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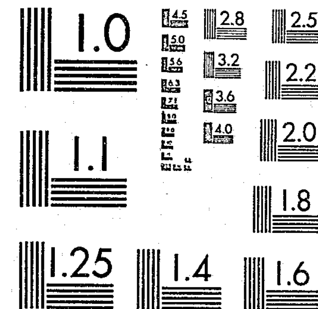

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THE MENTALLY ILL IN VIRGINIA'S JAILS

FINAL REPORT OF THE JOINT TASK FORCE

Department of Mental Health and Mental Retardation

Department of Corrections

October, 1984

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THE MENTALLY ILL IN VIRGINIA'S JAILS

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ACQUISITIONS

THE JOINT TASK FORCE ON THE MENTALLY ILL IN VIRGINIA'S JAILS

INTRODUCTION

In March of 1984, Commissioner Joseph Bevilacqua of the Department of Mental Health and Mental Retardation and Director Robert Landon of the Department of Corrections created the Joint Task Force on the Mentally Ill in Virginia's Jails to assess the current status of mental health needs and services within the state's jails and to recommend measures for improving these services. Dr. Michael A. Solomon, Director of the Forensic Treatment Program at Western State Hospital and jail psychiatrist for the Albemarle-Charlottesville Joint Security Complex, was appointed as chairman of the Task Force. The Task Force is a multidisciplinary group, consisting of community mental health and state hospital clinicians and administrators, corrections and law enforcement officials, jail mental health staff, as well as an attorney, a judge, a prosecutor, and a legislator.

The Task Force visited six jail sites in Virginia: Richmond, Charlottesville, Abingdon, Fairfax, South Boston, and Norfolk. We interviewed community mental health administrators, sheriffs, correctional officers, jail nurses, inmates, and jail mental health staff. We heard testimony from representatives of organizations such as the Police Executive Research Forum and the National Coalition for Jail Reform. We conducted a survey of all of Virginia's jails and reviewed pertinent literature.

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SUMMARY

The Task Force on the Mentally Ill in Virginia's Jails is a joint effort sponsored by the Department of Corrections and the Department of Mental Health and Mental Retardation. It was created to assess the current status of mental health needs and services within the state's jails.

Based upon the results of a survey which the Task Force conducted of all Virginia jails, we estimate that each year there are approximately 12,000 admissions of severely mentally ill persons to the state's jails. In addition to being a source of considerable human suffering, mentally ill jail inmates can pose a management problem and security risk for corrections officers and are a potential source of liability for sheriffs and jail administrators.

The past decade has witnessed a drastic reduction in the number of patients housed in Virginia's large state mental hospitals. Consequently, there is an urgent need for more community services for the former state hospital patient. Many of the deinstitutionalized chronically mentally ill are unable to avail themselves of the community supports that do exist. Some of them get jailed on very minor charges, such as trespassing, disorderly conduct, or failure to identify oneself to a law enforcement officer.

The chronically mentally ill who enter jail after being booked on nuisance violations should be diverted back into the mental health system. There are other mentally ill jail inmates, however, who face serious charges and for whom diversion is not a viable option. These inmates need to receive treatment while in jail. The range of mental health problems faced by such inmates is diverse;

it includes psychosis, suicide attempts, self injury, alcohol or drug withdrawal, depression, and massive anxiety.

There is no one right way in which to establish a jail mental health service. Arrangements vary with the size and location of the detention facility. Some large jails contract out for private psychiatric services. We found that Community Services Boards (CSB's) can often provide very effective mental health services in jails. The CSB clinicians generally have considerable skill and experience in working with the chronically mentally ill. As a result of the Department of Mental Health and Mental Retardation sponsored program which trains CSB clinicians in performing forensic evaluations, they are gaining familiarity with the problems of the mentally ill within the criminal justice system.

With the goal of decreasing the number of chronically mentally ill within Virginia's jails and improving the level of services to the mentally ill who will remain within our jails, the Task Force has developed a set of nineteen recommendations. These include increasing resources such as residential and day support programs for the chronically mentally ill in the community and establishing means by which mentally ill persons booked on minor nuisance violations can be swiftly diverted from jail. We recommend increased coordination among law enforcement agencies, sheriffs, and CSB's and call for CSB's to assume a central role in planning local jail mental health services. There are several arrangements through which jail mental health services can be funded.

Sheriffs and jail administrators should implement measures to decrease some of the stresses associated with their facilities which can precipitate mental breakdown and suicide among inmates. Such measures can be taken without compromising jail security. All jails need an established protocol for management of the suicidal inmate.

Follow-up services for newly released inmates should be given high priority. The current statutes governing jail to hospital transfer are overly elaborate, confusing, and serve as an obstacle to prompt hospitalization when it is needed. A new uniform jail to hospital transfer statute is recommended.

Training in mental health issues needs to be expanded for correctional staff. The Department of Mental Health and Mental Retardation's current support for the training of community clinicians in forensic services needs to be broadened to include jail mental health care. The involvement of the mentally ill in the criminal justice system is an important area of research which is worthy of both Departments' support.

Finally, the implementation of these recommendations will require further collaboration between the Department of Mental Health and Mental Retardation and the Department of Corrections.

THE MENTALLY ILL IN JAILS

A. SCOPE AND MAGNITUDE OF THE PROBLEM

In the Task Force's survey of Virginia's jails, sheriffs and jail administrators reported that 6.1% of their jail inmates were seen as having a severe behavior problem. One quarter of this group with severe behavior problems was subsequently hospitalized. Approximately three-fourths of this 6.1% of all inmates appear to have been psychotic. This does not include those inmates with psychotic illnesses who did not constitute a behavioral management problem within the jail. Our findings correspond well with national studies conducted within the last decade which reveal that between 5% and 10% of all jail inmates suffer from psychotic illnesses.

During the most recent year for which we have complete figures - fiscal 1982 - there were 199,206 commitments to Virginia jails. Using this number plus the conservative estimate of 6% of all inmates translates into approximately 12,000 individuals with severe mental disorders passing through Virginia's jails each year. Many of these inmates need supportive services including medication for relief of their psychotic symptoms.

The above figures account only for the most severe mental disorders among jail inmates. In the few Virginia jails that provided comprehensive mental health services we found that approximately 25% of all inmates experienced enough mental disorder or psychological distress to require being seen by the mental health service. The problems of these inmates range from psychotic illness, suicide attempts, self injury, and depression, to massive anxiety and inability to sleep.

In many jails more than half of the inmates have significant alcohol or drug problems. In one of Virginia's largest detention facilities we were told that 90% of the inmates have substance abuse problems.

The best studies conducted in other states place the proportion of mentally retarded inmates in correctional facilities at around 10%. The number of retarded persons in Virginia's jails is unknown.

B. THE CRIMINALIZATION OF THE MENTALLY ILL

Jails have been used historically to detain impoverished or unruly mentally ill persons but it is widely reported that in the past decade an increasing number of severely mentally ill persons have been jailed. The Task Force identified a substantial number of mentally ill individuals who are jailed on minor misdemeanor charges such as trespassing, failure to identify, or disorderly conduct. These minor charges serve as a means for getting mentally ill persons who are not functioning well in the community off of the street. Often, these are persons who in the era prior to large scale deinstitutionalization would have spent a major portion of their lives as patients within state hospitals.

Thus, issues that should be defined as mental health problems have been transformed into criminal justice problems. This has been aggravated by the as yet incomplete transition from a state hospital to a community basis of treatment.

To put the chronically mentally ill back into the state hospitals is not the solution. For economic reasons this will not happen--and it would not be desirable even if it were feasible. Rather, the use of jails as a place to hold disruptive or destitute mentally ill persons is a systemic problem that needs to be addressed at a community level. Underlying this misuse of jails is the lack of alternative programs for the disabled mentally ill, short of state hospitalization.

A weekly or monthly visit to a clinic to pick up medications and receive counselling is not adequate community treatment for a large proportion of deinstitutionalized persons. There is an urgent need for more comprehensive programs to address the chronically ill person's need for supervised housing and to provide supportive day services.

The Task Force found that in some communities in Virginia, such as Abingdon, where there has been a clear commitment to the chronically mentally ill and an allocation of resources, innovative programs have been established. In such places jails are less likely to serve as holding tanks for the mentally ill. Programs like the psychosocial clubhouse in Abingdon are relatively inexpensive, particularly when compared to the cost of jailing or hospitalizing persons and processing them through the courts.

The police play a very important role in determining whether a mentally ill person gets jailed or taken to obtain treatment. In many jurisdictions in Virginia, police report that when they are called to see a disruptive or obviously suffering mentally ill person they have no sanction to take the person to receive help from a mental health agency. In the absence of statutory

authority to initiate emergency hospitalization, police are put in the unfortunate position of having to use arrest as the only available option for getting the chronically mentally ill person off of the street.

At present in Virginia the criminal justice system is too often the first system invoked to manage the chronically mentally ill. For early diversion of the mentally ill away from the criminal justice system to take place requires a high degree of cooperation between the community mental health centers and local police. In communities where this has occurred--such as Staunton and Augusta County--mental health clinicians have been designated specifically to work with the police department, sometimes accompanying officers to make house calls in crisis situations.

The chronically mentally ill who get jailed are frequently psychotic, assaultive, and - at least initially - uncooperative for treatment. Providing services for them can be particularly frustrating. Once booked, they tend to stay in jail. In the absence of an adequate disposition no one is eager to get them out. If the mentally ill person continues to be disruptive in jail, he may find himself being isolated in "the hole" where his mental condition may deteriorate dramatically.

The members of the Task Force recognize, however, that to regard chronically mentally ill persons as uniformly not responsible for their conduct can be doing them a disservice. Instant diversion from jail is not always the soundest action to take when a mentally ill person is charged with an offense particularly if the person is not overtly psychotic or grossly out of touch with reality at that time. Occasionally, the experience of being arrested and booked

into jail can even have a therapeutic impact. In such instances, the decision of whether to divert a person or to provide treatment within the jail needs to be made carefully on an individualized basis. Factors that need to be considered here include the nature of the alleged offense, whether the person was overtly psychotic upon intake, the availability of treatment within the jail, and the likelihood that the person will be able to withstand the stresses of confinement in the jail without decompensating.

The Task Force noted one area of definite improvement with regard to holding mentally ill persons within jails. Until several years ago it was an occasional practice to keep persons in jail who were on Temporary Detention Orders (TDO's) awaiting civil commitment hearings. Thus, mentally ill persons who had no criminal charges lodged against them could spend several days in jail or in local lockups. This practice, which exposed sheriffs and jail administrators to lawsuits, was clinically unwise and hazardous. In December 1979, the State Mental Health and Mental Retardation Board approved a set of Rules and Regulations for the approval of detention rooms in jails and lockups which prohibit the use of jails for T.D.O. clients unless stringent standards are met. Currently no jails in Virginia have applied for approval.

A closely related issue is the jailing of public inebriates. There are 54,000 arrests annually in Virginia for public intoxication; this results in over one-fourth of the admissions to local jails. A large national study found that a high proportion of those who committed suicide in jail were intoxicated and more than half of these deaths occurred within the first twelve hours of confinement. In addition to constituting a high suicide risk, intoxicated persons present a significant medical hazard while in jail because of the numerous complications of chronic alcholism. Diverting persons picked up for public drunkenness away from jail and into inebriate shelters or detoxification facilities is a sound practice both from a medical and an economic standpoint.

Diversion programs to keep some of the chronically mentally ill out of jail are needed, but a substantial number of jail inmates require mental health services and are not suitable candidates for diversion. This includes inmates who face serious charges and those for whom transfer to a hospital is not clinically indicated. These inmates should receive ongoing support and treatment within the jail.

C. THE STRESSES OF CONFINEMENT

The experience of being incarcerated within a jail is often stressful whether or not the person being jailed initially suffers from mental illness. The acute experience of admission to a jail can be the most devastating aspect of incarceration even for inmates who have spent substantial portions of their lives confined within detention and correctional facilities.

The individual who suddenly finds himself locked up in jail experiences a jarring discontinuity. The transition from street life to jail -- where one is subjected to confinement, observation, and regimentation -- is abrupt. It includes severance of contact with friends, associates, and family--one's entire social support system.

The suddenness of the transition is aggravated by uncertainty. An inmate in jail awaiting trial or convicted but awaiting sentencing usually has little contact with his lawyer. More often than not the attorney is court appointed rather than privately retained and, hence, may have has little financial incentive for spending time with his client. Often the inmate receives very little information about decisions which determine what will happen to him.

His involvement in the process which determines his fate may be marginal, at best.

The stresses experienced by inmates are compounded by the prolonged, enforced inactivity which is a prominent feature of jail life. Inmates spend long hours in their cell blocks with nothing to do other than to mull over what they are missing and wonder about what the future hold in store for them. They may fear that their wives or girlfriends will abandon them. They may be terrified at the prospect of "going down the road" to the state correctional system, particularly after hearing other inmates exchange stories about the prevalence of assaults and sexual victimization within prisons.

Mental health clinicians need to be familiar with the stresses of jail life if they are to render effective assistance to troubled inmates. It is equally important that clinicians work together with jail staff and administrators to implement practical, efficient measures to alleviate some of the psychological stresses of jail confinement. Such measures may take the form of classification schemes to reduce potential for victimization, structured programmatic activities, orientation classes for inmates, instruction in coping with the system, or even increasing inmates' supervised access to telephones.

Measures which lessen the pains of confinement can be implemented without compromising jail security. In fact, to the extent that they relieve the overall atmosphere of tension within the facility,such measures may actually enhance jail security.

D. MENTAL HEALTH PROBLEMS OF JAIL INMATES

Psychosis

When mental health clinicians use the term "psychosis" they are referring to the severe type of mental illness in which an individual loses touch with reality. Symptoms include hallucinations and gross disorganization of thinking.

Psychosis has a wide variety of causes. Occasionally it is seen in jail inmates as a consequence of intoxication or withdrawal from street drugs such as phencyclidine (PCP) or alcohol. Sometimes psychosis is secondary to medical conditions such as kidney or liver failure, endocrine disorders, brain tumors or masses, or untoward reactions to medications.

Most commonly, psychosis is seen in jail inmates who suffer from chronic mental disease--either schizophrenia or manic-depressive illness. While the illnesses tend to be chronic, the psychotic symptoms wax and wane over time.

The recurrence of psychotic symptoms in a person with a chronic mental illness may be brought on by a variety of factors, the most prominent of which are discontinuation of antipsychotic medications and emotional stress. Typical stresses include termination of an important relationship, loss of a job, or loss of a place in which to stay. Jail staff and administrators need to understand that the emotional stress that accompanies incarceration does not usually cause psychosis in inmates; rather, the stresses may precipitate or

bring out psychotic symptoms in an inmate who already has a pre-existent vulnerability.

How big a problem is jail psychosis? Surveys show that between 5% and 10% of jail inmates are diagnosed as having a chronic psychotic illness. In some localities today the proportion of psychotic inmates may be higher today as persons come through the jails who in the past would have been in state hospitals.

The figures on prevalence alone do not accurately portray the magnitude of the problem. Disruptive, agitated psychotic inmates may injure jail officers and other inmates. They are also more likely to receive injuries. A hyperactive psychotic inmate may keep other inmates awake as he paces his cell at night, talking to himself. The psychotic inmate is often particularly susceptible to the stresses of incarceration and can be more readily victimized by other predatory inmates.

What can be done about this? Psychotic inmates and inmates at high risk for psychosis need to be promptly identified by jail staff. This requires careful screening at intake. Community mental health clinicians should notify the jail mental health worker when a client is taken into custody when this is possible within the confines of reasonable confidentiality.

The psychotic person who has been booked on an order violation (such as trespassing, disorderly conduct, or failure to identify) should be diverted from the jail for treatment and, if necessary, supportive services that provide food and shelter. Inmates who cannot or should not be diverted will need treatment

within the jail. This usually involves administering an antipsychotic medication which should be monitored by a physician, preferably a psychiatrist. A jail mental health clinician needs to see the psychotic inmate on a regular ongoing basis to reassess symptoms and to help the inmate begin to sort out his confusion.

A psychotic inmate who cannot be safely and adequately stabilized within a jail should be transferred to a hospital.

Suicide

Studies have found the suicide rate among jail inmates to be sixteen times the suicide rate of the general population. Inmates at highest risk for committing suicide include those who are intoxicated, those spending their first 48 hours within the jail, those who are in isolation, and those who have made previous suicide attempts. The most common method of completed suicide involves an inmate using a piece of cloth to hang himself.

Most suicidal inmates let other people know that they are becoming increasingly hopeless. Jail staff need to be alert to these signals and should also be familiar with the signs and symptoms of depression. When officers are concerned that an inmate may be suicidal the issue needs to be directly and openly discussed with the inmate. Such an inmate should be asked, "Have you been feeling suicidal? What thoughts about this have you had? Have you made any plans?" Assessment of suicide risk can be done by mental health clinicians and jail staff working together.

Suicidal inmates usually should not be put into isolation which often can make the situation worse. Rather, they need frequent human contact and sometimes require continuous observation. In some states jail administrators have used paid inmate trustees who have been trained as suicide prevention aides for this purpose.

Self Injury

There is also a substantial group of inmates who don't commit suicide but rather injure themselves, often by cutting an arm or a wrist. Such inmates may be accused of "trying to get attention" and not being "serious" about trying to kill themselves. Such responses serve as expressions of our irritation with these often very irritating people.

If one takes time to listen to these individuals, however, they will usually tell you quite frankly that they were not attempting to kill themselves. Rather, they state that they have found cutting themselves to be a way to relieve intolerable tension. In any case, such action often represents a desperate move. Such inmates should be seen as severely disturbed.

Alcohol and Drug Intoxication and Withdrawal

Inmates who have alcohol or drug problems should be screened at intake for the likelihood of withdrawal. If there is a significant risk of withdrawal such inmates may need to undergo detoxification while in jail. If the jail is unable to provide medical detoxification transfer to a facility which does have this capacity is indicated. Jail can also serve as a source of referral for some

inmates with substance abuse problems who may be motivated by detention to enter a program for treatment of their drug dependence.

E. PROVISION OF MENTAL HEALTH SERVICES IN JAILS

Who Provides the Services?

Jail mental health services are ideally delivered by a multidisciplinary team, including a psychiatrist and members of other mental health disciplines, such as social workers, clinical psychologists, psychiatric nurses, or qualified counsellors.

Jails of medium size (50 to 150 inmates) may have at least one full time nurse or physician's assistant whose responibilities include providing for basic health care within the facility. The jail nurse has regular and direct contact with inmates and has an essential role in helping the clinician identify mental health problems and deliver services to the inmates.

There is no one right way in which to establish a jail mental health service. Program structure depends upon the size and location of the detention facility as well as the preéxisting arrangement of mental health services within the community. The Task Force reviewed several viable options currently in operation.

In some instances, particularly within larger jails, the sheriff or jail administrator may want to contract out for private psychiatric services or to hire his own mental health staff. In this situation it is important that the

Community Services Board be involved in the planning phase and in provision of follow-up for inmates who would not otherwise receive these services elsewhere upon their eventual release.

Often, the best provider of jail mental health services is the Community Services Board (CSB). Clinicians in a CSB are accustomed to working in a multidisciplinary team. The CSB's are also heavily involved in providing treatment and supportive services for the chronically mentally ill, who are sometimes jailed for lack of a more suitable disposition. CSB staff are generally the most knowledgeable and experienced clinicians to work with this population whose needs are often so difficult to meet. Our Task Force was favorably impressed with the wide array of direct mental health services which some Virginia CSB's provide in local jails.

The range of potential involvement for the Community Services Boards in local jail mental health services is quite broad. The CSB can assist the local sheriff or jail administrator in planning for adequate mental health services. This includes assessing needs and identifying resources.

In limited arrangements, CSB mental health staff respond to requests for emergency evaluation and crisis intervention. This includes prescreening for hospitalization and for commitment. It requires that a CSB clinician be available to the jail on a round-the-clock emergency on-call basis. Some CSB's provide regular mental health and substance abuse evaluations in the jail at the request of jail personnel when the routine screening and classification process reveals an inmate with a significant problem.

What is most needed and in small or medium sized facilities least often provided is direct treatment within the jail. This requires that clinicians visit the jail on a regular (once or twice weekly) basis. The treatment that can most reasonably be rendered within jails is not long term intensive psychotherapy directed at personality change. Rather, the mode of treatment usually needs to be brief, crisis-oriented, supportive psychotherapy for the purpose of acutely stabilizing the inmate and strengthening his ability to cope with the immediate stresses that impinge upon him.

Other important forms of direct treatment include antipsychotic medication and, occasionally, antidepressant medication. The use of minor tranquilizers or sedative hypnotic agents (sleeping pills) should usually be discouraged as they can be habit forming and many inmates already have problems with substance dependency.

Because of the high incidence of alcohol and drug abuse among jail inmates, it is important to assure that a variety of substance abuse services be available to the jail. This should include group counseling, individual counseling, and an active alcoholics anonymous program. Since many individuals are not willing to acknowledge their problems with alcohol or drugs it is useful for jail personnel to encourage peer referral for these services.

Who Pays For Services?

Jail mental health services are funded in a variety of ways. Usually, the jail pays for medical services through a contractual agreement with a local

provider. Similarly, large jails pay for private psychiatric care or hire in-house mental health staff.

When the CSB is the direct provider of care funding can be arranged in several ways. In communities where the county or municipal source of funds for the CSB places a high priority upon delivery of mental health services within the jail the CSB may cover the cost of care. In other localities, consultation services by the CSB are paid for by the jail, while the costs of direct services to inmates are covered by the CSB, or the inmate is charged directly using existing CSB reimbursement guidelines. In one locality where this combination arrangement is used, the jail pays a retainer based upon the cost of delivering an average number of hours of services during a week. When the demand for consultation exceeds the number of hours on which the retainer fee is based, additional hours of service are provided by the CSB without additional payment.

These funding arrangements should be worked out on a local level. Regardless of who pays for the service and who provides the service, a formal contract is strongly recommended between the jail and the CSB. Because Community Services Boards and jail budgets are always tight, communities which turn to the CSB for jail mental health services should work to share the costs between these agencies, both of which are responsible for delivery of mental health services to inmates.

F. INDICATIONS FOR TRANSFER TO A HOSPITAL

Some mentally ill jail inmates should be transferred to a hospital facility. The decision on transfer is as much dependent upon resources

available within the jail as it is upon the clinical status of the inmate. The clinician needs to ask whether or not the jail can provide adequate and effective treatment without endangering the health or life of the inmate.

If a psychotic inmate consistently refuses medication while his condition worsens, this is an indication for transfer. While in hospitals, psychotic patients are sometimes administered medications over their objections; this should not be done in jail except in situations of dire emergency and even then only while transfer is actively being sought.

Similarly, psychotic inmates often deteriorate when kept in prolonged isolation. If the jail is able to respond to a psychotic inmate's behavior only by continuously isolating that inmate, transfer to a hospital is usually indicated.

Clinicians and jail staff also need to consider transferring the chronically mentally ill inmate who never should have been jailed in the first place -- the person brought to the detention facility on a minor order violation because hospitalization was unavailable or inconvenient. Such individuals are often hospitalized ostensibly for Restoration to Competency to Stand Trial (Virginia Code Section 19.2-169.2). While this might appear to be inconsistent with the intent of the statute, it may in fact represent a well meaning attempt to respond to perceived treatment needs. In any case, perhaps it is better to seek hospitalization for these persons under Emergency Treatment Prior to Trial (Virginia Code Section 19.2-169.6).

Currently, there are too many sections of the Virginia Criminal Code covering transfer from jail to hospital. They contribute to making the process of transfer elaborate, inconsistent, and confusing. They often serve as an obstacle to hospitalization when it is sorely needed. The various sections of the Code need to be consolidated and the gaps eliminated so that jail to hospital transfer can be accomplished in a speedy and efficient manner while ensuring due process.

G. FOLLOW-UP SERVICES

The Task Force noted that mentally ill inmates who do get treatment in jail often do not get follow-up services upon release. Important follow-up services include mental health treatment, substance abuse programs, and organizations such as Offenders Aid and Restoration (OAR) which offers released inmates vocational guidance and helps them to resettle productively in the community. Community diversion programs may also be involved at this juncture. Occasionally, there is duplication of efforts with no overall coordination, and the inmate-client gets lost in the process.

Each jail needs an individual designated as case manager for the inmates who receive mental health services. Depending upon the local arrangement, this individual could be one of the jail mental health staff or the officer in charge of classification for the jail. The case manager's job is to link the inmate with needed services and then assure follow-through upon discharge.

In preparing for discharge, appointments should be made before the inmate leaves the jail. If at all possible, a relationship should be established

between client and care-giver well before discharge. The case manager should make sure that pertinent release forms are signed and information is sent to the agencies which will be working with the client. Finally, follow-up phone calls should be made to be certain that the client receives the needed services. While giving the newly released client the phone number of the clinic is occasionally adequate to ensure follow-up, many instances require a more assertive approach. This may involve contacting the released inmate after discharge.

H. THE NEED FOR TRAINING

The mentally ill within the criminal justice system present a unique and often particularly difficult set of problems. Both jail staff and mental health clinicians need considerable knowledge and experience in order to be able to deal effectively with these issues. Yet, this is an area in which specific training is usually neglected.

Jail officers should receive instructions in recognizing the more subtle signs of mental illness and need a straightforward scheme for differentiating between the various forms of severe mental illness. Time should be devoted to coverage of drug and alcohol problems. Finally, jail officers need instruction in recognizing the suicidal inmate, preventing suicide and managing inmates who injure themselves. In Virginia, the Department of Criminal Justice Services (DCJS) sets minimum training standards for law enforcement, custodial, and corrections officers. The State Department of Corrections Academy in Waynesboro provides basic and in-service training to DOC employees as well as to some local

law enforcement agencies. In addition, several regional police academies offer instruction for police officers and sheriffs' deputies.

Currently, Michael Pogue of the Department of Corrections offers a comprehensive one-day course in suicide prevention and management for sheriffs, jail administrators, and officers at the DOC facility in Fairfax.

The DOC and DCJS do offer some instruction in the management of mentally ill inmates for corrections and jail staff, but mental health clinicians, on the other hand, generally receive no training in working with jail inmates and receive minimal specific training in the treatment of violent patients and the care of the chronically ill. Psychiatric residencies, psychology internships, and social work and nursing programs generally do not provide trainees with supervised clinical experience in working with the mentally ill in the criminal justice system.

The Department of Mental Health and Mental Retardation currently sponsors a program in which community mental health clinicians throughout the state of Virginia participate in a seven-day training course in performing forensic evaluations. The Forensic Evaluation, Training and Research Center (FETRC) provides detailed instruction in assessing competency to stand trial and mental state at the time of the offense as well as the preparation of pre-sentence reports. Trainees then attend biannual continuing education seminars. The FETRC program has received national attention and has been very successful in achieving its goals. Through this training program CSB clinicians have increased their familiarity with the problems of the mentally ill within the

criminal justice system. The current emphasis upon forensic evaluations should be broadened to include delivery of mental health services to jail inmates.

A state wide training program in jail mental health services could either be modeled on or added to the existing Forensic Evaluation Training and Research Center. The program should draw upon the expertise that has already been developed by Community Services Board clinicians who currently work in local jails and who could play a central role in teaching the course.

RECOMMENDATIONS

With the goal of decreasing the number of mentally ill inmates within Virginia's jails and improving the services available to the mentally ill inmates who will remain in jail the Task Force developed the following set of recommendations. The recommendations address five interrelated areas of concern: 1) keeping the mentally ill out of jail; 2) providing mental health services to jail inmates; 3) transfer from jail to hospital; 4) follow-up services; and 5) training.

1. Funding of Programs for the Chronic Mentally Ill in the Communities

The Department of Mental Health and Mental Retardation should seek significantly more funding from the General Assembly for residential and day support programs for the chronic mentally ill.

2. Development of Programs for the Chronic Mentally Ill in the Communities

The Community Services Boards across Virginia, using state funds as well as other resources that can be made available at a local level, should continue to develop and implement high quality community support services for the chronic mentally ill. These services include residential and day support programs.

3. Establishment of Inebriate Shelters and Detoxification Services

The Department of Mental Health and Mental Retardation and the Department of Criminal Justice Services should continue to seek significantly more funding from the General Assembly for the establishment of a statewide system of public inebriate shelters and community based detoxification services.

4. Development of Twenty-Four Hour Emergency Services

The Department of Mental Health and Mental Retardation needs to ensure that Community Services Boards establish adequate twenty-four hour emergency service programs as mandated by the General Assembly. The Community Services Boards should educate local police departments regarding available emergency mental health services to assist law enforcement offices in diverting chronic mentally ill persons and inebriates to appropriate treatment or detoxification services when appropriate. In some localities CSB's may want to designate specific clinicians to work with the police department.

5. Granting Police the Authority to Take Mentally Ill Persons to Obtain Services Without Having to Arrest Them

The Department of Mental Health and Mental Retardation and the Department of Corrections should seek legislation that would grant police officers the specific authority to take a disruptive or overtly psychotic mentally ill person who appears to meet civil commitment criteria into brief temporary custody for the purpose of transporting that person to a magistrate or other judicial officer and obtaining appropriate evaluation and services in accordance with section 37.1 of the Virginia Code.

6. The Magistrate's Role in Diverting the Mentally Ill From Jail

The Department of Mental Health and Mental Retardation and the Department of Corrections should seek legislation authorizing magistrates and other judicial officers qualified to issue arrest warrants to have the option to divert from the criminal justice process to the mental health system a person for whom an arrest warrant is sought (pursuant to Sections 19.2-72 or 19.2-82) where the offense alleged is a very minor oneand the alleged offender has been

examined by a qualified mental health professional who has found the person to be mentally disordered and in need of treatment that is available from a program willing to accept the person. Such diversion may include the initiation of involuntary commitment proceedings, when indicated, or referral to a community mental health agency, substance abuse program, or other service provider in the community.

This provision would expedite the provision of treatment for persons whose very minor offenses could be understood only within the context of their overtly disordered mental state. The provision is designed to eliminate the jailing and trial of mentally ill minor offenders whose ultimate disposition would be treatment whether or not a trial were held.

In addition, the two Departments should seek legislation that would enhance the authority of magistrates, on the advice of a qualified mental health professional, to order participation in an available and willing treatment program as a condition of pretrial release. This provision would allow for the diversion of the mentally ill from jail to a program of treatment without the dismissal of charges.

7. The Community Services Board's Role in Planning Jail Mental Health Services

The Department of Mental Health and Mental Retardation should ask the Community Services Boards to offer to assist local jails in planning for jail mental health services. Plans which are developed may call for provision of services by the CSB staff, by jail staff, by private caregivers, or by a combination of these.

Jail mental health services are ideally delivered by a multidisciplinary team, including a psychiatrist and representatives of other mental health disciplines such as clinical social workers, psychologists, psychiatric nurses or qualified counsellors. The CSB is often the best source for such a team.

The relationship between the CSB and the local jail should be spelled out in a formal written agreement.

8. Funding of Jail Mental Health Services

It is the responsibility of the Sheriff to provide adequate mental health services in the jail according to DOC policy. Mental health services provided to the jail by CSB's should be offered at low enough charge to enable the CSB to share in the expenses associated with the services. When the CSB is the primary provider of mental health services, the sheriff or local jail administrator and the CSB director should identify how best to cover the costs so that no single party is unduly burdened.

9. Intake Screening

The Department of Correction should mandate improvement in jail intake screening procedures in order to identify inmates who are at risk for suicide, self injury, mental breakdown, and drug or alcohol intoxication and withdrawal, as they enter the Facility.

10. Inmate Classification

The Department of Corrections should establish guidelines for and mandate classification of jail inmates to follow up on intake screening. Inmates can be classified by predatory potential, vulnerability, size, history of previous

incarceration, and gravity of offense. This is a means for lowering the incidence of jail rape and inmate exploitation of other inmates.

11. Suicide Prevention

The Department of Corrections should ensure that all jails have a written suicide prevention policy for the management of inmates at risk for self injury. (A sample suicide prevention protocol is included as Appendix B.) It is essential for all detention facilities to have the capability to provide continuous round-the-clock observation of inmates at high risk for suicide (as opposed to fifteen minute checks).

We suggest that the Department of Corrections study the feasibility of using inmate trustees trained as suicide prevention aides to provide continuous observation of other inmates to supplement the observations of jail staff.

When suicidal inmates cannot be managed safely, jails need a straight-forward procedure for transfer to a hospital. (See Recommendation Number 13)

12. Reducing Stress in Jails

The Department of Corrections should establish guidelines and institute measures for alleviating inmate tensions and the overall stress of confinement. These measures can also be an effective means of enhancing jail security. For example, the problem of inactivity can be addressed by instituting work programs where feasible. The stresses encountered by inmates abruptly cut off from their social support systems can be reduced by allowing supervised access to telephones. Jail staff can also orient prisoners new to the system in effective

methods for adaptation in the state correctional system, thereby decreasing inmates' fears of what lies in store for them.

13. New Uniform Jail to Hospital Transfer Statute

Currently, too many sections of the Virginia Criminal Code cover jail to hospital transfers. These sections need to be consolidated and the gaps eliminated. A uniform, consistent procedure is needed so that transfer can be accomplished in a speedy and efficient manner while ensuring due process.

Pending legislative changes, we recommend that the committee which follows up on this Task Force's recommendations draft a brief pamphlet outlining the procedures required for transfer under Virginia's present systems.

14. Providing Adequate Follow-up When Persons are Released From Jail

The Department of Mental Health and Mental Retardation should require that all inmates who receive mental health service while in jail have a follow up plan prepared by the jail staff for use by the Community Services Board or other provider of care. For this to occur requires open communication and transfer of information between the jail and the community mental health center. Often organizations such as OAR (Offender Aid and Restoration) or Community Diversion programs also need to be involved in this process.

When CSB directors meet with local sheriffs' departments for the purpose of planning jail mental health services (see Recommendation number 7) they should establish a procedure for the transfer of information concerning inmates in need of past discharge services. This transfer of information should be initiated by the person responsible for the classification process in the local jail. This

person should contact the CSB or other follow-up care provider prior to the inmate's release from jail.

The state Sheriff's Association should inform sheriffs throughout the state concerning this plan and encourage sheriffs to work together with mental health clinicians in the transfer of information.

15. Training for Correctional Officers and Police.

We recommend that the amount of time devoted to training for jail staff and police in mental illness, drug and alcohol problems and suicide prevention be increased. The standards for current training programs are set by the Department of Criminal Justice Services (DCJS). The committee created to implement the Task Force's recommendations should work together with DCJS, the DOC, and the Police Executive Research Forum to expand such training programs.

16. Training for Community Mental Health Clinicians

The Department of Mental Health and Mental Retardation should develop a program for training community mental health clinicians in the delivery of services to jail inmates.

The training program in jail mental health services could be either modeled on or added to the existing Forensic Evaluation Training and Research Center. It should draw upon the expertise that has been developed by community mental health clinicians currently working in local jails and CSB's.

17. Including Jail Mental Health Needs as Part of Mental Health Professionals' Basic Training

The Commissioner of Mental Health and Mental Retardation and the Director of the Department of Corrections should encourage Virginia's colleges and universities to ensure that curricula in psychiatry, social work, psychology, and nursing include coursework and clinical experience in service delivery to the chronic mentally ill and to the mentally ill within the criminal justice system.

Jails and CSB's should be encouraged to develop internships and field placements to provide trainees with supervised experience in delivering clinical services to jail inmates.

18. Research

The Department of Mental Health and Mental Retardation and the Department of Corrections need to strongly support the efforts underway to assess the criminalization of the mentally ill. This research addresses the question of what happens to persons who have been discharged from state hospitals and provides an empirical measurement of the scope and magnitude of transinstitutionalization (the movement of former and would be state hospital patients into the corrections system).

19. The Standing Interagency Committee

The Commissioner of the Department of Mental Health and Mental Retardation and the Director of the Department of Corrections should appoint a standing interagency coordinating committee to meet on a regular ongoing basis for the purpose of identifying and responding to problems of mutual concern to the two

departments with regard to the issues discussed in this report. This would include overseeing the implementation of this Task Force's recommendations. The interagency committee could include the DMHMR's Director of Forensic Services and representatives of the Department of Corrections, the Community Services Boards, the Department of Criminal Justice Services, the Sheriffs Association, Central and Western State Hospitals' Forensic Programs, and the Attorney General's Office.

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APPENDIX A

The Task Force's Survey of Virginia's Jails

Prepared by Allen Gouse, Ph.D.

Task Force Survey Findings

Two separate studies were conducted in order to provide the task force with some basic information on the problems of mental illness in jails. The first study, which will be referred to as the jail survey, requested information from local sheriffs regarding policies, procedures, and problems relating to the provision of mental health services for jail inmates. The second survey, which will be referred to as the inmate audit, requested information on specific inmates who, in the opinion of jail staff, were felt to be experiencing significant mental or emotional disturbances. The two studies, taken together, were intended to provide an indication of the degree to which mental health service delivery system/jails collaboration had been developed, the degree to which such collaboration needed to be further developed, and impediments to such development.

I. Jail Survey

The first set of information which the task force deemed important to have was some data on what services were in fact currently available to jail inmates experiencing psychological problems. The task force was able to view first-hand mental health services in only a limited number of jails; more extensive information was therefore sought through a survey sent to sheriffs in all localities.

A brief survey was sent to the sheriff of each city/county in Virginia. Sheriffs were requested to complete the survey themselves or to have it completed by a jail staff member who could best describe what mental health services were available, how they were provided, and what problems existed relative to service provision. Responses were received from 74 sheriffs.

As can be seen in Table 1, most jails reported having access to both in-house medical/psychiatric services (either by medical staff or an outside physician) and Community Services Board (CSB) evaluation/treatment (either in the jail or in the clinic). Approximately 90% of the jails had access to some type of in-house services. Smaller jails tended to obtain these services from an outside physician, while larger jails typically relied on in-house medical staff.

Accessibility to community services board evaluation and treatment was also wide spread. Overall 94.2% of the jails reported access to these services either in the jail or at a clinic. Among the services most frequently available were diagnostic evaluations and crisis intervention. The size of the jail seemed to have some impact on whether or not certain other CSB services were provided. Small and medium size jails tended to have access to outpatient treatment more often than did large jails. Presumably, larger size jails had an increased demand for outpatient services, leading them to rely upon alternate means of securing needed services (e.g., in-house staff). In addition, the increased demand in larger jails may have exceeded some CSBs' capacity to provide needed services, therefore leading to the development of alternate forms of CSB - jail collaboration. Supporting this hypothesis is the fact that larger jails reported access to CSB consultation services more than did small and medium size jails.

While most jails did report having access to some forms of local mental health clinic services, most jails indicated demand for services still greatly exceeded the CSBs' capacity to provide those services. When asked what additional types of jail-based programs, mental health services, and/or consultation were needed in order to better deal with mentally ill and drug/alcohol dependent inmates, many sheriffs indicated greater amounts of services already being provided (i.e., more service, not different services) were needed. Specific services which were sought to a greater degree included crisis intervention (both in the jail and in the community services boards) and outpatient counseling.

Table 1

BREAKDOWN OF JAIL SURVEY RESPONSES BY SIZE OF JAIL

	SIZE OF JAIL*			
	SMALL	MEDIUM	LARGE	TOTAL
Access to Psychiatric Services				
Cells for Mentally Ill Inmates Only	15.4%	38.5%	46.2%	28.8%
Medical/Psychiatric Services In Jail	88.5%	92.3%	92.3%	80.5%
-From Medical Staff	42.3%	92.3%	92.3%	67.3%
-From Outside M.D.	73.1%	76.9%	69.2%	73.1%
CSB Evaluation & Treatment	92.3%	92.3%	100.0%	94.2%
-In Jail	80-8%	61.5%	92.3%	78.8%
-At the Clinic	80.8%	84.6%	61.5%	76.9%
Substance Abuse Services	53.8%	76.9%	100.0%	71.2%
-AA or Related Program	34.6%	69.2%	92.3%	57.7%
-Medically Supervised Detox	42.3%	61.5%	92.3%	59.6%
Emergency Room Backup	76.9%	76.9%	76.9%	76.9%
CSB Services				
Diagnostic Evaluations	88.5%	92.3%	84.6%	88.5%
Counselling Sessions	84.6%	84.6%	61.5%	78.8%
Crisis Intervention	69.2%	76.9%	92.3%	76.9%
Pre-Admission Screening	42.3%	53.8%	46.2%	46.2%
Inservice training	26.9%	15.4%	53.8%	30.8%
Consultation	53.8%	69.2%	76.9%	63.5%
Medication	53.8%	69.2%	76.9%	63.5%
Forensic Evaluations	57.7%	84.6%	92.3%	73.1%

	SIZE OF JAIL*			
	SMALL	MEDIUM	LARGE	TOTAL
<u>Payment for CSB Services</u>				
Fee for Service Basis	36.0%	46.2%	8.3%	32.0%
Contractual Retainer	0.0%	0.0%	8.3%	2.0%
No Charge	64.0%	53.8%	83.3%	66.0%
<u>Jail Staff Training</u>				
Basic Academy on Mental Health/ Substance Abuse Problems	67.3%	58.1%	86.5%	70.8%
Inservice Training	51.0%	39.4%	62.2%	50.9%
Outside Seminar	1.1%	10.3%	15.5%	7.4%
Class/Course on Mental Health/ Substance Abuse	4.0%	8.5%	13.4%	7.6%
Outside Reading	10.5%	14.9%	10.3%	11.6%
Primarily on the Job	46.5%	55.8%	26.2%	43.8%
<u>Manpower Costs Associated With Serving Population</u>				
Overall (Any type of cost)	38.5%	30.8%	53.8%	40.4%
-Injuries to Staff	11.5%	7.7%	38.5%	17.3%
-Sick Leave After Injury	3.8%	7.7%	30.8%	11.5%
-Overtime	30.8%	30.8%	30.8%	30.8%

* SMALL: 0-30 rated inmate capacity
MEDIUM: 31-99 " " "
LARGE: 100 and above " " "

When asked what payment (if any) was made for CSB services, approximately 2/3 of the sheriffs responding indicated that they were not charged for such services. Payment vs. nonpayment for services did, however, seem to relate to the size of the jail. Over 80% of large jails reported no charge for CSB services, compared to 64% and 54% for small and medium size jails, respectively. This difference may reflect 1) the capacity of the CSB to absorb the cost of service provision (i.e., the larger staffing and budget of some community services boards may allow them greater freedom in allocating staff/s time) and/or 2) the more staff-intensive services which small jails reportedly had access to (e.g., outpatient counseling and crisis intervention).

Over 40% of the sheriffs who responded to the survey cited significant manpower costs associated with serving/controlling mentally ill inmates during the past three months. Approximately 17% of the sheriffs noted that one or more custody staff had been injured by mentally ill inmates during the past three months. Approximately 2/3 of those injuries resulted in staff having to take sick leave. The most frequently cited manpower cost associated with serving mentally ill inmates was staff overtime. Approximately one-third of all sheriffs reported using overtime during the past three months solely for the purpose of dealing with seriously disturbed inmates.

II. <u>Inmate Audit</u>

In order to understand the types of problems which inmates were experiencing, a random sample of jails were asked to provide information on those inmates who, in the opinion of jail staff, were experiencing significant mental disturbances. Jails selected for this audit were asked to 1) identify all inmates who, during the past 30 days, displayed a significant mental disturbance (i.e., identified using daily logs) and 2) complete a brief survey on each of these inmates, documenting the behaviors observed.

It is important to note that only those inmates whose disturbances were noted in a daily log were included in this study. This approach differs significantly from that of other research on the prevalence of mental illness in jails and prisons and therefore is worthy of some discussion. Previous research in this area has documented the prevalence of psychiatric disorders as diagnosed by a psychiatrist or psychologist. In many of Virginia's jails, a psychiatrist or psychologist is not available to perform such a diagnosis. Reliance, then, on diagnoses could lead to an inappropriate estimation to the magnitude of mental disturbances in jails. Furthermore, where any such diagnoses would be made in a number of jails and by a number of mental health professionals, any results would be a function of the degree of vigor with which the diagnoses were made. For this reason, it was felt that an alternate method was needed. During task force visits, jail staffs indicated that all incidents reflective of a mental disturbance would be recorded in a daily log. It was therefore decided to use this common denominator as a means of identifying cases.

This method provides certain strengths and weakness which should be noted. First, it may not include the large number of individuals who are briefly incarcerated on a charge of drunkenness in public. These individuals may not have been included unless they presented a non-routine need or situation (e.g., significant risk for delirium tremens). Where approximately 25% of all jail incarcerations are for drunkenness in public (1982 Virginia Department of Corrections data), omitting these individuals permits a more focused analysis,

concentrating on those individuals who are experiencing significant disturbances. This approach, however, may underestimate the prevalence of substance abuse related problems in the jail population. Also to be noted is the fact that this method does not capture the silent or compliant individual who is experiencing a psychiatric disturbance. Only those who come to the attention of jail staff are included.

Perhaps the most important strength to note is that the study captures the perspective of jail custody staff regarding the magnitude of significant problems. Previous research has maintained a clinical focus, wherein the mental health professional identifies problems. In this study, only that which custody staff consider significant is included. Custody staff are not asked to draw inferences, but rather to simply report observed behaviors.

Data was received on 171 inmates from eight different jails who were identified as mentally ill and having significant behavior problems. These 171 inmates represented 6.1% of the inmates held in those eight jails during a 30 day period. It should be noted that the response rate for this audit was not sufficiently high to insure the representativeness of the findings. The statistics reported herein should therefore be treated as general indicators of problem areas, subject to further verification. The sample from which these statistics were drawn was primarily male (93.6%), between the ages of 18 and 40 (87.7%), and most likely charged with offenses against property or persons (38.6% and 23.4%, respectively).

Audit respondents were asked to indicate which of 16 different symptoms or behaviors each identified inmate displayed. As can be seen from Table 2, the most frequently observed behaviors or problems were "appears depressed" and "talks of suicide; wishes he/she were dead." The next most frequently cited behavior was "changes mood with no apparent reason", noted in 30.4% of the sample. Other behaviors noted in at least 25% of the sample included "reports strange ideas", "threatens/commits violence toward others", and "displays bizarre habits or behaviors." Percentage figures add up to more than 100% in that inmates could and typically did display more than one problem behavior or symptom.

Where combinations of symptoms might provide more focused information, factor analyses were performed on the 16 items. These analyses were designed to identify symptom clusters that inmates presented. Identified symptom clusters corresponded generally to schizophrenic disorders, manic episodes, major depression, need for detoxification, mental retardation, and other disorders. Strict concordance with DSM-III disorders or diagnoses should not be assumed, largely because the full array of behaviors/symptoms (from which a DSM-III diagnosis would be drawn) were not included in this audit. The most prevalent symptom cluster observed in the inmates sampled was major depression, seen in 47.4% of those sampled. Approximately 40% of the sample showed behaviors indicative of a schizophrenic disorder. Slightly more than 21% of the inmates sampled displayed symptoms suggestive of a manic episode. Allowing for inmates loading on to more than one symptom cluster, approximately 3/4's of the inmates sampled displayed behaviors indicative of a major mental disease (e.g., schizophrenic disorder, manic episode, and major depression).

Over 80% of inmates sampled for this audit, problem behaviors/symptoms were first observed prior to or during classification. One-third of the inmates

sampled were identified as having a significant mental disturbance at their booking. An additional 19.3% of the inmates were identified as showing problem behaviors within the first 24 hours of incarceration; 30.4% were identified during classification. For only 17% of the inmates sampled were problem behaviors first observed after classification.

Table 2

BREAKDOWN OF SIGNS AND SYMPTOMS AMONG INMATES IDENTIFIED AS MENTALLY ILL AND HAVING SEVERE BEHAVIOR PROBLEMS

Problem Behavior	Symptom
Appears depressed	32.2%
Appears overly nervous or panicky	21.1%
Appears overly frightened	7.6%
Reports strange ideas	28.7%
Talks of suicide; wishes he/she were dead	32.2%
Suicidal attempt	6.4%
Reports hearing voices/seeing strange things	19.1%
Appears to be under the influence of alcohol or drugs	20.5%
Appears to be going through drug or alcohol withdrawal	9.9%
Experiences seizures	1.2%
Threatens/commits violence toward others	25.1%
Appears to be overly confused	20.5%
Displays bizarre habits or behaviors	28.1%
Changes mood with no apparent reason	30.4%
Appears to be mentally retarded	5.3%
Other behaviors or symptoms	5.3%

N = 171

APPENDIX B

Sample of A Jail Suicide Prevention Protocol

From the Albemarle-Charlottesville Joint Security Complex.

Prepared by Eugene Claibourne, Mike McMahan, and Michael A. Solomon from material written by Michael Pogue of Virginia's Department of Corrections

SUBJECT: Suicide Prevention

PURPOSE: To provide Complex employees with written guidelines covering suicide prevention and responses to suicide attempts.

POLICY: Confinement in jail and the circumstances that led to it can cause feelings of desperation in inmates, prompting some to seriously consider suicide.

Since Complex employees who supervise inmates are responsible for preventing suicides, special procedures are needed for inmates who threaten suicide or who are known to be suicidal. Although most experts agree that a person who really wants to kill himself will eventually do so, the jail does, however, have a legal and moral responsibility to prevent suicide if possible. A jail employee could be liable to an inmate, or his family, as well as subjected to disciplinary action for negligent performance of duty, if a suicidal inmate is injured or dies. Negligent performance of duty might consist of, for example, ignoring obvious signs or intentions of suicide.

Complex employees who work with inmates should consider all suicide threats by inmates to be serious and take appropriate steps to prevent the inmate from carrying out his treats. This includes constant observation of the inmate and seeking professional mental health assistance for him. Correctional officers and other staff should recognize the symptoms of potential suicide, such as depression or a sudden change in the inmate's behavior, and attempt to find out what is troubling the inmate. It is a serious mistake to ignore suicide threats or invite an inmate to go ahead and kill himself.
Prevention is the key and should be a primary concern of Complex staff.

PREVENTION

I. Suicidal Types

Anyone who is confined to the Complex should be considered a potential suicide risk.

However, there are three (3) major classifications of suicidal persons in the jail and the factors described below can help jail staff identify them.

A. Inmate Facing a Crisis Situation

1. This person is reacting to a real, immediate problem, such as:
   a) news that his wife is living with another man or is filing for divorce;
   b) being found guilty or receiving a long sentence; or
   c) fear of sexual assaults.

2. Feeling shame, disgrace, frustration, and/or hopelessness over a crisis situation. These inmates should be observed carefully:
   a) bereaved inmates who have suffered a recent loss of a loved one due to divorce or death;

   b) young impulsive inmates having a difficult time adjusting to the confinement of a jail setting;
   c) homosexual inmates;
   d) incarcerated ex-law enforcement officers or professionals;
   e) first offenders; and
   f) persons who have committed a crime of passion.

3. A narcotic addict or alcoholic may go through withdrawal shortly after entering jail. At this time severe depression may set in, leading to a suicide attempt. The person may see suicide as a way out of going through withdrawal.

B. Person in a Serious Depression

A person defined by experts as being in a "depressed" state mentally does not merely have a case of the "blues". It is normal to react to some problems in life by being temporarily sad or despondent. But a depressed person who is prone to suicide seems to be completely changed by his depression.
Below are some warning signs of serious depression. Complex employees who see these signs should refer the inmate to the jail physician or a mental health professional (jail psychiatrist).

1. Physical warning signs of serious depression:
   a) sleeping difficulties: insomnia, irregular hours, early morning awakening;
   b) depressed physical appearance;
   c) walks slowly;
   d) weight loss or loss of appetite;
   e) slumps when walking or sitting; sits in the corner in the fetal position; and
   f) general loss of energy.

2. Behavioral warning signs of serious depression:
   a) cries frequently or for no apparent reason;
   b) retarded thinking, speaks slowly;
   c) apathy and despondency;
   d) sudden social withdrawal, little communication with inmates or officers;
   e) feelings of helplessness and hopelessness;
   f) a lot of talk of self-pity, of life not being worth it, of people being happier if the inmate were to kill himself;
   g) talks of suicide, composes and leaves suicide notes;
   h) gives away personal possessions;
   i) talks of getting out of jail unrealistically;
   j) has previously attempted suicide and talks about it; or
   k) exhibits sudden changes in behavior, such as making an unprovoked attack upon an officer or another inmate.

3) Losing touch with reality: Occasionally an inmate will become so depressed that he loses touch with reality completely. He may have hallucinations, fear he is sick, or have overwhelming feelings of being "sinful" or worthless. These symptoms may or may not be part of a serious depression, but they are serious

mental symptoms, and the inmate should be promptly referred to the jail physician or mental health professional.

C. Manipulative and Impulsive Inmates
It is frustrating for us as jail employees to try to be professional and concerned about suicide prevention when we know that a certain number of inmates use the threat of suicide to manipulate the staff.

Employees should remember that anyone who would slash his wrists is emotionally unbalanced and needs professional help. Many people are immature and impulsive; they act without thinking about the consequences of their actions. For an inmate who uses suicide as a threat, this type of behavior can be fatal--many inmates who wanted to be manipulative have died because their "fake" suicide attempt went further than they anticipated.

II. Suicidal Inmates - Responding to Them

A. Treat all potentially suicidal inmates as if they were sincere. Do not automatically assume that the inmate is merely trying to be manipulative.

B. If you are approached by an inmate who threatens suicide or who appears to be suicidal, take time to talk to and listen to the inmate.
1) The inmate may not be totally set on suicide yet and may just be crying out for help. To ignore the inmate could cause him to decide to kill himself because no one cares.

C. Don't be afraid to discuss the inmate's suicidal thoughts. Encourage the inmate to verbalize his feelings. Being made aware of his intentions and planned methods of accomplishing the suicide will help you and your fellow staff in trying to prevent the suicide. Also, talking and listening to the inmate will:
1) help you further assess the risk;
2) help determine what problems may be causing the inmate to contemplate suicide since once you find out the problem, you may be able to help him resolve it; and
3) help you to find out if family, friends, or a minister needs to be contacted to help resolve the conflict within the inmate.

D. As the reporting officer, once you have talked to the inmate and assessed the situation, meet with your shift commander so that a decision can be made about immediate preventive measures which need to be taken.

E. Advice should be sought from the jail physician or mental health professional regarding need for transfer to UVA Crisis Intervention or another facility for treatment.

F. A rounds schedule of 15 minutes or less should be instituted.

G. Several custody statuses and housing options which may be available to you and your shift commander are:
1) leave the inmate in his present cell but under close supervision by staff;
2) reclassify to another cellblock (if the problem seems to be caused by inmates in present cell) and make frequent rounds;
3) place inmate in an isolation cell with a bed and toilet, with or without personal property items;
4) place in FS-1 without personal property; or
5) take to UVa Crisis Intervention or Emergency Room.

H. The area where the inmate is housed should be easily observable and frequently patrolled by staff.

I. A report must be filed by the reporting officer and his shift commander to the Chief Correctional Officer, the medical staff, and the Chief of Inmate Services.

J. The reporting officer or the Shift Commander will make an entry in the log book in R and D to make sure the next shift is aware of the suicide risk.
Each subsequent shift should make log book entries on any unusual incidents regarding the inmate.

III. How to Respond in an Actual Suicide Attempt

A. The natural tendency is to rush in and make an immediate rescue. All too frequently, however, unwise, unplanned action may lead to injury or death. The officer should keep in mind that if the death is imminent, there is little he can do to prevent it. The first step is to assess any threats to his own safety or to that of others.

B. The officer should call for assistance and secure the area as quickly as possible. This includes locking the other inmates in their individual cells or moving them into another housing area and out of the immediate area where the suicide incident has taken place.

C. If the inmate can be negotiated with and rescued, give First Aid and see that necessary medical attention is received. Once medical problems have been addressed, place in FS-1 or FS-2 with clothes removed and no personal property items.

D. Mental health professionals or jail physician should be reached to advise.

E. Leave in FS-1 or FS-2 pending review by Classification Officer or ICC within 48 hours.

F. Rounds, 15 minutes or less, must be instituted and documented.

G. If the officer arrives on the scene of the suicide too late to prevent the inmate from killing himself, the following steps need to be taken.

1) Secure the area. Move all other inmates and lock off the area.
2) Notify the Coroner and jail physician.
3) Once the inmate has been pronounced dead and removed from the area, have the area cleaned thoroughly.
4) Observe the other inmates who were in the area at the time of the suicide for possible aftereffects.

APPENDIX C

Proposed Legislation for a Revised Jail to Hospital Transfer Statute

Prepared by W. Lawrence Fitch

Modification of Procedure for Psychiatric Hospitalization of Jail and Prison Inmates

SEC 19.2-169.6 should be amended and reenacted as follows:

SEC 19.2-169.6. Psychiatric hospitalization of jail and prison inmates.

A. The person responsible for the administration of any jail, or his designee, may petition for the voluntary psychiatric hospitalization of any person incarcerated in such jail. An order for voluntary psychiatric hospitalization may be issued by a judge, special justice, or magistrate, upon a finding, based on the opinion of a psychiatrist or a psychologist, that the incarcerated person is mentally ill, requires treatment in a hospital rather than in the jail, and is able and willing to admit himself to the hospital as a voluntary patient.

B. An order for involuntary psychiatric hospitalization may be issued under this section for any person who is incarcerated in a jail only after a commitment proceeding conducted according to the procedures set forth in SEC 37.1-67.1 through SEC 37.1-70, as modified by the following provisions:

(i) only the person responsible for the administration of the jail in which the person is incarcerated, or his designee, may petition for commitment under this section;

(ii) in addition to the criteria for commitment specified in SEC 37.1-67.3, the judge must find that the person requires treatment in a hospital rather than in the jail;

(iii) if the person has not been tried and sentenced, his attorney, if available, shall be notified and given an opportunity to represent the person at the commitment hearing;

(iv) if the person has not been tried and sentenced, any order for hospitalization also shall indicate whether the admitting facility should evaluate the defendant's competency to stand trial pursuant to SEC 19.2-169.1, mental state at the time of the offense pursuant to SEC 19.2-169.5, or mental state for sentencing purposes.

C. If any person hospitalized pursuant to this section has not been tried and sentenced, copies of the hospitalization order shall be provided to this attorney and to the court with jurisdiction over his case.

D. Upon issuance of a hospitalization order under this section, the person shall be presented for admission to a willing hospital designated by the Commissioner or appropriate for the treatment and evaluation of persons charged with or convicted of crime. Upon presentation of a person under a hospitalization order issued under this section, a psychiatrist or a psychologist on the staff of the hospital shall conduct an evaluation of the person and determine whether he requires treatment in a hospital rather than in a jail. If the psychiatrist or psychologist determines that treatment in a hospital is required, the person shall be admitted; if the psychiatrist or psychologist determines that treatment in a hospital is not required, the person shall immediately be returned to the jail.

E. Any person hospitalized pursuant to this section who has not completed service of his sentence or against whom criminal charges remain pending shall immediately be returned to the jail upon charge.

F. In no event shall hospitalization ordered pursuant to this section be continued beyond the expiration date of the person's sentence, unless the person is committed pursuant to SEC's 37.1-67.1 et seq; nor shall such hospitalization be ground for a delay of trial, so long as the defendant remains competent to stand trial.

The proposed provision is designed to remedy a number of problems with the current procedures for the psychiatric hospitalization of jail inmates (SEC 19.2-169.6, 19.2-176, 19.2-177). First, it would obviate the need for full due process when the inmate has no objection to hospitalization.

With regard to the involuntary hospitalization of jail and prison inmates, the existing provisions have been criticized both by experts in constitutional law and by mental health professionals because they appear to require hospitalization without due regard for the rights of the detainees. (See *Vitek v. Jones*, 100 S.Ct. 1254 (1979)). The proposed provision is designed to accommodate constitutional concerns by establishing procedures that differ from procedures governing the involuntary admission of persons not incarcerated *only in those respects in which differential treatment is necessary to protect the interests of the Commonwealth*.

At the same time that it provides a meaningful degree of due process protection, the proposed provision facilitates the prompt hospitalization (i.e., prehearing involuntary detention) of pretrial jail detainees by eliminating the present requirements 1) that the defense attorney be notified and given an opportunity to challenge the mental health professional's findings prior to such hospitalization and 2) that only the judge with jurisdiction over the defendant's case be empowered to order commitment. (Judges, attorneys, and mental health professionals throughout Virginia have complained that these requirements have rendered the present law unworkable because, so often, the relevant legal officials are not available when the need for hospitalization arises).

Finally, the proposed provision establishes one consistent procedure for the hospitalization of jail inmates. The present hospitalization laws differ dramatically from each other in substance and procedure, resulting in confusion among jail and mental health personnel regarding their responsibilities in the hospitalization process.

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