MENTAL HEALTH TALKING POINTS
Sheriff Beth Arthur, Arlington County

Our jail ADP is 550 35-38% of our inmates have been diagnosed with a Serious Mental Illness. i.e. Schizophrenia, Bi-Polar, Major Depression.

About 164 out of approximately 550 inmates are on psychotropic medications in the Jail.

The specialized MH unit has close to a 100% occupancy rate on the male side and could easily fill an additional 15-20 beds.

Jails do not have a right to refuse and end up being the default place for a lot of the Seriously Mentally Ill (SMI)

We have found that people in jail with SMI spend significantly longer time incarcerated than those without for the same offense.

It is difficult to treat people in the jail environment because of the design; confinement structure, supervision and routine (SO don't have the staff/training to manage these individuals safely). This can lead to serious tragedies such as serious assaults, suicide, and self destructive behavior.

We are fortunate to have a 30 bed mental unit with forensic staff for those who are unstable and in crisis. Most jails do not have units designed for housing this population or the staff. Our forensic staffing includes a MH supervisor and two therapists

Forensic and medical care for those in jail is expensive and can deplete budgets causing overruns or shifting of funds from other priorities. SO do not have the budgets to absorb these issues. It currently costs $146 per day to house an individual in the ACDF and this does not include medical issues above basic care.

We spent $96,664.80 in 2007 for medications for SMI.

Many inmates also have a dual diagnosis of substance abuse disorder making it difficult to treat one without the other.

Examples of this are:

Example #1: A Young Vietnamese man who had a liver transplant at the age of 13. He also has seizures which may be related to his renal issues. He is diagnosed with Schizophrenia but has trouble with medications because of the way that they are filtered through his system.

Additionally he is a cocaine abuser. He has family whom he lives with but he chooses to go to the local Vietnamese shopping area where he is banned from. This leads to repeat incarcerations. His typically is arrested for Trespass which is a misdemeanor and leads to him being incarcerated. He goes to the GDC and the court orders him to be evaluated for a 19.2-169.1 Motion. The court psychiatrist meets with the inmate and determines that he is unable to stand trial and reports his/her findings back to the court. The court orders a 19.2-169.1 motion and forwards the order to our Transportation Section Supervisor. Our Transportation Section Supervisor notifies Western State Hospital and faxes a copy of the order. Western or Central State Hospital then assigns the inmate to the waiting list. The wait time to facilitate a transfer of an inmate to Western State Hospital or Central State Hospital is between 3-6 weeks if not longer. The inmate is transported to Western or Central State Hospital stabilized and then returned back to the ACDF. The inmate returns to court and is often given a time served sentence. The mentally ill inmate often spends more time in the jail and the criminal justice system then a non mental health inmate charged with the same offense.

Example #2: A Male who is diagnosed with Major Depressive Disorder and Borderline Personality Disorder comes into the jail on a number of charges related to drug use. He is an active heroin addict who was extremely high when he was incarcerated. He became suicidal and was placed in the crisis cell. Attempted to do a forensic TDO to Western but he would not pass medical clearance as he was HIV+ and had Hepatitis C. We had to manage him in the jail over the weekend. We were able to stabilize him without hospitalization.

Example #3: A Paraplegic male is incarcerated after an attempted "death by cop." He is actively suicidal throughout his detainment. He has Major Depressive Disorder as well as ongoing medical needs to include basic hygiene, bed turning and movement assistance. He attempted to kill himself many times during his incarceration. **He was given s state sentence and later committed suicide while serving his sentence at the DOC.**

We have not had much success at placing people in state facilities in emergency situations. One of the common issues is that they do not want to take anyone who is not medically cleared. When we take individuals to Virginia Hospital Center for a medical clearance the inmate often refuses to get vitals and such done so that he/she can be medically cleared. The state facility is then hesitant to take the person because they are "not a stand alone medical facility" and they would have to hospitalize the person if need be. Jails are not stand alone medical

facilities either. Again, the locality then foots the medical bills (and often the charges are for minor offenses).

Sheriffs play a key role in the Temporary Detention Order (TDO) Process

Each month we average 57 civil transports for those with SMI.

The shortage of psychiatric beds in our jurisdiction and the region present **huge** challenges and stress on Law Enforcement.

Deputies end up traveling thousands of miles transporting those with SMI across the state.

We conduct mental health civil commitment hearings on M,W, & F

I'd like to share these comments from our Lead Transportation Deputy:

The situations are always the same. The mental hearings are conducted. The Person is committed and there is no bed space. We wait for hours on bed space. Often due to various delays with the courts/medical clearance/locating a bed we spend much of our day waiting. Then have to leave Arlington as late as 5:00 p.m. to take mental patients to Rappahannock General Hospital in Kilmarnock, VA (2hrs 50 min one way, 140.49 miles one way without traffic) or Piedmont Geriatric Hospital in Amelia County (2 hrs 49 min one way, 161.25 miles one way). Often before you can get on the road down state you also have to make local stops to places like, Virginia Hospital Center, Dominion, Northern Virginia Mental Health Institute, Prince William and Snowden before beginning our journey to the long distance hospitals. The times are map quest estimates used to compile monthly reports and do not take in to consideration traffic.

We work very closely with our legislatures at appropriate times and constantly with our Community Services Board who we have a great partnership with.

For over two years the CSB Executive Director has chaired a monthly Mental Health Criminal Justice Committee with Judges, CA's Office, Sheriff, Police, Chief Magistrate, Dept. of Human Services, and Community Advocates exploring resources and alternatives. Thus far we have had two Forensic Case Managers funded by the State who work on jail diversion and links to services for those getting released. Our goal is ultimately to develop a Crisis Intervention Center (CIC) with collaboration from all of the above. There is a lack of funding for the CIC, but we continue forward with components of the overall program. New police officers have been trained in recognizing SMI and jail diversion.

Currently we are working on funding for and developing a Sequential Intercept Model for a Post Booking Magistrate Program to divert non violent SMI inmates to treatment.

Other ACDF initiatives include:

- ACDF is being considered to host the American Jail Association class "managing mental health inmates in your jail" in June of 2009.
- Established peer support groups for MH patients through NAMI.
- All new deputies and current special management unit deputies go through management training specific to the population they supervise.
- 8 deps/supervisors who work with the mental health inmates have gone through the new Crisis Intervention Team (CIT) training to recognize and work with the special management inmates. Program offered through DHS. Though since we are not the primary LE agency in Arlington it is not uncommon for PD to make an arrest hence brining individuals to the ACDF so that they do not have to deal with the TDO process (I can't blame them but it puts the burden on me).
- We are currently looking into the TOMAR program – a program that is very successful in Maryland that provides mental health, substance abuse, and trauma treatment for men and women in jail. This was a presentation at the governor's consortium on mental health. (Free training) – 15 week program. Contact – Dr. Joan Gilece @ 703-739-9333

At this point – we are unable to determine the impact of laws passed in July. But, there has been no impact to date in dealing with TDO's and 169 motions due to the lack of MH beds available in Northern Virginia.

19.2-169.1. raising question of competency to stand trial or plead; evaluation and determination of competency.

A. Raising competency issue; appointment of evaluators. - If, at any time after the attorney for the defendant has been retained or appointed and before the end of trial, the court finds, upon hearing evidence or representations of counsel for the defendant or the attorney for the Commonwealth, that there is probable cause to believe that the defendant, whether a juvenile transferred pursuant to § 16.1-269.1 or adult, lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense, the court shall order that a competency evaluation be performed by at least one psychiatrist or clinical psychologist who is qualified by training and experience in forensic evaluation.

B. Location of evaluation. - The evaluation shall be performed on an outpatient basis at a mental health facility or in jail unless the court specifically finds that outpatient

evaluation services are unavailable or unless the results of outpatient evaluation indicate that hospitalization of the defendant for evaluation on competency is necessary. If the court finds that hospitalization is necessary, the court, under authority of this subsection, may order the defendant sent to a hospital designated by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services as appropriate for evaluations of persons under criminal charge. The defendant shall be hospitalized for such time as the director of the hospital deems necessary to perform an adequate evaluation of the defendant's competency, but not to exceed 30 days from the date of admission to the hospital.

C. Provision of information to evaluators. - The court shall require the attorney for the Commonwealth to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) a copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant, and the judge ordering the evaluation; (iii) information about the alleged crime; and (iv) a summary of the reasons for the evaluation request. The court shall require the attorney for the defendant to provide any available psychiatric records and other information that is deemed relevant. The court shall require that information be provided to the evaluator within 96 hours of the issuance of the court order pursuant to this section.

D. The competency report. - Upon completion of the evaluation, the evaluators shall promptly submit a report in writing to the court and the attorneys of record concerning (i) the defendant's capacity to understand the proceedings against him; (ii) his ability to assist his attorney; and (iii) his need for treatment in the event he is found incompetent but restorable, or incompetent for the foreseeable future. No statements of the defendant relating to the time period of the alleged offense shall be included in the report.

E. The competency determination. - After receiving the report described in subsection D, the court shall promptly determine whether the defendant is competent to stand trial. A hearing on the defendant's competency is not required unless one is requested by the attorney for the Commonwealth or the attorney for the defendant, or unless the court has reasonable cause to believe the defendant will be hospitalized under § 19.2-169.2. If a hearing is held, the party alleging that the defendant is incompetent shall bear the burden of proving by a preponderance of the evidence the defendant's incompetency. The defendant shall have the right to notice of the hearing, the right to counsel at the hearing and the right to personally participate in and introduce evidence at the hearing.

The fact that the defendant claims to be unable to remember the time period surrounding the alleged offense shall not, by itself, bar a finding of competency if the defendant otherwise understands the charges against him and can assist in his defense. Nor shall the fact that the defendant is under the influence of medication bar a finding of competency if the defendant is able to understand the charges against him and assist in his defense while medicated.

(1982, c. 653; 1983, c. 373; 1985, c. 307; 2003, c. 735; 2007, c. 781.)