

We want to thank Delegate Bell and the subcommittee members for inviting us to share our thoughts regarding the locus of accountability for quality oversight of jail based behavioral health care services for offenders with serious mental illness (SMI) and particularly whether one level of the accountability should rest within the Office of the State Inspector General (OSIG).

As you are aware, correctional facilities are the only settings for which the overall provision of healthcare services, including behavioral health treatment, is mandated by the U.S. Constitution. Correctional facilities are also a setting where the individual receiving services has the least amount of say in service delivery. For example, individuals in correctional settings do not have the option to choose their treatment providers, yet we became acutely aware from the very public coverage of the death of Jamycheal Mitchell that offenders' lives are dependent on the integrity and quality of those services AND the service providers.

Mr. Mitchell's death and the resulting review by OSIG was the primary reason the three of us submitted our whistleblower complaint to the Attorney General's Office, as allowed by law. We are pleased to report that many of the concerns we raised are being actively addressed by the leadership of the office, which will enhance the integrity of the work provided.

So...what needs to change in order for the citizens of Virginia to feel confident that, as a matter of overall public safety, individuals in jails receive the care and treatment they are constitutionally guaranteed in order to live successful lives while incarcerated and in the community upon their release.

In deliberating the question of what role, if any, OSIG should play in reviewing the quality of behavioral healthcare in the jails, we asked ourselves two fairly simple questions, which we offer to you to consider:

1. Are you, as members of this committee, satisfied with the work OSIG completed during its investigation of the case?
2. Do you believe, based on the investigation that was completed, that the OSIG leadership fulfilled their responsibilities as defined by the Code of Virginia to their fullest capacity?

Obviously, we did not believe that occurred and continue to maintain that belief. For example, we all learned that the AG's office informed OSIG that according to the Code of Virginia, the office DID have jurisdiction to review the services provided by NaphCare as a designated provider. When the OSIG Director of BHDS entered that facility to conduct an investigation, she had reasonable assurance of the authority to do so, or we believe she simply would never have gone.

Yet a thorough review of those services did not occur as evidenced by the report in which not one single recommendation for service improvement was directed towards NaphCare, the provider the office did have jurisdiction over.

Do you believe that by increasing the Office's authority, it will compel the same leaders to honor their responsibilities any better when they failed to investigate to the extent of the authority they had previously?

You may hear from the jails and other stakeholders that it will take more staff and more resources to adequately treat offenders with SMI in the jails. Granted, assuring quality services in these local and multi-jurisdictional settings is complicated, but we believe it is as much about attitude and willingness to provide quality services as it is about resources. When taken at face value, it is true jails are not treatment facilities, but that does not negate their constitutional mandate or protect them or the Commonwealth from liability when the adequacy of the services are challenged.

We even understand there has been some discussion about removing the BHDS unit from OSIG and making it a separate office. Again we ask that you consider what will that accomplish if the same leaders transfer with the office and remain in charge?

Our concerns about the manner in which the leaders at OSIG handled the Mitchell death went deeper than the Mitchell investigative report. Our office had vital information about Eastern State Hospital prior to and during the Mitchell investigation that we believe was not effectively addressed because the information was suppressed from disclosure. We (the whistleblowers) could never understand why critical data relevant to staff and patient safety, and staff workloads was not allowed to be included in two other reporting processes by OSIG; a report and a managerial letter.

The media has speculated that there was a major conflict of interest between the principles at OSIG and ESH, which raised the question of independence in conducting the review and in our minds raised other issues. This conflict of interest and its impact has been minimized, which we remain concerned about and believe full disclosure on this issue is vital to examining the role of OSIG and its leaders, particularly if considering giving the office more duties. I received a complaint regarding the conflict of interest issue, which I turned over to the State Hotline operated by OSIG for investigation. I have no idea what the office chose to do with the complaint, which was also forwarded to other offices by the complainant.

It appears to us that Attorney General Herring lost confidence in the current processes for holding the jails accountable when he asked the DOJ to intervene to review the care provided at the Hampton Roads Regional Jail. We strongly believe that the provision of quality behavioral health care in Virginia should not be defined through the courts or require oversight by federal entities, such as the Department of Justice. These options have repeatedly been proven to be costly. It also places the control for defining care and the service delivery system to entities outside of the Commonwealth. You may want to ask yourself if intervention by the DOJ would even be necessary if the watchdog office had done what it was designed to do.

We appreciate that every year the GA tackles many important issues, and in the budget strapped environment our leaders and representatives are currently facing, the task becomes even more daunting, but we are grateful to this subcommittee for assuring that the rights of persons with SMI remains a part of the dialogue. We were very discouraged when we were never asked about our whistleblower complaint by either the GO or the AG's office, so we sincerely thank you for this opportunity. We are willing to respond to any questions you may have.

Ann White, William Thomas, and Cathy Hill