

**SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth  
in the 21st Century**

**Work Group #2: Criminal Justice Diversion**

**Meeting Summary**

**Wednesday, October 26, 2016**

**General Assembly Building, Richmond, Virginia**

Work Group #2: Criminal Justice Diversion Work Group (the work group) of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) held its third meeting of the 2016 interim on Wednesday, October 26, 2016 in Richmond.

**Follow-Up on the Office of the State Inspector General Report on the Investigation into the Death of Jamycheal Mitchell**

Delegate Robert B. Bell, chair of the work group, noted that at the Joint Subcommittee meeting on April 19, 2016, there was a presentation from June W. Jennings, State Inspector General, and Ms. Priscilla Smith on the investigation of the Office of the State Inspector General (OSIG) into the death of Jamycheal Mitchell while in the custody of the Hampton Roads Regional Jail (HRRJ). Delegate Bell stated that the members of the Joint Subcommittee were unhappy with the quality of the OSIG investigation and report.

On July 20, 2016, three employees of OSIG, Cathy Hill, Ann White, and William (Jerry) Thomas, filed a whistleblower complaint requesting that Attorney General Mark Herring investigate the substance of the complaint. Ms. Hill, Ms. White, and Mr. Thomas discussed, via conference call, the OSIG report and the whistleblower complaint with the work group.

Ms. White introduced herself and noted that she has worked in the behavioral health and developmental services field for 27 years, including as a consultant with the Department of Behavioral Health and Developmental Services (DBHDS) Office of Inspector General from 2005 until 2012 and as a consultant with OSIG from 2012 until July of 2016. Ms. White explained that correctional facilities are the only settings for which the overall provision of health care services, including behavioral health treatment, is mandated by the U.S. Constitution, but that such facilities are also the setting where the individuals receiving services have the least amount of say in service delivery and do not have the option to choose their treatment providers.

At this point, Ms. Hill introduced herself and noted that she has 30 years of clinical and regulatory experience in settings that serve persons with mental illness, developmental disabilities, and substance abuse disorders and that she was appointed to the position of Director of Inspections of DBHDS Office of Inspector General in 2000 and continued in a similar position when that office was absorbed into OSIG.

Ms. Hill stated that there are two relevant questions in determining what role the OSIG should play in reviewing the quality of behavioral health care in the jails: (i) Are the members of the Joint Subcommittee satisfied with the work OSIG completed during its investigation of the death of Jamycheal Mitchell, and (ii) Did OSIG leadership fulfill their responsibilities as defined by law to their fullest capacity? In the opinion of Ms. Hill and the other whistleblowers, the answer to the second question is no. Ms. Hill said that they learned that the Attorney General's

Office informed OSIG that it had jurisdiction to review the services provided by NaphCare, Inc., the medical service provider in HRRJ at the time of the death. However, Ms. Hill stated that the OSIG did not conduct a thorough review of those services, as evidenced by the report in which no recommendations for service improvement were directed towards NaphCare, Inc.

Ms. Hill also explained that OSIG had information regarding Eastern State Hospital prior to and during the investigation into the death of Jamychoel Mitchell regarding staff and patient safety and staff workloads that was suppressed from disclosure. Ms. Hill also stated that there was a major conflict of interest between OSIG and Eastern State Hospital. Specifically, the husband of the Inspector General, June Jennings, is the current director of quality at Eastern State Hospital, and Priscilla Smith, who is responsible for reviewing Eastern State Hospital at OSIG, is the former director of quality at Eastern State Hospital.

Next, Mr. Thomas introduced himself and noted that he had 23 years of experience in the field of behavioral health and developmental services. Mr. Thomas expressed his opinion that the Attorney General's Office has lost confidence in the current processes for investigating and holding jails accountable, as evidenced by its request for the U.S. Department of Justice to review the care provided at HRRJ. He also noted that he and the other two whistleblowers were very discouraged by the fact that neither the Governor's Office nor the Attorney General's Office ever discussed their complaint with them.

Delegate Bell then engaged in extensive questioning of the whistleblowers regarding the conduct of OSIG during the investigation of the death of Jamychoel Mitchell, including what actions OSIG did and did not take in conducting the investigation.

### **Update on Activities of the Criminal Justice Diversion Expert Advisory Panel**

Leslie Weisman, chair of the expert advisory panel formed to assist the work group, updated the work group on the panel's activities since the work group's last meeting on August 22, 2016. The panel has held two meetings, the first on September 15, 2016, and the second on October 11, 2015, and has focused its efforts on four areas.

First, Ms. Weisman discussed behavioral health dockets. In response to a question from Delegate Bell at a previous work group meeting regarding why individuals agree to participate in a docket when the conditions of such participation are frequently more onerous than the criminal punishment that would be imposed, the panel is going to collect data from participants in behavioral health dockets in the Commonwealth and attempt to determine the reason for their participation. Ms. Weisman then updated the work group on the Behavioral Health Docket Advisory Committee of the Supreme Court of Virginia (Supreme Court), which is developing the standards that must be used by a court that wants to establish a behavioral health docket and the application that must be submitted and approved by the Supreme Court before a court can set up a behavioral health docket. Ms. Weisman noted that this work is almost complete and the Supreme Court may be considering a rule authorizing behavioral health dockets, as well as other specialty dockets, before the end of 2016.

Second, Ms. Weisman discussed the need for minimum standards for mental health treatment in jails and noted that the panel recommends that all jails use a standardized screening instrument, such as the Brief Jail Mental Health Screen.

Third, Ms. Weisman stated that the panel believes that jail discharge planning is of paramount importance and that every jail should have access to a jail discharge planner. She noted that community services boards (CSBs) perform this service for individuals being discharged from state hospitals. The panel recommends that DBHDS develop a plan to ensure that discharge planning occurs at every jail.

Finally, Ms. Weisman discussed the benefits of creating local criminal justice stakeholder groups to monitor any changes in services provided to persons with mental illnesses involved in the justice system. The panel is developing a survey to send out to the CSBs to determine what similar stakeholder groups are already in operation.

### **Use of Standardized Mental Health Screening Instrument by Jails**

Dr. Jack Barber, Acting Commissioner of DBHDS, noted that the use of mental health screening is included in most best practices guidelines for the operation of jails and provides a cost-effective means to identify inmates in need of services. He explained there are six validated screening tools that have been developed for identifying inmates in need of services. Several of these tools, including the Brief Jail Mental Health Screen (BJMHS), the Correctional Mental Health Screen for Men (CMHS-M), and the Correctional Mental Health Screen for Women (CMHS-W), can be administered in five minutes or less and can be administered by either medical or correctional staff. He stressed the importance of the ease of administration since many jails do not have medical staff readily available to administer a screening instrument and lack the personnel to invest significant time in administering the instrument.

Dr. Barber stated that DBHDS recommends that the General Assembly mandate each jail be required to use a standardized screening instrument upon intake of a prisoner. Currently, DBHDS recommends jails use BJMHS for male prisoners, which has a 74 percent accuracy rate, and CMHS-W for female prisoners, which has a 75 percent accuracy rate. However, Dr. Barber noted that any mandate from the General Assembly should not specify any particular instrument in case screening instruments that yield better accuracy rates are developed.

After the completion of Dr. Barber's presentation, Delegate Bell reviewed the work group's legislative proposals. The first proposal is to provide authority to an appropriate entity to investigate in-custody deaths in jails. A discussion then ensued with relevant stakeholders, including representatives of the sheriffs and the regional jails, about the possibility of providing the Board of Corrections with the authority to conduct such investigations. No consensus was reached at the meeting, and discussion will continue. The second proposal is to require the use of a standardized instrument upon intake of persons into jails to screen for mental illnesses. The third and final proposal is to have DBHDS develop a plan for the provision of discharge planning services for persons being released from jail that ensures that each jail in the Commonwealth has access to such services. The plan shall include an estimate of the cost of providing discharge planning services as well as an estimate of any cost savings that may result from the provision of such services.