient funds to serve these populations (Va. Code Annotated § 2.1-757.C., 2001).

Funding from the CSA is complex and does not cover all children. The "mandated" population is those children for whom the Commonwealth must provide funding and services. However, not all service needs of mandated populations can be funded with mandated dollars. Some services are considered eligible only for nonmandated funding. No locality is required to fund services to "nonmandated" populations and many do not because of insufficient funds.

Using the current information system, the amount of CSA funds spent for juveniles involved in the criminal justice system with a diagnosed need for mental health and substance abuse services cannot be tracked. On the local level, juvenile offenders are most likely to fall in the "nonmandated" category of the CSA. While total CSA expenditures have increased from $105 million in fiscal year 1994 (first year of CSA) to $205 million in fiscal year 2000, the amount spent on the nonmandated population, which includes juvenile justice and mental health, has remained about the same, decreasing from $10 million in 1994 to $9.96 million in 2000 (Office of Comprehensive Services, 2001). As of April 2000, 61 percent of children served by CSA were referred by the Department of Social Services, 13 percent by the Department of Education, seven percent by DJJ, and 19 percent from other referral sources (Department of Criminal Justice Services, 2000b). In 2000, the General Assembly appropriated $4.25 million each year of the biennium to DMHMRSAS to be used for services to nonmandated youth. All available funds have been used or encumbered for 523 children; at least 17 percent of those children had a referral from the juvenile justice system.

F. INTERAGENCY COLLABORATION

Responsibility for mental health treatment services for juvenile offenders is not clearly defined. Detention facilities view their primary role as providing for the public's safety and the safety and security of the juvenile while in the facility. With a few exceptions, CSBs provide mental health assessments when the detention facility has identified a need through a screening. Additional services to the juvenile detainee by the CSB are limited. Since discharge plans are rarely completed upon a juvenile's release from detention, it is left to the juvenile and his/her family to locate services that will allow the juvenile to begin or continue treatment. The coordinating role of the local CPMTs of the CSA is limited since, as previously discussed, many of the offenders are considered nonmandated. There are few or, in some localities, no resources to pay for services, even when the juveniles are eligible through the CSA.

The Interagency Drug Offender Program promotes coordination and cooperation toward improving the integration of substance abuse identification and treatment within the criminal justice system. However, similar, statewide initiatives have not been implemented for offenders with mental illness. The Interagency Drug Offender Screening and Assessment Committee was created by § 2.2-223 of the Code of Virginia. The Committee oversees the screening and assessment provisions contained in the Code (Interagency Drug Offender Screening and Assessment Committee, 2001a, p.1). The Committee serves to promote interagency coordination and cooperation and is responsible for implementing an evaluation process to measure the efficacy of substance abuse screening and assessment for offenders.

There are several projects currently being implemented in various regions of the Commonwealth that attempt to expand and enhance collaboration within local systems of care. One example is the Keep Our Kids At Home (KOKAH) project ($360,000 in 2000-2002) that was implemented by Blue Ridge Behavioral Health Authority. The goal of KOKAH is to reduce the utilization of child and adolescent state inpatient facilities through the purchase of local inpatient and hospital-based day treatment (Department of Mental Health, Mental Retardation and Substance Abuse Services, 1999a). This program has demonstrated success in reducing state inpatient hospitalization by diverting children to community-based services. During this transition to localized treatment, providers have recognized the need for a broader array of community-based diversion and step-down services.

The Virginia Beach CSB has also implemented a multisystemic program that focuses on reducing juvenile delinquency and recidivism. This program is currently funded with a federal grant, and operates by providing an array of services for children and their families in each community, regardless of whether they fall into a particular category. The specialized array of services that the plan incorporates includes family support services, crisis intervention services, case management, outpatient services, intensive community-based services, vocational training, and community-based residential services. However, continuation of this approach requires a specific funding stream that could support the needed infrastructure.

G. DATA COLLECTION, EVALUATION, AND INFORMATION SHARING

The Commonwealth and its localities spend a substantial amount of money each year to provide mental health and substance abuse treatment services to children and adolescents. However, information on the effectiveness of services is not available. A comprehensive system of data collection and evaluation would enable the Commonwealth to ensure that the services provided are meeting the needs of the youth population.

It has long been recognized as essential that policy makers and those responsible for appropriations have complete and accurate data on which to base their decisions. The result of not having outcome evaluation data can be the over-utilization of certain types of services and the underutilization of others. Complicating this is the fact that some categories can include a variety of services. For example, in-home services can include a one-on-one aide, individual child and family counseling, and the provision of life and parenting skills. However, there is little information regarding the effectiveness of these services.

Virginia is not bereft of data. Agencies do maintain records regarding programs and services provided or funded by them. However, these systems are limited to information specific to the agency's clients and services. Not only are there systemic barriers to interagency sharing and analysis of data, but barriers also can exist within the same agency and their local or regional offices. Databases may collect different elements or systems are not compatible for integration. The multiple systems used by localities, including the various software packages used to report CSA data, are also problematic.

Virginia's current efforts to evaluate the services and care provided to children lie primarily with utilization management. The utilization management process is generally employed to evaluate the efficiency and appropriateness of the services. Utilization management is defined by the Office of Comprehensive Services as "a set of techniques used by, or on behalf of purchasers of health and human services to manage the provision and cost of services by influencing client care and decision making through systematic data driven processes" (Office of Comprehensive Services, 2001).

The Office of Comprehensive Services has developed a utilization management process through which the appropriate level of service for the child can be determined. However, within this particular level of service, several treatment and placement options are available. Determination of the most appropriate service within that level is frequently determined by availability of that service, access to funds for the service and one's opinion and experience with it. Consequently, there is a need for additional information designed to assist human service professionals in determining whether a particular treatment or provider is appropriate, or both, given the problems and disorders of the child. As the Joint Legislative Audit and Review Commission identified, linking program and participant outcomes could provide "a meaningful tool to assess whether providers are producing the type of results required given the nature of the children they receive" (Joint Legislative Audit and Review Commission, 1998).

H. SURVEY RESULTS

In order to assess the availability of mental health and substance abuse treatment for juvenile offenders, the Committee staff conducted written surveys of the CSU directors and detention home superintendents. The purpose of these two surveys was to provide the Committee with a better understanding of the scope of current services offered by these agencies and the level of need for additional mental health and substance abuse services. Information was requested regarding screening and assessment procedures, as well as service availability and coordination for juveniles with mental health and substance abuse treatment needs. Copies the survey instruments are included in the Appendix.

The first survey was sent to the directors at 32 state-operated and three locally operated the CSUs. Of the 35 CSU directors surveyed, 33 (94 percent) responded. The second was sent to the detention home superintendents at 21 locally operated facilities and one state-operated home. Of 22 superintendents surveyed, 16 responses (73 percent) were received.

1. Mental Health Treatment Needs

a. Juveniles in Need of Services

Court Service Units. The survey asked the CSU directors to estimate the percentage of their populations that require mental health services. More than half of the CSU directors estimated that 26-50 percent of the juvenile offenders in their facilities need mental health services, with more than 17 percent estimating the number to be greater than 50 percent.

Survey results also showed that 24 percent of the respondents reported that the CSU staff provided mental health services to juvenile offenders. However, 94 percent reported that the local community services boards furnish mental health services to their populations. Seventy-one percent of respondents also reported contracting with other entities for mental health services. This number may include facilities that use CSB services as well.

Percentage of CSU Caseloads Requiring Mental Health Services

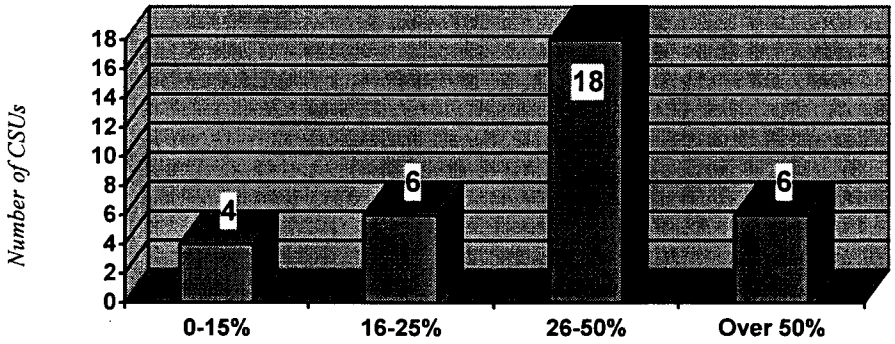


Chart 1

Source: Virginia Commission on Youth graphic of Court Service Unit Director Survey Results, Fall 2001

Detention Homes. Detention home superintendents were asked to estimate the percentage of their populations that require mental health services. Because only six detention home superintendents responded to this question, a valuable comparison cannot be made between the CSU and detention home rates. The detention home responses were equally divided between 0-15 percent (2), 16-25 percent (2), and 26-50 percent (2) of the population.

Of the detention homes responding, 88 percent indicated that mental health services are available in their facilities. Eighteen percent reported that they currently employ staff that provides mental health services. However, 88 percent receive some and 53 percent receive exclusive services from the local CSBs. Forty percent of respondents reported using a combination of agencies for these services, while seven percent reported using the CSU services only.

b. Screening and Assessment

Court Service Units. Twenty-seven percent of respondents reported that the CSU intake officers screen juveniles for mental health needs. Of those facilities responding, 10 percent use a standardized screening instrument and 60 percent conduct an assessment if the screening indicates a need. Fourteen percent of those who conduct an assessment reported use of a standardized assessment instrument. CSBs (50 percent), CSUs (13 percent), private providers (13 percent) or other entities (25 percent) may conduct assessments.

The survey also found that 18 percent of the CSUs routinely screen juveniles for mental health needs when a judge orders probation supervision, and each of these facilities conduct a mental health assessment if a need is indicated by the screening. However, only one CSU reported use of a standardized screening instrument for these juveniles, and only half use a standardized assessment instrument. Fifty percent of the respondents reported that assessments are conducted by the local CSB.

The CSU directors reported that 12 percent of juvenile offenders are screened for mental health treatment needs upon their return from JCCs. Of those responding positively, 12 percent responded that they conduct an assessment if screening indicates a need, and 75 percent use a standardized assessment instrument. Most of the assessments (75 percent) are conducted by CSBs. However, survey results also indicated that 91 percent of the CSU respondents receive information from the Juvenile Correctional Centers about the mental health treatment history or treatment needs of juvenile offenders. Seventy-seven percent of these respondents believe that the information that they receive from the JCCs is adequate.

Detention Homes. All respondent detention home superintendents reported that they screen juveniles for mental health needs upon admission, and 69 percent indicated that they use a standardized screening instrument. Detention center staff (59 percent), followed by intake staff (29 percent) and child-care staff (12 percent) most often conduct mental health screenings. In addition, 94 percent conduct an assessment if the screening indicates a need. Thirty-eight percent of respondents reported that they use a standardized assessment instrument. The CSBs were reported to conduct 81 percent of the assessments.

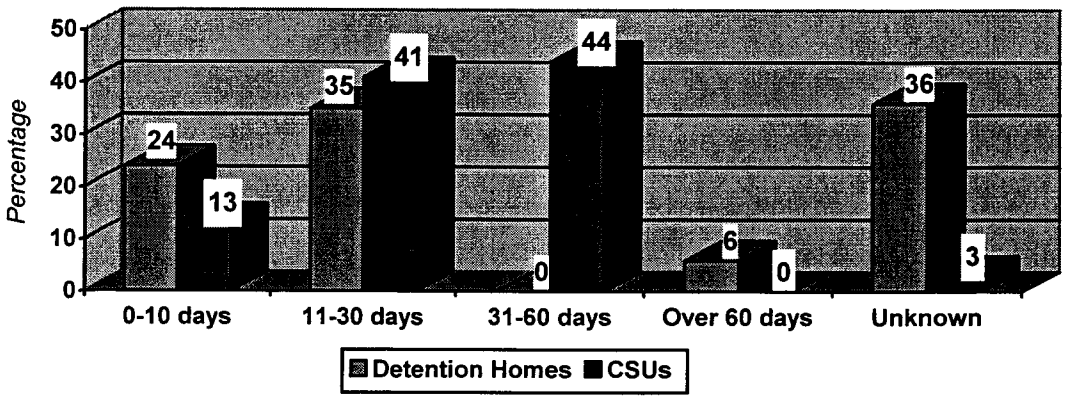
c. Wait Time for First Mental Health Appointment

Court Service Units. Respondents were asked to estimate how long a juvenile has to wait for a first appointment to receive mental health services in the community. Approximately 88% of the CSUs reported that the average wait time for the first mental health appointment is greater than 10 days. Almost half (47percent) reported an average wait of 30 days or more.

Detention Homes. Of detention home respondents, 24 percent reported an average wait time of 0-10 days, 35 percent reported a wait of 11-30 days, and six percent reported more than 60 days. However, 36 percent reported that this information was unknown.

It is also important to note that 70 percent of detention home superintendents reported having problems handling juveniles who require acute psychiatric care. However, 94 percent indicated that predispositional emergency treatment is available to detainees and services are rendered in less than one day.

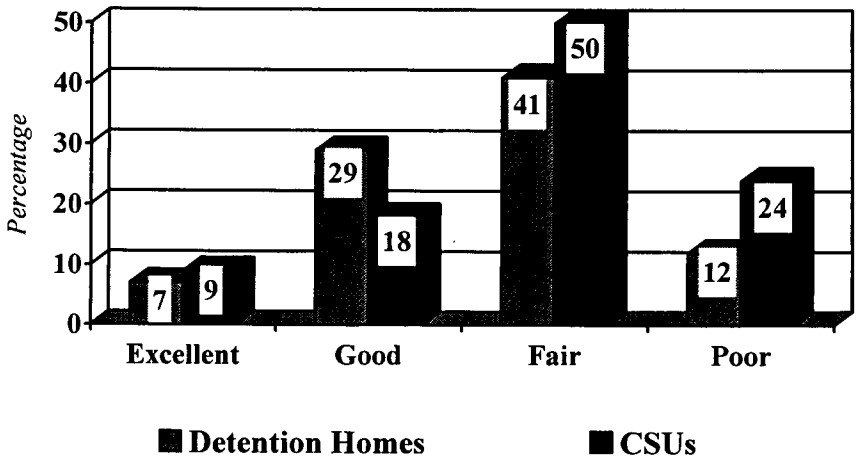
Chart 2
Wait Time for First Mental Health Appointment
Source: Virginia Commission on Youth graphic of Detention Home Superintendents Survey Results, Fall 2001



d. Level of Mental Health Services Received

The survey asked the CSUs and detention homes to rate the level of mental health services provided to the population they serve as excellent, good, fair or poor. The results showed that 74 percent of the CSU units and 53 percent of the detention homes describe these services as fair or poor. Of the CSUs, only nine percent (9%) rated the level of service as excellent and 18 percent rated the services as good. In comparison, seven percent (7%) of detention homes rated the services as excellent and 29 percent rated the services as good.

Chart 3
Level of Mental Health Services Received



Source: Virginia Commission on Youth graphic of Court Service Unit Directors and Detention Home Superintendents Survey Results, Fall 2001

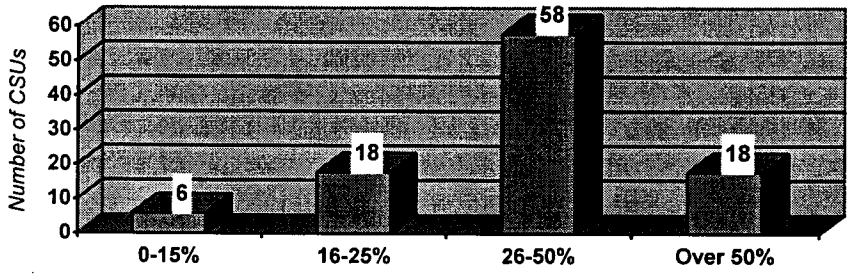
2. Substance Abuse Treatment Needs

a. Juveniles in Need of Services

Court Service Units. The survey asked respondents to estimate the percentage of juveniles in their facilities who need substance abuse treatment services. Approximately 18 percent estimated that more than 50 percent of the juveniles in their facilities need substance abuse services. An additional 58 percent estimated that 26-50 percent of their populations need these services.

Detention Homes. The estimates of the percentage of juveniles who need substance abuse treatment in detention homes once again cannot be compared to the CSUs, as only four of the superintendents responded to this question. There was one response for each of the categories: 0-15% (25%), 16-25% (25%), 26-50% (25%), and over 50 (25%).

Chart 4
Percentage of the CSU Caseloads that Require Substance Abuse Services



Source: Virginia Commission on Youth graphic of Court Service Unit Directors and Detention Home Superintendents Survey Results, Fall 2001

b. Screening and Assessment

Court Service Units. Forty-seven percent of respondents reported that the CSU staff provides substance abuse treatment services to juvenile offenders. However, CSBs were reported to furnish substance abuse treatment services to 94 percent of respondents, and 68 percent use other entities to provide substance abuse treatment services.

Survey results also indicated that 15 percent of the CSUs screen for substance abuse needs at intake. There is a legislative mandate under Va. Code Ann.§ 16.1-273 that a drug screening take place if the judge orders a pre-dispositional investigation or a social history, or when a juvenile is convicted of a felony or certain misdemeanor drug offenses or a juvenile is convicted of any first-time drug offense violation (Va. Code Ann. § 16.1-278.8:01, 2001).

Sixty percent of these facilities use a standardized screening instrument, the most common being the Substance Abuse Subtle Screening Inventory (SASSI). Each CSU reported that it conducts a standardized assessment if the screening indicates potential substance abuse treatment needs.

The survey also found that 94 percent of the CSUs routinely screen when a judge orders probation supervision. A standardized screening instrument is typically used. In all cases, if the screening indicates potential substance abuse treatment needs, an additional assessment is conducted. Ninety-seven percent of respondents reported using a standardized assessment instrument. In 90 percent of the cases, the CSU staff conducts the assessment.

Results showed that 18 percent of the respondents screen juveniles released from the JCCs for substance abuse treatment needs. Screenings are generally conducted by probation officers, certified substance abuse counselors employed in the Substance Abuse Reduction Effort (SABRE), parole officers, and Court Service Unit staff. Each of the six CSUs that screen for potential substance abuse treatment needs use a standardized screening instrument. The most commonly used instrument is the SASSI. All six CSUs reported that they conduct a substance abuse assessment if the screening indicates the need.

Ninety-seven percent of the respondents reported that the JCCs forward the substance abuse treatment history of juvenile offenders to the CSU. Seventy-seven percent indicated that the information received from these facilities is adequate.

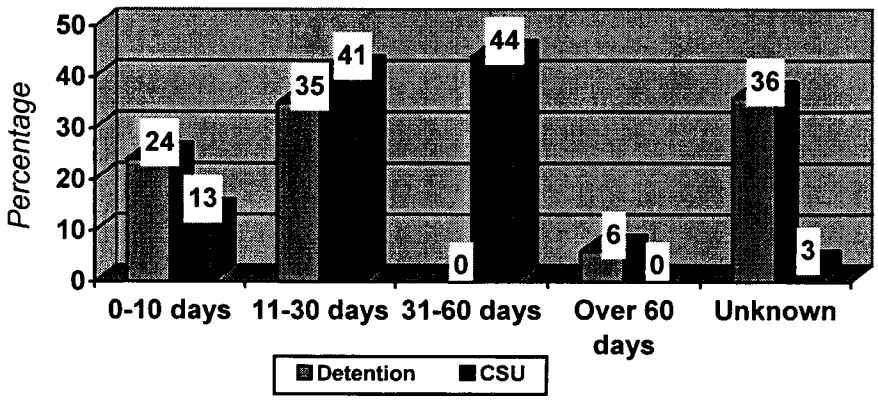
Detention Homes. Approximately 65 percent of detention home respondents indicated that substance abuse treatment services are available in their detention homes. However, only 12 percent reported that detention staff furnishes substance abuse services. CSBs provide substance abuse treatment services to 59 percent of respondents, and 47 percent use sources other than, or in addition to, CSBs for substance abuse services.

Forty-seven percent of respondents indicated that juveniles are screened for substance abuse when they are admitted. Among those detention homes, 50 percent reported use of a standardized screening instrument. Of the facilities that screen, 57 percent conduct a substance abuse assessment if the screening indicates a need. Follow-up substance abuse assessments are generally conducted by the CSU staff (25%), CSB staff (25%), or by a combination of both agencies (25%).

c. Wait Time for First Substance Abuse Treatment Appointment

The CSUs reported that approximately 85 percent of juveniles are seen within 30 days for substance abuse treatment needs. As depicted in Chart 5, the highest percentage of these respondents (46%) reported an average wait time of 11-30 days. The detention homes reported a longer average wait time for the first substance abuse appointment, as only 53 percent of juveniles are seen within 30 days of referral.

Chart 5
Wait Time for First Substance Abuse Appointment

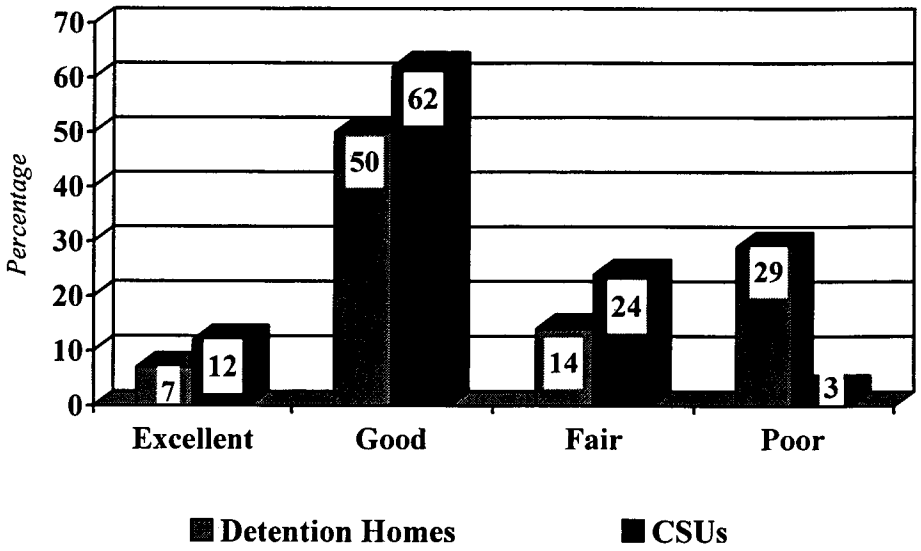


Source: Virginia Commission on Youth Graphic of Court Service Unit Directors and Detention Home Superintendents Survey Results, Fall 2001

d. Level of Substance Abuse Treatment Services Received

Of the respondents, almost 74 percent of the CSUs and 57 percent of the detention homes rated the level of substance abuse services received by juveniles as Excellent or Good. However, 29 percent of detention homes rated the level of service as Poor, in comparison to only three percent (3%) of the CSUs. Chart 6 shows these differences.

Chart 6
Level of Substance Abuse Services Received



Source: Virginia Commission on Youth graphic of Court Service Unit Directors and Detention Home Superintendents Survey Results, Fall 2001

3. Barriers to Treatment

The CSUs were asked to report the factors that contributed most significantly to juveniles not receiving mental health and substance abuse treatment when they need it. Related to mental health services, the factor that was most frequently cited was the lack of treatment options (34%), followed by the juvenile or family's resistance (27%). For substance abuse treatment, the most significant barrier cited was the juvenile's or family's resistance (55%), followed by the lack of funding or resources (23%). Waiting lists proved to be more significant for mental health treatment (12%) than for substance abuse treatment (3%).

Chart 7 (a)

Barriers to Treatment-Mental Health

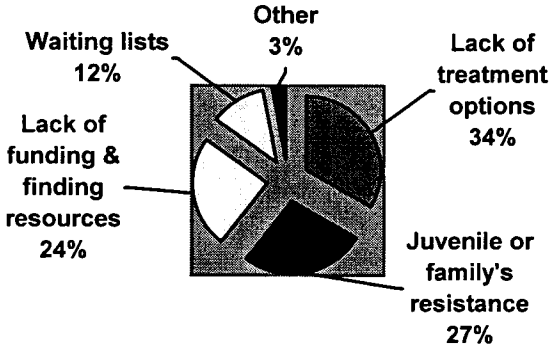
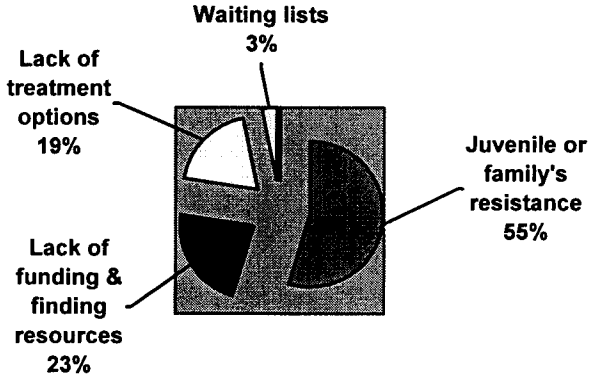


Chart 7 (b)

Barriers to Treatment-Substance Abuse



Source: Virginia Commission on Youth graphic of Court Service Unit Directors and Detention Home Superintendents Survey Results, Fall 2001

4. Service Coordination for Juvenile Detainees

The survey found that 18 percent of detention homes develop a service release plan for mental health services for juveniles held prior to disposition, while 71.4% develop this plan for juveniles held after disposition. The majority of respondents (59%) reported that once a juvenile is released, the average wait time for the first mental health appointment in the community is 30 days or less. For juvenile detainees with substance abuse needs, the average wait time for the first substance abuse appointment in the community was similar. Fifty-three percent of detention facilities reported that juveniles were served in 30 days or less of release.

I. FINDINGS AND RECOMMENDATIONS--JUVENILE OFFENDERS

Finding 1: Interagency Collaboration. *Additional formal interagency commitment and collaboration are needed to plan integrated, comprehensive services delivery systems for juvenile offenders with mental illness. Moreover, interagency responsibilities for serving juvenile offenders with mental illness in local detention homes or through the services of the Comprehensive Services Act (CSA) are not clearly defined. Local Community Policy and Management Teams serve as the financing and coordinating effort for CSA; however, no one agency takes responsibility for the juvenile offender's mental health needs. Juvenile felons, certain misdemeanants and first-time drug offenders are required to undergo a substance abuse screening and, if necessary, a follow-up assessment, to identify an offender's substance abuse problems and treatment needs. The Interagency Drug Offender Program promotes coordination and cooperation toward improving the integration of substance abuse identification and treatment within the criminal justice system. However, similar initiatives have not been implemented for offenders with mental illness.*

Recommendation 15: Establish an interagency work group under the leadership of this committee to develop a screening-assessment-treatment model for juvenile offender groups with mental health needs. The work group should identify or develop:

- Consensus concerning the statutory assignment of responsibility for providing mental health treatment services to juvenile offenders in local and regional detention homes or under the supervision of Court Service Units;
- A regional planning process to foster state/local interagency collaboration;
- A defined continuum of care;
- Model memoranda of agreement that detail responsibilities of the treatment provider and the purchasing agency and provisions for exchange of information, cross training for staff, confidentiality and payment terms; and
- A framework to pilot the memoranda and evaluate the results.

The work group should consist of the following entities:

- Department of Juvenile Justice
- Department of Mental Health, Mental Retardation, and Substance Abuse Services
- Department of Social Services
- Virginia Association of Community Services Boards
- Office of the Comprehensive Services Act
- Virginia Sheriffs' Association
- Virginia Council of Juvenile Detention Homes

Finding 2: Capacity. *Due to limited access to mental health and substance abuse services, juveniles are more apt now to be involved with the juvenile justice system than ever before. Some families may turn to the juvenile justice system as a last resort with the hope that their child will be able to access the needed services. Such limited access can be attributed to the absence of services or the lack of sufficient funding to provide access. DJJ believes it is adequately staffed to provide sex offender and mental health services in state facilities. However, additional funding and staff are needed to provide substance abuse treatment to a population where approximately 70 percent of 1,100 youth in care need substance abuse treatment. On the local level, juvenile offenders are most likely to fall in the "non-mandated" category of the CSA. While total CSA expenditures have increased from $105 million in 1994 (first year of CSA) to $205 million in 2000, the amount spent on the non-mandated population, which includes juvenile justice and mental health, has remained about the same, decreasing from $10 million in 1994 to $9.96 million in 2000. The Commission on Youth, through its Study of Children and Youth with Serious Emotional Disturbance Requiring Out-of-Home Placement (HJR 119), is continuing*

to examine the needs of non-mandated youth, which are often greater than the needs of mandated children. However, the availability of funding provides little relief if the needed service is unavailable. Gaps in the full continuum of care place stress upon existing services and reduce the success of the services. The Keep Our Kids At Home (KOKAH) project ($360,000 in 2000-2002) has demonstrated success in reducing state inpatient hospitalization; however, the project has recognized a need for a broader array of community-based diversion and step-down services and standards for hospital utilization rates.

Recommendation 16: Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services and Department of Juvenile Justice, where appropriate, to identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate supply of residential beds for the treatment of juveniles with mental health treatment needs, including those who are mentally retarded, aggressive, or sex offenders and those juveniles who need short-term crisis stabilization short of psychiatric hospitalization.

Recommendation 17: Support and endorse the concept of KOKAH or other similar models in which an array of community-based services is emphasized. Support the continuation of existing funding levels for the KOKAH model implemented by Blue Ridge Community Services.

Recommendation 18: Amend in the current biennium budget (323K) and continue in the 2002-2004 budget the language that requires "Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Juvenile Justice, and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, and Court Service Units" to "develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, <u>including juvenile offenders</u>, to mental health, <u>substance abuse</u> and mental retardation services..." Require Departments to report on the plan to the Senate Committee on Finance and House Committee on Appropriations by June 30, 2002.

Once a juvenile is within the juvenile justice system, many communities lack sufficient capacity to treat juvenile offenders with mental health needs while they are in local detention homes and when they are released from a state juvenile correctional center or a local detention home. DJJ reports that juveniles may be kept in secure detention while waiting for needed services, such as substance abuse treatment or mental health counseling.

Recommendation 19: Request that the Department of Juvenile Justice provide information to localities on opportunities for using Virginia Juvenile Community Crime Control Act funds that address mental health treatment services, including the provision of intensive individual and family treatment, and structured day treatment and structured residential programs as authorized in Va. Code § 16.1-309.3.

Recommendation 20: Request that the Department of Juvenile Justice, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Criminal Justice Services examine opportunities to leverage nongeneral fund sources of funding to meet the need for mental health and substance abuse assessment and treatment services accessible to juveniles in local detention homes.

An adequate number of acute care psychiatric beds are not available for children and adolescents in Virginia. Almost 69 percent of the detention homes that responded to the Committee's questionnaire indicated problems handling juveniles who require acute psychiatric care. Obtaining an accurate count of the number of beds that are available for use on a given day is difficult because beds may be licensed but not staffed, and some hospitals operate "swing" beds that can serve adults or children. Also, acute care beds may be converted to residential treatment beds.

Several hospitals throughout the United States are utilizing web-based programs that track bed availability and distribution. These programs use Internet-based programs to share emergency room status and bed capacity updates in real time. Such an approach could also be applied to tracking the number of acute care psychiatric beds available to juveniles.

Recommendation 21: Request the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services to work with the private sector to develop and maintain a web-based database of licensed and available acute psychiatric beds for children and adolescents, updated daily.

Recommendation 22: Direct Virginia Health Information to provide the number of licensed and staffed acute care psychiatric beds and residential treatment beds for children and adolescents in public and private facilities, as well as the actual demand and trend data for these beds, to the General Assembly by December 1, 2002.

Recommendation 23: Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to identify and create opportunities for public-private partnerships and the incentives necessary to establish and maintain an adequate supply of acute care psychiatric beds for children and adolescents, while acknowledging the Commonwealth's responsibility to serve this population.

Recommendation 24: Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to ensure an adequate supply of acute psychiatric beds for children and adolescents.

Fifty localities in Virginia have been designated as Mental Health Professional Shortage Areas. The 2000-2002 biennium budget includes $500,000 each year for the recruitment and retention of psychiatrists in medically underserved areas.

Recommendation 25: Continue the current funding level for recruitment and retention of psychiatrists under the Gilmore Fellows Program (2000-2002 Budget Item 323G), in which psychiatry residents are paid a stipend to work in underserved areas with a portion designated for the recruitment and retention of child psychiatrists.

Recommendation 26: Appropriate $50,000 for and direct the Virginia Department of Health (VDH) to pursue the expansion of the National Health Service Corp (NHSC) - Virginia Loan Repayment Program to include mental health professionals (as defined by the NHSC). Financial support should include support for VDH staff to administer the program.

Recommendation 27: Request that the Virginia Department of Health explore the expanded use of telepsychiatry for underserved areas.

Finding 3: Clinical Guidelines. *Neither local detention homes nor the CSU intake officers conduct uniform screening and assessments for mental illness. Of the detention homes that responded to the Committee's questionnaire, only 37.5% indicated that a standardized mental health assessment instrument is used. DJJ regulations require that staff at each secure detention facility shall "ascertain the resident's need for a mental health assessment and if staff determine that a mental health assessment is needed, it shall take place within 24 hours of such determination." However, regulations do not give the detention homes basic guidelines for conducting screenings or assessments. Further, uniform clinical guidelines for mental health treatment services to be provided in Virginia detention homes do not exist for pre-dispositional detention. In addition, discharge plans are not routinely developed and oversight responsibilities are not routinely assigned when juvenile offenders with mental illness or substance abuse disorders are released from detention homes. Of the CSUs responding to the survey, 41 percent indicated that juveniles wait 11 to 30 days for their first mental health appointment; 49 percent indicated that juveniles wait from 31 to 60 days for a first appointment. Of the detention homes that responded to the questionnaire, 35 percent indicated that juveniles wait 11 to 30 days for a first mental heath appointment; 36 percent responded "unknown" when asked about the wait time for a first appointment.*

Recommendation 28: Request that the Department of Juvenile Justice design and implement a uniform mental health screening instrument and interview process for juveniles identified by probation officers as needing a mental health screening. For those juveniles identified as needing a mental health assessment, a qualified individual should conduct the assessment.

Recommendation 29: Request that the Department of Juvenile Justice and the Department of Mental Health, Mental Retardation and Substance Abuse Services develop a process of identifying and communicating to families information about mental health and substance abuse resources available in the community.

Recommendation 30: Direct the Board of Juvenile Justice in conjunction with the State Mental Health, Mental Retardation and Substance Abuse Services Board to develop (i) minimum guidelines for including mental health screening and assessments in predispositional investigations, (ii) minimum guidelines for the provision of mental health services and substance abuse services including uniform screening and assessment in local detention homes, (iii) a standard discharge plan that includes mental health and substance abuse services if needed, and (iv) a plan, including the necessary fiscal and staff resources for meeting the standards.

Finding 4: Cross Training. *Law enforcement, judges, detention home staff, Court Services Unit staff and community treatment staff should receive training in balancing therapeutic goals with security needs and public safety.*

Recommendation 31: Request that the Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with the Department of Criminal Justice Services, the Department of Juvenile Justice and the Office of the Executive Secretary of the Supreme Court of Virginia, develop a curriculum and make recommendations for its implementation to train law-enforcement officers, judges, detention staff and Court Service Unit staff in security and treatment, including confidentiality, records management protocols, and treatment and security reference guides.

Finding 5: Data Collection, Evaluation and Information Sharing. *The Commonwealth and its localities spend a substantial amount of money each year to provide mental health and substance abuse treatment services to children and adolescents. The Office of Comprehensive Services has developed a utilization management process through which the appropriate level of service for the child can be determined. However, within this particular level of service, several treatment and placement options are available. Additional information designed to assist human service professionals determines whether a particular treatment or provider or both is appropriate, given the problems and disorders of the child, would result in better outcomes. As the Joint Legislative Audit and Review Commission in its Review of the Comprehensive Services Act, Senate Document 26 (1998) identified, linking program and participant outcomes could provide "a meaningful tool to assess whether providers are producing the type of results required given the nature of the children they receive."*

Recommendation 32: Request that the Secretary of Public Safety and the Secretary of Health and Human Resources develop a plan, including the estimated cost, for the collection of data on treatment services provided to and needed by state-responsible offenders and for the evaluation of the effectiveness of treatment services.

Recommendation 33: Direct the Virginia Commission on Youth to coordinate the collection and dissemination of -empirically based information that would identify the treatment modalities and practices recognized as effective for the treatment of children, including juvenile offenders, with mental health treatment needs, symptoms and disorders. An advisory committee composed of state and local representatives from the Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Social Services, Department of Medical Assistance Services, Department of Juvenile Justice, Department of Education, Department of Health, Office of Comprehensive Services, private providers and parent representatives should assist in and guide this effort.

Upon completion, client-specific information on the types of services utilized for certain conditions and behaviors in Virginia should be collected. This information should be shared with entities involved in efforts to develop a policy and plan for improving children's access to mental health services as required under current biennium language (item 323 K).

The results of the study shall be used to plan future services and resources within the Commonwealth for children with serious emotional disturbance or at risk of serious emotional disturbance; to identify effective models that could be replicated; and to identify effective means to transfer technology regarding effective programs, such as education, training and program development to public and private providers.

V. CONCLUSION AND FINAL RECOMMENDATION

The Committee brought together members of the Joint Commission on Behavioral Health Care, the Virginia State Crime Commission and the Virginia Commission on Youth to apply their individual expertise to the study of issues related to adult and juvenile offenders with mental illness and substance abuse disorders. During their deliberations, the members collected a great deal of information and acquired additional expertise, both individually and collectively, on issues that cross the boundaries between the criminal justice system and mental health/substance abuse treatment systems.

Because of the realities of the current budgetary situation, most of the Committee's recommendations are designed to lay the groundwork for future action: fostering interagency collaboration and planning; maintaining funds that are appropriated in the current biennium budget; gathering information about unmet needs; establishing minimum clinical guidelines; and providing a framework for information sharing and evaluating the effectiveness of current programs. A summary of the Committee's legislation and budget proposals to the 2002 Session of the General Assembly is included in Appendix B.

The members of the Committee would like to use the expertise that they have acquired to track the activities that they set in motion, provide legislative oversight to the interagency group that will develop a screening-assessment-treatment model for offender groups with mental health needs and continue their research into programs that will prevent persons with mental illness and substance abuse disorders from entering the criminal justice system in the first place. The Committee's final recommendation is to continue the study of treatment options for offenders with mental illness or substance abuse disorders. To build on the excellent working relationship that has developed between the executive and legislative branches of state government on these issues, the Committee would also like to expand its membership to include the Secretaries of Public Safety and Health and Human Resources to serve as ex officio members.

Recommendation 34: Continue the Committee Studying Treatment Options for Offenders with Mental Illness and Substance Abuse Disorders, with the addition of the Secretaries of Public Safety and Health and Human Resources as ex officio members, to oversee implementation of its recommendations and to conduct further research into diversion programs that will prevent persons with mental illness and substance abuse disorders from entering the criminal justice system in the first place.

REFERENCES

Aronhalt, Gary K. (2001). Inmate Population Forecasts: FY 2002 to FY 2011. [Online]. Available: *http://www.publicsafety.state.va.us:8000/sections/publications/inmatepopulations/2002_2011.pdf.* [03/09/02].

American Psychiatric Association (2000). Psychiatric Services in Jails and Prisons (2nd Edition). Washington, D.C.: American Psychiatric Association.

Brad H., et al. v. The City of New York, et al. July 12, 2000. Brief for Amici Curiae. (712 N.Y.S. 2nd 336).

Bureau of Primary Health Care, Health Resources and Services Administration. Criteria for Designation of Areas Having Shortages of Mental Health Professionals. U.S. Health and Human Services Administration. [Online]. Available: *http://bphc.hrsa.gov/dsd/default.htm.* [03/20/02].

Burrus, Gail, LPC, LSATP. (2001, May 31). Presentation to the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440). Richmond, Virginia.

Center on Crime, Communities, and Culture. (1996, November). Mental Illness in US Jails: Diverting the Nonviolent, Low-Level Offender. Research Brief, Occasional Paper Series, No. 1. [Online]. Available: *http://www.soros.org/crime/research/research_brief_1.html.* [02/02/2001].

Child and Family Services Council. (1999). Virginia's Continuing Policy to Take Away State Psychiatric Hospitals for Children Without Increasing Community Service Options. A Position Paper of the Child and Family Services Council.

Coalition for Juvenile Justice. (2000). Annual Report: Handle with Care: Serving the Mental Health Needs of Young Offenders. Washington, D.C.: Author.

Compensation Board. (2001). FY 2000 Jail Cost Report. Richmond, Virginia: Author.

Department of Corrections. (2001a). Overview of Prison Substance Abuse Services. Unpublished Manuscript.

Department of Corrections. (2001b, May 31). Presentation to the SJR 440 Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders. Richmond, Virginia.

Department of Criminal Justice Services. (2000a). Comprehensive Community Corrections Act for Local-Responsible Offenders and Pretrial Services Act: Annual Legislative Report July 1999-June 2000. Richmond, Virginia: Author.

Department of Criminal Justice Services (2000b). Virginia's Three-Year Plan, 2000-2002 Juvenile Justice and Delinquency Prevention Act. [Online]. Available: *http://www.dcjs.state.va.us/juvenile/reports/3yearplan/index.htm.* [01/30/02].

Department of Criminal Justice Services. (2001). Virginia's Drug Court Programs (Senate Document 4). Richmond, Virginia: Author.

Department of Juvenile Justice. (1999). Profiles of Incarcerated Adolescents in Virginia Correctional Facilities: 1993-1998, 1999. Richmond, Virginia: Author.

Department of Juvenile Justice. (2000a). Fiscal Year 1999 Statistics Revision. Richmond, Virginia: Author.

Department of Juvenile Justice. (2000b). Juvenile Correctional Center Information. Richmond, Virginia: Author.

Department of Juvenile Justice (2001a). About DJJ: Agency Vision. [Online]. Available: *http://www.djj.state.va.us/about/about_djj.htm*. [12/20/01].

Department of Juvenile Justice, (2001b). Community Funded Programs and Services. [Online]. Available: *http://www.djj.state.va.us/programs_and_facilities/community_funded_programs_and_services.htm*. [02/18/01].

Department of Juvenile Justice. (2001c). Juvenile Detention: What's Going On in Virginia?" Utilization of Pre-dispositional Juvenile Detention in Virginia. Fiscal Year 2000. Richmond, Virginia: Author.

Department of Juvenile Justice. (2001d). Juvenile Justice Process. [Online]. Available: *www.djj.state.va.us/juvenile_justice/juvenile_justice_process.htm*. [01/31/02].

Department of Juvenile Justice. (2001e, June 28). Presentation to the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440). Richmond, Virginia.

Department of Juvenile Justice, (2001f). Programs and Facilities: Court Service Unit Functions. [Online]. Available: *http://www.djj.state.va.us/programs_and_facilities/court_service_units_community_programs.htm*. [12/18/01].

Department of Juvenile Justice, (2001g). Programs and Facilities: Office on Youth. [Online]. Available: *http://www.djj.state.va.us/programs_and_facilities/offices_on_youth.htm*. [12/18/01].

Department of Juvenile Justice, (2001h). Programs and Facilities: Services for Non-State Wards. [Online]. Available: *http://www.djj.state.va.us/programs_and_facilities/division_of_community_programs.htm*. [12/20/01].

Department of Juvenile Justice, (2001i). Programs and Facilities: Services for State Wards, Juvenile Correctional Centers. [Online]. Available: *http://www.djj.state.va.us/programs_and_facilities/division_of_institutions_jcc.htm*. [12/20/01].

Department of Juvenile Justice, (2001j). Programs and Facilities: Youth Industries. [Online]. Available: *http://www.djj.state.va.us/programs_and_facilities/division_of_institutions_jcc.htm*. [02/13/02].

Department of Juvenile Justice, (2001k). Statistics on Community Population Information. [Online]. Available: *http://www.djj.state.va.us/statistics/community_population_information.htm*. [02/13/02].

Department of Juvenile Justice. (2001l, December). The Virginia Department of Juvenile Justice, Agency Overview. Richmond, Virginia: Author.

Department of Planning and Budget. (2000). A Study of the Indian Creek Correctional Center's Data Collection and Evaluation Capabilities. Richmond, Virginia: Author.

Department of Mental Health, Mental Retardation and Substance Abuse Services. (1994). The Impact of Public Inebriates on Community and Criminal Justice Services Systems (House Document 46). Richmond, Virginia: Author.

Department of Mental Health, Mental Retardation and Substance Abuse Services. (1999a). Keeping Our Kids at Home (KOKAH) Project: A Study of the Feasibility, Efficacy, and Cost-Effectiveness of Expanding the Project Statewide. Richmond, Virginia: Author.

Department of Mental Health, Mental Retardation, and Substance Abuse Services. (1999b). Substance Abuse and Treatment Need Among Arrestees (SANTA). Unpublished Paper. Richmond, Virginia: Author.

Department of Mental Health, Mental Retardation and Substance Abuse Services. (2002). POMS Annual Report. Richmond, Virginia: Author.

Ditton, Paula M. (1999, July). Mental Health and Treatment of Inmates and Probationers. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Eastern Kentucky University's Training Resource Center. (2001). Participant Guide: Mental Health Issues and Juvenile Justice. [Online]. Available: *http://www.juvenilenet.org/jjtap/mentalhealth/downloads.html.* [03/09/02].

Hays-Smith, Melissa. (2001, June 28). Presentation to the SJR 440 Study Committee by the Virginia Association of Community Services Boards. Richmond, Virginia.

Interagency Drug Offender Screening and Assessment Committee. (2001a). The Status and Effectiveness of Drug Offender Screening, Assessment, and Treatment (Senate Document 22). Richmond, Virginia: Author.

Interagency Drug Offender Screening and Assessment Committee. (2001b). Substance Abuse Reduction Effort (SABRE) (2001). [Online]. Available: *http://www.sabre.state.va.us.* [12/31/01].

Izumi, Lance T., Schiller, Mark, and Hayward, Steven. (1996, September). Corrections, Criminal Justice, and the Mentally Ill: Some Observations about Costs in California. San Francisco, California: Pacific Research Organization. [Online]. Available: *http://www.pacificrearch.org/issues/health/mental_hlth.html.* [03/08/2001].

Joint Legislative Audit and Review Commission. (1994). Evaluation of Inmate Mental Health Care. (House Document 5). Richmond, Virginia: Author.

Joint Legislative Audit and Review Commission. (1995). Oversight of Health and Safety Conditions in Local Jails. (Senate Document 17). Richmond, Virginia: Author.

Joint Legislative Audit and Review Commission. (1998). Review of the Comprehensive Services Act. (Senate Document 26). Richmond, Virginia: Author.

Kellogg, Richard E. (2001, July 27). Virginia Model Jail and Juvenile Detention Center Mental Health and Substance Abuse Programs and Jail and Juvenile Detention Center Survey Results. Presentation to the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440). Richmond, Virginia.

Kincaid, Sergeant Thomas W. (2001, September 27). Memorandum to the Joint Commission on Behavioral Health Care.

Lexcen, F. and Redding, R.E. (2000). Substance Abuse and Dependence in Juvenile Offenders. Juvenile Fact Sheet. Charlottesville, Virginia: Institute of Law, Psychiatry and Public Policy, University of Virginia.

McGarvey, E. L. & Waite, D. (2000). Mental Health Needs among Adolescents Committed to the Virginia Department of Juvenile Justice. Juvenile Justice Fact Sheet. Charlottesville, VA: Institute of Law, Psychiatry, & Public Policy, University of Virginia.

National Alliance for the Mentally Ill. (1999, July). Families on the Brink: The Impact of Ignoring Children With Serious Mental Illness, Results of a National Survey of Parents and Caregivers. Arlington, Virginia: Author.

National GAINS Center. (1997). The Prevalence of Co-occurring Mental and Substance Abuse Disorders in the Criminal Justice System. (Online). Available: *http://www.prainc.com/gains/publications/just_the_facts.htm.* [03/22/2001].

Office of Comprehensive Services. (2001). Comprehensive Services Act for At-Risk Youth and Families. [Online]. Available: *http://www.csa.state.va.us.* [12/01].

Pretrial Services Resource Center. The Criminal Justice/Mental Health Consensus Project. [Online]. Available: *http://www.pretrial.org/csg.htm.* [04/09/2001].

Redding, Richard E. (1999). Barriers to Meeting the Mental Health Needs of Juvenile Offenders. Developments in Mental Health Law, 19, 1-4, 14.

Redding, Richard E. (2001, July 27). Meeting the Mental Health Needs of Juvenile Offenders. Presentation to the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440). Richmond, Virginia.

Shoemaker, Donald J. (1999). Evaluation Report for the Drug Treatment Court Program, Twenty-Third Judicial Circuit of Virginia. Blacksburg, Virginia: Virginia Polytechnic Institute and State University.

Sigurdson, Chris. (2000, December). The Mad, the Bad and the Abandoned: The Mentally Ill in Prisons and Jails. American Correctional Association: Corrections Today, 70-78.

Steadman, Henry J. and Veysey, Bonita M. (1997, January). Providing Services for Jail Inmates with Mental Disorders. Washington, D.C.: National Institute of Justice, U.S. Department of Justice.

Steadman, Henry J.; Brown, Collie; and Davidson, Susan. (2001, April). Mental Health Courts: Their Promise and Unanswered Questions. Psychiatric Services, 52 (4).

Substance Abuse Reduction Effort. (2001). [Online]. Available: *http://www.sabre.state.va.us.* (12/31/2001).

Thompson, Michael. (2001, July 27). Presentation to the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440). Richmond, Virginia.

Virginia Association of Community Services Boards. (2001, May 31). Presentation to the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440). Richmond, Virginia.

Va. Code Ann. § 2.1-757.C (2001).

Va. Code Ann. § 16.1-248.1 (2001).

Va. Code Ann. § 16.1-248.2 (2001).

Va. Code Ann. § 16.1-260 (2001).

Va. Code Ann. § 16.1-269.1 (2001).

Va. Code Ann. § 16.1-273 (2001).

Va. Code Ann. § 16.1-275 (2001).

Va. Code Ann. § 16.1-278.8

Va. Code Ann. § 16.1-278.8:01 (2001).

Va. Code Ann. § 16.1-309.2 (2001)

Va. Code Ann. § 37.1-194 (2001).

Virginia Commission on Youth. (2001). Youth with Emotional Disturbance Requiring Out-of-Home Treatment. (House Document 49). Richmond, Virginia: Author.

Virginia Commission on Youth. (2002). Youth with Emotional Disturbance Requiring Out-of-Home Treatment. (House Document No. 23). Richmond, Virginia: Author.

Virginia Policy Design Team. (1994). Mental Health Needs of Youth in Virginia's Juvenile Detention Centers. Richmond, Virginia: Department of Criminal Justice Services.

Virginia Sheriffs' Association. (2001, May 31). Presentation to the Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440). Richmond, Virginia.

Wallace, Austin. (2001). Virginia's Legal Obligations to Offenders with Mental Illness or Substance Abuse Disorders. Unpublished. Richmond, Virginia: Division of Legislative Services.

Wish, Eric. (1997). Drug Treatment Needs Among Adult Arrestees in Baltimore. Washington, D.C.: National Institute of Justice.

VI. APPENDIX

Appendix A

Senate Joint Resolution 440 (2001)

summary | pdf

SENATE JOINT RESOLUTION NO. 440

Directing the Joint Commission on Behavioral Health Care, in conjunction with the Virginia State Crime Commission and the Virginia Commission on Youth, to study treatment options for offenders who have mental illness or substance abuse disorders.

Agreed to by the Senate, February 22, 2001
Agreed to by the House of Delegates, February 21, 2001

WHEREAS, a national study by the National Gains Center titled "The Prevalence of Co-Occurring Mental and Substance Abuse Disorders in the Criminal Justice System" (1997) indicated that approximately seven percent of jail detainees suffer from acute and serious mental illness at booking and many others have less serious mental disorders that require treatment and mental health services; and

WHEREAS, approximately one-third of jail detainees meet diagnostic criteria for alcohol or other drug dependence but fewer than 15 percent of incarcerated adult offenders who admit their drug histories receive the treatment they need for their addictive disorders; and

WHEREAS, five percent of jail inmates have concurrent mental illness and substance abuse disorders; and

WHEREAS, in 1993, the Joint Legislative Audit and Review Commission (JLARC) found that the Department of Corrections had not "fully developed a system of comprehensive mental health care" (House Document No. 5, 1994) and, in 1994, JLARC found that the Department of Corrections needed to strengthen its oversight of health and safety conditions in local jails (Senate Document No. 17, 1995); and

WHEREAS, a 1994 study titled "Mental Health Needs of Youth in Virginia's Juvenile Detention Centers," reported that eight to 10 percent of youths in secure detention homes have serious mental health problems, which require immediate attention, and that adequate resources do not exist to address the needs of many of these youths; and

WHEREAS, appropriate treatment of mental illnesses and substance abuse disorders of inmates in local jails and juvenile detention centers would reduce disciplinary problems and recidivism, improve the inmate's chance of success upon release, and reduce costs for the taxpayers of Virginia; and

WHEREAS, successful treatment programs must include the specialized training of law-enforcement personnel to identify and address the unique needs of people with serious mental illness and substance abuse disorders, as well as coordination of all mental health and substance abuse treatment plans and social services, such as life skills training, housing, vocational training, education, job placement, health care, and relapse prevention; and

WHEREAS, identifying workable treatment options and funding alternatives for offenders with mental illness or substance abuse disorders and developing strategies to secure specialized training for law-enforcement personnel will require coordination among various state agencies with concurrent responsibilities in this area; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Behavioral Health Care, in conjunction with the Virginia State Crime Commission and the Virginia Commission on Youth, study treatment options for offenders who have mental illness or substance abuse disorders. In conducting the study, the Commission shall examine, but not be limited to examining: (i) the incidence of

mental illness and substance abuse among offenders; (ii) the current system for delivering mental health and substance abuse services, including assessment, treatment, post-release, and follow-up; (iii) model treatment programs for offenders; (iv) the costs and benefits of private versus public treatment services; (v) the need for specialized training of local law enforcement and court personnel to identify and handle offenders with mental illness and substance abuse disorders; and (vi) funding, sources of funding, and legislation required to ensure adequate assessment and treatment services.

As it deems appropriate, the Joint Commission on Behavioral Health Care shall request the participation of state and local agencies and organizations who represent or whose responsibilities involve services to offenders with mental illness and substance abuse disorders.

The Division of Legislative Services and the staffs of the Virginia State Crime Commission and the Virginia Commission on Youth shall provide staff support for the study.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Behavioral Health Care for this study, upon request.

The direct costs of this study shall not exceed $10,000.

The Joint Commission on Behavioral Health Care shall provide a progress report concerning the study to the Senate Committee on Finance and the House Committee on Appropriations, and it shall complete its work in time to submit its findings and recommendations by November 30, 2001, to the Governor and the 2002 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Legislative Information System

Appendix B

Legislation and Budget Amendments As Proposed to the 2002 Session of the General Assembly

Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders (SJR 440)
Proposed Legislation and Budget Amendments (As Introduced)
2002 Session of the General Assembly

Legislation

1. **SJR 97 (Martin); HJR 142 (Weatherholtz)** Continuing the Study of the Treatment Needs of Offenders with Mental Illness and Substance Abuse Disorders by the Joint Commission on Behavioral Health Care, in conjunction with the Virginia State Crime Commission and the Virginia Commission on Youth, and authorizing the continuation of the special study committee and the establishment of an interagency work group to develop a screening-assessment-treatment model for offender groups with mental health needs.

2. **SJR 96 (Martin); HJR 141 (Weatherholtz)** Requesting the Department of Corrections and the Department of Mental Health, Mental Retardation and Substance Abuse Services to examine ways to ensure access by offenders to appropriate medications and management of medications when they are released from state correctional facilities.

3. **SJR 95 (Martin); HJR 84 (Albo)** Requesting the Secretary of Public Safety, in conjunction with the Secretary of Health and Human Resources and the Secretary of Administration, to develop a plan, including the estimated cost, for the collection of data on treatment services provided to and needed by state responsible offenders and for the evaluation of the effectiveness of treatment services.

4. **SJR 101 (Houck); HJR 121 (Tata)** Requesting the Department of Juvenile Justice to design and implement a uniform mental health screening instrument and interview process for juvenile offenders identified by probation officers as needing a mental health screening.

5. **SJR 99 (Houck); HJR 119 (Tata)** Directing the Virginia Commission on Youth to coordinate the collection and dissemination of empirically-based information on treatment modalities and practices recognized as effective for the treatment of children, including juvenile offenders, with mental health treatment needs, symptoms and disorders.

6. **SJR 84 (Howell)** Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services to explore ways to communicate information about innovative practices among providers of mental health and substance abuse treatment services to offenders.

7. **SJR 83 (Howell)** Requesting the Office of the Executive Secretary of the Supreme Court to examine the feasibility of designing and implementing a model court order that addresses mental health services.

8. **HJR 85 (Albo)** Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with the Virginia Hospital and Healthcare Association and private providers, to study the feasibility of developing a web-based system for providing daily updated information on licensed and available acute inpatient psychiatric beds for children and adolescents.

9. **HJR 140 (Weatherholtz)** Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with the Office of the Executive Secretary of the Supreme Court, the Department of Criminal Justice Services and the Department of Juvenile Justice, to develop and make recommendations for implementing a curriculum for cross-training law enforcement officers, judges, jail and detention home staff, and community mental health treatment staff in security and treatment services.

10. **SJR 100 (Houck)** Requesting the Department of Medical Assistance Services, in conjunction with the Department of Corrections and the Department of Juvenile Justice, to examine ways to provide immediate access to Medicaid benefits for eligible offenders when they are released from prisons, jails, juvenile correctional centers or detention homes.

11. **SB 426 (Houck); HB 887 (Hamilton-Youth Commission)** A bill to amend and reenact §§ 32.1-276.4 and 32.1-276.6 of the Code of Virginia, relating to information regarding psychiatric and residential treatment beds for youths and adolescents.

Proposed Budget Amendments

HB/SB 29

Item 323 #1h/#2s: The Department of Mental Health, Mental Retardation and Substance Abuse Services, *the Department of Juvenile Justice* and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, and Court Service Units shall develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, *including juvenile offenders,* to mental health, substance abuse and mental retardation services. The plan shall identify the services needed by children, the cost and source of funding for the services, the strengths and weaknesses of the current service delivery system and administrative structure, and recommendations for improvement. *The Departments of Mental Health, Mental Retardation and Substance Abuse Services, Juvenile Justice and Medical Assistance Services shall report on their plan to Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Behavioral Health Care by June 30, 2002.*

HB/SB 30

Item 426 #1h/#1s: The Department of Criminal Justice Services, in collaboration with the Department of Corrections, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Medical Assistance Services, the Virginia Association of Community Services Boards, Community Criminal Justice Boards, the Virginia Sheriffs' Association, and the Regional Jails Association, shall identify the unmet need for mental health and substance abuse treatment services for offenders and develop a comprehensive plan, including the necessary resources and funding sources, for covering the increasing costs of providing existing services and to fill service gaps. The Department shall include opportunities to leverage non-general funds in its plan. The Department shall submit the plan, including the necessary resources and funding sources, to the Chairmen of the Senate Finance and House Appropriations Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 329 #3h/#9s: The Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, in consultation with the Department of Corrections, Virginia Sheriffs' Association, the Regional Jails Association, and the Virginia Association of Community Services Boards, shall make recommendations to the Chairmen of the Senate Finance and House Appropriations Committees and the Joint Commission on Behavioral Health Care concerning access to psychiatric care for jail inmates, including the availability of inpatient beds, judicially-ordered treatment and atypical antipsychotic medications. The recommendations shall include consideration for use of state facilities belonging to the Department of Corrections and Department of Mental Health, Mental Retardation and Substance Abuse Services and designated sections of regional jails. The Commissioner shall submit his recommendations to the Chairmen of the Senate Finance and House Appropriations Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 329 #14h/312 #5s: The Department Health and the Department of Mental Health, Mental Retardation and Substance Abuse Services shall explore the expanded use of telepsychiatry for medical shortage areas and submit their findings and recommendations, including the necessary resources, to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 408#2h/#2s: The State Board of Corrections and the State Mental Health, Mental Retardation and Substance Abuse Services Board, in consultation with the Virginia Sheriffs' Association, the Regional Jails Association, and the Virginia Association of Community Services Boards, shall develop (i) minimum guidelines for the provision of mental health and substance abuse treatment services in local and regional jails that reflect an adequate continuum of services, including the availability of atypical antipsychotic medications; and (ii) a plan, including the necessary fiscal and staff resources, for meeting the guidelines. The State Board of Corrections and the State Mental Health, Mental Retardation and Substance Abuse Services Board shall report their findings and recommendations to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 329 #2h/#8s: The Department of Mental Health, Mental Retardation and Substance Abuse Services shall issue a Request-for-Proposal to conduct a comprehensive process and outcome evaluation of therapeutic communities in local jails. The Department shall report the cost of the comprehensive evaluation to the Chairmen of the Senate Finance and House Appropriations Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 329 #13h/#11s: The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Juvenile Justice shall identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate supply of residential beds for the treatment of juveniles with mental health treatment needs, including those who are mentally retarded, aggressive, or sex offenders and those juveniles who need short-term crisis stabilization short of psychiatric hospitalization. The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Juvenile Justice shall report their findings to the Chairmen of the Senate Finance and House Appropriations Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 329 #4h/#10s: The Department of Mental Health, Mental Retardation and Substance Abuse Services, *the Department of Juvenile Justice* and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, and Court Service Units shall develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, *including juvenile offenders*, to mental health, *substance abuse* and mental retardation services. The plan shall identify the services needed by children, the cost and source of funding for the services, the strengths and weaknesses of the current service delivery system and administrative structure, and recommendations for improvement. *The Departments of Mental Health, Mental Retardation and Substance Abuse Services, Juvenile Justice and Medical Assistance Services shall report on updates to their plan to Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Behavioral Health Care by June 30 of each year.*

Item 440 #1h/1s: The Departments of Juvenile Justice, Mental Health, Mental Retardation and Substance Abuse Services, and Criminal Justice Services shall examine opportunities to leverage non-general fund sources of funding to meet the need for mental health and substance abuse assessment and treatment services accessible to juveniles in local detention homes. The Departments shall report their findings to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 329 #8h/12s: The Department of Mental Health, Mental Retardation and Substance Abuse Services shall ensure an adequate supply of acute psychiatric beds for children and adolescents. The Department shall identify and create opportunities for public-private partnerships and develop the incentives necessary to establish and maintain an adequate supply of acute care psychiatric beds for children and adolescents, while acknowledging the Commonwealth's responsibility to serve this population. The Department shall report its actions, findings and recommendations to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 306 #7h/#1s: Out of this appropriation, $500,000 the first year and $500,000 the second year shall be provided from the general fund for a program to maximize recruitment and retention of graduate medical students in psychiatry to serve in underserved areas.

Item 306 #6h/#2s: Included in this appropriation is $50,000 each year for expansion of the National Health Service Corp (NHSC) - Virginia Loan Repayment Program to include mental health professionals (as defined by the NHSC).

Item 440#2h/#2s: The Board of Juvenile Justice in conjunction with the State Mental Health, Mental Retardation and Substance Abuse Services Board shall develop (i) minimum guidelines for including mental health screening and assessments in pre-dispositional investigations; (ii) minimum guidelines for the provision of mental health services and substance abuse services including uniform screening and assessment in local detention homes; (iii) a standard discharge plan that includes mental health and substance abuse services if needed; and (iv) a plan, including the necessary fiscal and staff resources for meeting the guidelines. The Board of Juvenile Justice and the State Mental Health, Mental Retardation and Substance Abuse Services Board shall report their findings and recommendations to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Behavioral Health Care by September 30, 2002.

Item 329 #7h/#7s: The Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with the Virginia Hospital and Healthcare Association and private providers, shall examine the feasibility of developing a web-based system for providing daily updated information on licensed and available acute psychiatric inpatient beds for children and adolescents. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall report its finding and recommendations to the Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders by September 30, 2002.

Appendix C

Committee Survey Questionnaires

Local and Regional Jail Survey

The 2001 Session of the Virginia General Assembly asked the Joint Commission on Behavioral Health Care, Virginia State Crime Commission and Virginia Commission on Youth to study services available to offenders who have mental illness or substance abuse disorders. We request your cooperation in completing the following survey, which will help us understand more about mental health and substance abuse treatment services that are available to inmates while they are in jail and upon release. Thank you for your assistance.

Part I--Descriptive Information

1. Name of Jail_____

2. Average Daily Inmate Population_____

3. Facility Capacity_____

4. Number of Full-time Equivalent (FTE) Staff:_____

5. a. Does your staff provide **mental health** services? ☐Yes ☐No
   b. If "Yes," what is the number of FTE staff providing **mental health** services? _____
   c. What is the funding source for **mental health** staff?
      1) State General Funds
         Amount $_____
      2) Other (Please specify source)
         Amount $_____
   d. Please estimate the percentage of inmates in your jail who need **mental health** services.
      ☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

6. a. Does your staff provide **substance abuse treatment** services? ☐Yes ☐No
   b. If "Yes," what is the number of FTE staff providing **substance abuse treatment**?_____
   c. What is the funding source for **substance abuse treatment** staff?
      1) State General Funds
         Amount $_____
      2) Other (Please specify source)
         Amount $_____
   d. Please estimate the percentage of inmates in your jail who need **substance abuse treatment**.
      ☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

7. a. Please name the Community Services Board(s) in your area._____

_____

b. Does the Community Services Board(s) provide **mental health** services to your inmates?
☐Yes ☐No ☐Unknown

c. Does some other entity provide **mental health** services to your inmates?
☐Yes ☐No (If "Yes," please name the entity_____)

d. Does the Community Services Board(s) provide **substance abuse assessment/treatment** services to your inmates? ☐Yes ☐No ☐Unknown

e. Does some other entity provide **substance abuse assessment/treatment** services to your inmates?
☐Yes ☐No (If "Yes," please name the entity_____)

Part II--Screening and Assessment

8. a. Are jail inmates screened for **mental health needs** when they are admitted?
☐Yes ☐No

b. If "Yes," who does the screening? _____

c. Is a standardized screening instrument used? ☐Yes ☐No

d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

e. If the screening indicates potential **mental health needs**, is an assessment conducted?
☐Yes ☐No

f. If "Yes," who conducts the assessment? ☐Jail staff ☐Local Community Corrections staff
☐CSB ☐Private Contract ☐Other (Please specify)_____

g. Is a standardized assessment instrument used? ☐Yes ☐No

h. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

9. a. Are jail inmates screened for **substance abuse treatment needs** when they are admitted?
☐Yes ☐No

b. If "Yes," who does the screening? _____

c. Is a standardized screening instrument used? ☐Yes ☐No

d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

e. If the screening indicates potential **substance abuse treatment needs**, is an assessment conducted? ☐Yes ☐No

f. If "Yes," who conducts the assessment? ☐Jail staff ☐Local Community Corrections staff
☐CSB ☐Private Contract ☐Other (Please specify)_____

g. Is a standardized assessment instrument used? ☐Yes ☐No

h. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

Part III--Services in Your Jail

10. a. Are **mental health** services available to inmates in your jail?

☐Yes ☐No *(If "No," please go to question 11).*

b. Who provides the services? (Check all that apply)

☐Your Staff ☐Private Contract ☐CSB ☐Other (Please Specify_____)

c. If "Your Staff" or "Private Contract," what is the source of funding?

1) State Compensation Board ____%

2) Local Funds _____%

3) Other (Please specify source) _____%_____

d. What services are available and what is the average waiting time for each service?

	Male			Female		
	YES	NO	AVER. WAIT (DAYS)	YES	NO	AVER. WAIT (DAYS)
Emergency Treatment						
Case Management						
Individual Counseling						
Group Counseling						
Medication Management						
Other (Please specify)						

11. a. Are **substance abuse treatment** services available to inmates in your jail?

☐Yes ☐No *(If "No," please go to question 12).*

b. If "Yes," who provides the services? (Check all that apply)

☐Your Staff ☐Private Contract ☐CSB

c. If "Your Staff" or "Private Contract," what is the source of funding?

1) State Compensation Board ____%

2) Local Funds _____%

3) Other (Please specify) _____%_____

d. What services are available and what is the average waiting time for each service?

	Male			Female		
	YES	NO	AVER. WAIT (DAYS)	YES	NO	AVER. WAIT (DAYS)
Emergency Treatment						
Case Management						
Individual Counseling						
Group Counseling						
Medication Management						
Other (Please specify)						

12. a. Have you experienced any problems handling persons who require acute psychiatric care? ☐ Yes ☐ No
    b. If "Yes," please describe the problems_____
    _____
    _____

Part IV--Service Coordination

13. Is the CSB contacted when an inmate who may need services is admitted?
    ☐Always ☐Never ☐Sometimes (Please explain)_____

14. Is a plan developed for services to be delivered in the community when the inmate is released? *(If "No," please go to question 18).*
    ☐Yes ☐No

15. If the answer to question 14 is "Yes," which agencies are involved in the development of the release plan?
    a. ☐Your jail
    b. ☐Community Services Board
    c. ☐Department of Social Services
    d. ☐Local Community Corrections
    e. ☐Other (Please specify) _____

16. Overall, which of the following best describes the relationship between community agencies and your jail in coordinating the release of inmates who need **mental health** or **substance abuse treatment**?
    ☐Excellent ☐Good ☐Fair ☐Poor

17. What services, if recommended, are included in the release plan? (If the answer is "No," please briefly explain the reason in the space provided).
    a. Case Management ☐Yes ☐No_____
    b. Medication Management ☐Yes ☐No_____
    c. Day Treatment ☐Yes ☐No_____
    d. Residential Treatment ☐Yes ☐No_____
    e. Individual Counseling ☐Yes ☐No_____
    f. Housing ☐Yes ☐No_____
    g. Family Support ☐Yes ☐No_____
    h. Job Search/Employment ☐Yes ☐No_____
    i. Other (Please specify)_____

18. On average, how long do former inmates have to wait for a first appointment to receive **mental health** services in the community?
    ☐0 to 10 days ☐11 to 30 days ☐31 to 60 days ☐Over 60 days ☐Unknown

19. On average, how long do former inmates have to wait for a first appointment to receive **substance abuse treatment** services in the community?
    ☐0 to 10 days ☐11 to 30 days ☐31 to 60 days ☐Over 60 days ☐Unknown

Part V--Overall Assessment

20. Please rate the level of **mental health** services in your jail by marking the appropriate number on the following scale.
(4= Comprehensive; 3=Counseling and Emergency Services;
2=Emergency Services Only; 1= No Services).
4.....3.....2.....1

21. Please rate the level of **substance abuse treatment** services in your jail by marking the appropriate number on the following scale.
(4= Comprehensive; 3=Counseling and Emergency Services;
2=Emergency Services Only; 1= No Services).
4.....3.....2.....1

22. Which of the following best describes the level of **mental health** services available in the community to former inmates?
☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown

23. Which of the following best describes the level of **substance abuse treatment** services available in the community to former inmates?
☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown

24. Would it be beneficial to require the court order to incorporate a release plan, including a plan for the delivery of needed **mental health** and **substance abuse treatment** services?
☐Yes ☐No

25. What changes or additional services in your jail or in the community would ensure a higher level of identification and treatment to inmates and former inmates who have **mental health** and **substance abuse treatment** needs? Please attach extra pages if necessary.

_____
_____
_____
_____
_____
_____
_____
_____

26. a. Name of person completing the survey _____
b. Telephone number _____

Thank you very much for your time and assistance.

Probation and Parole Survey

The 2001 Session of the Virginia General Assembly asked the Joint Commission on Behavioral Health Care, Virginia State Crime Commission and Virginia Commission on Youth to study services available to offenders who have mental illness or substance abuse disorders. We request your cooperation in completing the following survey, which will help us understand more about mental health and substance abuse treatment services that are available to individuals while they are under the supervision of Probation and Parole. Thank you for your assistance.

Part I--Descriptive Information

1. Name of Probation and Parole District_____ #_____

2. Current Caseload (August 31, 2001) _____

3. Number of Full-time Equivalent (FTE) Staff (Supervisory/Professional/Clerical) _____

4. a. Does your staff provide **mental health** services? ☐Yes ☐No (*If "No," go to question 5*)
   b. If "Yes," what is the number of FTE staff providing **mental health** services? _____
   c. What is the funding source for **mental health** staff?
      1) State General Funds
         Amount $_____
      2) Other (Please specify source)
         Amount $_____

5. a. Does your staff provide **substance abuse treatment** services? ☐Yes ☐No (*If "No," go to question 6*)
   b. If "Yes," what is the number of FTE staff providing substance abuse treatment?_____
   c. What is the funding source for **substance abuse treatment** staff?
      1) State General Funds
         Amount $_____
      2) Other (Please specify source)
         Amount $_____

6. a. Please name the Community Services Board(s) in your area._____
   _____
   b. Does the Community Services Board(s) provide **mental health** services to offenders?
      ☐Yes ☐No ☐Unknown
   c. Does some other entity (or entities) provide **mental health** services to offenders?
      ☐Yes ☐No (If "Yes," please name the entity_____).
   d. Does the Community Services Board(s) provide **substance abuse assessment/treatment** services to offenders? ☐Yes ☐No ☐Unknown
   e. Does some other entity (or entities) provide **substance abuse assessment/treatment** services to offenders? ☐Yes ☐No (If "Yes," please name the entity_____).

Part II--Screening and Assessment

7. **Mental Health Screening and Assessment**
   a. Are offenders **screened** for **mental health** treatment needs when they are released from the correctional facility? ☐Yes ☐No ☐Screened at the correctional facility
   (If the answer is other than "Yes," please go to question 8).
   b. If "Yes," who does the **screening**? _____
   c. Is a standardized **screening** instrument used? ☐Yes ☐No
   d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
   _____
   e. If the screening indicates potential **mental health** treatment needs, is an **assessment** conducted? ☐Yes ☐No
   f. Who conducts the **assessment**? ☐Probation and Parole staff ☐CSB ☐Private Contract ☐Other (Please specify)_____
   g. Is a standardized **assessment** instrument used? ☐Yes ☐No
   h. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
   _____

8. **Substance Abuse Screening and Assessment**
   a. Are offenders **screened** for **substance abuse** when they are transferred from the correctional facility?
   ☐Yes ☐No ☐Screened at the correctional facility *(If the answer is other than "Yes," please go to question 9).*
   b. If "Yes," who does the **screening**? _____
   c. Is a standardized **screening** instrument used? ☐Yes ☐No
   d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
   _____
   e. If screening indicates potential **substance abuse treatment** needs, is an **assessment** conducted? ☐Yes ☐No
   f. Who conducts the **assessment**? ☐Probation and Parole staff ☐CSB ☐Private Contract ☐Other (Please specify)_____
   g. Is a standardized **assessment** instrument used? ☐Yes ☐No
   h. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
   _____

9. What percentage of your caseload requires **mental health** services?
   ☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

10. What percentage of your caseload requires **substance abuse treatment** services?
   ☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

Part III--Service Coordination

11. a. Do you receive a **mental health** treatment history when an offender is released from a correctional facility? ☐Yes ☐No
    b. Is the information adequate? ☐Yes ☐No

12. a. Do you receive a **substance abuse** treatment history when an offender is released from a correctional facility? ☐Yes ☐No
    b. Is the information adequate? ☐Yes ☐No

13. a. Do offenders receive a discharge plan from the correctional facility if they need mental health or substance abuse services? ☐Yes ☐No
    b. If "Yes," who oversees the discharge plan?
       ☐Probation Officer ☐Other (Please specify)_____
    c. Do offenders receive a temporary supply of prescription medications and/or a back-up prescription, if needed, when they are released from a correctional facility?
       ☐Yes ☐No ☐Unknown
    d. If "Yes," how long is the supply intended to last?
       ☐5 to 10 days ☐11 to 30 days ☐Over 30 days ☐Unknown

14. On average, how long do offenders have to wait for a first appointment to receive **mental health** services in the community?
    ☐0 to 10 days ☐11 to 30 days ☐31 to 60 days ☐Over 60 days ☐Unknown

15. On average, how long do offenders have to wait for a first appointment to receive **substance abuse treatment** services in the community?
    ☐0 to 10 days ☐11 to 30 days ☐31 to 60 days ☐Over 60 days ☐Unknown

Part IV--Overall Assessment

16. Which of the following best describes the level of **mental health** services available to offenders? ☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown

17. Which of the following best describes the level of **substance abuse treatment** services available to offenders? ☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown

18. What are the most important treatment needs in your community?_____
    _____
    _____
    _____
    _____
    _____
    _____

19. a. Name of person completing the survey_____
    b. Telephone number_____

Thank you very much for your time and assistance.

Local and Regional Detention Home Survey

The 2001 Session of the Virginia General Assembly asked the Joint Commission on Behavioral Health Care, Virginia State Crime Commission and Virginia Commission on Youth to study services available to offenders who have mental illness or substance abuse disorders. We request your cooperation in completing the following survey, which will help us understand more about mental health and substance abuse treatment services that are available to juveniles while they are in detention and upon release. Thank you for your assistance.

Part I--Descriptive Information

1. Name of Detention Home_____

2. Average Daily Population_____

3. Facility Capacity_____

4. Number of Full-time Equivalent (FTE) Staff_____

5. a. Does your staff provide **mental health** services? ☐Yes ☐No (*If "No," go to question 6*)
   b. If "Yes," what is the number of FTE staff providing **mental health** services? _____
   c. What is the funding source for **mental health** staff?
      1) State Funds: Amount $_____ 2) Local Funds: Amount $_____
      3) Other: Amount $_____ (Source)_____
   d. Please estimate the percentage of detainees who need **mental health** services.
      ☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

6. a. Does your staff provide **substance abuse treatment** services? ☐Yes ☐No (*If "No," go to question 7*)
   b. If "Yes," what is the number of FTE staff providing **substance abuse treatment**?_____
   c. What is the funding source for **substance abuse treatment** staff?
      1) State Funds: Amount $_____ 2) Local Funds: Amount $_____
      3) Other: Amount $_____ (Source)_____
   d. Please estimate the percentage of detainees who need **substance abuse treatment**.
      ☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

7. a. Please name the Community Services Board(s) in your area._____
   _____
   b. Does the Community Services Board(s) provide **mental health** services to detainees?
      ☐Yes ☐No ☐Unknown
   c. Does some other entity provide **mental health** services to detainees?
      ☐Yes ☐No (If "Yes," please name the entity_____)
   d. Does the Community Services Board(s) provide **substance abuse assessment/treatment** services to detainees? ☐Yes ☐No ☐Unknown
   e. Does some other entity provide **substance abuse assessment/treatment** services to detainees?
      ☐Yes ☐No (If "Yes," please name the entity_____)

Part II—Screening and Assessment

8. a. Are detainees screened for **mental health** treatment needs when they are admitted?
☐Yes ☐No

b. If "Yes," who does the screening? _____

c. Is a standardized screening instrument used? ☐Yes ☐No

d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

e. If the screening indicates potential **mental health** treatment needs, is an assessment conducted? ☐Yes ☐No

f. Who conducts the assessment? ☐ Detention staff ☐CSU staff ☐CSB ☐Private Contract
☐Other (Please specify)_____

g. Is a standardized assessment instrument used? ☐Yes ☐No

h. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

9. a. Are detainees screened for **substance abuse treatment** needs when they are admitted?
☐Yes ☐No

b. If "Yes," who does the screening? _____

c. Is a standardized screening instrument used? ☐Yes ☐No

d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

e. If screening indicates potential **substance abuse treatment** needs, is an assessment conducted?
☐Yes ☐No

f. Who conducts the assessment? ☐ Detention staff ☐CSU staff ☐CSB ☐Private Contract
☐Other (Please specify)_____

g. Is a standardized assessment instrument used? ☐Yes ☐No

h. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

Part III - Services in Your Detention Home

10. a. Are **mental health** services available to juveniles in your detention home?
☐Yes ☐No

b. Who provides the services? (Check all that apply)
☐ Detention staff ☐CSU staff ☐CSB ☐Private Contract
☐Other (Please specify)_____

c. If Detention staff or private contract, what is the source of funding?
1) State General Funds ____%
2) Local Funds _____%
3) Other (Please specify) _____%

d. What **mental health** services are available for **predispositional** cases and what is the average waiting period?

Mental Health Services	**Predispositional**		
	YES	**NO**	**AVER. WAIT (DAYS)**
Emergency Treatment			
Case Management			
Individual Counseling			
Group Counseling			
Medication Management			
Other (Please specify)			

e. What **mental health** services are available for **postdispositional** cases and what is the average waiting period?

Mental Health Services	**Postdispositional**		
	YES	**NO**	**AVER. WAIT (DAYS)**
Emergency Treatment			
Case Management			
Individual Counseling			
Group Counseling			
Medication Management			
Other (Please specify)			

11. a. Are **substance abuse treatment** services available to juveniles in your detention home?
☐Yes ☐No

b. Who provides the services? (Check all that apply)
☐ Detention staff ☐CSU staff ☐CSB ☐Private Contract
☐Other (Please specify)_____

c. If provided by detention staff or private contract, what is the source of funding?
1) State General Funds ____%
2) Local Funds _____%
3) Other (Please specify) _____%

d. What **substance abuse treatment** services are available for **predispositional** cases and what is the average waiting time for services?

Substance Abuse Treatment	**Predispositional**		
	YES	**NO**	**AVER. WAIT (DAYS)**
Emergency Treatment			
Case Management			
Individual Counseling			
Group Counseling			
Medication Management			
Other (Please specify)			

e. What **substance abuse treatment** services are available for **postdispositional** cases and what is the average waiting time for services?

Substance Abuse Treatment	**Postdispositional**		
	YES	**NO**	**AVER. WAIT (DAYS)**
Emergency Treatment			
Case Management			
Individual Counseling			
Group Counseling			
Medication Management			
Other (Please specify)			

12. a. Have you experienced any problems handling juveniles who required acute psychiatric care? ☐Yes ☐No
    b. If "Yes," please explain the problems_____
    _____
    _____
    _____

Part IV--Service Coordination Upon Release

13. Is a plan developed for services to be delivered in the community when the juvenile is released?
    a. Predispositional ☐Yes ☐No
    b. Postdispositional ☐Yes ☐No

14. If the answer to question 13 is "Yes," which agencies are involved in the development of the release plan? (Please check all that apply).
    a. ☐ Your Detention Home
    b. ☐ Court Service Unit
    c. ☐ Community Services Board
    d. ☐ Department of Social Services
    e. ☐ Interagency Planning Team (ex: CSA)
    f. ☐ Juvenile and Domestic Relations District Court
    h. ☐ Other (Please specify)_____

15. Which of the following best describes the relationship between your detention home and other community agencies in coordinating the release of juveniles who need **mental health** and **substance abuse treatment**? ☐Excellent ☐Good ☐Fair ☐Poor

16. What services, if needed, are included in the release plan? (If the answer is "No," please explain the reason in the space provided).
    a. Case Management ☐Yes ☐No_____
    b. Medication Management ☐Yes ☐No_____
    c. Day Treatment ☐Yes ☐No_____
    d. Residential Treatment ☐Yes ☐No_____
    e. Individual Counseling ☐Yes ☐No_____
    f. Housing ☐Yes ☐No_____
    g. Family Support ☐Yes ☐No_____
    h. Job Search/Employment ☐Yes ☐No_____
    i. Education/Family Counseling ☐Yes ☐No_____
    j. Other (Please specify)_____

17. On average, how long do juveniles have to wait for a first appointment to receive **mental health** services in the community?
    ☐0 to 10 days ☐11 to 30 days ☐31 to 60 days ☐Over 60 days ☐Unknown

18. On average, how long do juveniles have to wait for a first appointment to receive **substance abuse** services in the community?
    ☐0 to 10 days ☐11 to 30 days ☐31 to 60 days ☐Over 60 days ☐Unknown

Part V - Overall Assessment

19. Which of the following best describes the level of **mental health** services in your detention home? ☐Excellent ☐Good ☐Fair ☐Poor

20. Which of the following best describes the level of **substance abuse treatment** services in your detention home? ☐Excellent ☐Good ☐Fair ☐Poor

21. Would it be beneficial to require the court order to incorporate a release plan, including a plan for the delivery of needed **mental health** and **substance abuse treatment** services?
    ☐Yes ☐No

22. What changes or additional services in your detention home or in the community would ensure a higher level of identification and treatment to juveniles who need **mental health** or **substance abuse treatment**? Please attach extra pages if necessary.

    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____

23. a. Name of person completing the survey _____
    b. Telephone number _____

Thank you very much for your time and assistance.

Court Service Unit Survey

The 2001 Session of the Virginia General Assembly asked the Joint Commission on Behavioral Health Care, Virginia State Crime Commission and Virginia Commission on Youth to study services available to offenders who have mental illness or substance abuse disorders. We request your cooperation in completing the following survey, which will help us understand more about mental health and substance abuse treatment services that are available to juveniles while they are served by the Court Service Unit. Thank you for your assistance.

Part I--Descriptive Information

1. Court Service Unit District_____

2. Average Daily Caseload
   a. Predisposition _____
   b. Postdisposition _____

3. Number of Full-time Equivalent (FTE) Staff_____

4. a. Does your staff provide **mental health** services? ☐Yes ☐No (*If "No," go to question 5*)
   b. If "Yes," what is the number of FTE staff providing **mental health** services? _____
   c. What is the funding source for **mental health** staff?
      1) State General Funds
         Amount $_____
      2) Other (Please specify source)
         Amount $_____

5. a. Does your staff provide **substance abuse treatment** services? ☐Yes ☐No (*If "No," go to question 6*)
   b. If "Yes," what is the number of FTE staff providing **substance abuse treatment**?_____
   c. What is the funding source for **substance abuse treatment** staff?
      1) State General Funds
         Amount $_____
      2) Other (Please specify source)
         Amount $_____

6. a. Please name the Community Services Board(s) in your area._____
   _____
   b. Does the Community Services Board(s) provide **mental health** services to your clients?
      ☐Yes ☐No ☐Unknown
   c. Does some other entity provide **mental health** services to your clients?
      ☐Yes ☐No (If "Yes," please name the entity_____)
   d. Does the Community Services Board(s) provide **substance abuse assessment/treatment** services to your clients? ☐Yes ☐No ☐Unknown
   e. Does some other entity provide **substance abuse assessment/treatment** services to your clients?
      ☐Yes ☐No (If "Yes," please name the entity_____)

Appendix C 4

Part II—Mental Health Screening and Assessment

7. a. Are juveniles screened for **mental health** treatment needs when they appear before an **intake officer**?
☐Yes ☐No (*If "No," please go to question 8*)
b. If "Yes," who does the screening? _____
c. Is a standardized screening instrument used? ☐Yes ☐No
d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
_____
e. If the screening indicates **mental health** treatment needs, is an assessment conducted?
☐Yes ☐No
f. Is a standardized assessment instrument used? ☐Yes ☐No
g. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
_____
h. Who conducts the assessment? ☐CSU staff ☐ CSB ☐ Private Contract
☐Other (Please specify)_____

8. a. Are juveniles routinely screened for **mental health** treatment needs when a judge orders **probation supervision**?
☐Yes ☐No (*If "No," please go to question 9*)
b. If "Yes," who does the screening? _____
c. Is a standardized screening instrument used? ☐Yes ☐No
d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
_____
e. If the screening indicates potential **mental health** treatment needs, is an assessment conducted?
☐Yes ☐No
f. Is a standardized assessment instrument used? ☐Yes ☐No
g. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
_____
h. Who conducts the assessment? ☐CSU staff ☐ CSB ☐ Private Contract
☐Other (Please specify)_____

9. a. Are juveniles routinely screened for **mental health** treatment needs upon their return from a **juvenile correctional center**? ☐Yes ☐No (*If "No," please go to question 10*)
b. If "Yes," who does the screening? _____
c. Is a standardized screening instrument used? ☐Yes ☐No
d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
_____
e. If the screening indicates **mental health** treatment needs, is an assessment conducted?
☐Yes ☐No
f. Is a standardized assessment instrument used? ☐Yes ☐No
g. If "Yes," please name the instrument(s) or attach a copy to your completed survey.
_____
h. Who conducts the assessment? ☐CSU staff ☐ CSB ☐ Private Contract
☐Other (Please specify)_____

10. a. Does the Department of Juvenile Justice or the juvenile correctional center forward to you information about the **mental health** treatment history or the treatment needs of the juvenile? ☐Yes ☐No
b. Is the information adequate? ☐Yes ☐No

Part III—Substance Abuse Screening and Assessment

11. a. Are juveniles routinely screened for **substance abuse treatment** needs when they appear before an **intake officer**?

☐Yes ☐No (*If "No," please go to question 12*)

b. If "Yes," who does the screening? _____

c. Is a standardized screening instrument used? ☐Yes ☐No

d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

e. If the screening indicates potential **substance abuse treatment** needs, is an assessment conducted?

☐Yes ☐No

f. Is a standardized assessment instrument used? ☐Yes ☐No

g. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

h. Who conducts the assessment? ☐CSU staff ☐ CSB ☐ Private Contract

☐Other (Please specify)_____

12. a. Are juveniles routinely screened for **substance abuse treatment** needs when a judge orders **probation supervision**? ☐Yes ☐No (*If "No," please go to question 13)*

b. If "Yes," who does the screening? _____

c. Do you use a standardized screening instrument? ☐Yes ☐No

d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

e. If the screening indicates potential **substance abuse treatment** needs, is an assessment conducted?

☐Yes ☐No

f. Is a standardized assessment instrument used? ☐Yes ☐No

g. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

h. Who conducts the assessment? ☐CSU staff ☐ CSB ☐ Private Contract

☐Other (Please specify)_____

13. a. Are juveniles screened for **substance abuse treatment** needs upon their return from a **juvenile correctional center**? ☐Yes ☐No (*If "No," please go to question 14*)

b. If "Yes," who does the screening? _____

c. Do you use a standardized screening instrument? ☐Yes ☐No

d. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

e. If the screening indicates potential **substance abuse treatment** needs, is an assessment conducted? ☐Yes ☐No

f. Is a standardized assessment instrument used? ☐Yes ☐No

g. If "Yes," please name the instrument(s) or attach a copy to your completed survey.

_____

h. Who conducts the assessment? ☐CSU staff ☐ CSB ☐ Private Contract

☐Other (Please specify)_____

14. a. Does the Department of Juvenile Justice or the juvenile correctional center forward to you information about the **substance abuse treatment** history or the treatment needs of the juvenile? ☐Yes ☐No

b. Is the information adequate? ☐Yes ☐No

Part IV—Mental Health and Substance Abuse Treatment Services

15. Please estimate the percentage of your caseload that requires **mental health** services.
☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

16. Please estimate the percentage of your caseload that requires **substance abuse treatment** services.
☐ 0 to 15% ☐ 16 to 25% ☐ 26 to 50% ☐ Over 50% ☐ Unknown

17. On average, how long does a juvenile have to wait for a first appointment to receive **mental health** services in the community?
☐ 0 to 10 days ☐ 11 to 30 days ☐ 31 to 60 days ☐ Over 60 days ☐ Unknown

18. If juveniles do not receive **mental health treatment** in the community when they need it, what are the TWO most significant (1=most significant, 2=second most significant) contributing factors?
☐ Lack of treatment options
☐ Lack of funding/financial resources
☐ Juvenile's resistance to participation
☐ Family's resistance to participation
☐ Waiting Lists
☐ Other_____
_____

19. On average, how long does a juvenile have to wait for a first appointment to receive **substance abuse treatment** services in the community?
☐ 0 to 10 days ☐ 11 to 30 days ☐ 31 to 60 days ☐ Over 60 days ☐ Unknown

20. If juveniles do not receive **substance abuse treatment** when they need it, what are the TWO most significant (1=most significant, 2=second most significant) contributing factors?
☐ Lack of treatment options
☐ Lack of funding/financial resources
☐ Juvenile's resistance to participation
☐ Family's resistance to participation
☐ Waiting Lists
☐ Other_____
_____

Part V--Overall Assessment

21. Which of the following best describes the level of **mental health** services available to the juveniles you serve? ☐ Excellent ☐Good ☐Fair ☐Poor ☐Unknown

22. Which of the following best describes the level of **substance abuse treatment** services available to the juveniles you serve?
☐ Excellent ☐Good ☐Fair ☐Poor ☐Unknown

23. What are the most important treatment needs in your community?_____
_____
_____
_____
_____
_____

24. a. Name of person completing the survey_____
b. Telephone number_____

Thank you very much for your time and assistance.

Appendix D

Virginia's Legal Obligations to Offenders with Mental Illness or Substance Abuse Disorders

Virginia's Legal Obligations to Offenders with Mental Illness or Substance Abuse Disorders

Austin Wallace
Research Assistant,
Division of Legislative Services

Prepared for the Joint Study Committee on Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders (SJR 440)

I. Introduction

Federal and Virginia law affords several key rights to incarcerated people with mental illness or substance abuse disorders. The Eighth Amendment prohibition against "cruel and unusual punishment" requires that anyone in custody suffering from a mental illness be given medical treatment for any "serious" illness. Rehabilitation for a substance abuse disorder, however, is not a right guaranteed under the Eighth Amendment. The Fourteenth Amendment "due process" clause provides a procedural safeguard protecting an inmate/prisoner's "liberty interest." Thus, when a prisoner is diagnosed with either a mental illness or substance abuse disorder requiring a detrimental change in one's "liberty interest," the Fourteenth Amendment requires either an adversarial hearing or an evidentiary hearing. However, it need not be before a judicial decision-maker, but can be before an administrative panel. The Americans with Disabilities Act of 1990 is the leading statutory provision of rights to people with mental illness or substance abuse disorders. If a jail or prison provides a benefit or service, it cannot exclude an inmate/prisoner based on their having either a mental illness or substance abuse disorder. Lastly, Virginia law closely tracks the minimum requirements of Federal law and goes beyond by requiring the provision of substance abuse treatment to those with such a disorder.

II. Federal Law

A. Eighth Amendment Rights

The leading case on a prisoner's right to medical treatment under the Eighth Amendment's prohibition against "cruel and unusual punishment" is *Estelle v. Gamble*[1]. There, the court held that in order for a prisoner to state a claim for violation of the Eighth Amendment, a prisoner/plaintiff must show that the prison officials showed a

[1] 429 U.S. 97 (1976).

"deliberate indifference to the prisoner's "serious" illness.[2] Thus, a prison must not *deliberately* ignore a prisoner's "*serious*" ailments. Furthermore, since there is "no underlying distinction between the right to medical care for physical ills and its psychological counterpart,"[3] the Eighth Amendment protections delineated in *Estelle* also apply to those with mental illnesses.[4]

Several courts have also attempted to define "deliberate indifference" and what constitutes a "serious" illness. The U.S. Court of Appeals for the eleventh circuit defined "deliberate indifference" to constitute "wantonness,"[5] while the Eight Circuit has indicated that even "multiple incidences of medical malpractice or negligence do not amount to deliberate indifference without some specific threat of harm from a related system-wide deficiency."[6] A "serious" illness entitling a prisoner to medical attention under *Estelle* is required if

> a physician or other medical health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.[7]

This care, however, is "limited to that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable."[8] Several courts have attempted to further refine the Eighth Amendment requirements of a "minimally adequate prison mental health care delivery system." The courts identified six components, including: 1) a

---

[2] Id. at 104. *See also* Little v. Lycoming County, 912 F.Supp. 809 (M.D. Pa. 1996) (citing Estelle v. Gamble, 429 U.S. 97 (1976) and Monmouth County Correctional Institution Inmates v. Lanzaro, 834 F.2d 326, 346 (3rd Cir. 1987) *cert. denied*, 486 U.S. 1006 (1988)).
[3] Bowring v. Godwin, 551 F.2d. 44, 47 (4th Cir. 1977).
[4] *But see* Milonas v. Williams, 691 F.2d 931 (10th Cir. 1982) (holding that the Eighth Amendment applies only in the criminal context and does not apply to the civil juvenile justice system).
[5] LeMarca v. Turner, 995 F.2d 1526, 1535 (11th Cir. 1993).
[6] Dulavy v. Carnahan, 132 F.3d 1234, 1245 (8th Cir. 1997).
[7] Bowring, 551 F.2d 44, 47 (4th Cir. 1977).
[8] Id at 48.

systematic program for screening and evaluating inmates to identify those in need of mental health care; 2) a treatment program that involves more than segregation and close supervision of inmates with mental illness; 3) employment of a sufficient number of trained mental health professionals; 4) maintenance of accurate, complete and confidential mental health treatment records; 5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and 6) a basic program to identify, treat, and supervise inmates at risk for suicide.[9]

A separate Eighth Amendment guarantee is derived from the holding in *Estelle* but contemplates future harm. In *Helling v. McKinney*[10] the U.S. Supreme Court held that the Eighth Amendment can be violated if a prison official is deliberately indifferent to conditions posing a substantial risk of serious future harm. In a claim involving a prison inmate alleging that exposure to high levels of environmental tobacco smoke constituted an unreasonable risk of serious future harm, the court held that a prison system cannot expose inmates to 1.) an unreasonable risk the likes of which are "so grave that it violates contemporary standards of decency to expose anyone unwillingly to such a risk,"[11] and 2.) the prison cannot be deliberately indifferent to the inmate's serious medical needs as defined in *Estelle*.

With regard to issues surrounding substance abuse, the court has held that there is no Eighth Amendment right to educational, vocational or rehabilitative services.[12]

B. Fourteenth Amendment Rights

A separate, but related, line of cases deal with the Fourteenth Amendment procedural due process elements of diagnosing and treating mental illness within the

---

[9] *See* Coleman v. Wilson, 912 F.Supp 1282, 1298 (E.D. CA. 1995) (citing Balla v. Idaho State Board of Corrections, 595 F.Supp 1558, 1577 (D. Idaho 1984)).
[10] 509 U.S. 25 (1993).
[11] Id. at 36.
[12] *See* Rhodes v. Chapman, 452 U.S. 337, 348 (1981).

prison environment. In *Vitek v. Jones*[13] the U.S. Supreme Court held that when a prisoner is diagnosed with a mental illness requiring transfer out of the prison to a mental hospital, the Fourteenth Amendment requires procedural due process protections in the form of either an adversarial hearing[14] or an evidentiary hearing[15]. Such procedural safeguards, however, need not be before a judicial decision-maker, but can be before an administrative panel.[16] Thus, if the diagnosis or treatment of a prisoner's mental illness involves a detrimental change in the liberty interest of the prisoner (including the "stigmatizing effect" of mental illness), the Fourteenth Amendment due process clause requires the above or similar procedures to protect the liberty interest of the prisoner.[17] While the court has never defined what constitutes a "liberty interest" implicating due process protections, the case law suggests that the court will consider involuntary commitment to a mental institution or the involuntary administration of psychotropic drugs to trigger a "liberty interest."[18]

A Fourteenth Amendment analysis has also been used to support the right for juveniles to receive rehabilitative services, despite court holdings to the contrary for adults. One suggested reason for the disparity in rights is the difference in the stated purposes of the two systems. For adults, a leading purpose in the justice system is punishment, while for juveniles the major purpose is rehabilitation.[19] Although there is a paucity of cases addressing this issue, the Supreme Court in *Youngberg v. Romero* held

---

[13] 445 U.S. 480 (1980).
[14] Id. at 496.
[15] *See e.g.* Bowring, 551 F.2d at 49.
[16] *See* Washington v. Harper, 494 U.S. 210, 228 (1990).
[17] It is worth noting that treatment for mental illness against one's will does not violate the procedural due process interests where a prisoner is found to be a danger to himself or others and the treatment is in his interest. *See* note 9.
[18] *See* Riggins v. Nevada, 504 U.S. 127 (1992) (applying to pretrial detainees); Harper, 494 U.S. 210 (1990); Mills v. Rogers, 457 U.S. 291 (1982). *See also* Johnson v. Silvers, 838 F.2d 466 (4th Cir. 1988) (unpublished table decision) (per curiam); United State v. Charters, 863 F.2d 302 (4th Cir. 1988) *cert. den.* 494 U.S. 1016 (1990); Washington v. Silber, 805 F.Supp 379 (W.D. Va.1982) *affd without op.* 993 F.2d 1541 (4th Cir. 1993).
[19] *See generally* UNIVERSITY OF VIRGINIA INSTITUTE OF LAW, PSYCHIATRY & PUBLIC POLICY, JUVENILE OFFENDERS' LEGAL RIGHT TO RECEIVE REHABILITATIVE TREATMENT 6 (1999).

that an adult with severe mental retardation civilly committed to a state hospital had a Fourteenth Amendment right to "such training as an appropriate professional would consider reasonable."[20] Thus, the court established a minimal right to "reasonable" treatment for civilly committed individuals. Other federal courts have applied this standard to juveniles, but have not extensively built upon its minimal requirements and discretion afforded to professional staff.[21] Other arguments supporting the right to rehabilitative treatment for juveniles have been less successful.[22] Thus, while there does seem to be some support for a Fourteenth Amendment right to rehabilitative treatment of juveniles, evidence of this right is derivative and indirect; given the lack of direction from the courts, most juvenile rights stem from state law.

C. Americans with Disabilities Act of 1990[23]

Title II of the Americans with Disabilities Act of 1990[24] deals with the obligations of public entities toward those with disabilities. The Act defines a public entity as any state or local government, department, agency, special purpose district or other instrumentality of the state or local government.[25] Specifically, the Act prohibits the exclusion of a "qualified individual with a disability" from participation in or the denial of the benefits of services, programs or activities provided by the public entity.[26] A "qualified individual with a disability" is a person who has a disability and "meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the public entity."[27] Title I of the Act defines a disability to be "(A) a physical or mental impairment that substantially limits one or more

[20] Youngberg v. Romero, 457 U.S. 307, 324 (1982).
[21] *See* JUVENILE OFFENDERS' LEGAL RIGHT TO RECEIVE REHABILITATIVE TREATMENT at 11-12.
[22] Ibid at 12-13.
[23] 42 U.S.C. § 12101 (2000) et. seq.
[24] 42 U.S.C. § 12131 et seq.(2000).
[25] 42 U.S.C. § 12131 (2000).
[26] 42 U.S.C. § 12132 (2000).
[27] 42 U.S.C. § 12131 (2000).

of the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such impairment."[28]

Interpreting this language, the U.S. Supreme Court held in *Pennsylvania Dept. of Corrections v. Yeskey*[29] that a prison is a public entity within the definition provided by Title II of the Act and that prisoners with a "qualified disability" could maintain an ADA claim. Moreover, because the definition of disability includes mental illness, a prisoner with a mental illness could sue the state for a violation of the ADA.

Furthermore, the ADA's definition of disability also seems to include those with substance abuse disorders. The Act states that, "Nothing in subsection (a) shall be construed to exclude as an individual with a disability an individual who-(1) has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use; (2) is participating in a supervised rehabilitation program and is no longer engaging in such use."[30] Thus, the language of the Act seems to cover those with substance abuse disorders, preventing the denial of services based on this ADA defined "disability." While federal courts have held that there is no constitutional right to educational, rehabilitative, or vocational programs in the prison context,[31] these cases have not addressed a prisoner's right to such services under the ADA. The practical impact of these requirements is that if a prison system provides a service or benefit (e.g. counseling, recreation etc.), the prison cannot exclude a

---

[28] 42 U.S.C. § 12102 (A) - (C) (2000).
[29] 524 U.S. 206 (1998).
[30] 42 U.S.C. § 12210(b)-(c) (2000). Subsection (a) referred to in the quote notes that the ADA is inapplicable to those currently using illegal drugs.
[31] *See* Zimmerman v. Tribble, 226 F.3d 568, 571 (7th Cir. 2000) (quoting Garza v. Miller 688 F.2d 480, 486 (7th Cir. 1982).

"qualified" inmate from those services/benefits based upon their being mentally ill or having a substance abuse disorder.[32]

III. State Law

State law substantially mirrors the requirements of federal law. Virginia law generally provides for medical services to be available to state prison inmates.[33] The state is obligated to provide "medically necessary" medical treatment[34], mirroring the Supreme Court's holding in *Estelle*. And since medical treatment includes psychiatric treatment,[35] Virginia law requires the treatment of a prisoner's mental illnesses so long as it is "medically necessary," as opposed to medically desirable.[36] Moreover, the state is obligated to provide substance abuse treatment programs within the state's prisons[37], thereby going beyond the minimum requirements of Federal law. Lastly, Virginia law meets the due process requirements for treatment without consent[38] as outlined in *Vitek, Washington v. Harper* and *Bowring*.

IV. Possible Future Developments

A. Eleventh Amendment

Recently, the U.S. Supreme Court has begun to limit the applicability of some federal laws to the states based on the requirements of the Eleventh Amendment. The Eleventh Amendment provides that "the Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another State, or by citizens or subjects of any

---

[32] Unless the prison can show that the inmate is a danger to himself or others in such a setting and can not make reasonable alternate accommodations for the provision of the services to the inmate.
[33] VA. CODE ANN. § 58.2-32 (2001).
[34] Id. at § 58.2-32(A) (2001).
[35] *See* Bowring, 551 F.2d at 47 (4th Cir. 1977).
[36] *But see* VA. CODE ANN. § 16.1-248.2 (2001) (requiring mental health screening within twenty-four hours of a professional determination that it may be needed); discussion *infra* Part II, B.
[37] VA. CODE ANN. § 58.2-32(B) (2001).
[38] *See* VA. CODE ANN. § 58.2-40.1 (2000).

Foreign State."[39] The court has interpreted this language to prevent non-consenting states from being sued by private individuals in federal court, absent a valid abrogation of the right by Congress.[40] A valid abrogation of the states' Eleventh Amendment rights requires an unequivocal intention by Congress to do so and action pursuant to a valid grant of constitutional authority (e.g. § 5 of the Fourteenth Amendment).[41] However, in *Seminole Tribe of Florida v. Florida*[42], the U.S. Supreme Court held that Congress cannot abrogate the states' Eleventh Amendment protections based upon its Article I Commerce clause powers. The effect of these interpretations is to limit the applicability of federal legislation on the states where a right of action is created in federal court and in particular, they may limit the applicability of the Americans with Disabilities Act of 1990 (ADA) to state prison systems.

Left unresolved in the *Yeskey* decision previously mentioned was the issue of *whether application of the ADA to state prisons is a constitutional exercise* of Congress' power under § 5 of the Fourteenth Amendment. Addressing this (at least tangentially), the Court in *Board of Regents of the University of Alabama v. Garrett*[43] held that Title I of the ADA (dealing with employment discrimination against those with disabilities) invalidly abrogated the state's Eleventh Amendment immunity against being sued in federal court for money-damages. Thus, a state cannot be sued in federal court for money damages on a claim of Title I employment discrimination. Writing for the majority, Chief Justice Rehnquist based his holding on previous cases delineating the scope of Congress' ability to abrogate a state's Eleventh Amendment immunity from suits in federal courts.[44] Noting the invalidity of an abrogation based on Commerce Clause powers, the court

---

[39] U.S. CONST. amend. XI.
[40] *See* Kimel v. Florida Board of Regents, 528 U.S. 62, 72-73 (2000)
[41] Id. at 73.
[42] 517 U.S. 44 (1996).
[43] 2001 WL 173556 (U.S. Ala.).
[44] *See* Kimel, 528 U.S. 62 (2000); City of Boerne v. Flores, 521 U.S. 507 (1997); Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985).

indicated that valid grants of constitutional authority usually come from an act passed under Congress' § 5 authority to enforce § 1 of the Fourteenth Amendment.[45] "[Section] 5 legislation reaching beyond the scope of § 1's actual guarantees must exhibit 'congruence and proportionality between the injury to be prevented or remedied and the means adopted to that end.'"[46] Similarly, a state's actions rationally furthering legitimate purposes is a defense against an allegation of discrimination in violation of such § 5 legislation.[47]

From this, the court examined whether Title I of the ADA was a valid use of Congress' § 5 powers in response to historic or patterned § 1 violations by the states.[48] After review of the ADA's legislative history, the court concluded that the sporadic incidents of discriminatory state employment practices were not enough to validate Congress' exercise of its § 5 powers.[49] Therefore, Congress' abrogation of the state's Eleventh Amendment immunity rights against money-damages in federal courts was an unconstitutional use of its § 5 powers.

Garrett is important in the context of this research since it seems to continue a trend toward restricting the federal government's powers over state operations. Although, strictly construed, the holding in *Garrett* only prevents states from being sued for money-damages in federal court based on a Title I claim[50], the dicta seems to indicate that Title II as applied to the states is in question. Thus, in the future, the

---

[45] Id. (quoting Fitzpatrick v. Bitzer, 427 U.S. 445, 456 (1976) for the proposition that "the Eleventh Amendment and the principle of state sovereignty which it embodies, are necessarily limited by the enforcement provisions of §5 of the Fourteenth Amendment"). *See also* Kimel, 528 U.S. at 79 (finding that Congress may not base its abrogation upon powers enumerated in Article I of the U.S. Constitution).
[46] Id. (quoting Boerne, 521 U.S. at 520).
[47] Id. at 7.
[48] Id. at 8.
[49] Id. at 8-11.
[50] According to the opinion, there doesn't seem to be anything especially offensive to the Eleventh Amendment with regard to money-damages that wouldn't also be true of other remedies. Title II's remedies for a violation of its terms basically only provide equitable relief (although some attorney's fees may be awarded). Indeed the Court has held that suits in federal court against a state are barred by the 11th Amendment even where money damages are not sought. *See* 72 AM JUR. 2D *States, Etc.* § 110-117 (1964).

reasoning in *Garrett* could be used to question the applicability of Title II of the ADA to the states.[51]

B. Discrimination by Category

Assuming that the ADA remains applicable to the states as written, another developing issue is the treatment of discrimination by category. That is, in the context of Title II of the ADA, does a prison have to treat those with a mental illness or substance abuse disorder in the same fashion as it treats someone who has a heart condition or paraplegia? "The courts are nearly unanimous that people may not be discriminated against on the basis of the severity of their disability", but are "divided on whether people with a particular disability may be disadvantaged in favor of people with another disability."[52] However, several Federal courts in various different contexts have acknowledged some form of discrimination by category prohibited by the ADA.[53] Of particular note is *Lewis v. Aetna Life Ins. Co*[54]. There, the U.S. District Court for the Eastern District of Virginia held that the "ADA prohibits discrimination on the basis of an individual's particular disability," regardless of whether "a disabled person is treated differently than a non-disabled person or another disabled person."[55] Thus, while there is little direct judicial treatment of discrimination by category, there does seem to be a growing (albeit slowly) body of precedent recognizing the ADA's prohibition against this form of discrimination. If, in the future, there is a more explicit ruling that the ADA

---

[51] *But see* Garrett, at 9, note 7 (noting that Justice Breyer's dissent catalogs numerous accounts of alleged discrimination by the states in the provision of public services, potentially providing enough evidence for the court to conclude that there is a history and pattern of state discrimination to validate Congress's use of its §5 powers to enact Title II of the ADA).
[52] Susan Stefan, *The Americans With Disabilities Act and Mental Health Law: Issues for the Twenty-first Century*, 10 J. CONTEMP. LEGAL ISSUES 131, 176 (1999).
[53] *See* Helen L. v. DiDario, 46 F.3d 325 (3rd. Cir. 1995); Martin v. Voinovich, 840 F.Supp. 1175 (S.D. OH 1993); Garrity v. Gallen, 522 F.Supp. 1711 (S.D. N.H. 1981) (interpreting §504 of the Rehabilitation Act of 1973, one of the ADA's predecessors). *See also* Olmstead v. L.C., 119 S.Ct. 2176 (1999). *But see* Trask v. General Signal Corp., 1999 WL 1995204 (D. Me. Aug. 13, 1999); Conners v. Maine Medical Center, 42 F.Supp.2d 34 (D. Me. 1999); Rogers v. Dept. of Health and Environmental Control, 985 F.Supp. 635 (D.S.C. 1997).
[54] 982 F.Supp. 1158 (E.D. Va. 1997).
[55] Id. at 1168.

prohibits discrimination by category, state prison systems may be required to more closely scrutinize the services they provide to their inmates with disabilities, ensuring that not only are services provided equally to those with and without disabilities, but that all inmates with disabilities (absent a legitimate professional judgement to the contrary) are treated equally.

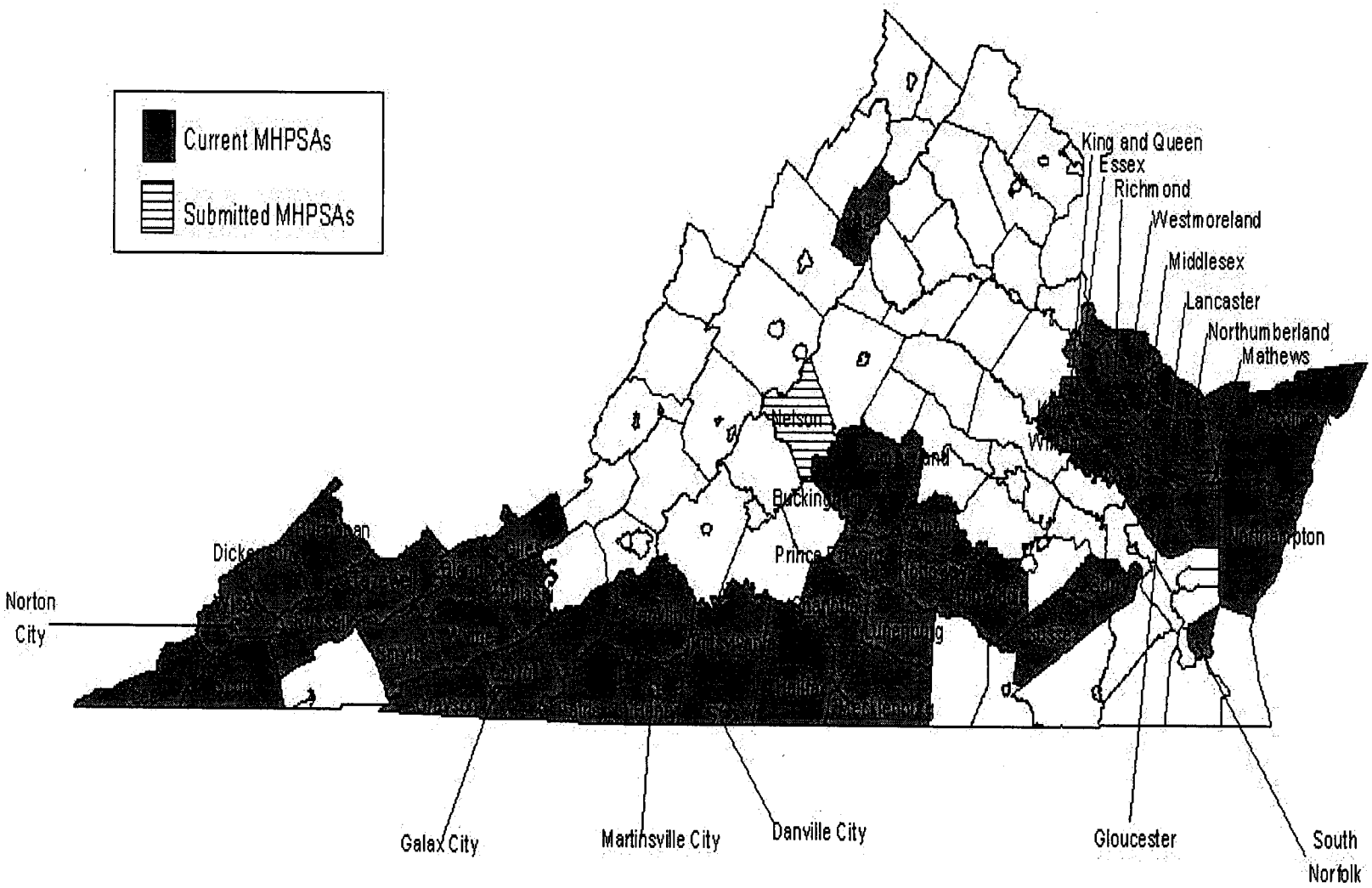
APPENDIX

CASE NAME	SUBJECT MATTER	KEY HOLDING
Estelle v. Gamble	8th Amendment	"Deliberate indifference" to prisoner's "serious" illness
Bowring v. Godwin	8th Amendment	Eighth Amend. protections apply to prisoner's with mental health problems
Balla v. Idaho State Board of Corrections	8th Amendment	Minimally Adequate Prison Mental Health Care Delivery System
Helling v. McKinney	8th Amendment	Deliberate Indifference to serious future harm
Vitek v. Jones	14th Amendment	Procedural Due Process in form of adversarial or evidentiary hearing when "liberty interest" changed
Washington v. Harper	14th Amendment	Adversarial or evidentiary hearing need not be before a judge, but can be before an administrative panel.
Youngberg v. Romero	14th Amendment	civilly committed adult has right to "reasonable [rehabilitative] treatment"
Pennsylvania Dept. of Corrections v. Yeskey	ADA	Title II of ADA applicable to state criminal justice systems (prisons & jails)
Board of Regents of the Univ. of Alabama v. Garrett	11th Amendment & ADA	Congress invalidly abrogated state's 11th Amend. immunity from being sued in Fed. court for money damages when they enacted Title I of ADA. Title I of ADA inapplicable to states.
Lewis v. Aetna Life Ins. Co.	ADA	ADA prohibits discrimination on the basis of individual's particular disability. ADA right to be free from discrimination by category?

Appendix E

Virginia Mental Health Professional Shortage Areas

Virginia Mental Health Professional Shortage Areas



Source: Virginia Department of Health (6/20/01)

Appendix F

Memorandum on Mental Health Courts

MEMORANDUM

TO: Parties Interested in Developing a Mental Health Court

FROM: Diana Dunker, Council of State Governments

DATE: August 23, 2001

RE: Mental Health Courts

"The past decade has been a fertile one for court reform. All across the country, courts - in concert with both government and community partners - have been experimenting with new ways to deliver justice. This wave of innovation goes by many names and takes many forms."[1]

Mental health courts are one example of the court reform trend. Similar to other problem-solving courts (*e.g.*, drug courts, domestic violence courts, community courts), mental health courts are based on "a desire to make courts more problem-solving and to improve the kinds of results that courts achieve for victims, litigants, defendants and communities."[2] While mental health courts may have some common characteristics, such as their philosophical foundation, the courts differ in their administration and practice.

The purpose of this memorandum is: 1) to explain the origins and increasing popularity of mental health courts; 2) to review the similarities and differences that mental health courts share; and 3) to identify significant issues that any jurisdiction contemplating the establishment of a mental health court must consider.

I. Origins of Mental Health Courts and Their Increasing Popularity

The genesis of the mental health court can be traced to the success of the first drug court in Dade County, Florida in 1989.[3] In order to address addiction-fueled recidivism the Dade County court

> sentence[d] addicted defendants to long-term, judicially-supervised drug treatment instead of incarceration. Participation in treatment [was] closely monitored by the drug court judge, who respond[ed] to progress or failure with a system of graduated rewards and sanctions, including short-term jail

[1] Greg Bergman and John Feinblatt, *"Problem-Solving Courts A Brief Primer,"* p. 3 (available at www.courtinnovation.org.)
[2] Id.
[3] Id at 4.

> sentences. If a participant successfully complete[d] treatment, the judge w[ould] reduce the charges or dismiss the case.[4]

The success of Dade County's experiment spurred the creation of drug courts throughout the country and popularized the concept of therapeutic jurisprudence. Professor David Wexler defines "therapeutic jurisprudence" as "a perspective that regards the law as a social force that produces behaviors and consequences." Therapeutic jurisprudence, according to Wexler, challenges law-makers, lawyers and judges to consider the human, emotional and psychological side of law and the legal process and its consequences.[5]

Officials in other jurisdictions have applied the drug court model and the principle of therapeutic jurisprudence to other types of crimes, such as domestic violence, gun and quality-of-life offenses. "[I]n the years since the opening of the Dade County drug court, dozens of other specialized, problem-solving courts have been developed to test new approaches to difficult cases and to improve both case outcomes for parties and systemic outcomes for the community at large."[6]

Mental health courts represent one of the most recent permutations of the drug court model. In addition to the growing support for problem-solving courts, a report by the Bureau of Justice Assistance points to the "large numbers of mentally ill persons in the criminal justice population,"[7] and "the national crisis of overcrowding in local jails"[8] as contributing factors to the growing popularity of mental health courts.

Broward County, Florida established the first mental health court in 1997. Since 1997, at least 11 additional jurisdictions established a mental health court.[9] Legislative action at the state and federal level has accelerated the spread of mental health courts. In November 2000, President Clinton signed into law the "America's Enforcement and Mental Health Project Act," hereinafter the "Mental Health Court Act."[10] The Mental Health Court Act "authorizes the creation of up to 100 mental health courts and $10 million a year for a period of four years for their maintenance."[11]

State legislatures have also been active in promoting the growth of mental health courts throughout the nation. In the first six months of 2001, legislation establishing mental health courts was pending in at least seven states. It is important to note that legislation is not necessary

---

[4] Id.

[5] David Wexler, "*Therapeutic Jurisprudence: An Overview,*" available at http://www/law/arizona.edu/upr-intj/intj-o.html.

[6] Berman at 4.

[7] John S. Goldkamp and Cheryl Irons-Guyun, Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino and Anchorage," p. 3 [hereinafter BJA]

[8] Id.

[9] Several states are currently planning to establish a mental health court.

[10] Pub. Law 106-515 (2000) Although Congress did not fund the program in FY2001, the Senate included $5 million in funding for FY2002. The House FY2002 appropriation did not include any funding for mental health courts.

[11] Hank Steadman et al., "*Mental Health Courts: Their Promise and Unanswered Questions,*" Psychiatric Services p. 457 (April 2001)

to establish a mental health court. For example, an administrative court order established the Broward County mental health court. Furthermore, existing programs and resources, like community supervision, can address a defendant's need for services without the need for a mental health court.

II. Similarities and Differences Among Mental Health Courts

The rush to establish mental health courts has led to an increasing number of dockets that target individuals with mental illness but lack uniformity in form or practice. Distant relatives, mental health courts and drug courts have little in common beyond common philosophies. "Unlike drug courts, [12] mental health courts have no [] infrastructure or model. Any similarities among current mental health courts occur more or less by chance at the implementation level and stem mostly from mirror-imaging by new jurisdictions seeking to replicate recently visited mental health courts or to duplicate drug courts."[13] Some argue that "almost any special effort by the courts to better address the needs of persons with serious mental illness who engage with the criminal justice system can qualify as a mental health court by current standards."[14] As such, it is difficult to define a "mental health court."

John S. Goldkamp in his monograph for the Bureau of Justice Assistance determined that the mental health courts in Fort Lauderdale, Seattle, San Bernardino and Anchorage had the following in common:

- Criminal history -- "[a]ll of the mental health courts accept individuals with extensive criminal histories";
- Judge -centered approach -- "[u]nder this approach, the judge sits at the center of the court treatment process and plays a variety of roles, formal and informal...The judge presides formally over any legal matters at the entry and completion stages of the process and may adjudicate cases of participants who opt out or fail in the program. Perhaps most importantly, the judge plays a hands on, therapeutically-oriented and directive role at the center of the treatment process."
- Partnership with mental health system -- "the mental health court redesigns the working relationship between the court and treatment services, brings the redesigned partnership in to the courtroom and holds it accountable to the judge."
- Special courtroom procedures/staff -- "each of the courtrooms shares in common the attempt to present a supportive environment in which participants have confidence that they can speak and have their problems addressed."
- Range of treatment and supportive services -- "each of the courts seeks to link their participants with appropriate treatment services...drawing together whatever appropriate services are available to assemble a network of services that can be responsible to the court."
- Multi-agency and System Support -- "a critical element of each of the strategies is multi-agency and system-wide support in both planning and operation. This is reflected in the

[12] "Despite an initial scattered start, drug courts rapidly moved to a common model aided by technical assistance and information on program models from national sources [ ]." Steadman at 457.
[13] Id.
[14] Id.

planning task forces producing the recommendations for the mental health courts and in the collaboration required in the day-to-day operation of the court and the work of the court team." [15]

As with drug courts, federal legislation may be helpful in setting a standard definition for mental health courts. The Mental Health Act has seven basic components for eligibility that can be used as a basic definition for these courts:

1. continuing judicial supervision;
2. specialized training for appropriate personnel;
3. voluntary outpatient or inpatient mental health treatment;
4. centralized criminal case management;
5. coordination of mental health services;
6. relapse prevention services; and
7. continuing supervision of treatment plan compliance.[16]

Contributing to the difficulty in determining key elements of an effective mental health court is the lack of any evaluative data on these courts. BJA's monograph on the first four mental health courts is the only comprehensive review of these courts to date. However, the BJA monograph is not an evaluation of these courts; it is more of a primer on the form and function of those four courts. Although evaluations of several courts are planned, the Broward County Mental Health Court is currently being evaluated by the faculty at the University of South Florida,[17] the lack of evaluative data means that the components essential to the success of a mental health court are unknown.

III. Issues to Consider in Establishing a Mental Health Court

The broad view of mental health courts presents both opportunities and obstacles. The lack of constraints on the scope, form and function of these courts allows local jurisdictions to tailor the court to address their specific needs and continue reforming court procedure and process. However, unstructured change can also set the foundation for greater problems down the road. For example, some jurisdictions could establish a mental health court that inadvertently increases the number of individuals under supervision and the duration of their contact with the criminal justice system. Widening the net of criminal justice supervision frustrates the goal of diversion programs by increasing participant entanglement with the criminal justice.

Jurisdictions seeking to address the problem of offenders with mental illness should first consider why there is a need for a mental health court. Certainly, the inadequacy of the mental health system contributes to the high rate of incarceration among individuals with mental illness.[18] Moreover, the creation of a mental health court will only increase the need for

---

[15] BJA at 59-69.
[16] Pub. Law 106-515 at 2.
[17] *See,* John Petrila, et al., "*Preliminary Observations From and Evaluation of the Broward County Florida Mental Health Court*".
[18] "A critical element of the emerging mental health court model involves identification of the necessary treatment and related services in the community, and the development of an effective working arrangement between the courts

adequate mental health services as courts move to direct increasing numbers of offenders into treatment. Implementation of a mental health court without addressing the inadequacies of the mental health system risks limiting the court's ability to offer meaningful treatment alternatives and can have the effect of creating crisis-based eligibility for treatment rather than prevention.

Another challenge for mental health courts is the "networking of services" intrinsic to any problem-solving court. The success of any problem-solving court requires that service providers be willing, accountable and have the resources to participate fully in the team atmosphere utilized by most of these courts. In this team approach, all service providers -- mental health, physical health, substance abuse, housing, and employment, among others -- play a vital role. The inability or reluctance of these key players to participate meaningfully in the court could lead to its failure. This is a special concern where mental health courts are legislated without requiring assurances by service providers outlining the scope of their participation and accountability for the court's failure. The importance of providing mental health courts with a range of services highlights the need for a dialogue between the criminal justice and treatment providers. A successful court will require the resolution of any conflicts in values and goals inherent in the criminal justice and treatment systems. [19]

Yet another possible complication for mental health courts is the confidentiality of mental health information. Eligibility for a mental health court is dependent upon the disclosure of mental health information. The disclosure of sensitive health information continues throughout the legal process as the court attempts to fashion a treatment alternative and supervises the participant's progress. Jurisdictions establishing a mental health court should take affirmative steps to protect confidential mental health information from unwarranted disclosure during and after the legal process and assure that any disclosures of mental health by the participant are voluntary and knowing. Of equal concern is the use of mental health information, including disclosures that the participant was on the mental health court docket, against the participant in future court proceedings. Allowing the disclosure or use of mental health information after a participant is no longer under court supervision would undermine the utility and safety that these courts are meant to engender.

In addition to the availability of services, the accountability of service providers and the management of information, jurisdictions contemplating the establishment of a mental health court need to consider several issues:

- Stigmatization -- How will the court address the stigmatizing affect of creating a separate court for persons with mental illness?
- Structure -- What approach will be used by the court? Will the mental health court be governed by consensus of the court personnel and service providers or will the judge be the final arbiter of treatment, sanctions, etc.? Will the mental health court include a new staff, such as boundary spanners? How will the court interface with other courts, like drug courts?

---

and the service providers that helps place participants in appropriate services and moves them out of jail." BJA at 75.

[19] *See,* BJA at 73.

- Court Jurisdiction -- How long will the court retain jurisdiction over a participant -- bearing in mind that jurisdiction exceeding the maximum jail or prison sentence may limit the appeal of the court to offenders and the defense bar?
- Eligibility -- Will participation in the mental health court be limited to misdemeanors, non-violent felonies, only individuals with serious mental illness? Will the mental health court accept individuals with a dual diagnosis? How will the mental health court interface with other specialty courts (*e.g.*, drug court)? Will the court require participants to enter a guilty plea in order to access the court? Will participants who opt for a trial be eligible for diversion to the mental health court if they are guilty?
- Sentencing -- Will the court suspend the sentence of mental health court participants? Will the court expunge the criminal record of participants upon successful completion of the program?
- Identification of Participants -- How will the court capture mentally ill candidates "at the earliest possible stages of processing to avoid the damaging experience of arrest and confinement"[20] while ensuring participant confidentiality?
- Competency -- What standard will be applied by the court to determine a participant's competency?
- Coercion -- Beyond competency, how will the court ensure that an individual's participation in the mental health court is voluntary and knowing?
- Violations / Sanctions -- What kinds of sanctions will be utilized by the court? Will judges have absolute discretion to impose a range of sanctions for violations?
- Success -- How will the court define its success? How will it define participant success?
- Evaluation -- How will the court evaluate its progress, success and failures?

While there are many challenges to creating a mental health court, it cannot be disputed that these courts present an opportunity to affect the lives of individuals with mental illness. Proponents argue that the courts are an innovative approach to respond to the growing number of individuals with mental illness appearing in court. Without data or a consensus about the essential components of a mental health court, however, it is difficult to know how effective this approach is.

[20] BJA at 71.

Appendix G

SJR 440 Committee Meeting Notes

SJR 440: Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders

May 3, 2001, Richmond

Senate Joint Resolution 440, agreed to by the 2001 Session of the General Assembly, directed the Joint Commission on Behavioral Health Care, in conjunction with the Virginia State Crime Commission and the Virginia Commission on Youth, to study treatment options for persons involved in the criminal justice system who have mental illness or substance abuse disorders. Each of the commissions appointed members to serve on the study committee. In addition, a work group comprised of consumers, providers, defense attorneys, law enforcement personnel, and criminal justice agency representatives and other experts will help identify issues, assist with data collection, and recommend solutions for consideration by the study committee.

The committee's review will include the (i) incidence of mental illness and substance abuse among offenders; (ii) current system for delivering mental health and substance abuse services, including assessment, treatment, post-release, and follow-up; (iii) model treatment programs for offenders; (iv) costs and benefits of private versus public delivery of treatment services; (v) need for specialized training of local law enforcement and court personnel; and (vi) funding, sources of funding and legislation required to ensure adequate assessment and treatment services.

Staff Report

Staff presented background material from national and state studies related to the prevalence of mental illness and substance abuse disorders in the criminal justice population, indicators of the problems that create gaps in services, and model programs for the treatment of adult and juvenile offenders. To prepare for in-depth discussions at future meetings, the staff outlined the adult criminal justice system from arrest to post trial and sentencing and described the mental health and substance abuse services available to persons who are under the supervision of the Department of Corrections (DOC). Staff also described Virginia's juvenile justice system from arrest to disposition and informed the committee about certain demographics related to juveniles in detention homes and state juvenile facilities.

Public Hearing

A public hearing followed the general meeting at which 15 people either spoke or submitted written testimony:

- A parent emphasized that the problems associated with the stigma and treatment of mental illness and substance abuse affect many families in Virginia and urged the committee to examine the issues and reshape public policy to provide solutions.
- A representative of the Coalition for the Mentally Disabled Citizens of Virginia urged the study committee to hold a full public discussion, including the opportunity for consumers and advocates to take a significant part.
- The Virginia Municipal League cited the shortage of substance abuse services in local jails and mental health services in detention homes.

- A representative of the Charlottesville/Albemarle Regional Jail spoke about positive results of the therapeutic community in the jail.
- Dealing with mental health problems is the most serious child care issue in the detention homes, according to a spokesperson for the Middle Peninsula Juvenile Detention Center (18 localities). On any given day, 35 to 40 percent of the residents are taking medication for mental health problems. Approximately 12 youths per year require emergency hospitalization, but beds are often difficult to find. When the youths are returned to detention, they will frequently have medications but follow-up or case management, monitoring and counseling are not available. More training and interaction with mental health professionals is needed to help the detention home staff who deal with these youths on a day-to-day basis. Funds have not been available to provide in-house mental health staff and on-site services, such as assessment and counseling. Recidivism and referrals to state juvenile facilities could be reduced with better local services.
- A consumer advocate described the need for more staff in local jails to provide services to individuals with mental illness and substance abuse disorders.
- The mother of an inmate with mental illness related her personal experiences with trying to get help for her son.
- Two members of Substance Abuse and Addiction Recovery Alliance described their experiences with local jails and their difficulty with obtaining identification of and services for co-occurring disorders, mental illness and substance abuse.
- A representative of the Highlands Juvenile Detention Center cited the need for in-house mental health staff.
- Staff from the Action Alliance for Virginia's Children and Youth emphasized the need for services in the community to prevent offenses from occurring in the first place. The staff also noted that Medicaid is not available to youths in detention centers.
- The jail services manager for District 19 Community Services Board noted that a waiting list exists for the therapeutic communities in local jails.
- A staff member of the Hampton/Newport News Community Services Board cited the limitations on psychiatric services. The general population must wait two to three months for an appointment with a psychiatrist, making services to detention homes and the travel time involved almost impossible. In response to a question, she said that a combination of factors (turf, personalities, resources, etc.) determines whether cooperation between jails and community services boards works in some localities and not others.

SJR 440: Joint Committee Studying Treatment Options for Offenders with Mental Illness and Substance Abuse Disorders

May 31, 2001, Richmond

The second meeting of the SJR 440 Joint Committee focused on the delivery of services to adult offenders in facilities and communities.

Department of Corrections

Mental Health. The mental health program director for the Department of Corrections (DOC) reported that mental health professionals, including psychologists, psychiatrists, clinical social workers, and mental health nurses, provide three levels (acute, residential, and outpatient) of mental health treatment, according to the inmate's needs, in 29 major DOC facilities. The "typical" mental health staffing, excluding acute care units at Marion and Fluvanna, is one psychologist for every 250 general population inmates and eight hours of contract psychiatric services per week. In contrast, the acute care staffing (120 beds) at Marion Correctional Treatment Center is four full-time psychiatrists, four full-time psychologists, four full-time clinical social workers, and 24-hour nursing. The average cost per inmate receiving mental health services at the Marion Correctional Treatment Center (acute care) is $56,979 per year, compared to the average cost per inmate in general population of $19,428 per year. Mental health classification codes ("severe impairment" to "no mental health services needs") are assigned by clinical staff at initial intake, reviewed a least annually, and reviewed again when the inmate is ready for release. Evaluations are based on interviews, record review and psychological testing.

Treatment. DOC focuses its treatment services on Axis I disorders, which include diagnoses of major depression, schizophrenia, and substance abuse. Aggregated data are not available but a spot sample showed that out of a population of 923 inmates at Red Onion maximum security facility, 629 (68 percent) had an Axis I diagnosis. Of the 629, 431 had a substance abuse diagnosis and 217 were dually diagnosed with Axis I mental illness and substance abuse. "Novel" or atypical antipsychotic medications (Clozaril, Risperdal, Seroquel, and Zyprexa) are available to inmates.

Discharge Planning. Offenders receiving mental health services are evaluated by a qualified mental health professional prior to release. A discharge summary is forwarded to the offender's Probation and Parole (P&P) District and the DOC mental health clinical supervisor. The DOC relies exclusively on community services boards (CSB) for post-release services. The first appointment with the CSB typically occurs six weeks after release.

Staff Training. In 2000, 3,025 DOC staff were trained in mental health services through the training academy. Classes vary in length from one to three days.

Critical Needs. Mental health specialist in each P&P District; regional mental health professionals for P&P districts; day treatment services; housing; services in the community for offenders with a history of violence; services in the community for dual or multiple diagnosed individuals; matching services to facilities based on mission of each and needs of offender population; evaluation of programs and services; identifying and developing transition services

and resources; and information management for tracking and monitoring diagnostic information, medication use, etc.

Substance Abuse. The substance abuse program manager for DOC noted that the statutory requirement for screening and assessment is contained in §§ 18.2-251.01 and 2.1-51.18:3 of the Code of Virginia. Virginia's system for identifying, sanctioning and treating drug-involved offenders consists of screening and assessment, community-based services for probationers, institutional-based services for inmates, transitional services for inmates being released to the community, and community-based services for newly released offenders. DOC, through Probation and Parole districts, has responsibility for screening and assessment of adult felons; adult misdemeanants are screened and assessed by local Alcohol and Safety Action Programs and Local Community Corrections Programs; all juveniles are screened and assessed by the Department of Juvenile Justice through Court Service Units. The Simple Screening Instrument (SSI), a 16-item, self-administered questionnaire, is used to screen adult offenders. If indicated by the screening, assessment is completed by means of a 130-question Standard Addiction Severity Index (ASI). Based on the assessment, the court requires education or treatment, as appropriate, as part of probation or as part of post-release supervision following incarceration. Treatment is provided by the DOC, community services boards or private providers if the community services board does not offer the required treatment. Contracts or memoranda of agreement between DOC and the CSBs define the services and access to those services. The Substance Abuse Reduction Effort (SABRE) provides additional positions and funds to purchase treatment services, residential transitional release, peer support programs, substance abuse treatment program management and training. Model court orders have been developed to assist the court with integrating treatment options with criminal justice sanctions, and model memoranda of agreement govern the relationship between the criminal justice agency and CSBs. Oversight of the system and the continuum of services is provided by an inter-agency committee, consisting of representatives of criminal justice and treatment agencies.

Prison Facilities. Substance abuse education programs are available in prison security levels 1 through 5; treatment programs are available in prison security levels 1 through 3. The therapeutic community is available in eight of the lowest security level facilities. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are available in most institutions.

Post-Release. The continuum of services available to post-release offenders includes NA/SA support groups, residential treatment, therapeutic communities, outpatient treatment, peer support, relapse prevention, and drug testing. Transitional release is available to drug offenders participating in DOC's in-prison therapeutic community treatment programs that include employment, community service, and treatment in a highly structured residential environment for at least six months. Approximately 100 beds will be opened in FY 2001, increasing to 200 in FY 2002 at multiple sites.

Funding Sources. Screening and assessment are funded through offender fees, and treatment funding sources vary according to the treatment setting. In-prison treatment is supported by state general funds; community treatment is supported by a combination of offender pay, federal funds and state general funds.

Staff Training. DOC is developing a training plan to ensure that training is provided to all field staff delivering services and/or screening and assessment.

Evaluation. An evaluation plan to measure outcomes is scheduled for completion by January 1.

Gaps in Services. Gaps include lack of family programs; limited availability of day treatment programs; bed shortage for detox, residential/in-patient services, halfway houses, and recovery houses; limited availability of aftercare/relapse prevention, post-residential, intensive outpatient, outpatient or prison programs; lack of residential programs for violent offenders; no system for matching offenders to programs; lack of uniformity of services statewide; no integrated communication system across programs/agencies; need to link drug treatment with vocational training and job placement; and lack of programs for the dually diagnosed.

Community Corrections. The chief of operations, Community Corrections, for the DOC reported that Probation and Parole has supervision for almost 40,000 offenders. At least 70 percent of those offenders who are screened for substance abuse require substance abuse education and treatment and at least 18 percent have co-occurring psychological disorders. Community Corrections maintains memoranda of agreement with 36 local CSBs and 36 contracts for inpatient and outpatient services. Forty-two staff are designated to provide clinical services and oversight. Plans are underway to expand substance abuse clinical staff. On the other hand, Community Corrections relies on CSBs for mental health services, but lacks the clinical capacity to oversee the services.

Gaps in Services. The gaps are similar to those reported for substance abuse treatment: no uniformity in service availability; lack of medical and social detoxification in some areas; few family programs; shortage of residential substance abuse treatment programs; insufficient programs for the dually diagnosed offender; lack of specialized housing, particularly for violent offenders, sex offenders, and chronically mentally ill offenders; need for more specialized training for officers and specialized caseloads for mentally ill offenders; need for a system to match services to offenders; need for more formal working arrangements with CSBs for dually-diagnosed offenders; lack of sufficient clinical oversight and technical assistance; need for improved management information and communication across programs and services; need for joint training and collaborative planning at the local and state levels; and need for smaller workloads to allow more individual attention to offenders.

Local and Regional Jails

The executive director of the Virginia Sheriffs' Association reported that 52 local jails are operated by sheriffs and 21 regional jails are operated by sheriffs or regional superintendents. The total jail population is 21,443, while operating capacity is 16,398. According to the executive director, cuts in allocations to local sheriffs and staffing pressures created by new responsibilities mean fewer resources for services other than those needed to maintain public safety. Preliminary results from a survey of local sheriffs indicated that the need for substance abuse treatment for inmates is an important concern. The Virginia Sheriffs' Association recently entered into an agreement with a medical insurance provider that has resulted in significant cost savings to jails that participate in the program. Whether and to what degree the insurance provides coverage for mental health services was unknown. Representatives of the Henrico and

Virginia Beach Sheriffs' Offices reiterated the problems that stem from lack of treatment options for offenders. Henrico has a well-developed system for screening and assessment, and the staff is trained in both mental illness and substance abuse so that offenders with co-occurring disorders get appropriate treatment. Virginia Beach indicated problems with (i) lack of appropriate facilities for housing inmates with mental illness and (ii) securing appropriate training in mental health issues for correctional officers.

Community Services Boards

A representative of the Virginia Association of Community Services Boards (VACSB) indicated that coordinated programs at the local level have emerged as local agencies have engaged in identifying needs and priorities, identifying funds, and planning, implementing, and coordinating services. As a result, services vary among localities. There is no state mandate or state funding for comprehensive mental health and substance abuse services to inmates in local jails. The availability of services often depends on local priorities, relationships, and resources.

Of the 29 CSBs that responded to a questionnaire, 26 provide some mental health services to jail inmates. The other three cited local jail contracts with private entities. Twenty-nine provide some substance abuse services to jail inmates and all 29 provide services to released offenders if the offenders present for services. All 29 CSBs also expressed the desire to provide more extensive services for jails if CSB and jail resources, including space, were available.

According to the VACSB representative, there are no statewide protocols for localities or funding streams to coordinate services. State agencies are often unable to go beyond their own systems. Communication, coordination, and linkage with case management among the CSBs, probation officers, or community corrections case managers are often lacking. Planning for services must begin while the offender is incarcerated to create a smooth transition to the community.

SJR 440: Joint Committee Studying Treatment Options for Offenders with Mental Illness and Substance Abuse Disorders

June 28, 2001, Richmond

The third meeting of the SJR 440 Joint Committee focused on the delivery of services to juvenile offenders in state facilities, local detention homes and communities.

Department of Juvenile Justice

The Department of Juvenile Justice (DJJ) operates seven residential correctional centers, a Reception and Diagnostic Center, and 32 court service units. Three additional court service units are operated locally in Fairfax County, Arlington, and Falls Church with substantial funding from the department. In addition, the department operates Culpeper Detention Center, which is attached to the Culpeper Juvenile Correctional Center, and oversees through policies and standards 22 locally operated detention homes.

The Virginia Juvenile Community Crime Control Act (VJCCCA) served more than 20,000 young people in fiscal year 2000 in programs designed to be alternatives to juvenile detention. Nevertheless, detention home admissions grew from 16,000 in fiscal year 1996 to more than 22,000 in fiscal year 2000. The average daily detention home population currently exceeds capacity, but additional expansions are planned for the next several years. The average length of stay in a detention home is approximately 18 days. Concurrently, the number of commitments to state juvenile correctional centers has decreased from 1,735 in fiscal year 1996 to 1,456 in fiscal year 2000. The trend continues in fiscal year 2001 with an expected decrease to 1,250 commitments.

Initial screening for substance abuse takes place within the court service units, followed by a more detailed assessment, if indicated, by qualified personnel using standard, validated instruments. The screening and assessment instruments are designed to be used specifically with adolescents: the Substance Abuse Subtle Screening Inventory (SASSI); the Child and Adolescent Functional Assessment Scale (CAFAS); and the Adolescent Problem Severity Index (APSI). Qualified and certified staff and screening and assessment instruments in each court service unit are funded through a combination of state general funds ($950,000), federal grants ($1.1 million), and the Drug Offender Assessment Fund ($300,000).

During the period from June 2000 through May 2001, 8,888 SASSI screenings and 2,549 assessments, using APSI or CAFAS, were completed for juveniles under the supervision of court service units; _____were completed, using either the APSI or the CAFAS. Thirty-four percent of the juveniles were identified as moderate to high risk for substance abuse. Alcohol and marijuana were the drugs used most frequently, and the age of first use for a large majority was below age 14. Significant numbers use alcohol or marijuana on a daily basis and about 30 percent use the drugs up to eight times per month. In addition, 72 percent of the juveniles who were assessed on the CAFAS test have a severe or moderate impairment from abuse of substances.

Treatment is accessed through a combination of private insurance, community services boards, local grant programs, VJCCCA, and the Substance Abuse Reduction Effort (SABRE).

The SABRE appropriation for fiscal year 2002 is $2.34 million. A critical issue is the lack of funding and availability of residential services to remove the juvenile from the home and the community to allow for stabilization and intervention. Such care is expensive and only one dedicated adolescent residential treatment facility (30 beds) exists.

DJJ does not have a system to collect information about the mental health needs of juveniles who come before the court. Section 16.1-275 provides for the court to order mental examinations of juveniles. If the family cannot pay for the cost of the examinations, DJJ is required to pay. DJJ expenditures for court-ordered mental health evaluations have increased from $218,486 in fiscal year 1998 to $364,213 in fiscal year 2001. Estimates from detention and juvenile correctional facilities suggest a significant level of need. A consistent message from court service units is that, in many localities, mental health services are often insufficient or difficult to access. There are limited numbers of public inpatient psychiatric beds and many children who are in the non-mandated category for the Comprehensive Services Act are often not served by the localities' Comprehensive Services Act Programs because of insufficient funds.

Juvenile Drug Treatment Courts

Juvenile Drug Treatment Courts combine intensive substance abuse treatment and probation supervision, relying on the court's authority to mandate the juvenile's compliance. There are currently two juvenile drug treatment court programs: (i) the City of Richmond and (ii) the City of Fredericksburg, in conjunction with the counties of Stafford, Spotsylvania, and King George. Federal funding has expired and funding depends on the DJJ and the localities. The projected capacity is 25 to 50 juveniles each. Two additional programs are in the planning stages in the City of Newport News and the City of Charlottesville. Charlottesville has an innovative program that involves the family in the process.

Virginia Juvenile Community Crime Control Act

Funding for the Virginia Juvenile Community Crime Control Act (VJCCCA) has grown from $11.1 million in fiscal year 1996 to almost $30 million in fiscal year 2002. Each locality prepares a plan based on court data and an assessment of the need for services and programs. Most of VJCCA placements are non-residential. In fiscal year 2000, VJCCCA served 20,742 youths. Of the 7,203 youths released from a VJCCCA program or service, nearly 57 percent had no new juvenile intakes or adult arrests after release. In fiscal year 2000, only 5.2 percent (1,938) of placements were for substance abuse assessment and treatment and 2.8 percent (1,054) of placements were for mental health assessments. Two percent ($928,092) of VJCCA funding was used for substance abuse assessment and treatment and 0.2 percent ($73,538) was used for mental health assessments. The largest categories of expenditures are for residential placements, outreach detention and electronic monitoring.

Juvenile Correctional Centers

Juvenile correctional centers serve approximately 1200 to 1300 youths per year. The percent of committed youths who need mental health treatment increased from 33.6 percent in 1993 to 61.7 percent in 2000. All youths committed to the DJJ are assessed at the Reception and Diagnostic Center. Psychological assessments may include intelligence testing, mental status, personality assessment, alcohol and drug questionnaire/interview, and referrals for psychiatric

consultation. Approximately 50 percent have a history of taking psychotropic medication prior to admission to the juvenile system; more than 20 percent of males and females have had a prior psychiatric hospitalization. More than 60 percent of males and more than 71 percent of females leave the Reception and Diagnostic Center with a designated mental health treatment need. Almost four percent of the males (three per month) meet the criteria for a psychotic disorder. Substance abuse assessments indicate that more than 35 percent of females and almost 40 percent of males exhibit a high probability for alcohol and drug dependence.

The DJJ Behavioral Services Unit provides mental health, sex offender, and substance abuse treatment services in the juvenile correctional centers. Mental health services are adequately staffed, according to a DJJ representative. The total mental health budget is $3.5 million for the eight juvenile correctional centers.

However, substance abuse services are not adequately staffed. Intensive residential services are available at only two facilities, Barrett and Bon Air, with a combined capacity of 124. There are significant waiting lists for prescriptive and substance abuse education services at the other facilities. There is a shortage of substance abuse counselors at Beaumont, Hanover, Culpeper, and Bon Air, although approximately 50 percent of the juveniles in these facilities have a diagnosed substance abuse treatment need. DJJ lacks an adequate number of certified substance abuse counselors. One hundred and forty-two youths are on a waiting list for services system-wide.

Detention Homes

Localities or multi-jurisdictional commissions operate 22 local detention homes. DJJ provides support in the form of capital construction and 50 percent of operating costs. A 1994 study by the Policy Design Team indicated that almost 50 percent of the juveniles in detention homes needed mental health services. A Department of Mental Health, Mental Retardation and Substance Abuse Services study of juvenile detainees in two detention homes, Norfolk and Rappahannock, indicated that more than 82 percent reported using both alcohol and drugs during their lifetimes. More than one-half of the juveniles met criteria for needing substance abuse treatment, but most were not receiving treatment at the time of arrest.

Detention homes are required by §16.1-248.2 to screen juveniles upon admission and to complete an assessment (if indicated) of mental health needs within 24 hours. A survey of detention homes found that community services boards, detention home staff, or private providers in all 22 detention homes provide at least limited mental health services. In contrast, only 17 provide substance abuse treatment services. The mental health and substance abuse treatment services are funded through a combination of detention home budgets, community services boards and grant funds. Eighteen homes provide mental health assessment, eight provide medication management, seven provide medication assessment and individual counseling and six provide group counseling. Similarly, eight provide substance abuse assessment and six provide group or individual counseling or education. Fifty percent (11) indicated discharge planning regarding mental health and only 38 percent (8) indicated discharge planning related to substance abuse treatment.

Representatives of the Fairfax County Juvenile Detention Center, a 121-bed facility, reported that 65 percent of juveniles in their center need mental health services. Of the 90

juveniles in the center on June 28, 80 were in the general population and 15 were in postdisposition. Mental health screening includes interviews with the juvenile and the parents or guardians. Fairfax is hiring new staff to deal with the mental health needs of their detainees. Postdispositional cases get more mental health services than the general population. The community services board provides the postdispositional program with two mental health professionals, two alcohol and drug service professionals and a consulting psychiatrist (4.5 hours per week). If parents cannot afford the services of the psychiatrist, the center absorbs the cost. Postdispositional cases are provided in-house services, psychiatric evaluations, medication consultations, and discharge planning. An aftercare counselor does intensive follow-up for 60 days after the juvenile is released from the detention center.

Shenandoah Juvenile Detention Home is a 32-bed, multi-jurisdictional facility located in Staunton, Virginia. The spokesperson for Shenandoah reported that the average population is 48 children per day, which is 150 percent of capacity. The average length of stay is 14 days because Shenandoah does not have a postdispositional program. The screening is similar to Fairfax but is intended only to identify the child who might commit suicide. Fifty percent of the juveniles who are admitted have mental health needs. A community services board employee is in the detention home several times a week. A juvenile with mental health needs will be assessed by the community services board employee and perhaps will be sent to the Commonwealth Center for Children and Adolescents. The Commonwealth Center, also located in Staunton, is not equipped to handle aggressive and violent children; Shenandoah is not equipped to handle children with mental health needs but receives children on a regular basis from the Commonwealth Center. The Shenandoah representative could not say what happens to a child who is released from detention.

Community Services Boards

Unlike individuals in the adult services system, many children do not receive their primary mental health, mental retardation and substance abuse services from a community services board (CSB). A representative of the Virginia Association of Community Services Boards reported that other sources of service might be public education, social services, juvenile justice, and private providers. Funding streams include Medicaid, private insurance, the Comprehensive Services Act (CSA) or local funds.

In some areas of the state, the CSB is the only provider of services to children. Many agencies may be involved in the child's treatment and coordination becomes more difficult with multiple agencies. Programs in localities vary, based on local priorities and identification of need, local planning and coordination, and available resources.

There is not a comprehensive public or private system of case management for children in Virginia. Complex funding streams come with specific requirements and specific services that may not allow the flexibility to meet children's special needs.

In addition, Virginia does not have enough children's psychiatric beds or child psychiatrists to meet current needs for these services. When a juvenile in a correctional setting needs psychiatric care and treatment, there is often no psychiatric bed available in Virginia. There were several days in the last quarter when no public or private child psychiatric beds were available.

According to the spokesperson, as children's inpatient beds have closed, there has been no concentration on community alternatives.

Funding from the CSA is complex and does not cover all children. The mandated population is those children for whom the state must provide funding and services based on federal law and regulations; i.e., children in foster care and children with Individual Education Plans. However, not all service needs of mandated populations can be funded with mandated dollars. Some services are considered eligible only for non-mandated funding. No locality is required to fund services to non-mandated populations and many do not because of insufficient funds.

In 2000, the General Assembly appropriated $4.25 million each year of the biennium to DMHMRSAS to be used for services to non-mandated youth. All available funds have been used or encumbered for 523 children; at least 17 percent of those children had a referral from the juvenile justice system.

For juveniles in the criminal justice system, funding streams include court service units, CSA, DMHMRSAS, SABRE, DJJ, local dollars targeted by particular localities, federal and state grants, and sliding fee scales. Juveniles lose their Medicaid eligibility when they enter a correctional facility. Blue Ridge Behavioral Healthcare has collaborated with the court service unit to use SABRE money to provide an array of substance abuse treatment, excluding residential treatment. The Virginia Beach CSB with a federal grant has developed a multisystemic program that is focused on reducing juvenile delinquency and recidivism. Since children lose Medicaid status in a correctional setting, there is no funding stream to support the treatment.

The spokesperson recommended that an array of services be developed for children and their families in each community to serve children whether or not they fall into a particular category. The specialized array of services would include family support services, crisis intervention services, case management, outpatient services, intensive community-based services, vocational training, and community-based residential services. The array of services needs a specific funding stream so that the infrastructure can be put in place.

In addition, the following steps were recommended:

- Establish direction in policy or the Code of Virginia for an array of community services to be made available to, and to follow, children wherever they go, whether it is a psychiatric unit or a correctional setting.
- Develop a specific funding stream for these services.
- Direct public funding sources such as Medicaid and the children's health program to define services so that the broadest numbers of children can receive them.
- Establish incentives for professionals who specialize in children's services to work in Virginia.
- Increase education and training opportunities at colleges and universities.
- Develop strategies that will increase the number of acute psychiatric beds for children, public and/or private.

Comprehensive Services Act (CSA)

The director of the Office of Comprehensive Services explained the purpose of CSA, the funding stream and the history of expenditures. There is no way to track with the current information system the amount of CSA funds spent for juveniles involved in the criminal justice system who have a diagnosed need for mental health and substance abuse services. While total CSA expenditures have increased from $105 million in 1994 (first year of CSA) to $205 million in 2000, the amount spent on the non-mandated population, which includes juvenile justice and mental health, has remained about the same, decreasing from $10 million in 1994 to $9.96 million in 2000.

SJR 440: Joint Subcommittee Studying Treatment Options for Offenders with Mental Illness and Substance Abuse Disorders

July 27, 2001, Richmond

The fourth meeting of the joint subcommittee focused on Virginia's legal obligations, barriers to meeting the mental health needs of juvenile offenders, model programs, and jail/community diversion and transition issues.

Virginia's Legal Obligations

Federal and Virginia law affords certain key rights to incarcerated persons with mental illness or substance abuse disorders. Staff from the Division of Legislative Services reported that the Eighth Amendment prohibition against "cruel and unusual punishment" requires that anyone in custody suffering from a mental illness be given medical treatment. However, the mandatory care is limited by considerations of cost, time, and medical necessity.

Several courts have identified components of a "minimally adequate" mental health care delivery system, including

- A systematic program for screening and assessing inmates to identify those in need of mental health care;
- A treatment program that involves more than segregation and close supervision of inmates;
- Employment of a sufficient number of trained mental health professionals;
- Maintenance of accurate, complete and confidential mental health treatment records; Administration of psychotropic medication only with appropriate supervision and periodic evaluation; and
- a basic program to identify, treat, and supervise inmates at risk for suicide.

Educational, vocational or rehabilitative services for a substance abuse disorder, however, are not guaranteed under the Eighth Amendment.

The Fourteenth Amendment's "due process" clause provides a procedural safeguard protecting an inmate/prisoner's "liberty interest." When a prisoner is diagnosed with either a mental illness or substance abuse disorder requiring a detrimental change in his "liberty interest," the Fourteenth Amendment requires either an adversarial hearing or an evidentiary hearing.

Under the provisions of the federal Americans with Disabilities Act of 1990 (ADA), a jail or prison cannot exclude an inmate from participating in a benefit or service because of his mental illness or substance abuse disorder. In addition, there seems to be a growing body of precedent recognizing that the ADA prohibits discrimination based on a person's particular disability (discrimination by category).

Virginia law closely tracks the minimum requirements of federal law, including "medically necessary" treatment, and goes beyond by requiring treatment for certain offenders with substance abuse disorders.

Mental Health Needs of Juvenile Offenders

National data indicate that more than 50 percent of detained adolescents experience problems with drug and alcohol abuse and depression. Substance abuse is the single strongest risk factor for juvenile involvement in violent activities. A study by the Virginia Department of Juvenile Justice showed that more than 40 percent of males and almost 60 percent of females in detention homes need mental health services; more than seven percent of males and more than 15 percent of females had urgent mental health treatment needs.

Risk factors related to behavior problems, such as substance abuse, delinquency, teenage pregnancy, school dropout, and violence, show a great deal of overlap. For example, addressing early and persistent antisocial behavior in the school setting may address behavior problems in a number of areas. Risk factors tend to have an interactive effect. That is, one single factor is not usually a cause, but rather multiple factors working together can create problem behavior. Other overlapping risk factors include extreme economic deprivation, family management problems, family conflict, academic failure beginning in elementary school, friends who engage in the problem behavior, and early initiation of the problem behavior.

Effective intervention programs address multiple risk factors, involve comprehensive services that are individualized and family- and child-centered, are delivered in collaboration with the family, occur in natural settings, and are delivered with skill, persistence, and a strong sense of accountability.

Juvenile Justice professionals in Virginia identified 10 key barriers to meeting the mental health needs of juvenile offenders:

1. Lack of a guiding philosophy for serving juvenile offenders;
2. Juvenile justice system used as a "dumping ground" for juveniles with mental health problems;
3. Undiagnosed learning problems;
4. Lack of early intervention, leading to an escalation of delinquent behaviors;
5. Need for greater parental involvement in, and accountability for, the child's treatment and rehabilitation;
6. Need for detention and community-based treatment;
7. Need for improved interagency collaboration and integrated comprehensive service delivery systems;
8. More local services needed for special populations of juveniles—insufficient advocacy for court-involved juveniles, post-adjudication;
9. Inadequate funding to localities to serve juvenile offenders; and
10. Legal confidentiality impediments to interagency records sharing and development of integrated data systems.

Jail/Community Linkages

National research indicates that between six and 15 percent of jail inmates have a serious mental illness. Nationally, there has been a correlation between the increase in persons with mental illness in jails and the downsizing of state hospitals.

A survey of Virginia sheriffs in 1997, conducted by the School of Social Work at Virginia Commonwealth University, found that linking inmates with community mental health providers was the problem most frequently mentioned by the sheriffs, rather than problems with managing the behavior in the jails; also mentioned were lack of diversion options, housing and medication. Ninety-two percent of the sheriffs believed that the relationships with community services boards were productive. The sheriffs made the following suggestions as alternatives to incarceration:

- Greater interaction between the court and mental health systems, including more consistent mandatory court-ordered treatment;
- A mental health professional assigned to every sheriff's and magistrate's office;
- Mandatory case management while the person is incarcerated;
- Greater continuity of care for persons with mental illness and substance abuse disorders;
- Assertive follow-up of persons with mental illness after incarceration;
- A diversion center within the state psychiatric hospitals to assess clients;
- Additional guidelines and training about mental illness;
- Transitional and supervised housing for offenders;
- Day treatment programs, outpatient training in self-care skills, and day reporting requirements;
- More intensive pretrial evaluation;
- Intensive probation with mental health workers, in-home counseling and medication monitoring; and
- Supervised community placement while awaiting trial.

Of "mental health managers" in Virginia's jails surveyed in 1995, most of whom work for community services boards, 59 percent reported that they were unable to provide some aspects of mental health treatment in the jail; 34 percent reported comprehensive mental health treatment capabilities on site; 39 percent reported the lack of acute, specialized psychiatric care, including detoxification and sex offender treatment; 32 percent reported a lack of adequate mental health and substance abuse evaluation and counseling; and 21 percent reported a lack of services for persons who are in jail for extended periods.

The survey also addressed the problems facing persons with mental illness in jail, including jail environment (mistreatment and overcrowding); unmet special needs (social skills and medication); and jail resource shortages (staff training, treatment information, and linkage services). Forty-six percent reported that their jail did not support family involvement. Families can become involved by providing direct care and assistance, advocating for medical care, bridging communication gaps between staff and the inmate, and becoming recipients of services themselves. A subsequent study revealed that jails that encouraged family involvement had a significantly higher percentage of inmates who successfully linked with the mental health system after they were released.

Community Transition

A Department of Justice study reported that approximately 20 percent of the persons who need mental health treatment in prisons and jails do not receive it; advocates point out that between 40 and 50 percent of the persons with serious mental illness in the communities are not receiving treatment. States have lost approximately one-third of their spending power for mental

health treatment when expenditures today are compared with expenditures in 1955, before deinstitutionalization began. Assertive community treatment teams, psychiatric rehabilitation programs, integrated treatment of dual diagnosed persons, and supported employment programs are showing very promising results, but unless the whole spectrum of problems is addressed, including homelessness, people will continue to end up in jail or prison.

There are various ways to divert persons with mental illness from prisons and jails, but a change in the community programs and additional resources will be required. The Village in Los Angeles is a fully comprehensive array of services that has kept people out of institutions and prisons and jails. The Memphis Crisis Intervention Team is a cadre of specially trained law enforcement officers. Wrap-around Milwaukee, a comprehensive program for juveniles, has established a track record of re-integrating juvenile offenders into the community and having them succeed.

Federal rules do not allow a federal Medicaid match for individuals while they are incarcerated, but they do not require that Medicaid be terminated; it can be suspended. However, all states do terminate Medicaid coverage, making it more difficult to get people back on the program when they are released. As a result, national data suggest that offenders may go 14 days or more without a Medicaid card after they are released. Making these services available more quickly could make a big difference. There is a slight risk if the federal government determines that the person is not eligible when he is released; however, people do not normally gain significant income or assets while they are incarcerated.

One option is to require prerelease planning to include all federal/state programs (SSI, SSDI, Medicaid, Medicare, Food Stamps, TANF, and Veterans' benefits). Several recent federal and state court cases have found that individuals are entitled to better prerelease planning. The New York mental health authority pays for psychiatric medications for offenders leaving jail or prison, pays for transition managers to help former inmates file benefit claims, and ensures that individuals apply for Medicaid. In Lane County, Oregon, state-only Medicaid is available for the first 14 days in jail after arrest to make sure that current medications are continued and basic mental health services are available. In Springfield, Massachusetts, local community health program staff assist jail inmates and provide services. Local programs are typically stretched and would need small grants to hire individuals to make these programs work.

Diversion/Transition

Several diversion/transition projects have shown results. The rate of officer injury rates during mental illness events decreased almost six-fold after the start of the Memphis crisis intervention team program. Albuquerque, New Mexico adopted the Memphis model, but they also follow-up with the individual in his home. Albuquerque also has a program to link people at the pretrial level with community services. Forty percent of the people who used to be held in jail have been diverted and only six percent have been rearrested, none for violent crimes. Project Link in Monroe County, New York, features a mobile treatment team with elements of the assertive community treatment model, a forensic psychiatrist, a dual diagnosis treatment residence, and culturally competent staff. Yearly jail days dropped from 107 to 46 per person; yearly hospital stays decreased from 115.9 to 7.4 days; the average number of arrests per person declined considerably; and no assaults, suicide attempts, or other reportable incidents occurred among the clientele.

There is no single definition of mental health courts, but their success depends on the support of the courts, the prosecutors and the defense bar. If community mental health services are not available, individuals may spend more time in jail as they wait for services. The Thresholds Jail Program in Chicago's Cook County jail, which provides long- and short-term aftercare services, found that jail time decreased 82.2 percent for the first 30 clients to complete one year of the program, resulting in a savings of $157,640 to the jail. In addition, there was an 85.5 percent decrease in the number of hospitalizations, resulting in savings of $916,000 to Illinois state hospitals.

DMHMRSAS

The commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) said that the department supports numerous programs providing psychiatric care for adult inmates in local regional jails and children and adolescents in juvenile detention homes across the Commonwealth.

The Virginia Code requires community services boards (CSBs) to maintain written agreements with courts and local sheriffs relative to the delivery and coordination of services (§ 37.1-197), and performance contracts require CSBs to provide forensic services. CSBs also provide emergency services to local and regional jails and juvenile detention homes and non-emergency evaluations. Through the Substance Abuse Prevention and Treatment (SAPT) block grant, the DMHMRSAS funds one substance abuse case manager in each CSB to identify cases and provide assessments and counseling. Nine CSBs receive funds totaling $1.1 million to provide intensive substance abuse treatment services in jails (Petersburg, Roanoke County, Roanoke City, Virginia Beach, Norfolk, Fairfax, Hampton, Martinsville, and the Middle Peninsula-Northern Neck areas). These programs have a total capacity of 211 beds, the average length of stay is between 90 and 180 days, and approximately 400 to 600 inmates per year participate in these programs. Five CSBs are funded ($561,215) to provide substance abuse treatment to juveniles in detention homes. In addition, many CSBs provide mental health and substance abuse services to the offender population through local initiatives and through 10 adult and two juvenile drug courts.

In fiscal year 2000, approximately 400 adult jail inmates and juvenile detention home residents were treated or evaluated in state mental health facilities. This number represents approximately 25 percent of the patients in state mental health facilities.

Several Virginia localities, including Fairfax County, Henrico, Alexandria, Virginia Beach, and Petersburg, have developed comprehensive jail or detention-based mental health or substance abuse programs. The following characteristics make them model programs:

- Use of nationally accepted and tested service models;
- Positive coordination between the criminal justice and mental health and substance abuse treatment staff in areas such as joint security and clinical services training; and
- Connections to continuing care programs in the community.

The commissioner also released the results of three surveys that the department conducted for the period from November 1, 2000, to April 30, 2001: (i) community services boards regarding services provided to local and regional jails and juvenile detention homes; (ii) juvenile detention home administrators; and (iii) sheriffs. The purpose was to estimate the number and cost of services provided or needed in jails and detention homes. The annualized cost of meeting the unmet need for mental health and substance abuse services in local jails, as estimated by community services boards, is $34 million; for juvenile detention homes, the estimated cost is $3.4 million. (Juvenile detention homes estimated the cost of unmet need for mental health and substance abuse services to be almost $4 million).

The commissioner listed several barriers and challenges for the provision of treatment services to adult and juvenile offenders, including the lack of:

- Defined statutory responsibilities for the provision of treatment services to adult and juvenile offenders;
- Standards for services that should be available to offenders;
- Meaningful agreements between jails, detention homes and community services boards for the delivery and coordination of services;
- Equitable access to care;
- Coordination between jails, detention homes and community services boards related to pre-release planning and connection to community services;
- Training for jail and treatment staff in balancing therapeutic goals with security needs;
- Sufficient number of psychiatrists; and
- Ongoing collection of complete and accurate data on treatment services provided to offenders.

His recommendations included the following:

- Legislation to assign the statutory authority to the criminal justice system for provision of mental health and substance abuse services in jails and detention homes;
- Definition of the continuum of care and a long-range plan to implement the standards;
- Integrated state policy and identification of funding;
- Local collaboration, including meaningful memoranda of agreement, training and new initiatives; and
- Pre-screening consistency among Code sections, including ensuring offenders are pre-screened by a CSB prior to admission to a state hospital.

SJR 440: Joint Committee Studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders

September 28, 2001, Henrico County

During the fifth meeting of the joint committee, the members heard presentations on juvenile detention and jail-based services in Henrico County as well as judicial, law-enforcement and consumer perspectives. The committee also held a work session on preliminary findings and recommendations.

Juvenile Detention. Every child who is admitted to Henrico Juvenile Detention is screened to determine the level of needed services. Approximately 50 percent of the juveniles are receiving prescription medication prior to admission. Thirty-three percent reported that they had been previously admitted to a psychiatric hospital. Despite the close working relationship and collaborative training between juvenile detention staff and the Henrico community services board staff, treatment gaps exist because of shortages of funding and qualified treatment personnel. An employee of the community services board provides 20 hours of mental health services per week, but more is needed, especially in light of the shortage of child and adolescent psychiatric beds in the Commonwealth. In addition, there is no formal substance abuse program, although the percent of substance abuse among juveniles is high.

Jail-Based Services. Henrico houses approximately 1,037 inmates per day. All inmates are screened by nursing staff to identify people at risk of harm to self or others and those who will receive treatment while they are incarcerated. Reflecting the increasing level of mental illness among the inmates, there has been a steep increase in the number of psychiatric hospitalizations during the past year. Paid for mostly with local funds, Henrico operates a therapeutic community for substance abuse treatment, which can accommodate 36 inmates at its jail east site. The committee heard from a panel of inmates who are participating in the therapeutic community, Project Fresh Start, about their positive experiences. Other inmates completed a five-question written questionnaire about their experiences. One inmate wrote, "It gives me a chance to do something positive for myself as well as society. I am not just 'doing time', then return to the streets to continue my actions. It lets me take a look a what I've done, why I've done it, and what can I do to keep from doing it again." Another inmate wrote, "[The worst thing about being in Project Fresh Start is] I had to find it in jail."

Judicial Perspective. The Chief Judge for Henrico General District Court observed that, over two years, he had seen a slow increase in the use of cocaine and heroin. He also observed that alcohol and other drugs were the root causes of more than 50 percent of the cases in his court. Among the obstacles that he sees is an insufficient number of residential placements or acute psychiatric beds. The Chief Judge for Henrico Juvenile and Domestic Relations Court cited the need for more beds for children and adolescents with mental health needs. She also cited the need for a new disposition category, "not guilty by reason of insanity," in order to ensure additional treatment options.

Law Enforcement. A representative of the Henrico County Division of Police said that police officers are frequently the first responders. He observed that law enforcement has experienced a steady increase in involvement with people with mental illness or substance abuse disorders since the 1980s. The community services board provides 30 hours of training and two days of practical experience in mental health issues to Henrico County officers. In contrast, a representative of the Waynesboro Police Department said that officers in that jurisdiction are afforded only the required five hours of basic training.

Consumer Perspective. A panel organized by NAMI Virginia included a family member of an individual who is dual-diagnosed with mental illness and a substance abuse disorder, and a defense attorney, both of whom related problems with obtaining needed services for persons involved with the criminal justice system. The executive director of

NAMI Virginia cited the need for more community care, jail diversion programs, crisis intervention training, acute care beds, and standards for behavioral health care in jails, including criteria for formularies. Specifically, NAMI recommended:

- Create more community care;
- Support changes being considered by the Crime Commission that would limit the amount of time a misdemeanant found not guilty by reason of insanity could be detained;
- Create more jail diversion programs;
- Create crisis intervention programs across the state for police officers;
- Create regional stabilization units to respond to the bed shortage;
- Ensure that mental health professionals are accessible and available throughout a person's incarceration; and
- Develop and enforce standards of care for mental health services in jails, including the development of criteria for medication formularies.

The committee concluded with a discussion of preliminary findings and recommendations, which will be made available for public comment.

The Honorable Stephen H. Martin, *Chairman*
Legislative Services contact: Nancy L. Roberts

November 8, 2001; November 29, 2001, Richmond

The joint committee held a public hearing on its preliminary recommendations on November 8, 2001, and on November 29, the committee made its final recommendations for 2001. The committee categorized its findings and recommendations into five areas related to adult and juvenile offenders: Interagency Collaboration, Capacity, Clinical Guidelines, Cross Training, and Data Collection, Evaluation and Information Sharing. Because of the current budgetary situation, most of the recommendations are designed to lay the groundwork for future action: maintaining funds that are appropriated in the current biennium budget; gathering information about unmet needs; fostering interagency collaboration and planning; establishing minimum clinical guidelines; and providing a framework for information sharing and evaluating the effectiveness of current programs. Due to the size and scope of the problem, the committee plans to ask the General Assembly to expand its membership to include the Secretaries of Health and Human Resources and Public Safety and to continue its work for another year. Highlights of this year's findings and recommendations follow.

Interagency Collaboration

Findings: Interagency collaboration and clearly defined responsibilities for serving adult and juvenile offenders with mental illness do not exist in many communities. Moreover, there does not appear to be a consensus as to whether the responsibility for providing treatment services should lie with the criminal justice or the mental health treatment system.

Key Recommendations:

1. Establish an interagency work group under the leadership of the joint committee to develop a screening-assessment-treatment model for offender groups with mental health needs. This work group will be asked to make recommendations concerning the statutory assignment of responsibility for providing needed treatment services; a regional planning process to foster state/local interagency collaboration; model memoranda of agreement that detail responsibilities for services, information exchange, and cross training of staff; and a framework to pilot the memoranda and evaluate the results.
2. Request the Office of the Secretary of the Supreme Court to examine the feasibility of designing and implementing a model court order that addresses mental health needs of offenders.

Capacity

Findings: Many communities lack sufficient capacity, including the availability of acute psychiatric care, to treat offenders with mental illness and substance abuse disorders while they are incarcerated and when they are released from state correctional facilities, jails or detention homes. Lack of a comprehensive and systemic approach to finding these services has resulted in inequitable access to care across Virginia. The community

services boards estimate that the cost of meeting the unmet need for mental health and substance abuse services in local jails is approximately $34 million per year. The estimated cost of meeting the unmet need for mental health and substance abuse services in detention homes is approximately $3.4 million per year.

Key Recommendations:

1. Direct the Department of Criminal Justice Services, in collaboration with other stakeholder agencies and groups, to identify the unmet need for mental health and substance abuse treatment services for adult offenders and to develop a comprehensive plan, including the necessary resources and funding sources for covering the increasing costs of providing existing services and to fill service gaps.
2. Direct the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services to make recommendations to the joint committee concerning access to psychiatric care for jail inmates and to ensure an adequate supply of acute psychiatric beds for children and adolescents.
3. Direct the Department of Medical Assistance Services to examine ways to provide immediate access to Medicaid to eligible offenders when they are released from prisons or jails.
4. Direct the Department of Corrections to recommend ways to ensure the appropriate management of medications for offenders when they are released from state correctional facilities.
5. Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Juvenile Justice to identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate number of residential and acute psychiatric beds for the treatment of juvenile offenders.
6. Continue the funding for the "Keep Our Kids At Home" (KOKAH) project, which has demonstrated success at reducing inpatient hospitalization.
7. Include juvenile offenders in the plan being developed as a result of Item 323K in the current biennium budget to provide and improve access by children to mental health, substance abuse and mental retardation services.
8. Continue the funding for recruitment and retention of psychiatrists in medically underserved areas, which is currently $500,000 each year.
9. Appropriate $50,000 to expand the National Health Service Corp–Virginia Loan Repayment Program to include mental health professionals.
10. Explore ways to expand the use of telepsychiatry in underserved areas.

Clinical Guidelines

Findings: The state has not developed clinical guidelines for local and regional jails or detention homes to ensure an adequate level of mental health services for persons who are incarcerated. Uniform screening and assessments, access to services, and discharge plans are not available in many jails or detention homes.

Key Recommendation: Direct the State Board of Corrections, the State Mental Health, Mental Retardation and Substance Abuse Services Board and the Board of Juvenile Justice as appropriate to develop minimum guidelines for the provision of mental health and substance abuse treatment services in jails and detention homes and a plan, including the necessary fiscal and staff resources, for meeting the guidelines.

Cross Training

Findings: Cross training in balancing therapeutic goals with security needs and public safety is needed for law enforcement, judges, jail and detention staff and community treatment staff.

Key Recommendation: Request that the Department of Mental Health, Mental Retardation and Substance Abuse Services develop and make recommendations for implementing a curriculum for cross training law enforcement officers, judges, jail staff, and community treatment staff in security and treatment.

Data Collection, Evaluation and Information Sharing

Findings: No comprehensive mechanism exists to systematically collect complete and accurate data on treatment services provided to and needed by adult and juvenile offenders or to evaluate the effectiveness of the services.

Key Recommendations:

1. Request that the Secretary of Public Safety, in conjunction with other Cabinet Secretaries, develop a plan, including the estimated cost, for the collection of data on treatment services provided to and needed by state responsible adult and juvenile offenders and for the evaluation of the effectiveness of treatment services.
2. Continue the funding for intensive substance abuse treatment services in jails for the next biennium and direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to conduct comprehensive process and outcome evaluation of therapeutic communities in local jails.
3. Direct the Virginia Commission on Youth to coordinate the collection and dissemination of information on effective treatment modalities and practices.

Appendix H

SJR 440 Work Group Membership

SJR 440 Work Group Membership

Janet Areson
Virginia Municipal League

Sheriff Beth Arthur/Mike Pinson
Arlington County Sheriffs' Office

Tricia Baggett-Phelps
Virginia Chapter, NAMI

Ken Batten
DMHMRSAS

Gail Burruss
Blue Ridge Behavioral Health

Gail Campbell
Fairfax County Community Services Board

Pamela F. Cooper
DMHMRSAS

George Corbin
Fairfax Detention

Sherri Diven
Juvenile Substance Abuse Services

Vicky Fisher
Mental Health Association of Virginia

Beulah Forbes
District 19 CSB

Tina Gayle
Richmond Public Defenders Office

Dr. Deborah Giorgi-Guarnieri
Department of Psychiatry-VCU/MCV

Richard Goemann
Public Defender Commission

Dick Hall-Sizemore
Department of Planning and Budget

Leslie Herdegen
VA Association of Community Services Boards

Lelia Hopper
Supreme Court of Virginia

Captain Rick Martin
Rappahannock Regional Jail

Dr. Jim May
Richmond Behavioral Health Authority

Gail Starling Marshall, Esq.

Martha Mead
DMHMRSAS

Annette Miller
Office of Public Defender

Andrew Molloy
Department of Criminal Justice Services

Linda Montgomery
SAARA Tidewater

William McCollum
Virginia Alcohol Safety Action Program

Mike McMahon
Department of Planning and Budget

Margaret Nimmo
Action Alliance for VA's Children & Youth

William Poggione
Chief Magistrate

Anna Powers
Department of Corrections

Beth Rafferty
Richmond Behavioral Health Authority

Scott Reiner
Department of Juvenile Justice

Scott Richeson
Department of Corrections

Dana Schrad
Virginia Association of Chiefs of Police

Pat Smith
Virginia Community Criminal Justice Assoc.

Robin L. Hulbert, Ph.D.
Department of Corrections

Robin Ihara
Substance Abuse and Addiction Recovery Alliance

Cathie R.B. Jackson, P.C.
Special Justice

David Jones
14th District Court Service Unit

P. Michael Leininger
Department of Corrections

Dean Lynch
Virginia Association of Counties

Sandra Thacker
Virginia Association of Regional Jails

Tom Treece
Goochland-Powhatan CSB

Dr. Dennis Waite
Department of Juvenile Justice

Roger Wiley
Hefty and Wiley, P.C.

Susan B. Williams
Commonwealth Attorneys' Services Council

Dave Ziegler, President
South Eastern Consulting, Inc.