



Behavioral health services in jails

2026

Commission draft

Commonwealth of Virginia
October 6, 2026

Behavioral Health Commission

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Purpose

The Commission is established in the legislative branch of state government for the purpose of studying and making recommendations for the improvement of behavioral health services and the behavioral health service system in the Commonwealth to encourage the adoption of policies to increase the quality and availability of and ensure access to the full continuum of high-quality, effective, and efficient behavioral health services for all persons in the Commonwealth. In carrying out its purpose, the Commission shall provide ongoing oversight of behavioral health services and the behavioral health service system in the Commonwealth, including monitoring and evaluation of established programs, services, and delivery and payment structures and implementation of new services and initiatives in the Commonwealth and development of recommendations for improving such programs, services, structures, and implementation.

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1 Background

In December 2024, the Behavioral Health Commission (BHC) directed staff to study mental health and substance use services in local and regional jails. BHC staff were directed to identify the behavioral health services and treatment provided in Virginia jails; review proposed minimum standards for behavioral health treatment in jails; examine barriers to providing services; and provide options and recommendations for addressing barriers to the treatment of inmates with serious mental illness.

To complete this study, BHC staff conducted interviews with state agency personnel responsible for the support and oversight of jails; visited five local and regional jails across Virginia and interviewed jail officers, jail administrators, and jail mental health staff; reviewed the research literature and reports on jail mental health and substance use services; surveyed inmates currently incarcerated in four local and regional jails; collected data on mental health and substance use from jails; and analyzed administrative data from state agencies (Appendix A).

Virginia jails are locally operated with some state oversight

Virginia's jail system is fundamentally local, but the state plays a role in funding and overseeing it. The state's local and regional jails are run at the local level and hold a shifting mix of local, state, and federal inmates at every stage of the legal process. This differs from prisons, which are operated and governed by a single state agency, the Department of Corrections (DOC), and hold only convicted inmates who have been sentenced to serve their time in state custody. No single state agency governs jails; instead, oversight and support are divided among several, chiefly the Board of Local and Regional Jails, which sets standards and inspects facilities, and the Compensation Board, which provides the state's share of funding.

Jails are operated at the local level

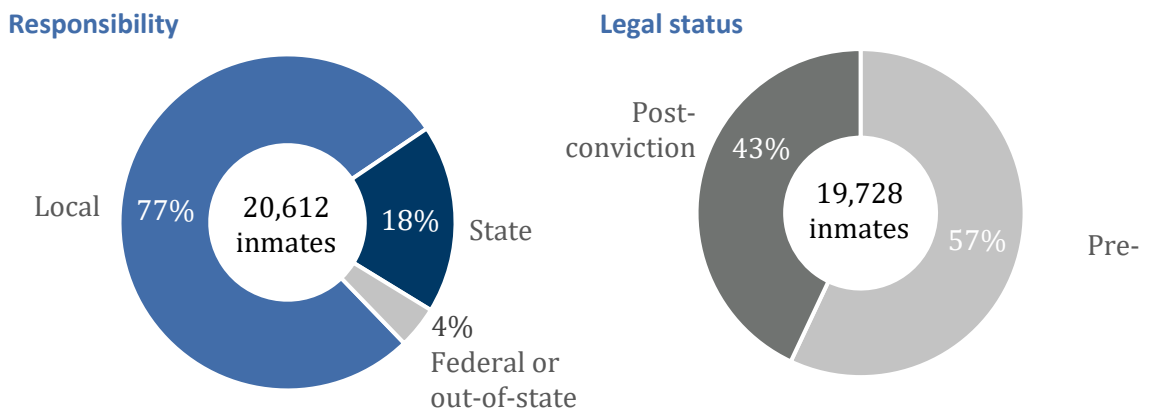
Virginia's 57 local and regional jails are operated locally (Appendix E). These include 31 local jails, which serve one specific city or county. Local jails are run by a sheriff, or by a jail administrator the sheriff hires. There are also 26 regional jails, which are either a substitute for local jails or a supplement. Regional jails are typically formed by three or more localities and are governed by a board that includes those localities' sheriffs and other stakeholders; a superintendent hired by the board oversees day-to-day operations. The 57 jails operate 66 facilities, because some run multiple locations — Southwestern Virginia Regional Jail, for example, has sites in Abingdon, Duffield, Haysi, and Tazewell. The Commonwealth also has 13 lock-ups, temporary holding spaces used to detain people briefly before transfer to a jail or prison.

Jails house more than local inmates

The jail population is transient, comprising local, state, and federal inmates at various stages of the legal process. In 2025, 57 percent of Virginia jail inmates were pretrial and 43 percent were post-conviction (Figure 1-1). Most (77 percent) were locally responsible, meaning they were awaiting trial or serving a sentence of less than one year; 18 percent were state responsible, having received a sentence of a year or more, and in most cases were awaiting transfer to a DOC facility. About four percent were federal or out-of-state inmates, who are excluded from the Compensation Board statistics used elsewhere in this report.

Figure 1-1

Jail population is made up of local, state, and federal inmates at various stages of the legal process (FY25)



Source: BHC staff analysis of data from *Mental Illness in Jails Report* (Compensation Board, 2025)

Multiple state agencies are involved in jail oversight and support

No single state agency governs Virginia's jails. Most state functions are split between two agencies. The Board of Local and Regional Jails (BLRJ) handles most standards and oversight: it develops operational standards, minimum health care standards, and regulatory governance for jails; inspects jails; and reviews deaths in custody.

The Compensation Board is responsible for providing jails with funding for the state's share of jail operating costs, including some jail employees' salaries, certain programs and services, and per diem payments based on the number of inmates. To administer the per diem funding, it maintains the Local Inmate Data System (LIDS) database, which tracks individuals entering and exiting jails. The Compensation Board also publishes an annual report, *Mental Illness in Jails*, which provides data on mental health and substance use diagnoses and services in jails, based on self-reported data from jails.

Two other agencies have narrower roles. The Department of Criminal Justice Services (DCJS) sets compulsory minimum training standards for deputy sheriffs and jail officers and administers behavioral health grant programs for jails. The Virginia Department of Health inspects jail facilities for health compliance.

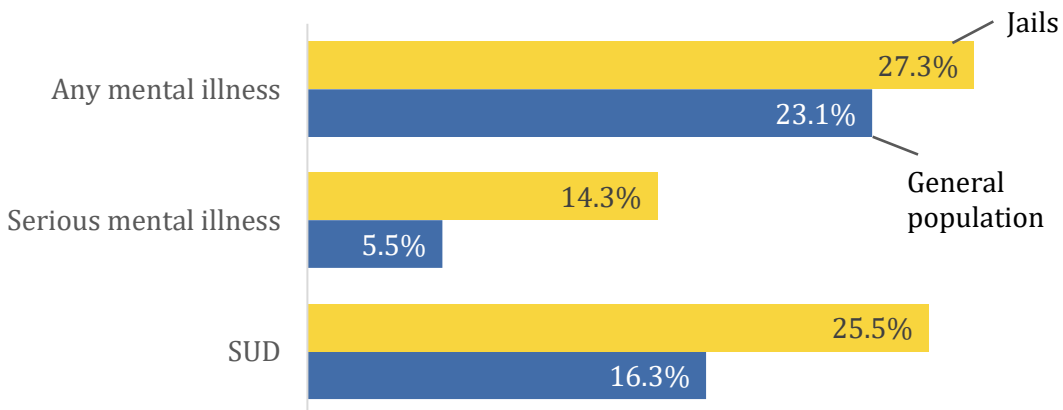
Jail inmates experience disproportionately high rates of mental illness and substance use disorders

Jail inmates have greater behavioral health needs than the general public. In any given year, 20 to 30 percent of Virginia jail inmates have a mental illness, and a comparable share have a substance use disorder (SUD). Jail administrators report this population has grown over time.

Incarcerated individuals experience serious mental illness and substance use disorders at higher rates than the general population

People in jail have behavioral health needs at higher rates than the general population. In the general population, about 23 percent of adult Virginians had a mental illness and 5.5 percent had a serious mental illness (SMI) in 2023-2024, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) (Figure 1-2). Virginia jails reported higher rates during that period: over 27 percent of the jail population was estimated to have a mental illness and 14 percent to have SMI, about 2.6 times the rate in the Virginia general population, based on surveys of jails conducted by the Compensation Board in 2023 and 2024 for its annual *Mental Illness in Jails* report. The rate of substance abuse estimated in jails was also significantly higher than in the general population, about 26 percent in jails compared to 16 percent among the Virginia population as a whole.

Figure 1-2
Prevalence of mental illness and substance abuse is higher in Virginia jails than in the state's general population (2023-2024)



Note: "Serious mental illness" is defined by symptoms and functional impairment by SAMHSA, and by diagnosis by the Compensation Board. Mental illness and substance use disorders are reported by individuals in data from SAMHSA, and by jails on behalf of inmates in data from the Compensation Board. Source: BHC staff analysis of data from the 2023-2024 National Survey on Drug Use and Health (NSDUH) state estimates by the Substance Abuse and Mental Health Services Administration), and the 2023 and 2024 *Mental Illness in Jails Report* by the Compensation Board

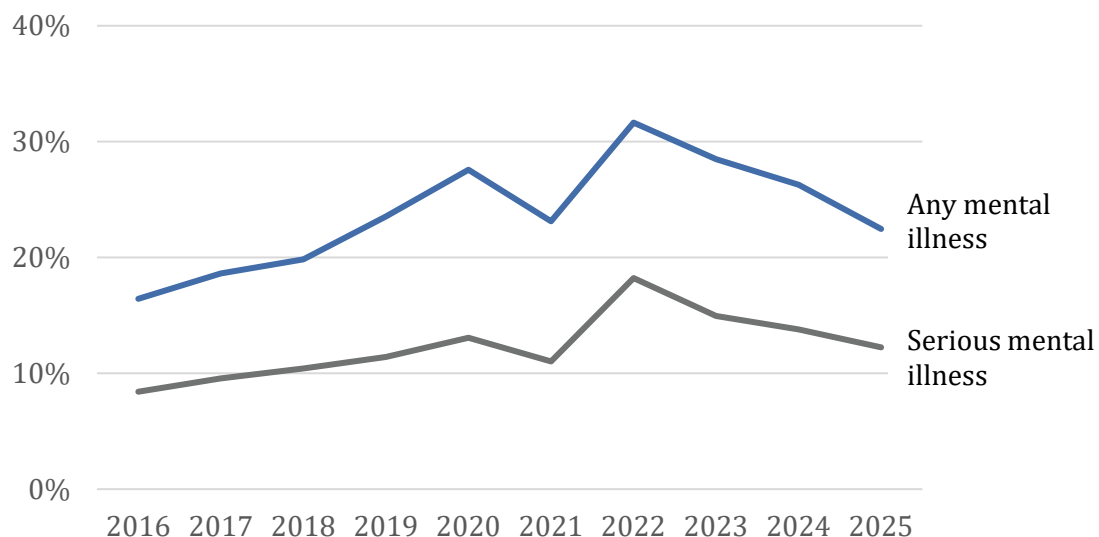
There are important methodological limitations that make comparisons challenging between jail and community rates of behavioral health conditions, and these rates should be viewed

as directional trends rather than precise estimates. SAMHSA defines serious mental illness using symptoms and functional impairment, whereas the Compensation Board uses diagnosis. The jail figures are also self-reported and depend on each jail's screening and diagnosis practices, so they may understate actual need. Older national data suggests the true rates of mental illness and SUD may be considerably higher than those reported by jails: the Bureau of Justice Statistics found in 2006 that 64 percent of local jail inmates showed symptoms of mental illness, and in 2009 that 63 percent of sentenced jail inmates met criteria for drug abuse or dependence.

Jail staff perceive an increase in mental illness among inmates

Jail staff have noticed more mental health needs in their jails, and the prevalence of mental illness in jails is higher than a decade ago. Jail administrators consistently reported in interviews that mental illness has become more common in their facilities, with some jail staff stating that they feel as though most people entering the jail have mental health needs. Data from Virginia jails partially supports the perceived increase in mental illness. Overall rates of mental illness among jail inmates rose from about 16 percent in 2016 to 22 percent in 2025 (Figure 1-3). Rates of serious mental illness followed a similar pattern, although they shifted upward in 2025. The Compensation Board's counts include people who jail staff suspect of having a mental illness but who have not received a formal diagnosis, so these numbers may partly reflect changes in jails' screening practices, staff training, or turnover rather than in actual prevalence. The sharp movements around 2020 to 2022 also coincide with pandemic-related changes in jail populations.

Figure 1-3
Rate of mental illness in jails has grown in the past decade



Source: BHC staff analysis of data from *Mental Illness in Jails Report* (Compensation Board, 2016-2025)

State hospital bed crisis may be increasing the number of inmates with mental illness

State agency staff, jail administrators, and other stakeholders expressed concern that an increasing number of people in crisis reach jail rather than treatment. Several identified the problem as the shortage of state psychiatric hospital beds. Jail staff at multiple facilities described the bed shortage leading to jailing of people in crisis. One administrator recounted that when state hospitals closed to new admissions during the pandemic, law enforcement began arresting people who met criteria for a temporary detention order (TDO) rather than pursuing hospitalization, and the practice did not fully reverse after the state hospitals reopened. Others described officers waiting days in a hospital with a person awaiting a bed and eventually arresting that person on a minor charge rather than continuing to wait.

Lack of treatment for mental illness and substance use in jails can lead to negative outcomes for inmates and staff

Untreated mental illness and substance use disorders in jails harm both inmates and staff. Untreated mental illness raises the risk that a person is placed in administrative segregation or an isolation cell, which can cause further decompensation and contribute to suicidality. Staff at multiple jails told BHC staff that they see people with mental illness decompensate quickly once placed in isolation. Suicide is a leading cause of death in jails nationally, and research has found that incarcerated people die by suicide at far higher rates than people in the community. Between 2000 and 2019, suicide accounted for 24 to 35 percent of deaths among local jail inmates in the United States. BLRJ reports that in 2025, there were ten completed suicides in Virginia jails.

Lack of treatment can also impair a person's recovery after release. Psychosis, a symptom of schizophrenia, bipolar I, and schizoaffective disorder, is one example: research has found that untreated episodes of psychosis can permanently worsen a person's mental illness and reduce the chance of full remission. Time in jail can also sever a person's relationships with community mental health providers, and released inmates may face waitlists to resume community care.

Untreated substance withdrawal carries its own risks. Research has found that methamphetamine withdrawal is associated with severe depression and anxiety, particularly in the first one to two weeks, and that people are at heightened risk of overdose and suicide after stopping opioid use. The overdose risk continues after release: drug tolerance falls during incarceration, so a dose a person previously tolerated can become fatal. Research on medication for opioid use disorder (MOUD) in jails has found that it significantly reduces the risk of fatal overdose and may lower recidivism.

Untreated behavioral health conditions also affect jail staff and operations. Unmanaged symptoms destabilize the jail environment, behavioral health crises demand additional staff time — such as one-to-one coverage for inmates on suicide watch—and jails face legal liability for failing to provide prompt treatment and for inmate suicides.

A patchwork of legal requirements governs behavioral health care in jails

Behavioral health care in Virginia's jails is governed by a mix of constitutional, statutory, and regulatory requirements, but few of them specify what care jails must actually provide. Inmates have a constitutional right to adequate care for serious medical and mental health needs, and several sections of the Code of Virginia address behavioral health in jails. Yet the state regulations that jails are inspected against require little beyond screening new inmates, and the comprehensive standards the General Assembly required in 2019 have not been established in regulations.

U.S. Constitution requires jails to provide mental health care

Inmates have a constitutional right to health care, including mental health care. In *Estelle v. Gamble* (1976), the U.S. Supreme Court held that deliberate indifference to an inmate's serious medical needs violates the Eighth Amendment's prohibition on cruel and unusual punishment. A year later, in *Bowring v. Godwin* (1977), a federal appeals court found no meaningful distinction between the right to care for physical and care for psychological conditions, extending *Estelle's* guarantee to psychiatric care.

That constitutional right is subject to certain conditions. Under *Bowring*, it applies when a provider, exercising ordinary skill, concludes with reasonable certainty that an inmate's symptoms reflect a serious condition, that the condition is treatable, and that delay or denial of care would cause substantial harm. The right extends only to care that is medically necessary, not merely desirable, and that can be provided at reasonable cost. Neither *Estelle* nor *Bowring* defined what specific conditions amount to deliberate indifference to mental health needs, and no federal law or regulation sets standards for mental health care in local jails.

Estelle and *Bowring* arose under the Eighth Amendment, which applies to convicted prisoners rather than pretrial detainees. However, pretrial detainees (who account for the majority of Virginia's jail population) hold an equivalent right to medical and mental health care under the Fourteenth Amendment's Due Process Clause.

Several sections of the Code address behavioral health in jails

Section 53.1-68(C), established in 2019, requires BLRJ to establish minimum behavioral health standards for jails—covering the provision of behavioral health services, screening and assessment, and discharge planning—along with procedures to enforce them, with advice from the Department of Behavioral Health and Developmental Services (DBHDS) and the State Inspector General. However, these standards have not been established in law through the regulatory process as of September 2026 (see Chapter 5). The Board convened a workgroup in 2019, which produced a report recommending 15 minimum behavioral health standards for jails and estimating their fiscal impact (Appendix C). Between June and November 2020, BLRJ considered the 15 behavioral health standards recommended by the 2019 workgroup report and the associated compliance indicators, which specify how a jail will demonstrate it is meeting a given standard. In November of 2020, BLRJ voted to move

forward with 14 of the 15 workgroup-recommended behavioral health standards. However, the standards approved by the Board have no legal standing, because they have not gone through the regulatory process.

Section 53.1-133.03 permits the sharing of inmates' medical and mental health records under certain circumstances, including with hospitals and Community Services Boards (CSBs) for treatment. Section 53.1-133.04 allows a jail to petition a court for an order to treat a person who is incapable of giving consent. Section 19.2-169.6 governs the admission of a jail inmate to a state psychiatric hospital for treatment.

Few regulations reference behavioral health care

BLRJ staff conduct inspections and audits of jails based on regulations found in the Virginia Administrative Code (VAC). There are currently five VAC “Life, Health, and Safety” standards that explicitly reference behavioral health (Table 1-1). These “Life, Health, and Safety” standards are separate from the minimum behavioral health standards required by §53.1-68, and none of them require jails to provide any behavioral healthcare or any specific programs or actions, other than the required screening of incoming inmates. BLRJ is currently working on an update of the VAC “Life, Health, and Safety” standards that will include changes to some of these standards. More information on the current jail standards related to behavioral health can be found in Appendix D.

Jails may also voluntarily seek accreditation from a third party, such as the National Commission on Correctional Health Care (NCCHC) or the American Correctional Association (ACA); these certify that a jail meets a certain standard for its health care (NCCHC), operations (ACA), or both (ACA).

Some other states require behavioral health care in their jails

Some states have set minimum behavioral health standards for their jails. California requires its Board of State and Community Corrections to develop regulations for minimum mental health care in jails that meet or exceed NCCHC standards in six areas, including mental health training for jail officers and mental health screenings. Colorado created a temporary Jail Standards Commission in 2022 to recommend standards for county jails, including mental health standards; county jails were required to comply beginning July 1, 2026. Neither state explicitly requires discharge planning for inmates with mental illness, though Colorado funds a program that connects released inmates to community care. Texas and Ohio also have some behavioral health standards for their jails.

Resources for behavioral health treatment in jails come from multiple sources

Behavioral health care in jails is funded through several layers: local dollars, a state staffing allocation, and a variety of state and federal grants. Jails generally pay for behavioral health services, treatment, and medication out of local funds, though at jails with a strong CSB relationship, the CSB may cover some or all medication costs.

Table 1-1

Virginia regulations contain five “Life, Health, and Safety” jail standards that address behavioral health

Administrative

Code section Relevant language

6VAC15-40-360	Twenty-Four Hour Emergency Medical Care – Written policy, procedure, and practice shall provide 24-hour emergency medical and <i>mental health care</i> availability.
6VAC15-40-370	Receiving and Medical Screening of Inmates – Written policy, procedure, and practice shall provide that receiving and medical screening be performed on all inmates upon admission at the facility. The medical screening shall...Specify screening for current symptoms regarding the inmate's <i>mental health</i> , dental problems, allergies, present medications, special dietary requirements, and symptoms of venereal disease...Include inquiry into <i>past and present drug and alcohol abuse, mental health status, depression, suicidal tendencies</i> , and skin condition.
6VAC15-40-420	Transfer of Summaries of Medical Record – Medical record summaries shall be transferred to the same facility to which the inmate is being transferred. Required information shall include: vital signs, current medications, current medical/dental problems, <i>mental health screening, mental health problems</i> [...]
6VAC15-40-450	Suicide Prevention and Intervention Plan – There shall be a written <i>suicide prevention and intervention</i> plan. These procedures shall be reviewed and documented by an appropriate medical or <i>mental health authority</i> prior to implementation and every three years thereafter. These procedures shall be reviewed every 12 months by staff having contact with inmates. Such reviews shall be documented.
6VAC15-40-1010	Mental Health Inmates – Written policy, procedure, and practice shall specify the handling of mental health inmates, including a current agreement to utilize <i>mental health services</i> from either a private contractor or the community services board

Source: BHC staff analysis of the Virginia Administrative Code

The state contributes a dedicated staffing allocation. Beginning in the 2022-2024 biennium, approximately \$6.9 million per year has been allocated to the Compensation Board for the purpose of hiring up to 125 behavioral health case managers (BHCMS). The Compensation Board publishes a yearly report on the BHCM positions that have been allocated and filled as a part of their *Mental Illness in Jails* report. However, there are methodological constraints that make this data difficult to interpret (See Chapter 4).

Table 1-2

Several major state and federal grant programs fund behavioral health services at some Virginia jails

Grant program	Description	Funding (2026)
DCJS-administered		
Jail Mental Health Pilot Program (JMHP)	Funds mental health programming in five jails. Grantees may be funded for no more than two years and must plan to sustain operations afterward.	\$2.1 million / year (General Fund)
Virginia Opioid Use Reduction and Substance Use Disorder Treatment and Transition Program (JSUT)	Funds jail-based substance use programs to expand access to SUD treatment and transitional services for jail inmates in 15 jails. Grantees have used the funds to pay for peer support specialist coverage, medications for opioid use disorder (MOUD), programming, Narcan, drug testing supplies, and counseling services.	\$1 million in 2026 Appropriation Act (Commonwealth Opioid Abatement and Remediation Fund)
Residential Substance Abuse Treatment Program (RSAT)	Federal program that funds evidence-based residential treatment and/or MOUD in five to six jails.	n/a
DBHDS-administered		
Forensic Discharge Planning (FDP) grant	Funds discharge planning services for mentally ill inmates at 29 jail sites. Funding is distributed through CSBs, and FDP programs are required to provide ongoing discharge planning services to inmates for a minimum of 30 days post-release.	\$3.7 million / year (General Fund)

Source: BHC staff analysis of information from DCJS and DBHDS

Beyond these funding streams, several major state and federal grant programs fund behavioral health services at some Virginia jails (Table 1-2). Each program reaches only a subset of jails, and the programs differ in how much funding they provide, which agency administers them, and what services they cover. Some grants flow through state agencies, while others are awarded directly to jails or localities. Other federal grants are available to jails, but there is no central repository that lists their recipients. For example, the Fairfax County Sheriff's Office has received funding through the High Intensity Drug Trafficking Area grant (White House Office of National Drug Control Policy) that supports two staffing positions.

Virginia has previously studied mental health in jails

Virginia has examined behavioral health in its jails for decades, and relevant findings and recommendations were considered for this report. In 1984, the Department of Mental Health and Mental Retardation— now DBHDS — and the Department of Corrections convened the Joint Task Force on the Mentally Ill in Virginia's Jails to assess mental health needs and services in jails and recommend improvements. The task force issued a report in October 1984 with 19 recommendations. Some have been implemented, such as a paperless Emergency Custody Order for law enforcement. Others have not been implemented, but remain relevant today, including increased mental health training for jail officers, revision of the statute governing jail TDOs, and post-release follow-up for people with behavioral health conditions.

In 2014, the Office of the State Inspector General (OSIG) published “A Review of Mental Health Services in Local and Regional Jails.” The report observed that jails lacked the capacity to meet demand for mental health services and that jails were designed to maximize safety as opposed to creating an environment that promotes recovery from mental illness. Some of OSIG’s 19 recommendations have been implemented—such as the creation of a forensic discharge planning program—while others remain unimplemented.

In 2018, two bills — SB 878 and HB 1487 — would have required behavioral health standards in jails. Neither passed, but they prompted DBHDS to convene a workgroup, which recommended 14 standards. Similar standards were subsequently recommended by the 2019 workgroup convened by BLRJ. DCJS published a report in 2021—“Estimated Costs of Meeting Minimum Standards for Mental and Behavioral Health Services in Virginia Jails”—on the estimated cost of meeting the minimum behavioral health standards in jails recommended by the BLRJ workgroup. The report could not provide specific estimates but laid the groundwork for future cost estimation and made several related recommendations for supporting the proposed minimum standards, such as the creation of funding for behavioral health case managers in jails (see Chapter 4).

2 Behavioral health care in Virginia jails

Jails are responsible for the behavioral health of a population with disproportionately high rates of mental illness and substance use disorder. Although every jail provides some level of care, the type and availability of services vary widely from one jail to the next and even within a single facility. Medication is the most commonly provided form of treatment, especially for serious mental illness. Jails report that they try to maintain all inmates on existing prescriptions, but that does not always occur. Counseling is available in most jails, but it is provided to a minority of inmates with a mental illness or substance use disorder (SUD), and it is limited to less than one hour per month in the majority of facilities, well below the standard of care in the community. Counseling also tends to be focused on crisis management rather than the longer-term therapy available in the community. Special programs for mental health and/or substance use are available in some jails, but participation is often limited to a subset of inmates. Jail size and fiscal conditions appear to be key drivers of access to services.

Access, type, and duration of behavioral health treatment vary significantly between jails

The services a person receives in jail can affect whether they are able to stabilize or whether they deteriorate; however, the types of behavioral health treatment available in Virginia jails and the extent to which inmates can access needed services vary significantly across jails, and sometimes within a single jail. Jails offer some mix of medication, counseling, and group programs that are delivered by jail staff, the local Community Services Board (CSB), or private contractors. Some jails also maintain separate mental health housing units, and these units can range from genuinely therapeutic environments to environments that function like administrative segregation.

The services available in a jail and the capacity of specific programs affects the proportion of inmates who can access behavioral health services. The amount of treatment an inmate receives ranges, with some inmates receiving no treatment at all and others receiving several hours of treatment a month. An inmate's ability to access behavioral health services can also depend on factors unrelated to clinical need, such as whether an inmate qualifies for a particular program or, in some regional jails, which locality they lived in before arrest.

Behavioral health treatment in jails includes both mental health services and substance use services. Across both mental health and substance use services, jails provide a narrower set of services than a person would typically receive outside a correctional setting. Medication is the most widely used form of mental health services in jails and is sometimes supplemented by counseling that is often brief and focused on crisis management. Substance use services in jails rely more on group-based treatment, including peer meetings such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) and psychoeducational classes.

Jails use a mix of staff to provide behavioral health services

Jail treatment can be provided by a variety of health care personnel. Most jails (80 percent) had access to a psychiatrist to prescribe medications and nearly half (47 percent) used a medical doctor (MD) either exclusively or to supplement their psychiatrist, based on responses from the 51 jails that participated in the 2025 survey administered by the Compensation Board for its annual *Mental Illness in Jails* report. Most jails (92 percent) also used non-MD staff to provide treatment. Providers' credentials and licensing vary, though Qualified Mental Health Professionals (QMHPs) deliver much of the services in jails.

Jails can provide behavioral health treatment with their own staff or through contracts and MOUs with CSBs or private providers. Nearly half of jails relied on CSBs for the majority of the treatment hours provided to inmates, while 28 percent used their own staff, and 24 percent used contract staff. Many jails (about two-thirds) also supplemented the treatment provided by their staff or contractors with CSB staff.

Mental health services mostly consist of medication and some counseling

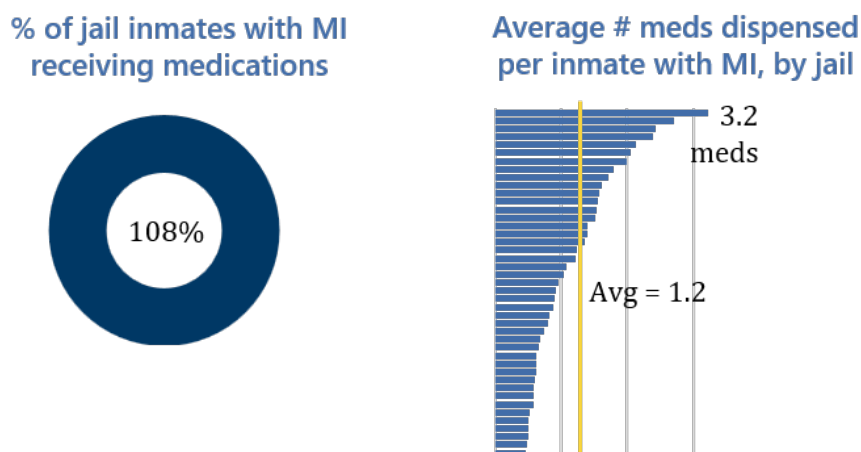
Mental health services in jails consist primarily of medication and counseling. Medication is the first-line preventive treatment, especially for serious mental illness, and it is the most widely used form of mental health treatment in jails. Counselors also use individual and group sessions to de-escalate a current or imminent crisis or to build practical skills, such as anger management or grief coping strategies. About half of inmates with a mental illness received individual counseling but the duration of this service was relatively short, based on information from the 2025 *Mental Illness in Jails* report. A small proportion of inmates also received group counseling and other forms of treatment for mental health, and these treatments were offered for similarly short periods of time compared to what they would have received in the community. The proportion of inmates who received services and the duration of services varied significantly between jails.

Jails commonly provide medication for mental illness, but the amount of medication provided varies across jails

Psychotropic medications are commonly prescribed in jails. About 19 percent of all inmates in Virginia jails were prescribed a psychotropic medication, in line with the number of inmates diagnosed with or suspected of having a mental illness. Limited data was available to analyze medication patterns except for the total number of medications dispensed in each jail. On average, 1.2 medications were dispensed per inmate with a mental illness. However, the ratio of medications to mentally ill inmates was below 1:1 in nearly half of jails, indicating that not all inmates with a mental illness received medication (Figure 2-1).

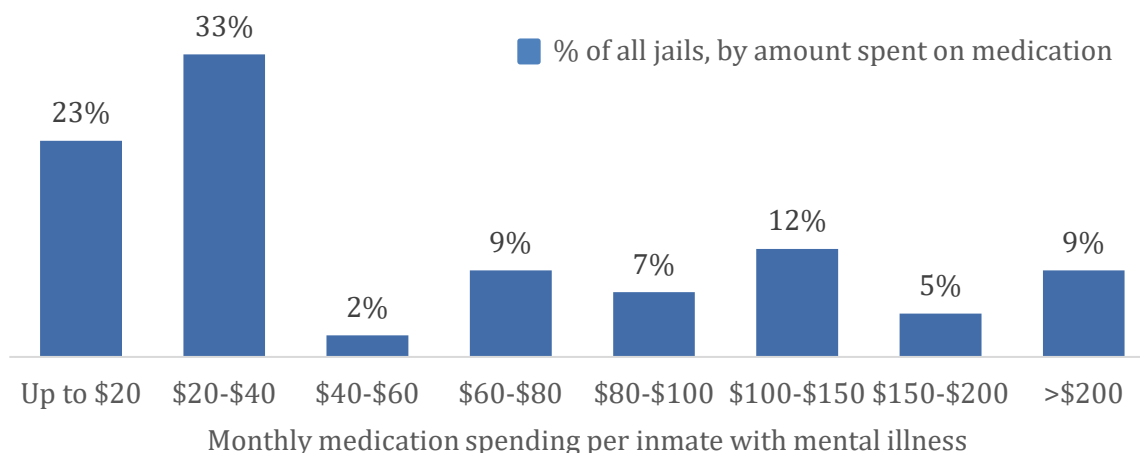
Medication made up 17 percent of jail mental health spending on average in 2025. Statewide, jails reported spending \$6.6 million on psychotropic medications; this equates to approximately \$65 a month per jail inmate with a mental illness, on average, across all jails. However, spending on psychotropic medication varied significantly between jails. The majority of jails (56 percent) spent less than \$40 a month per jail inmate with a mental illness, and nine percent spent more than \$200 (Figure 2-2). Jails that use long-acting injectable (LAI) antipsychotic medications can have much higher monthly costs (see Chapter 4).

Figure 2-1
Access to medication varies by jail (June 2025)



Note: N=43 jails provided usable information about medications and inmates with a mental illness.
Source: BHC staff analysis of data from 2025 *Mental Illness in Jails Report* (Compensation Board)

Figure 2-2
Majority of jails spent under \$40/month on medication per mentally ill inmate (2025)



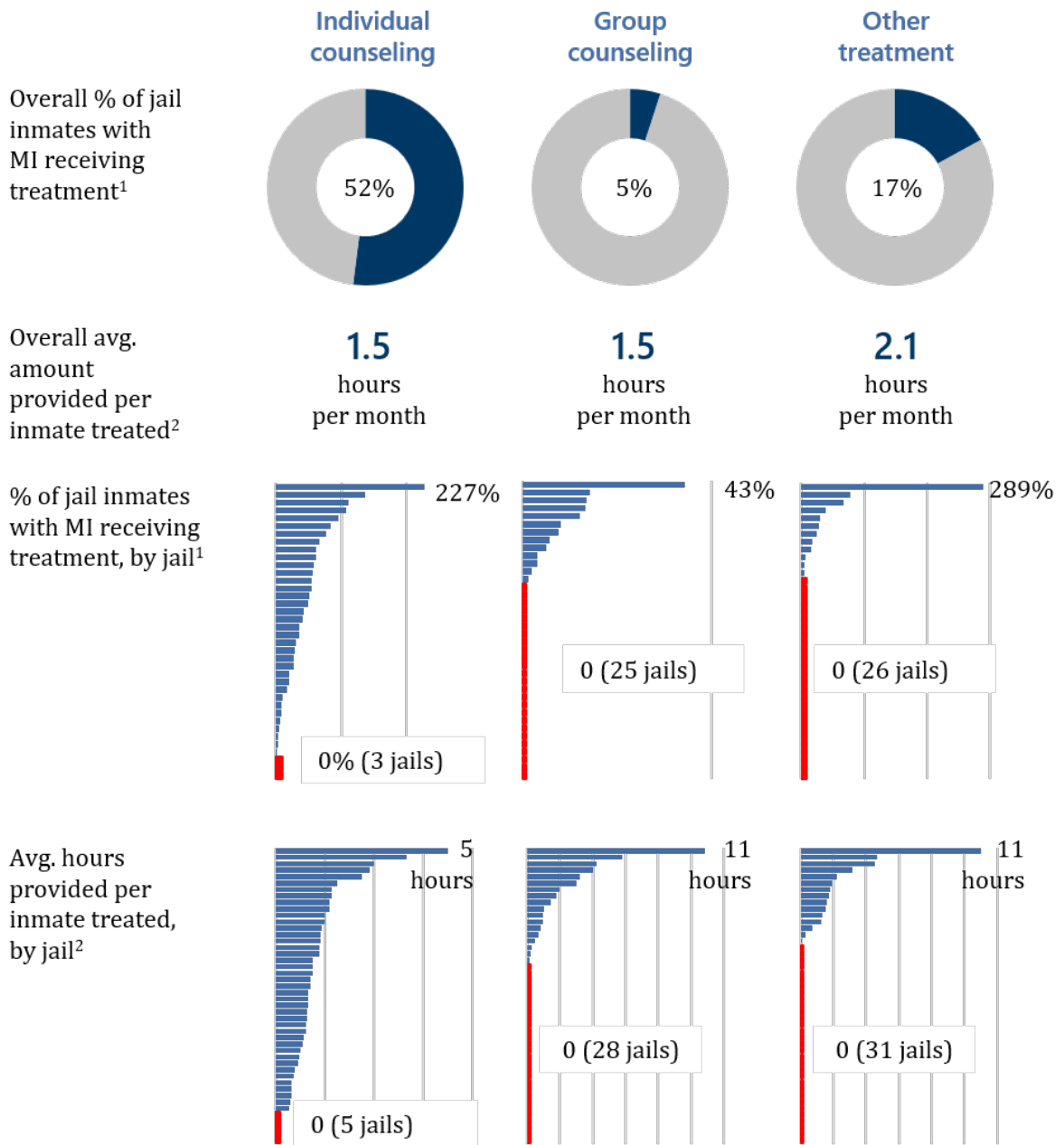
Note: N= 43 jails provided usable information about inmates with a mental illness.
Source: BHC staff analysis of data from 2025 *Mental Illness in Jails Report* (Compensation Board)

Counseling services in jail are time-limited and target specific needs

Many jails also provide counseling, though access to counseling, its duration, and intensity vary considerably across jails. About half (52 percent) of jail inmates with a mental illness received individual counseling and about five percent received group counseling overall, with significant variation among jails (Figure 2-3).

Figure 2-3

Access to mental health counseling and duration vary by type of treatment and by jail (June 2025)



¹N=46 jails reported information on types of treatment provided and number of inmates treated

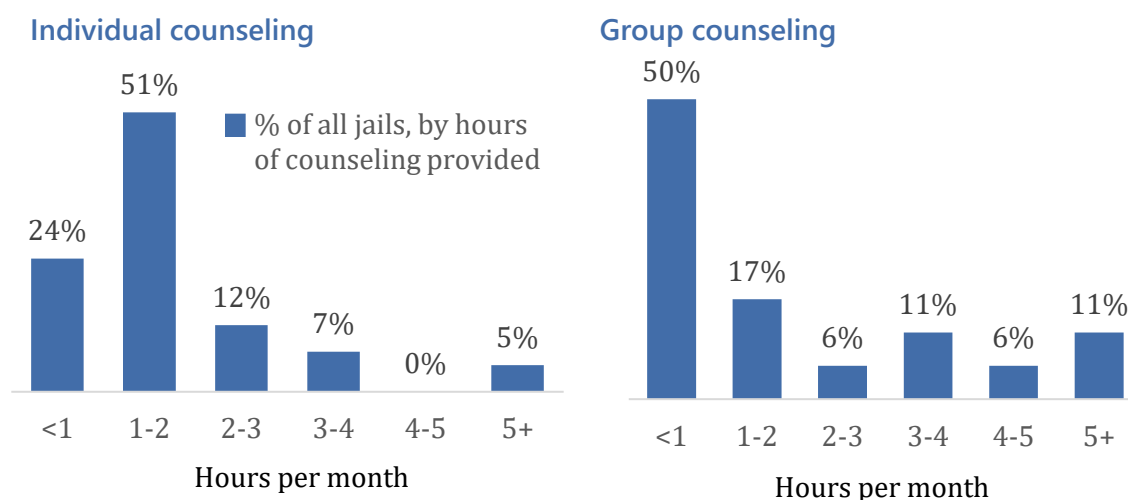
²N=38 jails provided usable information about inmates with a mental illness, types of treatment provided, and number of inmates treated

Note: "Other treatment" includes all other types of individual or group mental health treatment identified by jail respondents.

Source: BHC staff analysis of data from 2025 Mental Illness in Jails Report (Compensation Board)

When inmates do receive counseling, it tends to be for a relatively short duration. On average, inmates received 1.5 hours per month of individual counseling or group counseling, according to data from the June 2025 Compensation Board survey. This is much less than what might be received in the community, where the typical standard for someone with mental illness is one to two outpatient sessions per week, or roughly three to eight hours per month. Hours of treatment per mentally ill inmate varied significantly from jail to jail. Nearly a quarter of jails provided less than one hour of individual counseling per month, and another 51 percent provided between one and two hours (Figure 2-4). In interviews with jail mental health staff during site visits, some said they met with inmates for more than 30 minutes at a time, but others described a five-minute check-in. As CSB staff at one jail put it, "we treat jail as surviving, not thriving; we're not going to unpack deep trauma while [an inmate is] here."

Figure 2-4
Majority of jails provided counseling for less than two hours per month (June 2025)



Note: N=46 jails reported information on types of treatment provided and number of inmates treated.
Source: BHC staff analysis of data from *2025 Mental Illness in Jails Report* (Compensation Board)

Counseling is not typically available to inmates 24-7, and inmates may not always be able to receive mental health care when they need it. Many jails visited for this study reported that mental health staff worked only typical business hours: roughly 9 a.m. to 5 p.m., Monday through Friday. Nursing staff are available around the clock to fill the gaps, but nurses do not always have the training or expertise to respond to a behavioral health emergency, and some functions of mental health staff — such as removing a person from suicide watch — cannot be performed by anyone other than mental health staff.

Limited mental health availability may also lead to wait times for counseling services. In a 2026 BHC staff survey of inmates administered in four Virginia jails, inmates who had requested an appointment with mental health staff reported waiting a median of 3.5 weeks to be seen, and some inmates said that they had waited upwards of six months for services.

"Mental health units" range from therapeutic to functionally restrictive

Mental health housing units are sometimes available, but their therapeutic quality varies. A housing unit is a section of a jail where inmates live together—often in a pod or a dormitory—and a mental health housing unit is a unit specifically for people with mental health needs. Forty percent of jails reported maintaining a mental health housing unit separate from the general population, based on the 2025 Compensation Board survey. No consistent definition or set of requirements governs these units, however, so jails use them for different purposes and to different effects.

At the more therapeutic end, some units provide environmental supports such as calming paint colors and dimmable lighting, and inmates may have greater access to supportive programming and behavioral health staff. Conversely, mental health units can also be functionally identical to administrative segregation, where inmates are confined to their cells for most of the day with little contact or activity. In practice, this high level of restriction effectively subjects individuals to solitary conditions. A substantial body of research links solitary confinement and prolonged isolation to worsening mental health, including intensified symptoms and decompensation among people with mental illness.

In a 2014 report on mental health in jails, the Office of the Inspector General recommended that the Board of Corrections (now the Board of Local and Regional Jails) "work with the jails that operate mental health units to identify standards for such units, including staff training and availability of treatment." However, no such standards have been developed.

Case study

At one jail visited for this study, mental health staff said their units were "not really therapeutic" and "set up more like an administrative segregation unit" with inmates allowed only 1.5 hours per day out of their cells. Jail staff attributed the restriction to understaffing rather than the clinical design of the mental health housing unit (see Chapter 3). Another jail ran four mental health units at varying levels of acuity: the lowest-acuity unit offered some additional therapy and programming, while the highest-acuity unit functioned as administrative segregation, confining inmates to their cells 23 hours per day, though mental health supervisors made daily rounds there.

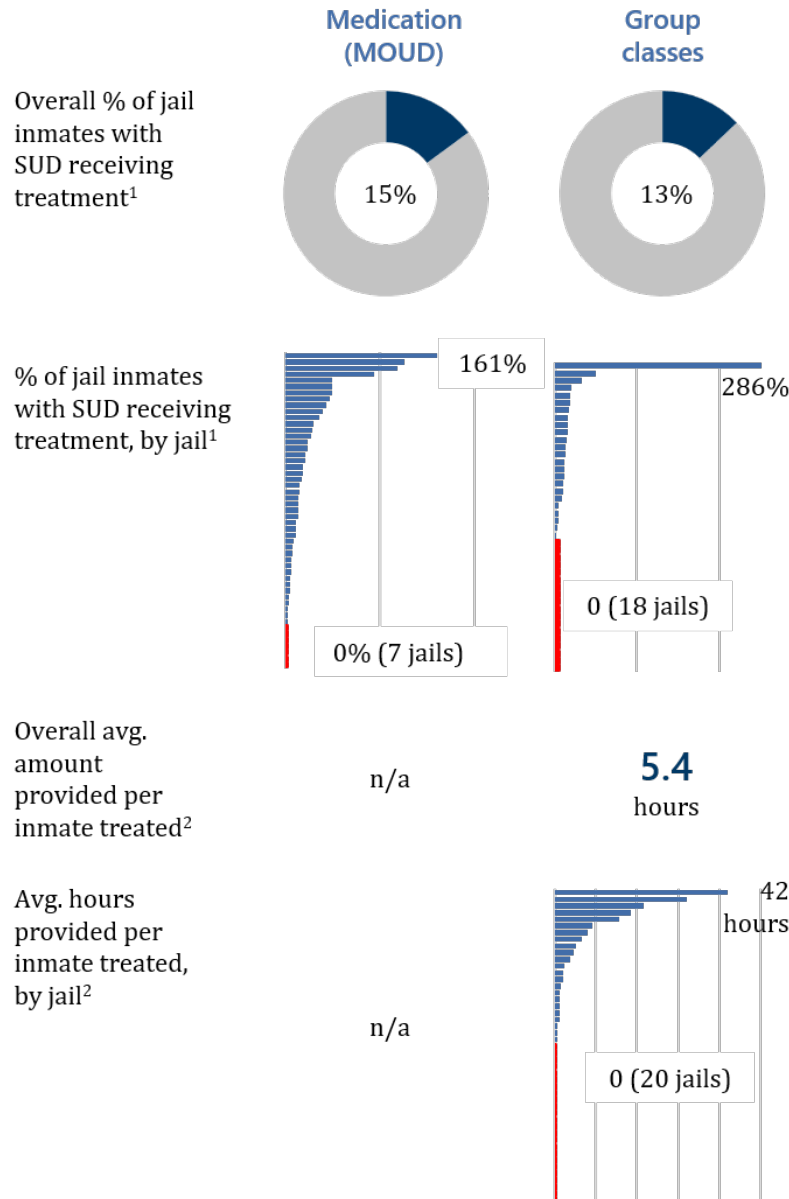
Substance use services include several forms of treatment

SUD treatment in jails generally consists of medications for opioid use disorder (MOUD), group substance use classes, and AA/NA meetings. About 13 percent of all inmates with SUD took part in a class, and participants were in class for an average of five hours a month in June 2025 (Figure 2-5). Most jails also offer MOUD, but not to every inmate who might benefit. In June 2026, about 15 percent of inmates with SUD received MOUD, though the number treated ranged widely between jails (Figure 2-5). In most jails visited for this study, inmates could access MOUD only if they held a prescription before incarceration. This practice, called "continuation," prioritizes inmates who would lose access to opioid treatment they were already prescribed over initiating treatment. Cost is a factor in these decisions: an administrator at one jail told BHC staff, "if we treated everyone on [MOUD], we wouldn't be able to afford insulin." AA or NA recovery groups held meetings in about two-thirds (66

percent) of jails in June 2026. About one-third of jails (36 percent) also had recovery housing units, separate units for inmates working toward recovery from substance use, where residents are expected to stay free of drugs and alcohol and may receive additional supports.

Figure 2-5

Access to substance use treatment was limited overall, with significant variation



¹N=51 jails reported information on MOUD provided and number of inmates with SUD, June 2026

²Group classes: N=46 jails provided information about group substance abuse counseling and number of inmates treated, June 2025

³Group classes: N=43 jails provided information about group substance abuse counseling and number of inmates with SUDs, June 2025

Source: BHC staff analysis of data from 2025 *Mental Illness in Jails Report* (Compensation Board); 2026 BHC/Compensation Board survey of jails

Jails may also offer other kinds of support when an inmate shows signs of withdrawal, as drug and alcohol withdrawal is a risk factor for inmate suicide. Nearly all jails (98 percent) that responded to the 2026 Compensation Board survey said they had written protocols for managing withdrawal from alcohol or other substances, and all but one of them said the protocol includes medical supervision during detoxification. However, those protocols may not always be strictly followed; only 27 percent of inmates who had detoxed from drugs or alcohol while in jail said they had received assistance from jail medical staff when experiencing detox, according to a 2026 BHC staff survey of inmates administered in four Virginia jails. Another 58 percent said that they had not received medical assistance, and the rest were unsure or declined to answer.

Variation in behavioral health treatment is driven partly by jail size and local fiscal conditions

A variety of internal and external factors shape the availability, type, and intensity of behavioral health treatment provided to inmates in local and regional jails. Many of those factors are hard to quantify, such as local priorities, building infrastructure, and recruiting challenges. Those are explored in greater detail in Chapters 3 and 4 of this report. Among the factors that can be analyzed, jail size and local fiscal conditions appear to be the most strongly associated with treatment overall. Larger jails and those located in areas with low fiscal stress spend more on behavioral health treatment and tend to provide treatment to a larger share of inmates who need these services. The experience of inmates can also vary even within a single jail, especially when jails have developed mental health or substance use programs that are available only to a subset of their populations.

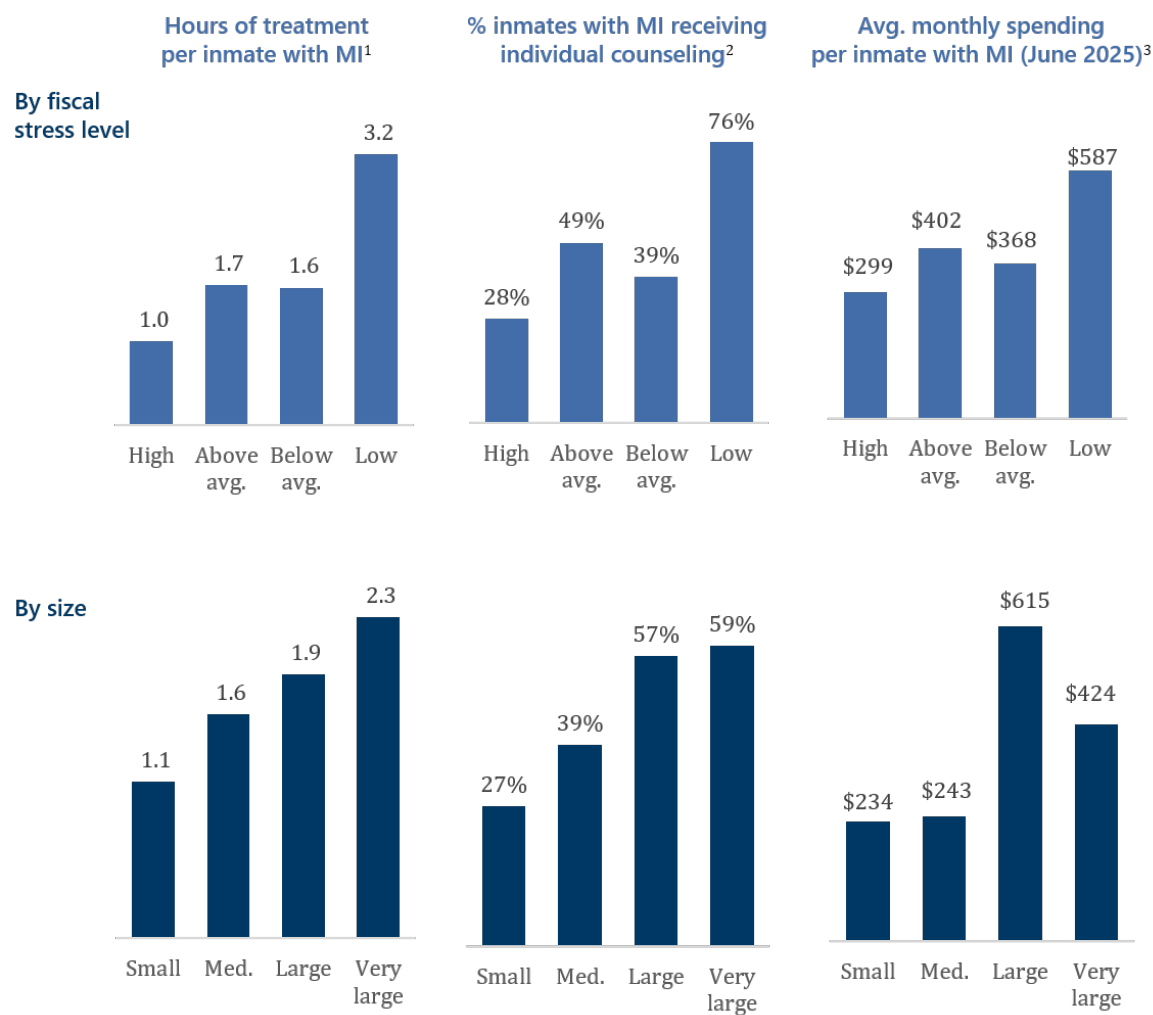
Behavioral health treatment varies based on jail size and local fiscal conditions

Access to behavioral health services and the types and intensity of treatment available vary depending upon the size of a jail and the fiscal condition of its feeder localities. As one Hampton Roads administrator put it, "it's an economic thing — areas with good tax revenue, where there's community expectation of services in jails, get more." For example, Fairfax Adult Detention Center had 23 full-time CSB behavioral health staff in summer 2026 while Northern Neck Regional Jail had three full-time behavioral health staff and one part-time staff—despite having a similar average daily population.

Larger jails generally spend more per inmate with a mental illness than their smaller counterparts (Figure 2-6). Larger jails also provide more hours of treatment to inmates with a mental illness, on average, and provide individual counseling to a larger share of inmates with a mental illness. Larger jails also rely less heavily on MDs, who may have limited behavioral health training or specialization, to treat inmates; MDs accounted for about two percent of all behavioral health treatment provided in large jails, compared to 15 percent in small jails.

Figure 2-6

Access to behavioral health care varies depending upon jail size and local fiscal conditions



¹N=46 jails reported information on types of treatment provided and number of inmates treated

²N=38 jails provided usable information about inmates with a mental illness, types of treatment provided, and number of inmates treated

³N= 42 jails provided usable information about inmates with a mental illness and spending on medication and services

Note: Jail size categories are based on quartiles using 2024-2025 jail average daily population (ADP) — Small <100, Medium 100-249, Large 250-499, Very large 500+; Fiscal stress categories from FY 2023 Fiscal Stress report.

Source: BHC staff analysis of data from *2025 Mental Illness in Jails Report* (Compensation Board); FY 2023 Fiscal Stress Index (Council on Local Government)

Local fiscal conditions also appear to play a role in the availability and amount of behavioral health services provided to jail inmates. The differences are especially pronounced among localities at both ends of the spectrum—those with either a very high or very low level of fiscal stress. Fiscal stress measures how much room a locality has to raise more local revenue,

based on its tax base, how heavily it already taxes that base, and its residents' incomes. Jails in less fiscally stressed areas spend more per inmate with a mental illness, compared to jails in more fiscally stressed areas; they tend to provide more hours of treatment to mentally ill inmates, and provide individual counseling to a larger share of their mentally ill population. Jails in less fiscally stressed areas also spend a smaller proportion of their mental health budget on medications compared to other forms of treatment; jails in localities with low fiscal stress spent five percent of their total mental health budget on medications, compared to 44 percent among jails in localities with high fiscal stress.

Services vary even within a single jail

Even within a single jail, behavioral health services are not always equally available to all inmates. Two things drive this internal variation: program eligibility and, in regional jails, an inmate's home locality. Jails that rely on grant-funded or opt-in programs with eligibility criteria may provide a higher level of care to inmates in those programs than to other inmates with behavioral health concerns. Some jails, for example, have SUD recovery units where residents receive additional counseling, AA/NA meetings, and career training that inmates with SUD outside the unit cannot access. Access can also depend on where an inmate lived before arrest. In regional jails staffed by CSB clinicians, services may hinge on which catchment area the inmate came from. For example, one regional jail visited for this study spans two CSB catchment areas: one CSB has staff on site serving inmates from its own area, while inmates from the second CSB's area receive limited services because that CSB has assigned no staff to the jail.

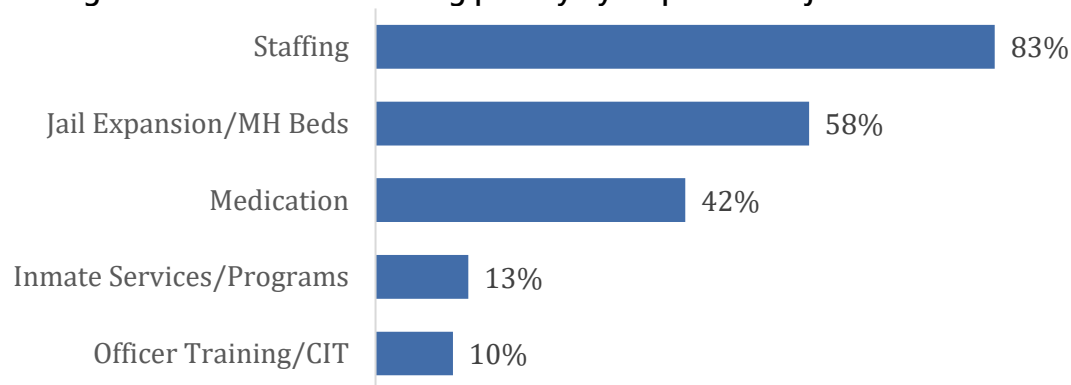
3 Constraints of the jail environment

Jails were not designed to deliver behavioral health care, and their environment shapes what care is possible. Some of these constraints are resource-driven as jails across Virginia struggle to hire and keep the behavioral health and security staff that are necessary for care. The jail setting itself also limits the kinds of therapy that can be provided and strains the relationship between security and clinical staff, whose priorities can conflict. The transient nature of the jail population and the lack of communication between courts and jails also makes it hard to plan for care after release. Other constraints emerge when clinical staff are stretched thin and employ tools, such as isolation and suicide watch, which can worsen the crises they are used to manage.

Insufficient and undertrained staff limit behavioral health care in jails

Most jails do not have sufficient clinical staff to provide and supervise behavioral health services, or security staff to keep inmates safe during treatment. In the 2025 Compensation Board (SCB) survey, most jails (83 percent) named staffing as one of their top priorities if state funding became available for their mentally ill population, more than any other need (Figure 3-1). Shortages of both behavioral health and security staff limit how much behavioral health care jails can offer. Having too few behavioral health clinicians restricts what services exist and how much care any inmate can access, and having too few jail officers means sessions cannot be staffed or supervised. Shortages and gaps in training among security officers can exacerbate crises, and untrained officer contact with inmates could worsen a crisis.

Figure 3-1
Staffing was identified as a funding priority by 83 percent of jails



Source: BHC staff analysis of data from 2025 *Mental Illness in Jails Report* (Compensation Board)

Ability to recruit and retain behavioral health staff limits the care jails can provide

Jail staff interviewed for this study consistently reported having insufficient behavioral health staff to serve their inmate population or meet their behavioral health needs. The availability of behavioral health personnel directly impacts what a jail can offer and how much care any one inmate can access. For example, one jail visited for this study had only two mental health staff for 600 inmates. Other behavioral health providers were present in the jail; however, these providers were dedicated to specific programs and housing units, leaving the two mental health staff to serve a large, high-acuity population. At that jail, individual counseling appointments are sometimes five minutes long so staff can see as many inmates as possible.

The shortage of behavioral health workers is statewide, but it is especially pronounced for jail-based services. Licensed clinicians are in high demand and can often find jobs that pay more and are safer than a jail. Recruitment and retention challenges affect jails that employ their own behavioral health staff, as well as Community Services Boards (CSBs) that deliver services in jails. As a superintendent of one regional jail put it, "even the CSBs can't find licensed clinicians — how can we?" Several jails told BHC staff they had ended or never started CSB programs because the CSB could not staff them.

Security staffing shortages affect the availability of behavioral health services

Security staffing shortages also limit behavioral health services. Jail officers (JOs) are the security staff who supervise inmates and control their movement within a jail. Most activities outside of a cell, including behavioral health sessions, require a JO to escort or monitor the inmate involved. When no jail officer is available to transport an inmate to a counselor's office or supervise a psychoeducational class, the session cannot happen. For example, behavioral health staff at one large jail said they would like to run group therapy but were unable to due to a lack of JOs; the same jail stopped bringing Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings into the facility during COVID-19 and has not been able to restart them, in part because of staffing. Jails are the most understaffed of any law enforcement category, according to Department of Criminal Justice Services (DCJS) staff, and jail administrators said they struggle to offer competitive salaries — a workforce challenge tied to how jail staffing is funded.

Jail culture can exacerbate tensions among staff and with inmates, but training helps reduce conflict

Jail culture can strain the relationship between behavioral health staff and security staff, whose roles pull toward different goals—individual treatment versus facility security. Behavioral health staff and JOs may interpret the same behavior differently, with clinical staff seeing a symptom that calls for treatment and JOs seeing actions that threaten safety and require a security response. Because security staff control inmate movement and daily operations, their reading of behaviors may determine what happens with the inmate even when behavioral health treatment is needed. An officer without mental health training, for

example, may treat a crisis as a disciplinary problem rather than a clinical emergency, a gap that can actively endanger the inmate.

Case study

Inmates placed on suicide watch must be monitored at all times, so in some jails, an officer sits one-on-one with the inmate in crisis, sometimes for an extended period. During a BHC site visit to a jail, behavioral health staff recounted that earlier the same day, an officer assigned to an inmate on suicide watch had been "egging him on" to self-harm, and the inmate's crisis de-escalated only once the officer was moved away. Clinical staff said that JOs at that facility needed training in crisis de-escalation, identifying the signs and symptoms of mental illness, and understanding how the jail's mental health system operates.

Training and regular, intentional communication between behavioral health staff and JOs appear to help reduce conflict and improve the relationships between all staff in a jail. Many jails already provide mental health training to officers. In the 2025 *Mental Illness in Jails* report, SCB noted that 38 of 49 reporting jails (78 percent) provide mental health training to new recruits, and 35 of 49 jails (71 percent) require additional mental health training annually.

Case study

Behavioral health staff at one jail that has invested in officer training told BHC staff that the facility's culture has improved over time, which they attributed to training, education, and more communication. Several jails said they sustain positive relationships between behavioral health and security staff through regular meetings on the needs of high-acuity inmates.

DCJS has developed revised jail officer training standards that expand required training related to mental health, substance use disorders, and de-escalation. The revised basic training standards are being incorporated into 6VAC20-50, which is currently in the Final Stage of the regulatory process and has been under review by the Secretary of Public Safety and Homeland Security since January 2026.

Separately, proposed amendments to 6VAC20-30 would require jail officers, as part of their 24 hours of required in-service training, to complete two hours of training on working with individuals with disabilities, mental health needs, or substance use disorders and eight hours on the lawful use of force and de-escalation techniques, including a minimum of four hours dedicated to practical exercises. The proposed amendments to 6VAC20-30 have completed review by the Secretary of Public Safety and Homeland Security and are currently awaiting review by the Governor's Office.

RECOMMENDATION 1

The Secretary of Public Safety and Homeland Security should complete their review of 6 VAC 20-50 as part of the regulatory process no later than December 1, 2026.

Jail environments constrain the ability to perform traditional treatment modalities

Even when a jail has the funding, staffing, and willingness to provide behavioral health treatment, the jail environment itself limits which therapies are appropriate. Traditional therapy relies on a stable relationship between practitioner and patient and on the patient's own agency, both of which are constrained in a jail. Because these conditions are inherent to the jail setting rather than a matter of resources, they limit what behavioral health treatment in jails can realistically accomplish, regardless of funding or staffing.

Approaches that depend on sustained vulnerability, such as processing trauma, are also generally not feasible. More contained, skills-based techniques may fit the jail setting better. Clinicians at two jails described building Cognitive Behavioral Therapy (CBT) skills into brief check-ins or giving inmates CBT and Dialectical Behavior Therapy workbooks to use on their own. However, when these techniques are used in jails, they may be delivered without the regular sessions and continuity that make them most effective.

Practitioners also hesitate to address deeper root causes through therapy in a jail setting, because the vulnerability therapy requires can be difficult or harmful for a patient who then returns to a housing unit, and high caseloads make it difficult to develop the relationships needed to perform traditional therapy with inmates. Therapy that surfaces trauma or painful emotions can destabilize a person and heighten distress in the short term, and a housing unit's lack of privacy, constant supervision, and potential for conflict provides little opportunity to process or recover. As one licensed practitioner put it, "the hardest thing for me...was knowing I couldn't use my therapy skills with inmates. You can't ask people to do a deep dive into trauma and then send them back to gen[eral] pop[ulation]."

The mismatch of the jail environment with traditional treatment methods also extends to some medication, especially medication for opioid use disorders like Suboxone, which are frequently diverted by inmates. Diversion — an inmate selling or distributing their own medication to others — was a concern raised by many of the jail staff BHC interviewed. Staff at one jail explained that an inmate who has built up a tolerance to Suboxone can skip doses without withdrawal, leaving extra medication to sell. Jails use various methods to prevent this, such as crushing tablets into water before dispensing or using injectable formulations. These precautions make dispensing slow: staff at one jail reported that dispensing a single inmate's dose can take up to 20 minutes.

Discharge planning for behavioral health can be challenging, exacerbated by unplanned court releases

Jails cannot do effective discharge planning for many inmates with behavioral health needs, because the timing of their release is often unpredictable and many jails lack staff dedicated to the task. Discharge planning — arranging follow-up appointments, medication refills, and Medicaid re-enrollment before release — is one of the most effective tools jails have for continuity of care. Research links discharge planning to greater engagement in treatment after release, and CSB staff interviewed for this study indicated it is among their best tools for

preventing recidivism. Without a discharge plan, people may leave jail with no scheduled follow-up for treatment, no medication refills, and often no Medicaid coverage, raising the risk that they disengage from treatment and return to jail—or suffer other effects of lack of treatment, such as mental health decompensation or overdose.

Jails house inmates who are at different stages of the criminal justice process, which impacts how long they stay in jail and how predictable their release date is. Inmates who are awaiting their trial or sentence represent the largest share of jail inmates (about two-thirds in June 2025), and their discharge date is the least predictable. These inmates may be released immediately if their case is dismissed or if they are sentenced to time served during their trial. Administrators at one jail said unplanned release is now more common than planned release, as people are increasingly released directly from court, often late in the evening, after building up enough jail credit to be released at a hearing. State-responsible inmates (about 18 percent of jail inmates in June 2025) can be transferred to a Department of Corrections facility with little to no notice, according to jail staff interviewed for this study. Local-responsible inmates who are serving their sentence in the jail have the most predictable release dates; however, they account for a minority of inmates (10 percent in June 2025).

Community conditions compound the challenge of discharge planning. Many inmates lack nearby family, and homelessness and a lack of transportation can keep people from reaching appointments even when a plan exists. State agency staff described people being "cut loose" when their time is served — no discharge plan, no one to pick them up — leaving discharge planners scrambling when they learn someone is being released the next day.

One state program is designed to mitigate the challenges of unplanned court releases. The Department of Behavioral Health and Developmental Services (DBHDS) funds 23 forensic discharge planning (FDP) programs administered by CSBs, which operate across 29 jail sites. These programs identify people with serious mental illness while they are still in jail and provide case management on release (Exhibit 3-1). These programs received \$3.7 million, served 1,916 individuals, and successfully linked two-thirds of discharged participants to community behavioral health services in FY25. (The reasons given for not linking someone were: the individual declining services, not participating, or moving out of the jurisdiction.) Unplanned releases remain difficult even with a discharge planner, but FDP staff work to anticipate challenges by identifying inmates with discharge planning needs early and by communicating with inmates' defense counsel for insight into case timelines.

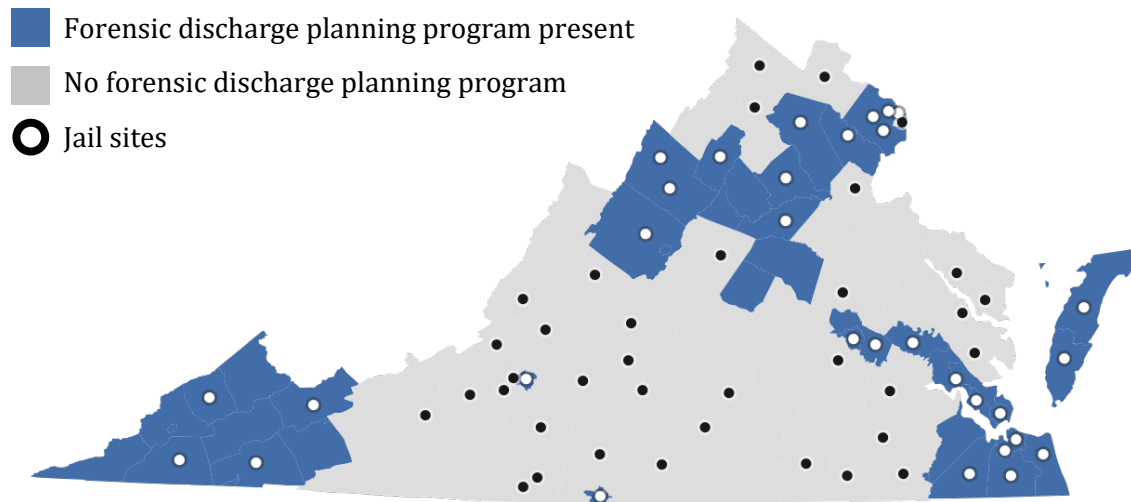
Under current law, discharge planning should be mandatory, but regulations that would prescribe what jails are required to do have not been issued by the Board of Local and Regional Jails. HB 1942 (2019) directed the Board of Corrections, now the Board of Local and Regional Jails, to establish minimum behavioral health standards for jails, including discharge-planning requirements. To date, the Board has not adopted regulations pertaining to discharge planning (see Chapter 5 for more information).

Many jails are not currently equipped to effectively conduct discharge planning and will struggle to meet discharge planning regulations, once those have been established. Jails that participate in the FDP program will be better prepared, and some may already be in compliance. Some jails that use state-funded behavioral health case managers (BHCMS) for discharge planning or participate in other grant programs with discharge-planning

requirements may also be better prepared or in compliance. However, only 19 percent of jails with a filled BHCM position reported that discharge planning was one of that role's duties in 2025, and jails without a dedicated discharge planner may struggle to comply, stretching existing staff even further.

Exhibit 3-1

Forensic Discharge Planning programs served 51 localities (29 jail sites) in Virginia in 2026



Created with Datawrapper

Source: BHC staff analysis of data from DBHDS

To facilitate broad compliance with statutory requirements and pending regulations, the General Assembly may wish to expand capacity for the FDP program. In addition to expanding the program to jails that do not currently participate, additional funding may be needed to fully meet the needs of jails that already participate.

OPTION 1

The General Assembly may wish to consider including additional funding in the 2027 Appropriation Act for the Department of Behavioral Health and Developmental Services to expand forensic discharge planning programs (i) to be implemented in jails that do not currently participate; and (ii) to serve additional inmates in jails that already participate in the program.

Suicide watch protects inmates in crisis but can harm their mental health

Jails rely on suicide watch to keep inmates in acute crisis safe, but its conditions can worsen the mental health of the people placed on it, and Virginia has no regulation requiring that they receive a mental health evaluation to monitor their condition and the need for continued

segregation. Suicide is a serious risk in jails: it was the single leading cause of death in U.S. jails, accounting for 31 percent of deaths in 2018, the most recent year for which data was available from the Bureau of Justice Statistics. In FY26, 71 percent of Virginia jails responding to a BHC/SCB survey reported at least one documented suicide attempt, of which six percent were fatal. When an inmate dies in custody, there is always an investigation—law enforcement and the Office of the Chief Medical Examiner lead the investigation, and the Board of Local and Regional Jails is responsible for examining whether the jail was compliant with regulations and took appropriate steps to escalate care. Jails also face significant liability risk after a death.

Suicide watch places an inmate in administrative segregation —defined in the Virginia Administrative Code as a separation from the general population in response to a serious threat to safety or facility order — with added restrictions. In the jails visited for this study, suicide watch usually takes a similar form: the inmate is held in a single cell, wearing a thin smock, under heightened supervision, either constant one-on-one observation or checks every 15 minutes. Some jails allow a sleeping mat and blanket; others provide nothing but the smock. Many suicide watch cells are lit around the clock with no way to dim the lights. Suicide watch is in some ways more restrictive than ordinary segregation since there is the additional deprivation of clothing, tablets, and personal items.

Used correctly, suicide watch is an important safety tool, but its conditions can harm the people it is meant to protect. Mental health staff at several jails visited for this study acknowledged the contradiction, explaining that the isolation and stress of suicide watch can deepen depression and worsen the conditions it is meant to address. It also limits treatment, because a provider may have to speak to the inmate through a heavy metal door.

Although regulations direct jails to have a suicide prevention and intervention plan in place, they currently provide little guidance on what those policies should contain. As a result, policies and procedures vary significantly from one jail to the next, which may lead to inmates in some jails being placed in isolation more frequently or for longer periods of time.

Case study

Two similarly sized jails visited for this study placed strikingly different numbers of inmates on suicide watch in June 2026 — 302 at one, six at the other — despite operating under nearly identical written policies. At both jails, any staff member can place an inmate on suicide watch, officers must complete suicide prevention training, and mental health staff use evidence-based or evidence-informed methods to assess suicidal ideation and intent. However, each jail sets its threshold for placing an inmate on suicide watch at different levels. One jail automatically places any inmate who refuses to engage during booking on a restricted status equivalent to suicide watch until they cooperate. In contrast, the other jail only places inmates assessed to be at genuine risk of suicide on watch.

Suicide watch is easy to start and hard to end. In many jails visited for this study, any staff member can place any inmate on watch, for a wide range of reasons — as staff at one jail put it, "if there's any safety concern at all... someone's dysphoric, acutely psychotic... they go on suicide watch." Usually, only mental health staff, or the jail physician in jails with no mental

health staff, can remove someone from suicide watch. Because mental health staff generally work weekday business hours, a person placed on watch on a Friday evening may remain in segregation until Monday, in some cases long after they are no longer suicidal.

Suicide watch and administrative segregation are blunt tools, and both are susceptible to overuse. In June 2026, jails reported placing 1,154 inmates on suicide watch during the month. In a 2026 BHC survey of inmates in four Virginia jails, a third of inmates who reported being placed in isolation said the reason was their mental health. One wrote, "I was suicidal called 911 sat in solitary for 7 days 4 without shower." Another said of their time in isolation, "It's an experience that can't be explained but makes you think of suicide makes you think of beating up the [jail officers] makes you think of escaping."

Some other states have recognized the detrimental effects that suicide watch can have on an inmate's mental health and built safeguards into their jail standards. Colorado's jail standards include a caution that "the restrictions of 'suicide watch' may exacerbate mental health conditions and heighten risk of suicide or self-harm. Property, privileges, and programming shall only be withheld based on an individual's mental health in the context of a short-term crisis intervention, unless such restriction has been ordered by a qualified medical or mental health professional[...]" Colorado also requires a mental health professional to assess all inmates in restrictive housing at least every 48 hours, and more frequently if possible, to determine whether there is an ongoing need for that placement. California requires that inmates placed in "safety cells" be reviewed for continued retention every four hours, and that a medical consultation on the inmate's retention in the safety cell happens within 12 hours of the inmate's placement there and every 24 hours thereafter. Virginia has no comparable regulation requiring that a person placed in isolation for mental health reasons receive care or evaluation.

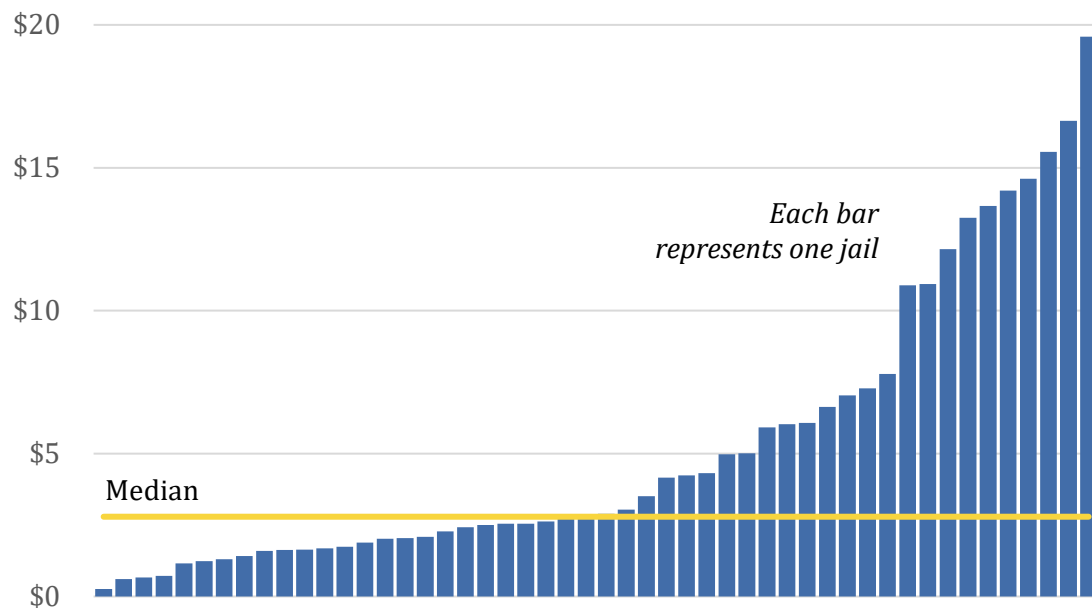
OPTION 2

The General Assembly may wish to consider directing the Board of Local and Regional Jails to promulgate regulations requiring that inmates who are placed on suicide watch or who are in administrative segregation for reasons related to mental health be evaluated by a medical or mental health provider within 12 hours of placement and at least every 24 hours thereafter by a mental health provider to determine whether there is an ongoing need for that placement. Regulations should be promulgated no later than the first day of the 2028 regular General Assembly session.

4 Resources and funding

The resources available to each jail have a direct impact on the behavioral health treatment they can offer to inmates. Because jails rely heavily on local government funding for behavioral health services and medication, community resources and priorities shape what can be provided, as described in Chapter 2, and each jail's mental health budget varies significantly (Figure 4-1). Medication is the most common form of treatment provided, and while jails report trying to maintain inmates on existing prescriptions, some facilities are not able to afford long-acting injectable medications that tend to be more effective in a jail environment. The General Assembly provides funding for some behavioral health positions, but those are not sufficient to support all inmates with behavioral health challenges. Although federal rules generally don't allow the use of Medicaid dollars to cover health services for incarcerated individuals, the state could pursue a reentry waiver to allow coverage of Medicaid state plan services, including behavioral health, for up to three months prior to release. When jails are unable to maintain the safety of inmates due to acute behavioral health crises, they can pursue emergency psychiatric hospitalizations in a state facility. However, the ability of jails to obtain an emergency placement appears to vary depending upon their relationship with their local Community Services Boards (CSBs), which acts as a gatekeeper. Pre-admission protocols could help reduce the variation in CSB practices.

Figure 4-1
Mental health spending per inmate, per day varies significantly among jails (2025)



Note: N=50 jails provided information on annual mental health expenditures.

Source: BHC staff analysis of data from 2025 *Mental Illness in Jails Report* (Compensation Board)

Medication is an essential mental health treatment option, but high costs strain jails

Jails struggle to afford some behavioral health medications, even though medication management is one of the primary tools for treating serious mental illness (SMI) in carceral settings, according to jail mental health staff and the research literature. It is also a major expense: jails spent an average of 28 percent of their mental health budgets on medication in 2025, according to the 2025 Mental Illness in Jails report. The amount each jail spends on medication varies greatly, from \$0.30 a month per inmate with mental illness in the Gloucester County jail to \$364 in the Roanoke City jail. Some jails, especially smaller and rural ones, struggle with the cost. As one rural jail told BHC staff, "our barrier with medications is that we have a very low budget. Expensive HIV and Hepatitis C meds trump expensive antipsychotics. We have \$500,000 [annually] for 900 inmates." At another rural jail, three of the four most expensive medications were behavioral health-related drugs; the fourth was for HIV.

Long-acting injectable (LAI) antipsychotics are among the most effective medications for serious mental illness, especially in carceral settings, and also among the most expensive, according to jails. Instead of a daily pill, an LAI is injected and releases medication over time, from two weeks to six months depending on the formulation. LAIs help ensure better adherence to medication compared to traditional pills, especially in jail settings, where "pill call" may take place at inconvenient times or while an inmate is asleep. LAIs can also help maintain inmates on their medication after they are released, acting as a bridge until the inmate can re-establish themselves with a community provider.

Nonadherence to medication is the greatest risk factor for relapse of psychosis and mania, and research has found that LAIs reduce nonadherence and are associated with significant reductions in suicide attempts and psychiatric hospitalizations for people with schizophrenia. LAIs cost far more than oral medications, in part because the extended-release delivery is more complex to manufacture; one administrator estimated their LAIs were 10 times the cost of a daily pill. When a jail cannot afford LAIs, inmates who arrive already stabilized on one, or who return to jail from a state hospital that started them on an LAI after an emergency psychiatric hospitalization, can lose that stability. This can lead to additional time in state hospitals, either for competency restoration or on a subsequent jail temporary detention order (TDO).

State entities have previously recommended implementing a state pharmacy contract to use the Commonwealth's purchasing power to secure lower medication prices for jails. A 2014 Office of the State Inspector General (OSIG) report recommended that the Board of Corrections work with stakeholders to determine whether a single pharmacy contract would be more cost-effective than current practice. A 2021 Department of Criminal Justice Services report likewise recommended state-negotiated contracts to lower the cost of behavioral health medications.

Jails in other states have used the federal 340B Drug Pricing Program as a way to reduce the cost of medications. 340B is a program of the Health Resources and Services Administration (HRSA) that requires drug manufacturers to provide pharmaceuticals to covered entities

(eligible health care organizations and other safety net providers) at significantly reduced prices. Under HRSA rules, jails may become 340B eligible through specific arrangements such as the Sexually Transmitted Disease Designation, for which the Virginia Department of Health is the primary grantee, or partnerships with covered entities, such as Federally Qualified Health Centers.

Several options exist to reduce the cost of behavioral health medications in jails, including a state pharmacy contract and 340B arrangements, and determining which best fits Virginia would require further study. The General Assembly may wish to establish a workgroup to explore strategies for jails to afford LAIs and to report back to the BHC with their findings and recommendations.

RECOMMENDATION 2

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Secretary of Health and Human Resources, with assistance from the Secretary of Public Safety, to convene a workgroup that includes the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services, and the Compensation Board to study how to lower the cost of psychotropic medications, medications for opioid use disorders, and long-acting injectable antipsychotics for jails and to present their recommendations to the Behavioral Health Commission by November 1, 2027.

State funding has helped jails hire more mental health staff but does not fully meet the need

Recent state funding for behavioral health staff has strengthened jails' behavioral health care, but exact uses of the funds are not fully tracked, and the need is not fully funded. Beginning in the 2023–2024 biennium, the Compensation Board has distributed funding for jails to hire behavioral health case managers (BHCs) and medical and treatment positions (PMED), reaching \$9.8 million per year in 2027–2028. Jail administrators have described this funding as extremely helpful for behavioral health services. But two challenges keep it from reaching its potential: the appropriation does not cover all the positions jails need, and the Compensation Board cannot tell how much of the funding is actually being used for behavioral health.

Current BHC funding is valuable to jails but covers a portion of the recommended positions

BHCs appear to be effective where jails have hired them, but current funding does not support all the positions needed to meet the staffing standard recommended by DCJS, and to provide closer monitoring of inmates who are on suicide watch. In a 2021 report, DCJS recommended a staffing standard of one full-time case manager for every 160 inmates, with at least one per jail — a ratio drawn from community behavioral health caseloads and the widely cited estimate that about half of inmates have a clinical need for mental or behavioral

health services. Applied across all local and regional jails, that standard would have required 249 case manager positions, based on the size of the jail population in 2019-2020. The General Assembly appropriated enough funding to support 125 case managers, or half the recommended level of positions.

Jails that filled the positions reported using them to add new services — reentry support, discharge planning, group counseling, and medications for opioid use disorder (MOUD) — and to improve existing ones, such as faster access to treatment and better continuity of care. Jail administrators praised the funding, calling it "a lifesaver" and "one of the best things we've seen happen."

Funding the remaining positions DCJS identified will be essential when the minimum behavioral health standards required by statute are established in law through regulations (see Chapter 5). A higher minimum allocation of BHCMS may also be necessary to provide additional monitoring to inmates on suicide watch, as recommended in Chapter 3. Smaller jails are currently allocated only one BHCM if their average inmate population is below 160, which typically limits the availability of behavioral health professionals to business hours on weekdays. To ensure inmates on suicide watch have access to a mental health professional at least every 24 hours, each jail should have at least two BHCM positions.

The size of the jail population has decreased significantly since 2021, and the estimated number of case managers needed to achieve the 1:160 staffing ratio with at least two BHCMS per jail is approximately 200—75 positions more than are currently funded but fewer than were originally recommended by DCJS. Better data on how jails use current funds (as discussed further in the next section) could also help target additional positions.

RECOMMENDATION 3

The General Assembly may wish to consider including additional funding in the 2027 Appropriation Act for the Compensation Board to allocate all behavioral health case manager positions needed to achieve the staffing standard of 1 case manager per 160 inmates recommended by the Department of Criminal Justice Services, with at least two case managers allocated to each jail. Language should also be included to specify that the funding can only be used for treatment, services, planning, and coordination related to behavioral health.

BHCM funding is not meaningfully tracked

Funding for BHCMS has helped jails expand behavioral health care, but the state does not have sufficient insight into how the money is used, and whether it is being used exclusively for behavioral health care. Currently, the Appropriation Act does not specify how unspent funding can be used by jails that do not fill all funded positions.

The Compensation Board distributes funding to jails and collects data on BHCM utilization through its annual survey of jails, but that data is limited. Jails are asked to report whether they have hired for the positions, and only about one-third had hired all the positions for which they received funding in 2025. Another 10 percent of responding jails had hired some of the positions, but it is not known how they used leftover funding from the vacancies, and

whether it was spent on behavioral health care. Most jails that had not filled any of their funded positions reported using at least some of the funds to contract out with a CSB or private provider—a use that meets the appropriation's intent. However, it is not clear how many contract positions are being funded, what portion of the funding is used to support them, and how any leftover funding might be used.

Additional clarity around the allowable uses of BHCM funding would help ensure state dollars are being used in line with legislative intent. One small rural jail told BHC staff that it had never hired for the position, partly out of confusion about what the funds could cover.

RECOMMENDATION 4

The Compensation Board should revise its annual survey, starting with the 2027 survey, to capture whether and how each jail is using its behavioral health case manager (BHCM) allocation for behavioral health — whether through direct hiring, a private contract, or a CSB contract — and the amount spent on contracted arrangements. The survey should enable the Board to determine the total share of jails using the funds as intended.

Virginia could pursue a Medicaid reentry waiver to help fund services

Localities bear a large share of the cost of treating and medicating inmates in part because Medicaid cannot cover the cost of services to individuals while they are incarcerated. Federal law, through the Medicaid Inmate Payment Exclusion Policy, has long barred using Medicaid funds for an "inmate of a public institution," except during an inpatient hospital stay of at least 24 hours. While individuals may remain enrolled in Medicaid while incarcerated, their benefits are suspended, which can leave gaps in care at the moment of reentry. Even inmates who are newly enrolled in Medicaid as a part of their discharge planning process may have to wait several weeks to be paired with a Managed Care Organization (MCO) after their release from jail. During this time, while they have full coverage of benefits, they typically do not receive the active care coordination that comes along with MCO enrollment and may not be aware their full benefits are active again. The weeks after leaving jail are high risk for overdose and decompensation (see Chapter 1), and insurance coverage—combined with discharge planning—can make a difference in a person's ability to access medication and other forms of healthcare.

Federal policy offers a way to bridge that gap. The 2018 SUPPORT Act directed the Centers for Medicare and Medicaid Services (CMS) to issue guidance to states on using Section 1115 demonstration waivers to cover reentry services for up to 90 days before release; 21 states and the District of Columbia have since been approved for a reentry waiver. A waiver would let Virginia use state and federal Medicaid dollars to pay for inmates' behavioral health services, including prescription drugs, for up to three months before release and to cover their care in the community immediately afterward. Two regional jail superintendents interviewed for this study indicated that securing Medicaid coverage was essential to any state effort to improve jail behavioral health.

DMAS has already implemented related changes for youth (at a smaller scale) after a change in federal law created a mandatory exception to the Medicaid Inmate Payment Exclusion Policy for youth offenders. That work established some of the cross-agency collaborations and information-sharing processes an 1115 reentry waiver would require. An adult waiver would still be a substantial undertaking, and implementation would require new positions to handle the federal monitoring the program demands upon approval.

A recent federal change may narrow the opportunity. In June 2026, CMS announced that beginning January 1, 2027, it will not approve new demonstrations, renewals, or amendments unless its Chief Actuary certifies that the project will not increase federal spending relative to the state's program without it. DMAS staff indicated that an approval may still be possible after that date, but that it would first require a feasibility study — to gauge the likelihood of success before committing to an effort-intensive application, and to examine models in states that have succeeded. A feasibility study could also estimate likely costs and savings and determine whether the waiver would be financially worthwhile for the state. DMAS has access to grant funds it could potentially use to pay for such a study.

RECOMMENDATION 5

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Department of Medical Assistance Services to conduct a study on the feasibility of a Section 1115 reentry waiver to enable Medicaid payment for certain health care services to incarcerated individuals in Virginia. The study should include an assessment of how federal budget neutrality requirements would be demonstrated and the potential costs and savings for the state. The Department of Corrections, the Compensation Board, and the Department of Juvenile Justice should collaborate with DMAS on the study, providing information and input as needed. DMAS should report its findings to the Behavioral Health Commission by December 1, 2027.

Jail relationships with their CSBs can impact inmates' access to state hospitals

When jails are unable to maintain the safety of inmates due to acute behavioral health crises, they can pursue emergency psychiatric hospitalizations in a state facility, but access to emergency hospitalization depends heavily on the jail's relationship with its community services board (CSB). Only a CSB pre-screener can evaluate an inmate for a temporary detention order (TDO), a magistrate may issue a TDO only "after considering the evaluation" of a CSB employee or designee, and no other provider can substitute. However, jail staff report that CSBs are not always willing to conduct pre-screens when the jail requests them, and that pre-screeners sometimes deny TDO recommendations for acutely ill inmates. This can lead to further decompensation in jails that are unequipped to provide robust mental health treatment for the person in crisis.

The General Assembly anticipated that CSBs might not respond to jail requests for a TDO prescreen— if a CSB fails to complete a requested pre-screening, § 19.2-169.6 directs the jail to escalate to the CSB's senior management — but that is the extent of the remedy. The Code

sets no deadline to respond, provides no alternative evaluator, and imposes no consequence if senior management also does not act. One administrator said that when his CSB does not respond, he goes straight to a magistrate, a route that departs from the CSB-centered process laid out in the Code.

Even when a CSB does respond, whether an inmate is placed under a TDO can depend on how the pre-screener interprets the eligibility criteria in the jail context. Section 19.2-169.6 applies criteria similar to a civil TDO: the person must, because of mental illness, have a substantial likelihood of serious physical harm to self or others, or of serious harm from an inability to care for himself, and must require hospitalization. Pre-screeners interpret "requires hospitalization" inconsistently for people held in jail, according to jail staff interviewed for this study, because a jail can often physically prevent a suicide or homicide through the use of administrative segregation and suicide watch — even at the cost of further decompensation (see Chapter 3). Several jails described situations involving acutely suicidal or psychotic inmates whom pre-screeners deemed ineligible for a TDO because they believed the jail had the ability to keep the person safe. However, a jail's ability to keep a person alive is not the same as providing effective treatment, and inmates in acute crisis who do not receive treatment may be at risk of further decompensation and long-term harm.

TDO rates vary widely across jails, consistent with these accounts. In FY25, rates ranged from zero to 22.2 TDOs per 100 jail inmates, as measured by average daily population (ADP); this was fairly consistent between FY21 and FY25 (Figure 4-2). The total number of statewide jail TDOs has held steady since FY22 (Figure 4-3). The variation between jails is difficult to attribute to any single cause because a jail's rate also reflects other factors, like the prevalence of mental illness in its community. Still, the CSB controls the only route to a TDO, so its responsiveness and screening decisions are among the factors driving this variation.

Figure 4-2
Number of TDOs per 100 ADP in jails varies widely across jails (FY25)

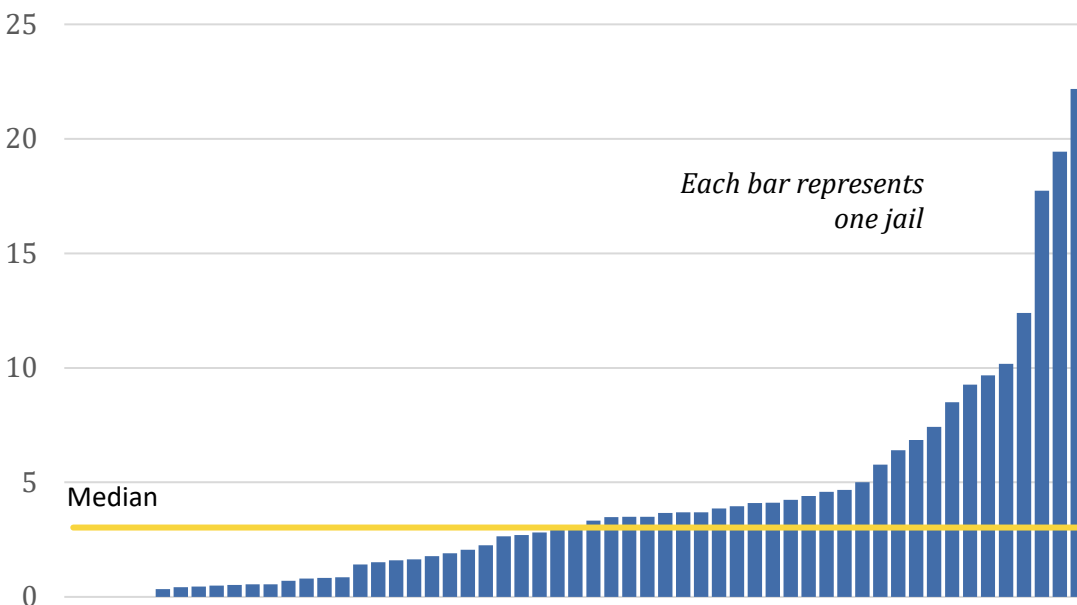
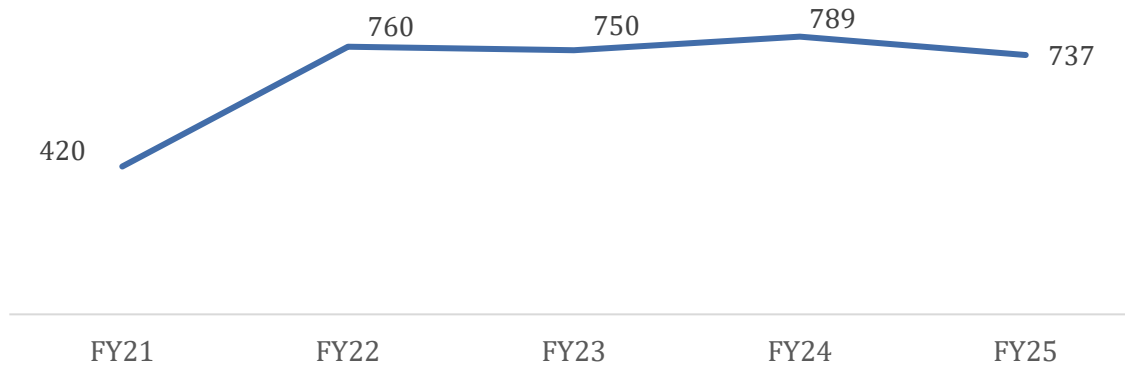


Figure 4-3

Number of jail TDOs admitted to state hospitals has remained relatively stable since FY22 (FY21-FY25)



Source: BHC staff analysis of Jail TDO admissions data from DBHDS

These challenges between jails and CSBs are not new. A 2014 study by OSIG reported that, “several jail administrators and medical staff noted challenges in getting CSB staff to conduct pre-admission screenings at the jail. Jail staff also cited an instance when an individual’s mental condition had to deteriorate to extreme levels in order to meet the criteria for hospitalization.” OSIG recommended that a workgroup be formed, consisting of jail medical staff, CSB emergency staff, and DBHDS facility medical staff, to develop protocols to guide the pre-admission screening process for jail inmates. Recommendations from this workgroup could aim to standardize the process and criteria for jail TDO evaluations to reduce the uneven application of TDO standards to inmates at different jails.

RECOMMENDATION 6

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Department of Behavioral Health and Developmental Services to form a workgroup that includes CSB staff and jail stakeholders to develop protocols to guide the pre-admission screening process for inmates of local and regional jails. DBHDS should issue final guidance document to CSBs and report on the guidance to the Behavioral Health Commission no later than November 1, 2027.

5 Standards and oversight for jail behavioral health

Virginia continues to lack minimum behavioral health standards for jails, seven years after the General Assembly passed a law requiring these standards. In the absence of minimum standards, the behavioral health care provided to inmates varies significantly among jails and may lead to negative outcomes for both inmates and jail staff. Further, jail administrators disagree on their responsibility toward inmates, and families, advocates, and legislators bring their own expectations, which often exceed what jails see as their role. The legislature directed the Board of Corrections, now the Board of Local and Regional Jails (BLRJ), to develop minimum standards for behavioral health in 2019, and although the Board developed and voted to adopt standards in 2020, those were never established in law through regulations. To ensure that legislative intent is achieved, the General Assembly should consider strengthening existing statute with more specific expectations for the provision of behavioral health services and setting a deadline for the Board to promulgate regulations. The General Assembly should also consider directing the Secretary of Public Safety and Homeland Security, in collaboration with the Secretary of Health and Human Resources, to convene a task force charged with developing proposed guidance documents to accompany regulations pertaining to minimum behavioral health standards.

There is no consensus among stakeholders on the role of jails in behavioral health care for inmates

Stakeholders do not consistently agree on what role jails should play in inmates' behavioral health care, and that disagreement complicates efforts to set expectations for jails. Among jail administrators, two broad views predominate. Some hold that jails are not psychiatric hospitals and should not be held to the treatment standards of a hospital or the community. Others contend that because jails already hold large numbers of people with mental illness and substance use disorders, they should provide the best behavioral health care they can. The positions are not incompatible, but the difference in emphasis reflects a divide in how administrators view their responsibility for mentally ill inmates.

Other stakeholders — legislators, state agency staff, families, and advocates — hold a wide range of views, and the gap between their expectations and what jails provide can be large. One jail administrator said families and community members expect their incarcerated relative to receive daily counseling: "We can't do that. We do [medication] management. I don't understand what the expectation is." Law enforcement, meanwhile, sometimes arrests a person in crisis on the belief that a jail will connect them to behavioral health services faster than the civil process would.

This absence of shared expectations is more than just a difference of opinion. Because administrators disagree about their role in treating mentally ill inmates — and because

funding varies as well (see Chapter 4) — the behavioral health care an inmate receives can depend heavily on which jail holds them. More fundamentally, this disagreement makes it harder to set and sustain the standards, funding, and accountability measures that comprehensive jail behavioral health care depends on. Standards can be established despite it — the General Assembly has required them since 2019 — but disagreement about the care that jails should provide inmates continues, and no standards have yet been implemented.

BLRJ has not established behavioral health standards in law, despite a 2019 mandate and a 2020 Board vote

Virginia lacks comprehensive minimum standards for the behavioral health services jails must provide, even though the General Assembly required this in 2019. HB 1942 (2019) directed the Board of Corrections, now the BLRJ to establish enforceable behavioral health standards for jails, including standards for the provision of services, screening and assessment, and discharge planning. More than seven years later, BLRJ has not promulgated any updates to its behavioral health regulations. Without standards and accompanying regulations, nothing requires a jail to provide any particular level of behavioral health care. A state workgroup has already recommended a comprehensive set of standards, which could be used to inform an update to the statute to provide more clarity on the General Assembly's intent for behavioral health regulations.

BLRJ has not established the behavioral health standards and enforcement procedures required by statute

The entity charged with setting standards for jails has not put into place minimum standards for behavioral health care in jails, despite a legal requirement to do so. BLRJ voted to proceed with 14 minimum standards in 2020, but did not establish the standards in law through regulations. Current regulations do not define what behavioral health services a jail must provide, beyond a few minimal policy requirements (Appendix D).

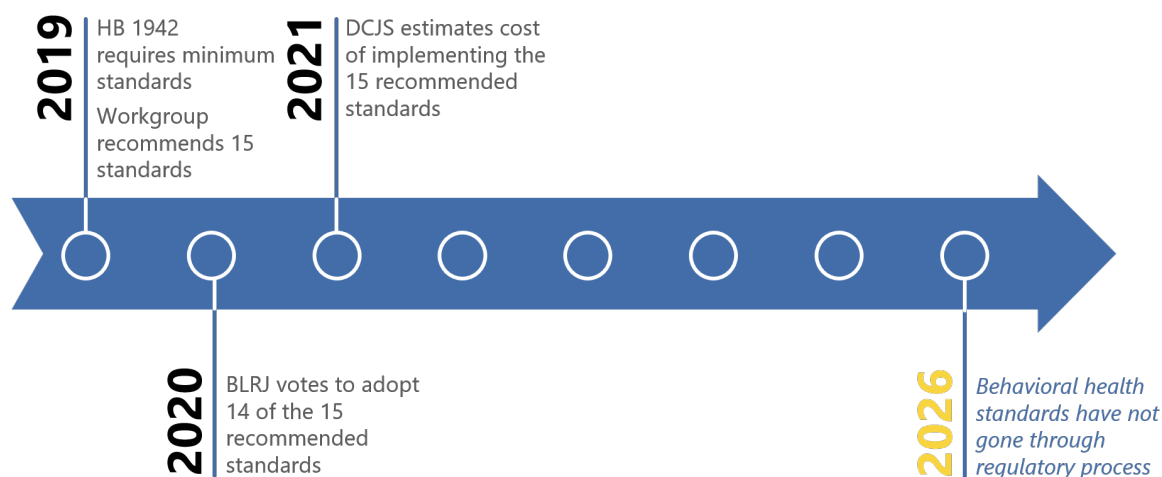
HB 1942 (2019) amended § 53.1-68 to require BLRJ, in consultation with the Commissioner of Behavioral Health and Developmental Services and the State Inspector General, to establish minimum behavioral health standards for jails and procedures to enforce them, including standards addressing:

- the provision of behavioral health services,
- screening and assessments for mental illness,
- discharge planning for people with SMI,
- sharing of behavioral health records, and
- provisions for Community Service Boards (CSBs) to bill sheriffs.

BLRJ formed a workgroup in 2019 to establish standards that would operationalize the broad requirements contained in statute, and the Board unanimously voted in November 2020 to adopt 14 of the 15 standards recommended by the workgroup (see Appendix F). Concurrently, the Department of Criminal Justice Services (DCJS) estimated the cost of implementing the standards, and released a report in 2021. The Board's next step was for the

adopted standards to be established in law through regulations, but this never occurred (Figure 5-1). Standards approved by the Board have no legal standing unless they have gone through the regulatory process, including a public comment period and executive review.

Figure 5-1
Behavioral health standards for jails were developed and adopted, but were not established in law through regulations



Source: BHC staff analysis of information from LIS, BLRJ, and DCJS

It is not known precisely why the adopted minimum standards did not move forward after the Board vote in 2020 or why there have been no attempts to establish them as regulations in the past six years. The substantial turnover among board members and staff between 2020 and 2024 may have been a factor; none of the Board members or Board staff who were part of the discussions in 2019 and 2020 are still in those roles, and current Board staff interviewed for this study had no knowledge of the 2020 Board vote to adopt the 14 standards. Much of the information that remains comes from Board meeting minutes, which capture decisions but not consistently the reasoning or intent behind them.

Board should adopt and promulgate newly developed standards to comply with statutory requirements

In the years since the General Assembly directed the Board to establish comprehensive behavioral health standards, the Board has made limited progress turning statutory requirements into regulations. New standards have recently been drafted to address some of the statutory requirements, but none have been approved by the full Board or entered the statutory process (Table 5-1).

Regulatory language addressing screening and assessment requirements has been drafted by staff and approved by BLRJ's Policy and Regulations Committee. However, the regulatory language has not been voted on by the full Board, nor has it been submitted to the formal

regulatory process as of September 2026. Board staff also recently presented draft language for discharge planning requirements to the BLRJ Policy and Regulations Committee, but the Committee did not take action on them. Committee members expressed skepticism that the requirement was feasible for all jails, and the Committee did not advance it for a vote. The full Board should vote to approve the standards for screening, assessment, and discharge planning and enter them into the regulatory process without delay in order to come into compliance with the screening, assessment, and discharge planning provisions of § 53.1-68 (C).

No draft regulations have been presented to the Board regarding the other required components of the section: provision of behavioral health services, sharing of records and CSB billing provisions. Board staff may need additional time to draft regulatory language for the standards on records and billing. Regulatory language on the provision of behavioral health services should be developed after the 2027 General Assembly session to allow for revisions to the statute, as recommended in the next section.

Table 5-1

Standards required by § 53.1-68(C) have not been established through regulations

Standard for behavioral health services required by § 53.1-68	Drafted for Board review	Approved by Policy & Regulations Committee	Approved by full Board	In regulations
Behavioral health screening	✓	✓		
Referral and assessment after screening	✓	✓		
Discharge planning for people with SMI	✓			
Provision of behavioral health services				
Sharing of records				
CSB billing provisions				

Source: BHC staff analysis of information from BLRJ, VAC, and LIS (September 2026)

RECOMMENDATION 7

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Board of Local and Regional Jails to adopt standards and promulgate regulations on (i) behavioral health screening, referrals for behavioral health assessments, discharge planning, sharing of records, and CSB billing provisions consistent with the requirements of § 53.1-68(C) no later than July 1, 2027; and (ii) the provision of services no later than the first day of the 2028 regular General Assembly session.

Statutory language should more clearly define requirements for provision of behavioral health services

The Board must establish minimum standards for the “provision of behavioral health services,” but this particular requirement is vague compared to the statutory language pertaining to screenings, assessments, and discharge planning services (see Appendix B). To ensure the legislature’s intent is clearly conveyed and carried out in regulations, more specific language should be added in statute.

Some of the minimum behavioral health standards adopted by BLRJ in 2020 could be included in the statute to provide additional clarity around the “provision of behavioral health services.” The standards took a comprehensive approach to implementing statute and added necessary specificity to the broad requirements set forth in statute.

Certain aspects of the previously adopted standards are already being addressed by revisions to existing regulations, which the full Board is expected to approve and enter into the regulatory process. However, six of the previously adopted standards have not been addressed at all and could form the basis for more specific statutory language:

- Access to care
- Communications of inmates’ needs
- Restrictive housing
- Continuity and coordination of services
- Primary mental health services
- Management of intoxication, withdrawal, and overdose

RECOMMENDATION 8

The General Assembly may wish to consider amending § 53.1-68 during the 2027 General Assembly session (C) to provide greater specificity around the standard for “requirements for the provision of behavioral health services.” Revised language should address access to care; communication of inmate needs; continuity and coordination of services; restrictive housing; primary mental health services; and management of intoxication, withdrawal, and overdose.

Task Force should be formed to help develop implementation guidance for behavioral health minimum standards

Regulatory guidance documents should be developed to help clarify what jails are expected to do, ensure jails are interpreting and implementing standards consistently, and give BLRJ inspectors specific guidance for what to enforce. Without adequate guidance, there will continue to be unnecessary variation in behavioral health care among jails. To assist the Board with gathering the input necessary to adopt guidance that balances rigor and feasibility, the Secretary of Public Safety and Homeland Security, with assistance from the Secretary of Health and Human Resources, could convene a task force. The task force would be responsible for developing proposed guidance documents and submitting those to the Board of Local and Regional Jails for their consideration. The Board would be responsible for reviewing and making any necessary revisions to the proposed guidance prior to adopting a final version, and for publishing the document to the Virginia Register of Regulations.

In developing guidance, the task force should examine the ability of different types of jails to comply with the standards, which is heavily driven by jail size and resources, and consider mechanisms that account for such differences, such as tiered compliance indicators that vary by size or local fiscal conditions.

Complying with standards may be especially challenging for small jails, as discussed in Chapter 4. Small jails typically have more limited resources for hiring behavioral health staff and funding treatment services like medications and programming. Even with more funding, small jails may deal with structural limitations related to physical space constraints, and jails may struggle to recruit the necessary mental health professionals.

As described throughout this report, many jails are concerned about the availability of resources needed to comply with standards. DCJS published a report in July 2021, which indicated that jails would need additional resources to implement the standards, primarily resources to support staffing (the General Assembly has funded half of the BHCM positions recommended by DCJS—see Chapter 4). DCJS also anticipated additional costs related to policy development, telehealth, and electronic case management systems.

The standards adopted by the Board in 2020 included compliance indicators, which could be used as a starting point to develop proposed guidance documents. These compliance indicators were detailed, comprehensive, and received support from major stakeholders. The workgroup that drafted the standards and compliance indicators was well positioned to judge both what is desirable and what is feasible in jail behavioral health. Convened by the Board of Corrections, BLRJ's predecessor, it included representatives of the Department of Behavioral Health and Developmental Services (DBHDS), the Office of the State Inspector General, the Compensation Board, DCJS, Virginia Department of Health, Department of Corrections, CSBs, mental health advocates, localities, sheriffs' offices, and local and regional jails. Building on the work of the 2019 workgroup, rather than relying on the Board to develop guidance documents independently, would draw on the expertise of a broad stakeholder group and potentially shorten the implementation timeline.

RECOMMENDATION 9

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Secretary of Public Safety and Homeland Security to convene a task force with the Secretary of Health and Human Resources to develop proposed guidance documents and compliance indicators for regulations established pursuant to § 53.1-68(C). The task force should assemble relevant stakeholders and consider how to account for differences among jails that may impact their ability to effectively implement regulations around behavioral health standards. The task force should also identify additional funding that may be necessary for jails to comply with regulations. The task force should provide proposed guidance documents to the Board of Local and Regional Jails for their consideration and to the Chair of the Behavioral Health Commission no later than November 15, 2027.

RECOMMENDATION 10

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Board of Local and Regional Jails to adopt guidance documents and compliance indicators for regulations established pursuant to § 53.1-68 (C), and to file with the Registrar of Regulations for publication in the Virginia Register of Regulations no later than June 30, 2028.

BLRJ needs additional resources to assess compliance with new standards

Adopting new behavioral health standards and guidance documents would add substantially to BLRJ's workload, which is already considerable relative to its staff. BLRJ has eight FTEs who promulgate jail regulations and standards, conduct regular jail audits, inspect every jail in Virginia at least once a year, review all jail deaths, and produce two statutorily required annual reports. Its compliance team of three FTEs inspects 82 facilities annually. A 2021 report found that BLRJ “currently lacks the capacity” to take on responsibilities associated with the workgroup’s proposed standards. Even if a task force accomplishes some of the work by drafting guidance documents, BLRJ staff will be responsible for assessing the new standards against compliance indicators as part of annual inspections already conducted by limited staff. The General Assembly may need to provide additional staff and funding to support this work.

RECOMMENDATION 11

The General Assembly may wish to consider including additional funding and three FTEs in the 2027 Appropriation Act for the Board of Local and Regional Jails to hire one policy analyst and two compliance analysts.

Recommendations and options: Behavioral health services in jails

BHC staff typically offer recommendations or options to address findings identified in its reports. Staff will usually propose options, rather than recommendations, when (i) the action proposed is a policy judgment best made by the General Assembly or other elected officials; (ii) the evidence indicates that addressing a report finding could be beneficial but the impact may not be significant; or (iii) there are multiple ways to address a finding, and there is insufficient evidence to determine the single best way to address the finding.

Recommendations

RECOMMENDATION 1

The Secretary of Public Safety and Homeland Security should complete their review of 6 VAC 20-50 as part of the regulatory process no later than December 1, 2026.

RECOMMENDATION 2

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Secretary of Health and Human Resources, with assistance from the Secretary of Public Safety, to convene a workgroup that includes the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services, and the Compensation Board to study how to lower the cost of psychotropic medications, medications for opioid use disorders, and long-acting injectable antipsychotics for jails and to present their recommendations to the Behavioral Health Commission by November 1, 2027.

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The General Assembly may wish to consider including additional funding in the 2027 Appropriation Act for the Compensation Board to allocate all behavioral health case manager positions needed to achieve the staffing standard of 1 case manager per 160 inmates recommended by the Department of Criminal Justice Services, with at least two case managers allocated to each jail. Language should also be included to specify that the funding can only be used for treatment, services, planning, and coordination related to behavioral health.

RECOMMENDATION 4

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RECOMMENDATION 5

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RECOMMENDATION 6

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Department of Behavioral Health and Developmental Services to form a workgroup that includes CSB staff and jail stakeholders to develop protocols to guide the pre-admission screening process for inmates of local and regional jails. DBHDS should issue final guidance document to CSBs and report on the guidance to the Behavioral Health Commission no later than November 1, 2027.

RECOMMENDATION 7

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Board of Local and Regional Jails to adopt standards and promulgate regulations on (i) behavioral health screening, referrals for behavioral health assessments, discharge planning, sharing of records, and CSB billing provisions consistent with the requirements of § 53.1-68(C) no later than July 1, 2027; and (ii) the provision of services no later than the first day of the 2028 regular General Assembly session.

RECOMMENDATION 8

The General Assembly may wish to consider amending § 53.1-68 during the 2027 General Assembly session (C) to provide greater specificity around the standard for “requirements for the provision of behavioral health services.” Revised language should address access to care; communication of inmate needs; continuity and coordination of services; restrictive housing; primary mental health services; and management of intoxication, withdrawal, and overdose.

RECOMMENDATION 9

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Secretary of Public Safety and Homeland Security to convene a task force with the Secretary of Health and Human Resources to develop proposed guidance documents and compliance indicators for regulations established pursuant to § 53.1-68(C). The task force should assemble relevant stakeholders and consider how to account for differences among jails that may impact their ability to effectively implement regulations around behavioral health standards. The task force should also identify additional funding that may be necessary for jails to comply with regulations. The task force should provide proposed guidance documents to the Board of Local and Regional Jails for their consideration and to the Chair of the Behavioral Health Commission no later than November 15, 2027.

RECOMMENDATION 10

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Board of Local and Regional Jails to adopt guidance documents and compliance indicators for regulations established pursuant to § 53.1-68 (C), and to file with the Registrar of Regulations for publication in the Virginia Register of Regulations no later than June 30, 2028.

RECOMMENDATION 11

The General Assembly may wish to consider including additional funding and three FTEs in the 2027 Appropriation Act for the Board of Local and Regional Jails to hire one policy analyst and two compliance analysts.

Options

OPTION 1

The General Assembly may wish to consider including additional funding in the 2027 Appropriation Act for the Department of Behavioral Health and Developmental Services to expand forensic discharge planning programs (i) to be implemented in jails that do not currently participate; and (ii) to serve additional inmates in jails that already participate in the program.

OPTION 2

The General Assembly may wish to consider directing the Board of Local and Regional Jails to promulgate regulations requiring that inmates who are placed on suicide watch or who are in administrative segregation for reasons related to mental health be evaluated by a medical or mental health provider within 12 hours of placement and at least every 24 hours thereafter by a mental health provider to determine whether there is an ongoing need for that placement. Regulations should be promulgated no later than the first day of the 2028 regular General Assembly session.

Appendix A: Research activities and methods

Key research activities performed by BHC staff for this study included:

- structured interviews with state agencies, jail staff, and jail associations;
- site visits to local and regional jails;
- a survey of jails;
- a survey of inmates in local and regional jails;
- review of state and national research;
- reviews of state law and policies relevant to behavioral health in jails;
- review of previous Virginia studies on mental health in jails;
- analysis of data from the Compensation Board's annual *Mental Illness in Jails* reports and jail TDO data from DBHDS.

Structured interviews

Structured interviews were a key research method for this report. Interviewees were asked about topics such as their experience with behavioral health treatment in a jail setting, the benefits and challenges of implementing increased service options, jail operations, regulatory and legislative history regarding behavioral health in jails, and recommendations for improving behavioral health services in jails. Key interviewees included:

- Jail administrators (current and former)
- Jail behavioral health staff (current and former)
- Association representatives for sheriffs and regional jails
- Staff of: the Board of Local and Regional Jails (BLRJ), Department of Behavioral Health and Developmental Services (DBHDS), Department of Criminal Justice Services (DCJS), Department of Medical Assistance Services (DMAS), and the Compensation Board

Site visits to jails

BHC staff conducted in-person site visits to five jails, which included meetings with jail administrators, jail officers, and jail behavioral health staff. Jail facilities were selected to offer variation in geography, population density, and jail population size, as well as variation between local and regional jails. The purpose of the visits was to learn about the implementation of behavioral health services and practices in a jail setting and hear staff perspectives on challenges, opportunities, and resource needs. Visits were conducted at the following jails:

- Fairfax Adult Detention Center (Fairfax, VA)
- New River Valley Regional Jail (Dublin, VA)
- Northern Neck Regional Jail (Warsaw, VA)
- Richmond City Justice Center (Richmond, VA)

- Sussex County Jail (Sussex, VA)

Surveys

Two surveys were conducted for this study: (1) a survey of jails, and (2) a survey of jail inmates

Jail Survey

BHC staff collaborated with the Compensation Board on their annual survey for the *Mental Illness in Jails* report. Jails were asked 11 questions provided by BHC in addition to the questions administered by the Compensation Board. The survey asked jails about suicide attempts, medications for opioid use disorder, jail policies, substance use recovery housing units, recovery groups, services for inmates with serious mental illness, telehealth, and use of suicide watch. 55 of 57 (96 percent of) jails submitted a completed response to the BHC portion of the survey.

Inmate survey

BHC staff administered an in-person paper survey to male and female inmates housed in general population units (and one specialty unit) in two local jails and two regional jails. Participation in the survey was voluntary. The purpose of the survey was to collect information on individuals' experiences with the mental health and substance use services in jail. The survey asked questions about experiences with mental health appointments, detox and withdrawal from substances, and time spent in isolation or administrative segregation. There were 137 survey responses.

Review of documents and literature

BHC staff reviewed numerous documents and research literature pertaining to behavioral health services in jails, including:

- Prior reports from state agencies on mental health in Virginia jails
- Virginia statute governing behavioral health in jails
- Virginia regulations governing behavioral health in jails
- Other states' statutory and regulatory requirements for behavioral health in jails
- National voluntary standards for correctional healthcare, such as NCCHC and ACA
- Legal opinions and law review articles on constitutional requirements for behavioral health services in jails
- Medical, psychological, and other research literature on behavioral health service provision in jails; the impacts of untreated mental illness and substance use in jails; and the impacts of isolation on inmates with behavioral health disorders

Data analysis

BHC staff analyzed a variety of data for this study, including data on mental illness and behavioral health services in Virginia jails contained in the *2025 Mental Illness in Jails Report* published by the Compensation Board.

Appendices

Jail-level data that was analyzed for this report can be found in the appendices of the *2025 Mental Illness in Jails Report*, listed below. This information was used to calculate averages and medians across all responding jails; averages per inmate or averages per inmate with a mental illness/substance use disorder in each jail, when relevant; and the variation in behavioral health services between jails. Jail responses were reviewed to identify erroneous information and outliers, and a note is featured on each graphic to indicate the number of responses included and the basis for exclusion.

- Appendix C – Number and diagnoses of inmate mental illness in jails: total population with a mental illness, population with a serious mental illness;
- Appendix J - Hours of mental health treatment services provided: hours of MD devoted to mental health, hours of treatment provided by jail mental health staff, hours of treatment provided by CSB, hours of treatment provided by private contractor;
- Appendix K – Type of mental health treatment services provided: number of inmates receiving and hours of treatment provided for individual counseling, group counseling, group substance abuse treatment, other treatment, and in total;
- Appendix L – Mental health medications dispensed: total dispensed psychotropic medications; and
- Appendix O – Mental health treatment expenditures: cost of medications, cost of mental health services; total funds.

Additional analysis was conducted to identify the causes of variation in behavioral health services between jails. The potential causes of variation examined included whether a jail was local vs. regional; jail size, assigned to quartiles based on FY25 average daily population; median income (2019-2023) in localities served by a jail; and categories of fiscal stress index (2023) assigned by the Council of Local Government.

Appendix B: § 53.1-68 of the Code of Virginia

§ 53.1-68. Minimum standards for local correctional facilities and lock-ups; health inspections, behavioral health services inspections, and personnel; access to counsel for inmates in local, regional, or community correctional facilities.

A. The Board shall establish minimum standards for the construction, equipment, administration, and operation of local correctional facilities, whether heretofore or hereafter established. However, no minimum standard shall be established that includes square footage requirements in excess of accepted national standards. The Board or its agents shall conduct at least one unannounced inspection of each local facility annually. However, in those years in which a certification audit of a facility is performed and the facility is in compliance with all the standards, the Board may elect to suspend the unannounced inspection based upon that certification audit and the history of compliance of the facility with the standards promulgated in accordance with this section, except in any year in which there is a change in the administration of a local or regional jail. The Board shall also establish minimum standards for the construction, equipment, and operation of lock-ups, whether heretofore or hereafter established. However, no minimum standard shall be established that includes square footage requirements in excess of accepted national standards.

B. Standards concerning sanitation in local correctional facilities and procedures for enforcing these standards shall be promulgated by the Board with the advice and guidance of the State Health Commissioner. The Board, in conjunction with the Board of Health, shall establish a procedure for the conduct of at least one unannounced annual health inspection by the State Health Commissioner or his agents of each local correctional facility. The Board and the State Health Commissioner may authorize such other announced or unannounced inspections as they consider appropriate.

C. The Board shall establish minimum standards for behavioral health services in local correctional facilities and procedures for enforcing such minimum standards, with the advice of and guidance from the Commissioner of Behavioral Health and Developmental Services and the State Inspector General.

Such standards shall include:

1. Requirements for behavioral health services provided in jails, including requirements for (i) behavioral health screening of individuals committed to local correctional facilities; (ii) referral of individuals committed to local correctional facilities for whom a behavioral health screening indicates reason to believe the person may have mental illness to a behavioral health service provider for a behavioral health assessment; and (iii) the provision of behavioral health services in local correctional facilities, as well as regulations directing the sharing of medical and mental health information and records in accordance with § [53.1-133.03](#). Requirements related to behavioral health screenings and assessments shall include a requirement that in cases in which there is reason to believe an individual is experiencing acute mental health distress or is at risk for suicide, (a) staff of the local correctional facility shall consult with the behavioral health service provider to implement immediate interventions and shall provide ongoing monitoring to ensure the safety of the individual and (b) the behavioral health assessment shall be completed within 72 hours of completion of the behavioral health screening, except that if the 72-hour period ends on a day that

is a Saturday, Sunday, or legal holiday, the assessment shall be completed by the close of business on the next day that is not a Saturday, Sunday, or legal holiday;

2. Requirements for discharge planning for individuals with serious mental illness assessed as requiring behavioral health services upon release from the local correctional facility, which shall include (i) creation of a discharge plan, as soon as practicable after completion of the assessment required pursuant to subdivision 1, and (ii) coordination of services and care with community providers, community supervision agencies, and, as appropriate, the individual's family in accordance with the discharge plan until such time as the individual has begun to receive services in accordance with the discharge plan or for a period of 30 days following release from the local correctional facility, whichever occurs sooner. Discharge plans shall ensure access to the full continuum of care for the individual upon release from the local correctional facility and shall include provisions for (a) linking the individual for whom the discharge plan has been prepared to the community services board in the jurisdiction in which he will reside following release and to other supports and services necessary to meet his service needs and (b) communication of information regarding the individual's treatment needs and exchange of treatment records among service providers;

3. A requirement for at least one unannounced annual inspection of each local correctional facility by the Board or its agents to determine compliance with the standards for behavioral health services established pursuant to this subsection and such other announced or unannounced inspections as the Board may deem necessary to ensure compliance with the standards for behavioral health services established pursuant to this subsection; and

4. Provisions for the billing of the sheriff in charge of a local correctional facility or superintendent of a regional correctional facility by and payment by such sheriff or superintendent to a community services board that provides behavioral health services in the local correctional facility, in accordance with § [53.1-126](#).

D. The Board shall establish standards to ensure access to counsel, including access to attorneys, paralegals, investigators, and other legal staff, for inmates held in any local, regional, or community correctional facility. Notwithstanding any other provision of law, the Board shall adhere to the provisions of the Administrative Process Act (§ [2.2-4000](#) et seq.) in promulgating these standards. Such standards shall include:

1. A requirement that, subject to safety, space, and resource constraints, inmates have in-person access to counsel in a confidential setting inside the facility, as well as access to counsel via secure and confidential telephone or video conference that is not recorded or monitored by any person. Access to counsel, either in person or via telephone or video conference, shall be available during regular business hours and at least some evenings and weekend days each week;

2. A requirement that local, regional, and community correctional facility policies and procedures for requesting and scheduling access to counsel be publicly posted and that counsel be promptly notified if their scheduled legal visit must be delayed, canceled, or otherwise restricted; and

3. A requirement that any denial or postponement of access to counsel be approved by a supervisor working in the correctional facility and accompanied by a rationale explaining the denial or postponement, which shall be provided in writing upon request of counsel.

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E. The Department of Criminal Justice Services, in accordance with § [9.1-102](#), shall establish minimum training standards for persons designated to provide courthouse and courtroom security pursuant to the provisions of § [53.1-120](#) and for persons employed as jail officers or custodial officers under the provisions of this title. The sheriff shall establish minimum performance standards and management practices to govern the employees for whom the sheriff is responsible.

F. The superintendent of a regional jail or jail farm shall establish minimum performance standards and management practices to govern the employees for whom the superintendent is responsible.

Appendix C: Standards recommended by the 2019 workgroup

Standard #1: ACCESS TO CARE

Inmates shall have access to a minimum level of care to meet their mental health needs/conditions identified through screening/assessment.

Compliance Indicators:

1. The jail administration and the responsible health authority (RHA) identifies and addresses any barriers to inmates receiving health care.
 2. The jail/responsible health authority has a sufficient supply of clinical staff to meet the needs of the inmate population either through the provision of on-site services or via contracts with providers.
 3. The jail/responsible health authority completes quarterly Continuous Quality Improvement reports addressing the healthcare being provided in the jail.
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Standard #2: POLICIES AND PROCEDURES

The facility has a manual or compilation of policies and defined procedures regarding behavioral healthcare services. Specific behavioral health policies may either be free-standing or may be part of larger health care manual.

Compliance Indicators:

1. Behavioral healthcare policies are site specific.
 2. Each policy and procedure in the behavioral healthcare manual is reviewed at least annually and revised as necessary under the direction of the responsible health authority (RHA) in conjunction with jail administration. The manual bears the date of the most recent review or revision and, at a minimum, the signatures of the facilities RHA, responsible health care provider, and jail administrator.
 3. The manual or compilation is accessible to behavioral healthcare staff as well as correctional staff.
 4. All aspects of the standard are addressed by written policy and defined procedures.
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Standard #3: COMMUNICATION OF INMATES' NEEDS

Communication occurs between the facility administration and behavioral healthcare professionals regarding inmates' significant behavioral healthcare needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or safety of the institution/staff. Communication is bi-directional and occurs on a regular basis either through planned meetings or impromptu meetings as the need arises.

Compliance Indicators:

1. Correctional staff are advised of inmates' behavioral healthcare needs that may affect housing, work and program assignments, disciplinary measures, and admissions to and transfers from institutions. Such communication is documented.
2. Behavioral healthcare providers and custody staff regularly communicate about the behavioral health needs of inmates.
3. Correctional staff know how to contact behavioral health staff to include communicating with behavioral health staff after-hours.
4. Behavioral health staff demonstrate an understanding of the jail's supervisory hierarchy and know who to call for which types of situations.
5. All aspects of the standard are addressed by written policy and defined procedures.

Standard #4: MENTAL HEALTH TRAINING FOR CORRECTIONAL OFFICERS

A training program established or approved by the responsible health authority in cooperation with the facility administration guides the mental health related training of all correctional officers who work with inmates.

Compliance Indicators.

1. Correctional officers who work with inmates receive mental health related training during their initial academy training and then at least annually thereafter. This training includes, at a minimum:
 - a. Recognizing the need for emergency care and intervention during a mental health crisis
 - b. Recognizing acute manifestation of intoxication and withdrawal, and adverse reaction to medications
 - c. Recognizing signs and symptoms of mental illness
 - d. Procedures for suicide prevention
 - e. Procedures for appropriate referral of inmates with mental health concerns to staff
 2. An outline of the training including course content and length is kept on file.
 3. A certification or other evidence of attendance is kept on site for each employee.
 4. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their mental health related trainings.
 5. More specialized/advanced training is available to those staff who work more closely with inmates with mental health challenges, those who work on specialized mental health units, those who work in medical/health services, and those who because of the nature of their duties are more likely to interact with individuals with mental health challenges.
 6. All aspects of the standard are addressed by written policy and defined procedures.
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Standard #5. MEDICATION SERVICES

Medication needs are reviewed as part of the intake/screening process. The jail has policies and procedures to guide the timeliness of responding to the medication needs of inmates. In general, for known existing conditions, which without the proper medications, could pose significant risk to health, medications are provided within one day of booking into the jail. For more routine, non-life threatening known conditions for which the inmate was receiving treatment in the community, the jail has policies/procedures to ensure a review is conducted by a healthcare provider within a reasonable time-frame. For conditions newly diagnosed within the jail, the jail has policies and procedures in place to ensure medications are timely acquired based on the doctor's order. Medication services policies in the jail should be consistent with generally accepted medical practices.

Compliance Indicators:

1. Prescription medications are administered or delivered to the patient only on the order of a physician, nurse practitioner, physician's assistant or other legally authorized individual.
 2. Medications are delivered in a timely fashion. The facility has a policy identifying the expected time frames from ordering to delivery and a backup plan if the time frames cannot be met.
 3. The responsible physician determines prescribing practices in the facility (taking into consider security implications).
 4. Medications are prescribed only when clinically indicated.
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Standard #6. MENTAL HEALTH SCREENING

Mental health screening is performed on all inmates on arrival at the intake facility to ensure that emergent and urgent mental health needs are met. For those inmates who are unable to be screened upon admission (due to issues to include acute intoxication, non-compliance, etc.) the jail has policies in place to screen such individuals when their condition has changed to the degree they can be successfully screened. The jail has policies in place to manage those inmates who are repeatedly re-admitted to the same jail on the same charges (i.e. weekenders) and policies that address screening for inmates who are transfers from other institutions rather than new admissions.

Compliance Indicators:

1. Intake personnel ensure mental health screening occurs and those that screen positive are referred for further assessment.
 2. A mental health screening takes place for all newly admitted inmates as soon as practical.
 3. A new screening is not required on weekenders or inmates transferred from one facility to another as long as the results of the initial screening are shared with the receiving facility and there have been no overt changes in the individual's mental status.
 4. The mental health screening tool shall be one designated by the Commissioner of DBHDS.
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5. The disposition of the inmate (e.g., immediate referral to services, placement in the general population) is appropriate to the findings of the mental health screening and is indicated on the screening form.
 6. Mental health screening forms are dated and timed immediately on completion and include the signature and title of the person completing the form.
 7. Screening includes identification of prescribed medications.
 8. Correctional personnel performing the mental health screen shall be trained in the use of the screening tool and appropriate referral processes.
 9. Mental health staff/ mental health provider/designee regularly monitors screenings to determine the effectiveness of this process.
 10. All aspects of the standard are addressed by written policy and defined procedures.
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Standard #7. MENTAL HEALTH ASSESSMENT

All inmates receive mental health screening; inmates with positive screens receive a mental health assessment.

Compliance Indicators:

1. Within 14 days of a positive result on a mental health screening, a qualified mental health professional, nurse, or licensed mental health professional conducts a preliminary review which includes a face to face meeting with the individual to review their answers on the screening tool (to ensure accuracy), gathers historical information, and reviews current symptoms to determine if a comprehensive assessment is needed.
 2. For those individuals who are in acute mental health distress there should be an immediate consultation between correctional staff and the jail provider as to whether immediate intervention is needed. The preliminary review and full assessment should be completed more quickly (within 48 hours).
 3. For those individuals who appear suicidal jails should intervene immediately and they should be assessed as soon as practicable.
 4. Inmates who appear to have or are suspected of having a serious mental illness based on the results of the preliminary review, have a comprehensive assessment within seven days of the preliminary review.
 5. Inmates who have remote histories of mental health treatment but who are currently asymptomatic, are not at increased risk for re-emergence of symptoms and do not present with any current mental health needs shall receive a full assessment based on the recommendation of the staff member conducting the preliminary review.
 6. The comprehensive mental health assessment includes a structured interview with inquiries into:
 - a. A history of:
 - I. Psychiatric hospitalization and outpatient treatment
 - II. Substance use treatment
 - III. Detoxification and outpatient treatment
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- IV. Suicidal behavior
- V. Self-Injurious behavior
- VI. Violent behavior
- VII. Victimization / traumatic experiences
- VIII. Special education placement
- IX. Cerebral trauma or seizures
- X. Sex offenses
- XI. Gender Dysphoria or Gender Identity issues

b. The current status of:

- I. Psychotropic medications
- II. Suicidal ideation
- III. Drug or alcohol use and substance use treatment
- IV. Orientation to person, place and time

c. Emotional response to incarceration.

d. A history of issues with cognitive impairments, learning disabilities, deficits in adaptive functioning.

e. History of benefits and entitlements.

7. The health record contains results of the preliminary review and assessment with documentation of referral or initiation of treatment when indicated.

8. Patients who require acute mental health services beyond those available on site are transferred to an appropriate facility.

9. There is a written policy and defined procedures addressing the post admission mental health screening and evaluation process.

Standard #8. EMERGENCY SERVICES

The facility provides 24 hour emergency mental health services.

Compliance Indicators:

1. A written plan includes arrangements for the following, which are carried out when necessary:
 - a. Emergency transport of the patient from the facility
 - b. Use of an emergency medical vehicle
 - c. Use of one or more designated hospital emergency departments or other appropriate facilities
 - d. Emergency on call physician or mental health services when the emergency health care facility is not nearby
 - e. Security procedures for the immediate transfer of patients for emergency mental health care
 - f. Notification to the person legally responsible for the facility
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2. A written plan that includes the process and procedure for contacting the responsible CSB to request a pre-admission screening.
 3. Procedures for monitoring individuals pending a CSB evaluation for involuntary hospitalization.
 4. All aspects of the standard are addressed by written policy and defined procedures.
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Standard #9. RESTRICTIVE HOUSING

When an inmate is held in restrictive housing, staff monitor his or her mental health.

Compliance Indicators:

1. Upon notification that an inmate is placed in restrictive housing, a qualified mental health care professional (RN/LPN/QMHP or other health professional that can conduct rounds) reviews the inmates mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation.

It should be noted that at times placement in restrictive housing may be detrimental to an individual's mental health, however the overall security needs and safety of the individual, other individuals, and staff may necessitate the continued placement in a restrictive housing setting. In such cases, mental health staff shall try to identify strategies to minimize the possible deleterious effects of restrictive housing. Such review is documented in the health record. The facility strives to house inmates in the least restrictive environment possible (without compromising safety).

2. A mental health professional conducts routine, face to face, rounds on all individuals housed in restrictive housing. The frequency of required rounds is dependent on the level of isolation as well as the individual's pre-existing mental health needs.

- a. Inmates who are in restrictive housing and have limited contact with staff or other inmates are reviewed every day by medical or mental health staff.
- b. Inmates who are allowed periods of recreation or other routine social contact among themselves while being held in restrictive housing are checked weekly by medical or mental health staff.
- c. The frequency of reviews can be adjusted depending on clinical judgment of the mental health professional depending on the person's clinical presentation as long as the rationale for altering the frequency of rounds is justified and documented in the clinical record.
- d. Rounds conducted by mental health professional do not substitute for required checks by correctional officers.

3. Documentation of restrictive housing rounds is made on individual logs or cell cards, or in an inmates health record and includes:

- a. The date and time of the contact.
- b. The signature or initials of the health staff member making the rounds.

4. Any significant mental health findings are documented in the inmates' health record.

5. Medical and mental health staff promptly identify and inform custody officials of inmates who are physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health. The individual's treatment plan is adjusted to address the change in mental status and outline strategies/interventions to aid the individual.
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6. All aspects of the standard are addressed by written policy and defined procedures.

Standard #10. CONTINUITY AND COORDINATION OF MENTAL HEALTH CARE DURING INCARCERATION

All aspects of mental health care are coordinated and monitored from admission to discharge.

Compliance Indicators:

1. Clinician orders are evidence based/evidence informed, are consistent with current standards of care, and are implemented in a timely manner.
 2. Deviations from standards of practice are clinically justified, documented and shared with the patient.
 3. Diagnostic tests, if indicated, and completed and reviewed by the clinician in a timely manner.
 4. Treatment plans may be modified as clinically indicated by diagnostic tests and treatment results.
 5. Treatment plans, including test results, are shared and discussed with patients.
 6. Patients are reviewed by a qualified provider upon return from a hospitalization, urgent care, or emergency department visit to ensure proper implementation of the discharge orders and to arrange appropriate follow up.
 7. Recommendations from specialty consultations are reviewed and acted upon by the clinician in a timely manner.
 8. If changes in treatment recommendations are clinically indicated, justification for the alternative treatment plan is documented and shared with the patient.
 9. Chart reviews are done to ensure that appropriate care is ordered and implemented and that care is coordinated by all health staff including medical, dental, mental health and nursing.
 10. The responsible provider determines the frequency and content of periodic health assessments based on protocols promulgated by nationally recognized professional organizations.
 11. All aspects of the standard are addressed by written policy and defined procedures.
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Standard #11. DISCHARGE PLANNING

Discharge planning is provided for inmates with mental health needs. The frequency and intensity of discharge planning services is dependent on the individual's level of need, the availability of services, having sufficient time to plan, and the individual's willingness to cooperate in the discharge planning process.

Compliance Indicators:

1. For all inmates known or suspected of having any form of mental health disorder, there is access to a list of community mental health resources for which the inmate might be eligible and which might help address their needs. At a minimum this list should include information about the local CSB(s) and procedures for accessing services via same day access. Information about other mental health service providers is provided as available. Information about local support groups/ self-help
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groups is also provided. Contact information for local offices of Department of Social Services, housing programs, etc. is provided as available.

2. For inmates known or suspected of having a serious mental illness (i.e. psychotic disorders, major affective disorders, and post-traumatic stress disorder) the jail should at a minimum:

- a. Arrange for an intake appointment with the willing provider on the day of release (for individuals who opt for CSB services) and as soon as possible for those opting for private providers.
- b. Arrange for a minimum of a two week supply of current psychotropic medications or scripts for a minimum of two weeks.
- c. Request signed releases of information so that treatment information can be sent to the next behavioral health provider.
- d. For those who are already connected to a provider in the community, facilitate the reconnection to services.

3. For jails that work with CSB's who receive state general funds to support discharge planning, services should include:

- a. Screening and assessment of psychiatric, medical, social services, employment, and residential needs, as well as risk factors, will occur as soon as possible after an individual's admission to jail.
 - b. A discharge plan is developed that will address the individual's needs, and include services and interventions that the individual will receive not only in the community upon release from jail, but also those that will begin in the jail prior to release (such as referrals to psychiatric services, medical services, and treatment programming).
 - c. Components of the plan include:
 - Linkage to a mental health provider in the community (CSB or private provider) that provides psychiatric, therapy, and/or case management services. This includes scheduling an appointment or directing the individual to Same Day Access at the CSB for follow-up services, Linkage to emergency or transitional housing if necessary (i.e., shelter, crisis stabilization, transitional housing).
 - Medicaid, GAP, SSDI/SSI application/reinstatement assistance.
 - Transportation assistance from the jail to the follow up appointments/providers or discharge placement; as resources are available.
 - Linkage to medical providers for treatment of any identified medical conditions.
 - d. A memorandum of understanding between the CSB and the Jail will outline specific roles and responsibilities in regard to the discharge plan, including the forensic discharge planner position (if available), and the level of participation and financial obligations of all entities in the process of discharge planning.
 - e. Policies and procedures to ensure communication between jail medical and mental health providers, jail correctional staff, and discharge planning staff occur to note relevant changes in
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the inmate's mental or physical health, level of risk to self or others, or discharge needs are incorporated into the detailed written discharge plan.

f. For planned discharges, the Jail, or assigned forensic discharge staff person, will:

- Arrange for a minimum of a two week supply of current psychotropic medications and ideally script for a minimum of two weeks.
- Request signed releases of information so that treatment information can be sent to the next behavioral health provider.
- Make arrangements or referrals for necessary follow up services with community clinicians, including exchange of clinically relevant information (see 2a. mandatory components of discharge plan).

4. All aspects of the standard are addressed by written policy and defined procedures

Standard #12. PRIMARY MENTAL HEALTH SERVICES

Mental health services are available for all inmates who suffer for serious mental illness. Additional services are provided, as available, to others with less acute, significant mental health needs.

Compliance Indicators:

1. Patients mental health needs are addressed on site or by referral to appropriate alternative providers or facilities. The needs are addressed by a range of mental health services of differing levels and focus, including residential components when indicated.
 2. Regardless of facility type or size, primary on site outpatient services include, at a minimum:
 - a. Screening, assessment, and referral of inmates with mental health needs.
 - b. Crisis intervention services.
 - c. Psychotropic medication management, when indicated.
 - d. Treatment documentation and follow-up.
 - e. Individual counseling or group counseling or peer recovery services or psychosocial/psychoeducational programs to meet any emerging urgent mental health needs.
 3. For those inmates who require transfer to an inpatient psychiatric setting (when clinically indicated), written procedures are consistent with Virginia law and are followed and the transfer occurs in a timely manner in cooperation with the accepting facility. Until such transfer can be accomplished the patient is safely housed and adequately monitored daily.
 4. Primary mental health services are offered as clinically indicated.
 5. A documented attempt is made at least but not limited to every 30 days to attempt to reengage individuals with serious mental illness who while not at risk of harm to self/others have declined treatment.
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6. Mental health, medical and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of any of these conditions on each other is adequately addressed.

7. All aspects of the standard are addressed by written policy and defined procedures.

Standard #13. SUICIDE PREVENTION PROGRAM

The facility identifies suicidal inmates and intervenes appropriately.

Compliance Indicators:

1. A suicide prevention program includes the following:

- a. Facility staff utilize evidence based/ evidenced informed processes to identify suicidal inmates immediately initiate precautions.
- b. Suicidal inmates are evaluated promptly by the designated health professional who directs the intervention and ensures follow up as needed.
- c. Acutely suicidal inmates are placed in a specialized cell with specialized clothing/bedding under close observation of staff. The frequency of checks and the degree of restrictions on clothing/bedding/other items is directed by the healthcare professional based on generally accepted standards of practice.
- d. Non-acutely suicidal inmates are monitored on a random schedule with no more than 15 minutes between checks. If however the non-acutely suicidal inmate is placed in an isolation cell with appropriate precautions.
- e. Assessment for need for hospitalization.

2. Key components of a suicide prevention program include the following:

- a. Training – Officers receive annual training on the proper processes for screening for suicidality.
 - b. Identification – Officers are instructed on proper methods for screening for the presence/absence of suicide ideation.
 - c. Referral – Officers receive annual training on the proper procedures for referring individuals to mental health staff for a comprehensive suicide assessment.
 - d. Evaluation – mental health staff utilize evidence based/ evidenced informed methods to assess for suicidal ideation/intent.
 - e. Treatment – The jail offers treatment through internal/external mental health providers to address the factors contributing to suicide ideation/intention.
 - f. Housing and monitoring – Housing placement takes into consideration the individuals current risk of suicidal ideation/intention and previous history of suicidal gestures.
 - g. Communication – The jail has processes in place to ensure those with a need to know are aware of inmates who have been placed under suicide precautions to ensure continuity of care and care coordination.
-

- h. Intervention – The jail has policies and procedures which outline the steps staff should take when responding to an inmate who may be suicidal.
 - i. Notification – The jail has policies and procedures in place to ensure jail administration is aware of all inmates placed on suicide watch/ suicide precautions.
 - j. Review – All inmates who have been placed on suicide watch/precaution are regularly evaluated by mental health staff to assess the need for ongoing precautions. At a minimum these reviews should occur daily. The review also includes an assessment of whether the inmate requires inpatient psychiatric hospitalization.
 - k. Debriefing (inmate) – After an individual has been removed from suicide watch a mental health staff member meets with the individual to review those factors which contributed to the individual developing suicide ideation/intention and to review strategies/interventions which might help mitigate future episodes of suicide ideation/intention.
 - l. Debriefing (staff) – For any staff member who has responded to a suicide attempt, the jail ensures the officer participates in a debriefing to review the incident, gather information to improve jail operations. In addition there is a review to address any secondary trauma the officer might be experiencing as a result of having responded to a traumatic event which could include EAP.
 - m. Suicide prevention strategies – The jail identifies policies and practices to help prevent inmates from becoming suicidal/ engaging in self injurious behavior to include jail programs, staff trained in crisis de-escalation, peer support activities, etc.
- 3. The use of other inmates in any way (e.g., companions, suicide prevention aids) is not a substitute for staff supervision.
 - 4. The responsible health authority approves the facilities suicide prevention plan; training curriculum for staff, including development of intake screening for suicide potential and referral protocols, and training for staff conducting the suicide screening at intake.
 - 5. All aspects of the standard are addressed by written policy and defined in procedures.
-

Standard #14. IDENTIFICATION AND TREATMENT OF SUBSTANCE USE DISORDERS

Inmates are screened for the existence of substance use disorders. For those inmates with substance use disorders, the jail evaluates for acute treatment needs (both behavioral health & medical) and provides treatment based on the individual's needs, amenability to treatment, and availability of treatment programs.

Compliance Indicators:

- 1. There are written guidelines for the screening, assessment, housing, and management of inmates suspected of having substance use disorders.
 - 2. There is evidence of communication and coordination between medical, behavioral health providers regarding SUD care.
 - 3. Medical conditions associated with SUD (e.g., HIV, liver disease) are recognized and treated.
 - 4. The correctional staff are trained in recognizing the signs/symptoms of alcohol/drug intoxication and withdrawal and what the local procedures to respond to such circumstances.
-

5. There are on-site individual counseling, group therapy, peer support, or self-help groups for inmates with SUD issues.
6. Inmates with SUD issues have access, upon release, to a list of community mental health resources for which the inmate might be eligible and which might help address their needs.
7. All aspects of the standard are addressed by written policy and defined procedures that define the respective roles of the mental health, substance abuse, and medical staff regarding provision of SUD services.

Standard #15. MANAGEMENT OF INTOXICATION & WITHDRAWAL AND OVERDOSE

Protocols exist for managing and responding to inmates under the influence of alcohol or other drugs and those undergoing withdrawal from alcohol, sedatives or opioids. Detoxification from alcohol, opiates, hypnotics, and other stimulants is conducted under medical supervision in accordance with local, state, and federal laws. When performed at the facility, detoxification is prescribed in accordance with clinical protocols approved by the health authority.

Compliance Indicators:

1. Established protocols are followed for the assessment, monitoring, and management of individuals manifesting symptoms of alcohol and drug intoxication or withdrawal, and overdose.
2. The protocols for intoxication, detoxification, and/or overdose are approved by the responsible physician, are current, and are consistent with national accepted treatment guidelines.
3. Individuals being monitored are housed in a safe location that allows for effective monitoring.
4. Inmates experiencing severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal are transferred immediately to a medical facility upon the recommendation of the jail medical provider or jail protocol.
5. The jail has policies/practices outlining the practice of using overdose reversal medications.
6. Individuals showing signs of intoxication or withdrawal are monitored by qualified health care professionals using recognized standard assessments at appropriate intervals until symptoms have resolved.
7. Detoxification is done under physician supervision.
8. If a pregnant inmate is admitted with opioid dependence or treatment (including methadone and buprenorphine), a qualified clinician is contacted so that the opioid dependence can be assessed and appropriately treated.
9. The facility has a policy that addresses the management of inmates, including pregnant inmates, on methadone, buprenorphine, or similar substances. Inmates entering the facility on such substances have their therapy continued as appropriate, or a plan for appropriate treatment of the methadone withdrawal syndrome is initiated.
10. All aspects of the standard are addressed by written policy and defined procedures.

Appendix D: Current Life Health and Safety standards related to behavioral health

The five standards noted with an asterisk explicitly reference behavioral health

LIFE, HEALTH, SAFETY STANDARD

6VAC15-40-320. Licensed Physician – A licensed physician shall supervise the facility’s medical and health care services. Facilities that contract with private medical facilities or vendors shall maintain a current copy of the agreement, unless employed by the facility.

6VAC15-40-340. Health Care Provider and Licensing, Certification and Qualification of Health Care Personnel – Each facility shall have a minimum of one licensed or qualified health care provider who is accessible to inmates a minimum of one time per week. Health care personnel shall meet appropriate and current licensing, certification, or qualification requirements.

***6VAC15-40-360. Twenty-Four Hour Emergency Medical Care** - Written policy, procedure, and practice shall provide 24-hour emergency care medical and mental health care availability.

***6VAC15-40-370. Receiving and Medical Screening of Inmates** - Written policy, procedure, and practice shall provide that receiving and medical screening be performed on all inmates upon admission at the facility. The medical screening shall:

1. Specify screening for current illnesses, health problems and conditions, and past history of communicable diseases;
2. Specify screening for current symptoms regarding the inmate’s mental health, dental problems, allergies, present medications, special dietary requirements, and symptoms of venereal disease;
3. Include inquiry into past and present drug and alcohol abuse, mental health status, depression, suicidal tendencies, and skin condition; and
4. For female inmates, include inquiry into possible pregnancy or gynecological problems.
5. All inmates shall receive a tuberculosis (TB) skin test within seven days of admission to the facility.

6VAC15-40-380. Inmate Access to Medical Services - Written policy, procedure, and practice shall be developed whereby inmates can be informed, at the time of admission to the facility, of the procedures for gaining access to medical services.

6VAC15-40-400. Management of Pharmaceuticals - Written procedures for the management of pharmaceuticals shall be established and approved by the medical authority or pharmacist, if applicable. Written policy, procedure, and practice shall provide for the proper management of pharmaceuticals, including receipt, storage, dispensing and distribution of drugs. These procedures shall be reviewed every 12 months by the medical authority or pharmacist. Such reviews shall be documented.

***6VAC15-40-420. Transfer of Summaries of Medical Record** – Medical record summaries shall be transferred to the same facility to which the inmate is being transferred. Required information shall include: vital signs, current medications, current medical/dental problems, mental health screening, mental health problems, TB skin test date and results, special inmate needs/accommodations, pending medical appointments, medical dispositions, overall comments, health care provider/personnel signature and date, and any additional pertinent medical information such as lab work, x-rays, etc.

***6VAC15-40-450. Suicide Prevention and Intervention Plan** – There shall be a written suicide prevention and intervention plan. These procedures shall be reviewed and documented by an appropriate medical or mental health authority prior to implementation and every three years thereafter. These procedures shall be reviewed every 12 months by staff having contact with inmates. Such reviews shall be documented.

***6VAC15-40-1010. Mental Health Inmates** - Written policy, procedure, and practice shall specify the handling of mental health inmates, including a current agreement to utilize mental health services from either a private contractor or the community services board.

6VAC15-40-1030. Assessment of Inmates in Disciplinary Detention or Administrative

Segregation –Written policy, procedure, and practice shall require that a documented assessment by medical personnel that shall include a personal interview and medical evaluation of vital signs, is conducted when an inmate remains in disciplinary detention or administrative segregation for 15 days and every 15 days thereafter. If an inmate refuses to be evaluated, such refusal shall be documented.

6VAC15-40-1040. Staff Training – The facility shall provide for 24-hour supervision of all inmates by trained personnel.

Appendix E: Virginia jails

Jail	Location(s)	Local/ regional ¹	Average Daily Population (June 2026)
Accomack County Jail	Accomac	Local	98
Albemarle/Charlottesville Regional Jail	Charlottesville	Regional	303
Alexandria Detention Center	Alexandria	Local	270
Alleghany/Covington Regional Jail	Covington	Regional	84
Arlington ADC	Arlington	Local	323
Blue Ridge Regional Jail	Bedford, Halifax, Lynchburg, Madison Heights, Rustburg	Regional	915
Botetourt-Craig Regional Jail	Fincastle	Regional	106
Central Virginia Regional Jail	Orange	Regional	413
Charlotte County Jail	Charlotte Courthouse	Local	31
Chesapeake City Jail	Chesapeake	Local	601
Chesterfield County Jail	Chesterfield	Local	343
Culpeper County Jail	Culpeper	Local	73
Danville City Jail Farm	Danville	Local	94
Danville City Jail	Danville	Local	176
Eastern Shore Regional Jail	Eastville	Regional	42
Fairfax County ADC	Fairfax	Local	492
Fauquier County Jail	Warrenton	Local	50
Franklin County Jail	Rocky Mount	Local	52
Gloucester County Jail	Gloucester	Local	25
Hampton Correctional Facility	Hampton	Local	146
Henrico County Jail East/West	Henrico	Regional	1,107
Henry County Jail	Martinsville	Local	202
Lancaster County Correctional Facility	Lancaster	Local	20
Loudoun County Jail	Leesburg	Local	296
Martinsville City Jail and Annex	Martinsville	Local	87
Meherrin River Regional Jail	Alberta	Regional	212
Middle Peninsula Reg Security Center	Saluda	Regional	147
Middle River Regional Jail	Staunton	Regional	569
Montgomery County Jail	Christiansburg	Local	61
New River Valley Regional Jail	Dublin	Regional	662

Appendices

Jail	Location(s)	Local/ regional ¹	Average Daily Population (June 2026)
Newport News City Jail	Newport News	Local	481
Norfolk City Jail	Norfolk	Local	660
Northern Neck Regional Jail	Warsaw	Regional	424
Northwestern Regional ADC	Winchester	Regional	569
Page County Jail	Luray	Local	70
Pamunkey Regional Jail	Hanover	Regional	383
Patrick County Jail	Stuart	Local	93
Piedmont Regional Jail	Farmville	Regional	540
Pittsylvania County Jail	Chatham	Local	67
Portsmouth City Jail	Portsmouth	Local	152
Prince William/Manassas Regional ADC	Manassas	Regional	544
Rappahannock Regional Jail	Stafford	Regional	1,162
Richmond City Justice Center	Richmond	Local	613
Riverside Regional Jail	Prince George	Regional	987
Roanoke City Jail	Roanoke	Local	342
Roanoke County Jail	Salem	Local	87
Rockbridge Regional Jail	Lexington	Regional	129
Rockingham/Harrisonburg Regional Jail	Harrisonburg	Regional	300
RSW Regional Jail	Front Royal	Regional	284
Southampton County Jail and Annex	Courtland	Local	44
Southside Regional Jail	Emporia	Regional	133
Southwest Virginia Regional Jail	Abingdon, Duffield, Haysi, Tazewell	Regional	1,632
Sussex County Jail	Sussex	Local	29
Virginia Beach Correctional Center	Virginia Beach	Local	1,085
Virginia Peninsula Regional Jail	Williamsburg	Regional	325
Western Tidewater Regional Jail	Suffolk	Regional	799
Western Virginia Regional Jail	Salem	Regional	584

¹This table uses the designation assigned by BLRJ. Some jails are designated as local or regional differently by BLRJ and the Compensation Board.

Appendix F: BLRJ meeting minutes from November 18, 2020

THE VIRGINIA BOARD OF LOCAL AND REGIONAL JAILS

The Virginia Board of Local and Regional Jails (Board) met on Wednesday, November 18, 2020 by **TELECONFERENCE** to Discuss General Business of the Board

BOARD MEMBERS PRESENT: The Honorable Vernie W. Francis, Jr., Chairman

Bobby Vassar, Vice Chairman

John F. Anderson, Jr., Secretary

Olivia Garland, PhD

Heather Masters, M.D., S.F.H.M., F.A.C.P.

Karen Nicely, LPC

Joanne Peña

BOARD MEMBERS ABSENT: The Honorable Charles Jett
Reverend Kevin L. Sykes

BOARD COUNSEL: Phillip Figura, Office of the Attorney General

ATTENDEES: Steve Goff, Virginia Department of Corrections
Tawana Ferguson, Virginia Department of Corrections
Bob Casey, Virginia Department of Corrections
Audrey Michael, Department of Corrections
Bill Wilson, Liaison Committee Member
Bruce Crusier, Mental Health America-Virginia

BOARD ATTENDANCE ROLL CALL:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay
Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Board members in attendance – **Quorum Present**

MOTION TO CONVENE

As you know, the Governor declared a state of emergency in effect from

March 12, 2020 and is ongoing because of the potential spread of COVID19, a communicable disease of public health threat and the anticipated effects of that spread. Given this threat, the Board cannot assemble in person because of the need for social distancing for a prolonged period of time. The work of the Board*

As you may know, Governor Northam amended the state budget to include the use of electronic meetings in HB30 (Chapter 1289) Section 4-0.01 It provides that this Board may conduct a public electronic meeting during a state of emergency if: “(i) the nature of the declared emergency makes it impracticable or unsafe for the public body or governing board to assemble in a single location; [and] (ii) the purpose of the meeting is to discuss or transact the business statutorily required.” The law requires that this Board “shall make available a recording or transcript of the meeting on its website ...and... Distribute minutes of a meeting.”

The purpose of the meeting is to take action on Board Certifications and Construction Projects as mandated by law. In light of this, I’ll entertain a *MOTION* with respect to this Emergency Electronic Meeting.

Motion read by made by Dr. Masters and Seconded by Dr. Garland.

BOARD ROLL CALL VOTE:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay
Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Votes in **FAVOR** of the **MOTION**, two **ABSENT** – **MOTION CARRIES**

That motion being carried unanimously among attendees we can begin this Electronic Meeting.

Chairman Francis asked for a motion to approve the September 16th, 2020 minutes.

I **MOVE** that the Board **APPROVE** the September 16th, 2020 meeting minutes

Motion made by Mr. Vassar, seconded by Dr. Masters.

ROLL CALL VOTE:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay

Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Votes in **FAVOR** of the **MOTION**, two **ABSENT** – **MOTION CARRIES**

BOARD CALENDAR

The Board calendar will resume the 2020 schedule with the Jail Review Committee and full Board meetings being scheduled for alternating months.

PUBLIC COMMENT

Bruce Crusier, Mental Health America-Virginia commented that he would like to see the Behavioral Health Standards posted on the Board of Local and Regional Jails website.

Added for public information – the BOLRJ website is currently under construction and there is no accessible space for this information at this time. It will be provided upon request. Please contact Donna Foster to request this information. It is expected to be offered for public comment and review on the Virginia Register in the near future.

BEHAVIORAL HEALTH STANDARDS

Dr. Olivia Garland – There are a total of 43 Board standards at this time, 11 of which directly or indirectly pertain to behavioral health. A committee of mental health professionals, sheriffs, jail administrators, and other stakeholders met to review, updated standards over several months in 2019. Fifteen standards were created and presented to the Board for review and comment. The Board made recommendations and determined that 14 standards would be recommended to replace the 11 former standards. Of the 15 that were reviewed, Standard #12 was eliminated as redundant, having been addressed in other recommended standards. The current recommended standards have been renumbered appropriately.

I MOVE that the Board APPROVE the Behavioral Health Standards as amended

Motion read by made by Mr. Vassar and Seconded by Dr. Masters.

ROLL CALL VOTE:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay
Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Votes in **FAVOR** of the **MOTION**, two **ABSENT** – **MOTION CARRIES**

AUDREY MICHAEL UPDATE

The Board of Local and Regional Jail Annual Jail Death Report has been submitted to the Deputy Secretary of Public Health, Jacqueline Katuin. She has recommended some changes and, once completed will be returned to her for approval to proceed to the Governor's office. This report is due on December 1, 2020.

CORRECTIONAL SERVICES COMMITTEE UPDATE/Policy & Regulations LOCAL FACILITIES SECTION – STAFFING/FUNDING AND UNANNOUNCED INSPECTIONS:

Compliance, Certification and Accreditation - Certifications Report:
Local/Regional/Community Facilities

BOARD ACTION REQUIRED

I make the following recommendations in the form of a Motion:

Unconditional certification as a result of 100% for:

BRRJA-Bedford Adult Detention Center
Sussex County Jail

Unconditional certification for:

Lancaster County Jail

Motion by Mr. Vassar and duly seconded by Dr. Garland.

ROLL CALL VOTE:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay
Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Votes in **FAVOR** of the **MOTION**, two **ABSENT** – **MOTION CARRIES**

BOARD ACTION REQUIRED

Jail inspections recommended suspensions.

I MOVE the Board of Local and Regional Jails, in recognition of the outstanding achievement of 100% compliance with standards, APPROVES the suspension of the 2020 annual inspection for the Blue Ridge Regional Jail Authority-Bedford Adult Detention Center and Sussex County Jail.

Motion by Mr. Vassar and duly seconded by Dr. Garland.

ROLL CALL VOTE:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay
Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Votes in FAVOR of the MOTION, two ABSENT – MOTION CARRIES

JAIL REVIEW COMMITTEE REPORT

The Jail Review Committee investigated the following cases by reviewing institutional, medical, and mental health records and other relevant evidence of the circumstances surrounding each death. The Jail Review Committee further finds that investigation did not reveal any evidence indicating that the facility was out of compliance with the regulations promulgated by the Board. NOW THEREFORE, I MOVE that the following cases be recommended to the Full Board for closure as a result of the following cases:

Case	Location	Date of Death
19-0001	SWVRJA-Abingdon	1/12/19
19-0003	Danville City Jail	1/19/19
19-0004	Virginia Beach Correctional Center	1/30/19
19-0005	Richmond City Justice Center	2/12/19
19-0007	Virginia Beach Correctional Center	3/4/19
19-0008	Piedmont Regional Jail	3/19/19
19-0009	SWVRJA-Abingdon	3/26/19
19-0012	Western Tidewater Regional Jail	4/16/19
19-0014	Henrico County Jail-West	4/26/19
19-0016	Danville City Jail	5/10/19
19-0020	RSW Regional Jail	7/17/19
19-0010	Portsmouth City Jail	4/12/19
19-0011	Northwestern Regional Jail	4/15/19
18-0051	Bristol City Jail	7/3/18

Motion made by Dr. Garland and duly seconded by Mr. Vassar.

ROLL CALL VOTE:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay
Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Votes in **FAVOR** of the **MOTION**, two **ABSENT** – **MOTION CARRIES**

ADDITIONAL ITEMS FOR DISCUSSION

Chairman Francis recognized Ms. Peña and her workgroup who are addressing the requirements set forth in HB1284, thanking them for their efforts. More on this topic will be offered during the January BOLRJ meeting.

Chairman Francis advised that the position of Executive Director for the Board of Local and Regional Jails has been advertised and updates will be forthcoming.

Mr. Vassar offered the following in the form of a motion, duly seconded by Dr. Garland:

I MOVE that the meeting be adjourned.

ROLL CALL VOTE:

John F. Anderson, Jr.	Yay
Vernie, W. Francis, Jr.	Yay
Dr. Olivia Garland	Yay
Dr. Heather Masters	Yay
Karen Nicely	Yay
Joanne Peña	Yay
Bobby Vassar	Yay

7 Votes in **FAVOR** of the **MOTION**, two **ABSENT** – **MOTION CARRIES**

Adjourned

