



# Virginia Department of Corrections

## Mental Health and Wellness Services

### Operating Procedure 730.3

#### *MHWS: Levels of Service*

#### **Authority:**

Directive 730, *Mental Health and Wellness Services*

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**Access:** ☐ Restricted ☒ Public ☐ Inmate

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## REVIEW

The Content Owner will review this operating procedure annually and re-write it no later than three years after the effective date.

*The content owner reviewed this operating procedure in September 2024 and necessary changes are being drafted.*

## COMPLIANCE

This operating procedure applies to all units operated by the Virginia Department of Corrections (DOC). Practices and procedures must comply with applicable State and Federal laws and regulations, American Correctional Association (ACA) standards, Prison Rape Elimination Act (PREA) standards, and DOC directives and operating procedures.

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## DEFINITIONS

**Acute Care Unit (ACU)** - A designated treatment unit licensed to provide inpatient mental health and wellness services for inmates whose functioning is so severely impaired by a mental disorder that they meet the criteria for involuntary admission in accordance with 12VAC35-105, *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*.

**Aftercare Services** - Services provided by community mental health professionals to inmates who still require mental health and wellness services after release from DOC facilities.

**Community Corrections Alternative Program (CCAP)** - A system of residential facilities operated by the Department of Corrections to provide evidence-based programming as a diversionary alternative to incarceration in accordance with COV §53.1-67.9, *Establishment of community corrections alternative program; supervision upon completion*.

**Facility** - Any institution or Community Corrections Alternative Program.

**Individualized Treatment Plan (ITP)** - A goal-oriented plan, developed and reviewed/revised on a regular basis by the Mental Health Treatment Team in conjunction with the inmate; the ITP identifies relevant problems or needs, treatment goals and objectives, and interventions for each inmate admitted to a Mental Health Unit within the Department of Corrections.

**Institution** - A prison facility operated by the Department of Corrections - includes major institutions, field units, and work centers.

**Intensive Diversionary Treatment Program (IDTP)** - A residential programming unit that is designated for inmates with repeated involvement in critical incidents which warrants administrative attention and consumes an inordinate amount of resources from medical, mental health, and/or security operations. Inmates in this programming unit should not meet the criteria for involuntary commitment under Code of Virginia, Section 53.1-40.

**Mental Health Classification Code** - A numeric code assigned to an inmate by a Mental Health Clinician that reflects the inmate's current mental health status and mental health and wellness service needs; the coding system is hierarchical, ranging from MH-0 representing no current need for mental health and wellness services to MH-4S representing the greatest need for mental health and wellness services.

**Mental Health Clinician** - An individual with at least a master's degree in psychology, social work, or relevant human services field with knowledge, training, and skills in the diagnosis and treatment of mental disorders, which may include a Psychiatric Provider, Social Worker, or Registered Nurse.

**Mental Health Residential Treatment Unit** - A designated licensed treatment unit where mental health and wellness services are provided to inmates who are unable to function in a general population setting due to a mental disorder but who typically do not meet the criteria for admission to an Acute Care Unit in accordance with 12VAC35-105, *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*; see Operating Procedure 735.2, *Sex Offender Treatment Services (Institutions)* for anything regarding Sex Offender Residential Treatment.

**Outpatient Services** - Services for inmates with mental disorders who are able to make a satisfactory adjustment in General Population settings or Restorative Housing Units and who do not need the level of services provided by an Acute Care or Residential Treatment Unit.

**Secure Diversionary Treatment Program (SDTP)** - A residential programming unit with bed assignments designated for eligible inmates who are classified as seriously mentally ill, and who meet the criteria for program admission. The SDTP is a formalized program that operates within structured security regulations and procedures, and provides for programming and treatment services conducive with evidence-based treatment protocols and individualized treatment plans.

**Serious Mental Illness (SMI)** - Psychotic Disorders, Bipolar Disorders, and Major Depressive Disorder; any diagnosed mental disorder (excluding substance use disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified Mental Health Clinician.

Psychological – *as relating to the mental and emotional state of an individual.*

Cognitive – *as relating to cognitive or intellectual abilities.*

Behavioral – *as relating to actions or reactions in response to external or internal stimuli that is observable and measurable.*

**Shared Allied Management (SAM) Unit** - A residential programming unit operated at designated institutions to deliver intensive services in a safe environment to specific inmate populations that typically require a high level of services from security, mental health and wellness services, and/or health services staff.

**Treatment Team** - An interdisciplinary team typically comprised of a Psychiatrist, Psychologist or Mental Health Clinician, clinical Social Worker, and Nurse who has a psychiatric background; the team works in conjunction with other support staff, including health services, counseling, and security staff, for the purpose of assessing the mental health status and services needs of the inmate and developing and implementing treatment, management, and aftercare plans.

## PURPOSE

This operating procedure provides for a mental health and wellness services system with appropriate levels of care for mentally disordered inmates/probationers/parolees housed in Department of Corrections (DOC) facilities or under community supervision.

## PROCEDURE

### I. Services

- A. The DOC offers a range of mental health and wellness services including Acute Care Unit (ACU), Residential Treatment, Outpatient Treatment, and Crisis Intervention.
- B. Upon initial intake into a DOC facility, with as needed and periodic reviews, each inmate is screened and assessed to determine the inmate's mental health status, service needs, and appropriate mental health classification; see Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*.
- C. Crisis Intervention and Emergency Care are available at each institution on a 24-hour basis. (5-ACI-6A-08; 4-ACRS-4C-03 [II])
  1. Facilities with full-time Mental Health Clinicians have a Mental Health Clinician on call at all times to provide emergency mental health and wellness services through consultation and, if needed, crisis intervention.
  2. Facilities without full-time Mental Health Clinicians request emergency mental health services by contacting the assigned Mental Health Clinical Supervisor or designated Mental Health Clinician at another facility; see *Guidelines to Access Emergency Mental Health Services*, Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*.
- D. Community Corrections Mental Health Clinicians provide assessment and referral services for probationers/parolees under P&P supervision in the community and in Community Corrections Alternative Programs (CCAP). (4-ACRS-4C-15 [CC])

### II. Levels of Care

#### A. ACU

##### 1. General

- a. When deemed clinically necessary, inmates who have serious mental disorders or a developmental disability are typically referred for involuntary admission to an ACU within the DOC or to an appropriate non-correctional facility e.g., upon the inmate's release from the DOC. (5-ACI-6A-37, 5-ACI-6A-39, 5-ACI-6C-12)
- b. Admission will be accomplished in accordance with COV §53.1-40.2, *Involuntary admission of prisoners with mental illness* through COV §53.1-40.9, *Civil admission proceeding prior to release*. (5-ACI-6C-12).
- c. Male inmates who are in need of an ACU may be admitted to Marion Correctional Treatment Center (MCTC) ACU. Female inmates who are in need of an ACU may be admitted to Fluvanna Correctional Center for Women (FCCW) ACU.

##### 2. ACU Admission

- a. Involuntary admission proceedings will be initiated when the inmate has a mental illness and there exists a substantial likelihood that, as a result of the mental illness, the inmate will, in the near future:
  - i. Cause serious physical harm to themselves as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information or
  - ii. Cause serious physical harm to others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information or

- iii. Suffer serious harm due to their lack of capacity to protect themselves from harm or to provide for their basic human needs, and
  - iv. Alternatives to involuntary admission have been explored and deemed unsuitable and there is no less restrictive alternative to such an admission.
- b. Inmates considered for transfer to the MCTC ACU or the FCCW ACU are typically diagnosed with and/or exhibit one or more of the following:
- i. Psychotic disorders
  - ii. Major affective disorders
  - iii. Incapacitating anxiety or dissociative disorders
  - iv. Cognitive disorders which preclude placement in a general population
  - v. Overtly suicidal or self-injurious behavior
  - vi. Intellectual disabilities when coexisting with conditions listed above
  - vii. Symptom presentation suggesting major mental disorder which requires an extended evaluation in an inpatient setting.
3. ACU Referral
- a. The referring Mental Health Clinician will first contact and discuss the referral with the ACU (MCTC or FCCW) Admissions Coordinator and the Senior Mental Health Clinician at Central Classification Services (CCS) or designee **BEFORE** petitioning a Judge or special justice for admission of an inmate. The Mental Health Clinician will then complete an assessment documented on a *Mental Health Transfer Request 730\_F6*.
- b. The *Mental Health Transfer Request* will be current (completed within the previous 14 days) at the time of the referral request. (5-ACI-6A-33) The original will be filed in Section IV of the inmate's health record and copies forwarded to the ACU and the Senior Mental Health Clinician at CCS or designee via electronic messaging or fax.
- i. If the ACU agrees to accept the transfer, the Mental Health Clinician of the referring facility will petition the Court for the involuntary admission.
  - ii. If the ACU does not agree to accept the transfer, the Senior Mental Health Clinician at CCS or designee will be contacted for placement options.
- c. In emergencies when there is insufficient time for the Mental Health Clinician of the referring facility to petition a Court regarding an inmate who meets the criteria for involuntary admission, arrangements can be made for a temporary, emergency transfer to an ACU. The Mental Health Clinician may contact the ACU Admissions Coordinator for approval of the emergency admission. Within five working days of the inmate's emergency admission to the ACU, the treatment staff will determine if the inmate is appropriately placed. (5-ACI-6C-12)
- i. If the assessing Mental Health Clinician determines that the referral is appropriate, the ACU staff will initiate involuntary admission proceedings as soon as possible after transfer and notify the Senior Mental Health Clinician at CCS or designee. (5-ACI-6C-12)
  - ii. If the assessing Mental Health Clinician, in consultation with the ACU Admissions Coordinator, determines that the referral is inappropriate, they will contact the Senior Mental Health Clinician at CCS or designee for transfer arrangements, typically back to the sending facility.
4. Involuntary Admission Hearing and Jurisdiction
- a. Judicial proceedings regarding admission of inmates to an ACU should typically occur within the jurisdiction of the referring DOC facility, based upon information provided by the Mental Health Clinician.
- b. Inmates may appeal involuntary admission orders within ten days of such orders, per COV §53.1-40.4, *Appeal of order authorizing involuntary admission*. (5-ACI-6C-12)
- c. If the petition for involuntary admission is granted, the referring Mental Health Clinician will contact the Senior Mental Health Clinician at CCS or designee and the ACU Admissions Coordinator for transfer arrangements.
- d. If the petition for involuntary admission is not granted, the referring Mental Health Clinician will

- notify the ACU Admissions Coordinator and will consult with the Senior Mental Health Clinician at CCS or designee for placement options.
- e. Involuntary admission may also occur when the ACU petitions the local court for an involuntary admission of an inmate whose current order is about to expire.
  - f. Involuntary admission forms include the *Petition for Order for Involuntary Admission to a Licensed Correctional Mental Health Facility* 730\_F4, *Affidavit in Support of Petition for Order for Involuntary Admission to A Licensed Correctional Mental Health Facility* 730\_F4A (to be completed by a Licensed Psychiatrist, Licensed Clinical Psychologist, Licensed Physician, Licensed Clinical Social Worker, or Licensed Professional Counselor), and the *Order for Involuntary Admission to a Licensed Correctional Mental Health Facility* 730\_F4B (to be completed by a Licensed Psychiatrist, Licensed Clinical Psychologist, Licensed Physician, Licensed Clinical Social Worker, Licensed Professional Counselor, Mental Health Clinician, or Director of the mental health care hospital, facility, or program). An original set of these documents must be sent to an ACU facility with the inmate along with the inmate's criminal record. A copy of these documents will be maintained at the local Court. Some court jurisdictions may require an original set of documents and when this occurs, two sets of original documents are required. Copies will also be filed in Section IV of the inmate's health record.
5. Provision of Medical and Mental Health Treatment of Inmates Incapable of Giving Consent (5-ACI-6C-04)
- a. In most cases, when the Court is petitioned to order the involuntary admission of an inmate to an ACU, the petitioner will also seek an order authorizing specific treatment for the inmate.
  - b. COV §53.1-40.1, *Medical and mental health treatment of prisoners incapable of giving consent* and COV §53.1-40.2, *Involuntary admission of prisoners with mental illness*, provides for the DOC to petition the Court for an order authorizing treatment for an inmate who is incapable either mentally or physically of giving consent to such treatment and the proposed treatment is in the best interests of the inmate; see the ACU section above for the process of involuntary admission to a licensed correctional mental health facility.
  - c. Obtaining the order authorizing treatment will be accomplished in accordance with COV §53.1-40.1, *Medical and mental health treatment of prisoners incapable of giving consent* and COV §53.1-40.2, *Involuntary admission of prisoners with mental illness*, using the appropriate forms; *Petition for Order Authorizing Involuntary Medical and/or Mental Health Treatment* 730\_F5, *Affidavit in Support of Petition for Order Authorizing Involuntary Medical and/or Mental Health Treatment* 730\_F5A (to be completed by a Licensed Psychiatrist, Licensed Clinical Psychologist, Licensed Physician, Licensed Clinical Social Worker, or Licensed Professional Counselor), *Order Authorizing Involuntary Medical and/or Mental Health Treatment* 730\_F5B (to be completed by a Licensed Psychiatrist, Licensed Clinical Psychologist, Licensed Physician, Licensed Clinical Social Worker, or Licensed Professional Counselor).
6. Voluntary Admission – qualifying inmates may submit an *Application for Voluntary Admission to a Licensed Correctional Mental Health Facility* 730\_F8. Voluntary admission status may be considered only when an inmate is currently involuntarily admitted to an ACU and one of the following conditions apply:
- a. The inmate's good time release or mandatory parole date is within 60 days of the expiration of the Involuntary Admission Order.
  - b. The inmate has a significant history of medication non-compliance that has resulted in rapid deterioration of mental health status.
  - c. The inmate has a significant medical appointment or consultation within 30 days of the expiration date of the Involuntary Admission Order.
  - d. The inmate no longer meets involuntary admission criteria, a discharge summary has been completed, and the inmate is awaiting transfer from the ACU within 30 days following the expiration of the Involuntary Admission Order.



- e. The inmate has been accepted for admission to a Residential Treatment Unit (RTU) and bed availability is expected within the next 30 days.
  - 7. Discharge from an ACU to a DOC non-Mental Health Unit (MHU) setting
    - a. Assignments to an ACU are temporary. The inmate should be returned to the referring facility upon discharge unless the placement is no longer appropriate. Inmates admitted from a Reception and Classification Center should be discharged to the initial permanent assignment unless the placement is no longer appropriate.
    - b. When staff at an ACU recommends inmate discharge, a *Mental Health Discharge Summary 730\_F7* will be completed within 14 days before the discharge. The *Mental Health Discharge Summary* should include placement recommendations.
    - c. The original will be filed in Section IV of the inmate's health record and a copy of the *Mental Health Discharge Summary* will be sent to the Senior Mental Health Clinician at CCS for completion of required classification processing. The Senior Mental Health Clinician at CCS or designee will review the request for transfer, execute the required classification paperwork, and provide a copy to the Senior Mental Health Clinician at the receiving facility.
  - 8. Discharge to a Mental Health RTU
    - a. Inmates whose mental status and services needs preclude their placement in general population may be discharged to a RTU.
    - b. The ACU's staff will seek approval from the RTU Director and the Senior Mental Health Clinician at CCS or designee for such a transfer.
    - c. When staff at an ACU recommends inmate discharge, a *Mental Health Discharge Summary 730\_F7* will be completed within 14 days before the discharge. The *Mental Health Discharge Summary* should include placement recommendations.
    - d. The original will be filed in Section IV of the inmate's health record and a copy of the *Mental Health Discharge Summary* will be sent to the Senior Mental Health Clinician at CCS for completion of required classification processing. The Senior Mental Health Clinician at CCS or designee will review the request for transfer, execute the required classification paperwork, and provide a copy to the Senior Mental Health Clinician or MHU Director at the receiving facility.
  - 9. Discharge to the Community; see *Discharge to the Community* section below.
- B. Mental Health RTUs (5-ACI-6A-38)
- 1. General
    - a. Inmates who do not require admission to an ACU but who would benefit from treatment and other services provided in a structured, therapeutic environment may be referred to a RTU.
    - b. Attachment 1, *Residential Treatment Admission Guidelines*, provides a list of currently available programs and the admission guidelines for each.
  - 2. Mental Health RTU Referral
    - a. The referring Mental Health Clinician will contact and discuss the referral with the Mental Health RTU Director and the Senior Mental Health Clinician at CCS or designee. The Mental Health Clinician will complete an assessment documented on a *Mental Health Transfer Request 730\_F6*. The *Mental Health Transfer Request* will be current (completed within the previous 14 days) at the time of the referral request. (5-ACI-6A-33) The original will be filed in Section IV of the inmate's health record and copies sent via electronic messaging or fax to the RTU Director and the Senior Mental Health Clinician at CCS or designee.
    - b. If the Mental Health RTU agrees to accept the transfer, the Senior Mental Health Clinician at CCS or designee will coordinate the transfer.
    - c. If the Mental Health RTU does not agree to accept the transfer, the Senior Mental Health Clinician at CCS or designee will be contacted for placement options.
  - 3. Discharge from a Mental Health RTU



- a. When the Mental Health Residential Treatment staff recommends discharge of an inmate and the receiving facility is within the DOC, a *Mental Health Discharge Summary* 730\_F7 will be completed within 14 days before the discharge and placed in Section IV of the inmate's health record. The *Mental Health Discharge Summary* should include placement recommendations. If the placement remains appropriate, the inmate should be returned to the referring facility upon discharge.
- b. A copy of the *Mental Health Discharge Summary* will be sent to the Senior Mental Health Clinician at CCS or designee for completion of required classification processing. The Senior Mental Health Clinician at CCS or designee will review the request for transfer, execute the required classification paperwork, and provide a copy to the Senior Mental Health Clinician or MHU Director at the receiving facility.
- c. Inmates admitted from a Reception and Classification Center should be discharged to the initial permanent assignment unless the placement is no longer appropriate.
- d. Discharge to the Community; see the *Discharge to the Community* Section below.

#### C. Treatment Planning and Interventions

1. An Individual Treatment Plan (ITP) is required for each inmate admitted to an ACU or RTU. A written ITP is encouraged but not required for inmates receiving outpatient services unless they have been classified as having a serious mental illness (SMI), in which case the *Serious Mental Illness Treatment Plan* 730\_F46 would be used. (5-ACI-6A-07)
2. In general, treatment planning is the process of:
  - a. Intake
    - i. Orientation to the MHU
    - ii. Preliminary assessment
    - iii. Development of preliminary ITP
  - b. Treatment Plan Development
  - c. Treatment Plan Reviews
  - d. Discharge Planning
3. Treatment Plan Development
  - a. The ITP is developed with the inmate, based upon the completed assessments.
  - b. See Attachment 2, *Individualized Treatment Planning Instructions*, for guidance completing the components of the ITP.
  - c. In ACU placement, a preliminary ITP is completed within 24 hours of admission. This preliminary ITP will remain in place no longer than 30 days and the Treatment Team reassesses the ITP as needed, but at least every 90 days.
  - d. The ITP is comprised of: (5-ACI-6A-07)
    - i. *Master Treatment Plan* 730\_F10
    - ii. *Inactive Problem List* 730\_F10A
    - iii. *Objectives and Intervention Plans* 730\_F10B
    - iv. *Interdisciplinary Team Reassessment* 730\_F10C

#### D. Transfer from Facility to Facility

1. Mental health and wellness services staff may consider an inmate for transfer from one facility to another to meet the inmate's specific identified mental health and wellness service needs.
2. The referring Mental Health Clinician will contact and discuss the referral with the Senior Mental Health Clinician at CCS or designee and the Senior Mental Health Clinician of the receiving facility; see *ACU* and *RTUs* sections above for transfers to DOC MHUs.
3. Within 14 days before the referral request, the referring Mental Health Clinician will complete an assessment documented on a *Mental Health Transfer Request* 730\_F6, file the original in Section IV

of the inmate's health record, and send copies via electronic messaging or fax to the Senior Mental Health Clinician at CCS or designee and the Senior Mental Health Clinician of the receiving facility. (5-ACI-6A-33)

4. If the request for transfer is approved, the Senior Mental Health Clinician at CCS or designee will complete the necessary classification processing.
5. Whenever an inmate that is receiving mental health and wellness services outside a MHU is transferred from one DOC facility to another, the sending Mental Health Clinician should complete and send an *Electronic Notification of Mental Health Inmate Transfer 730\_F11* to the receiving Senior Mental Health Clinician. This is a courtesy notification with the intent of providing as much relevant information as needed, if the inmate were coming to the facility of the Mental Health Clinician who was completing the *Electronic Notification of Mental Health Inmate Transfer* and is not intended for inclusion in the inmate's health record.

#### E. Secure Diversionary Treatment Program (SDTP)

1. SDTP- Overall program
  - a. High Security Diversionary Treatment Program (HSDTP) – Wallens Ridge State Prison
  - b. Intensive Diversionary Treatment Program (IDTP)- Marion Correctional Treatment Center
  - c. Diversionary Treatment Program (DTP)- River North Correctional Center
    - i. Enhanced Prosocial Interaction Community (EPIC)
    - ii. Secure Communicative and Reintegration Environment (SCORE)
2. The SDTP provides treatment in a secure setting to inmates who have been designated as SMI who frequently engage in assaultive, disruptive, and/ or unmanageable behaviors. The following inmates are eligible for referral to an SDTP:
  - a. Inmates who are housed in Restorative Housing and will not be released to the institution's General Population or moved into SD-1 or SD-2 within 28 days
  - b. Inmates assigned to Security Level S who are classified as SMI
  - c. Inmates transferring from one SDTP to another for appropriate housing
  - d. Inmates who were committed to Marion Correctional Treatment Center for AC from a SDTP site
3. The MDT will conduct a formal Institutional Classification Assessment Hearing and refer eligible SMI inmates for review and assignment to the appropriate SDTP in accordance with Operating Procedure 830.5, *Transfers, Institution Reassignments*.

#### F. Shared Allied Management (SAM) Unit

1. The SAM Unit promotes safety within institutions by avoiding the use of Restorative Housing to manage inmates that typically require a high level of services from security, mental health and wellness services, and/or health services staff.
2. Three specific inmate populations are eligible for assignment to a SAM Unit (Mental Health, Medical, and Vulnerable).
  - a. Mentally ill or inmates who have been diagnosed as SMI are eligible for assignment to a SAM Unit if they do not currently meet the criteria for assignment to an ACU, a Mental Health Residential Treatment, or a SDTP; and they are at a greater risk to cycle in and out of Restorative Housing and/or MHUs for disruptive behavior, which may be related to their mental health diagnoses and symptoms which may include:
    - i. A Mental Health Code 2 or 2S and are housed in RHU with a history of repeated misbehavior due to their mental illness
    - ii. Recently released from a MHU
    - iii. Had suicidal/self-harm incidents and/or thoughts in the last three months
    - iv. Have a difficult time adapting to the basic demands of their current housing status due to the

symptoms of their mental health diagnosis but do not currently meet the criteria for a MHU

b. Medically infirmed inmates requiring intensive medical attention, but not requiring admission to the infirmary.

c. Inmates who are at a great risk for victimization or being bullied in general population due to characteristics such as cognitive challenge, age (seniors and youthful), small in stature, or timid personalities.

3. Eligible inmates will be referred for assignment to a SAM Unit in accordance with Operating Procedure 830.5, *Transfers, Institution Reassignments*.

#### G. Outpatient Care

1. Outpatient mental health and wellness services are available to inmates in all major facilities, and crisis intervention and assessment services are provided as needed to inmates assigned to field units. (4-ACRS-4C-15 [I])
2. Community Corrections Mental Health Clinicians provide mental health and wellness services to probationers/parolees on P&P supervision in the community and at CCAPs. The community mental health and wellness services staff include the Community Corrections Mental Health Clinical Supervisor (MHCS), Regional Mental Health Clinicians (RMHCs), and District Mental Health Clinicians (DMHCs). DMHCs are assigned to cover each P&P District and CCAP under the supervision of the RMHC in their respective regions. A full-time Mental Health Clinician is assigned to Chesterfield Women's CCAP. (4-ACRS-4C-03 [CC], 4-ACRS-4C-15 [CC])
  - a. Situations that warrant a referral to a Community Corrections Mental Health Clinician may include but are not limited to:
    - i. A probationer/parolee has previously received mental health treatment or appears to have mental health problems that could impact the ability to comply with conditions of probation, parole, and/or post release supervision.
    - ii. There is a question if, based on the probationer's/parolee's mental health status, they should continue to be assigned to a particular site or program.
    - iii. A mentally disordered probationer/parolee has violated the conditions of probation and/or parole and there is a question of whether to impose sanctions or pursue treatment options.
  - b. For situations requiring mental health intervention that arise during regular working hours at a CCAP:
    - i. The Superintendent, Senior P&P Officer, or Nurse at the facility will contact the appropriate Community Corrections Mental Health Clinician to discuss the situation.
    - ii. Typically, the Community Corrections Mental Health Clinician will meet with and assess the CCAP probationer/parolee at the referring facility and will make recommendations for further action and/or follow up services.
    - iii. The Community Corrections Mental Health Clinician will document the intervention/assessment on an external note uploaded to VACORIS or via a *Mental Health Services Progress Note 730\_F30* filed in the CCAP probationer's/parolee's health record at the facility.
    - iv. If the assigned Community Corrections Mental Health Clinician determines that mental health services are warranted, the Mental Health Clinician will relay this to the referring individual so that the appropriate follow up action(s) can occur.
    - v. If the Community Corrections Mental Health Clinician cannot be reached, the referring unit should contact the RMHC or Mental Health Clinical Supervisor.
  - c. For situations arising after regular working hours at a CCAP:
    - i. The Superintendent, Senior P&P Officer, or Nurse at the facility will contact the assigned Community Corrections Mental Health Clinician to discuss the situation. If unable to reach the DMHC, the RMHC or MHCS should be contacted.
    - ii. Based on the information provided, the RMHC/MHCS will make recommendations for further action and/or follow up services including crisis services that are available by community

providers and will follow up with the appropriate DMHC no later than the next working day. This will be communicated verbally to the referring staff or designee.

- iii. No later than the next working day, the DMHC will document the intervention/assessment on an external note uploaded to VACORIS or via a *Mental Health Services Progress Note 730\_F30* filed in the CCAP probationer's/parolee's health record.

#### H. Discharge to the Community

##### 1. Community Release Planning (5-ACI-6A-34)

- a. **Problematic Release:** Facility staff should contact the Community Release Unit soon as possible once an inmate is identified as a problematic release. Depending on the complexity of the case, a referral to the Problematic Release Unit should be made up to 12 months and no less than 90 days before the inmate's anticipated release date by completing and submitting a *Request for Assistance-Problematic Release 820\_F9*. The form must be completed in Word and sent via email to the Community Release Mailbox, and this process should be coordinated between mental health and wellness services staff and the Re-entry Counselor. Facility staff should contact the appropriate DMHC at least 60 days prior to the release date to coordinate release planning.
- b. **Disability Applications:** Inmates with a Code of MH-2 or higher will need to be screened to determine if they are potentially eligible for SSI benefits; see Operating Procedure 820.2, *Inmate Re-entry Planning*.
- c. The disability process should begin prior to the inmate's release because of the MOU between DOC and the Social Security Administration/Disability Determination Services (SSA/DDS). Under this agreement, inmates who apply prior to release will get priority status for a decision from DDS. If not completed prior to release, it could take six to 12 months for an inmate to receive benefits in the community.
  - i. The screening will be completed within 180 days of release, with the facility Mental Health Clinician reviewing available mental health and wellness services information. The facility Mental Health Clinician can consult with the appropriate Community Corrections Mental Health Clinicians for consultation on factors related to the inmate's eligibility for disability determination.
  - ii. Issues for consideration in the screening may include determining if the inmate has a diagnosis identified by the SSA on its Listing of Impairments; see *SSA Blue Book Criteria* on the *DOC Intranet*, noting the severity of the illness as well as how the disorder impacts the ability of the inmate to engage in gainful activity.
  - iii. For those inmates who may be eligible for benefits, the Mental Health Clinician will complete a *Mental Health Appraisal for Disability 730\_F42*.
  - iv. The Mental Health Clinician will confer with health services staff at the facility to ensure that the inmate's medical problems or physical limitations are documented on the *Mental Health Appraisal for Disability 730\_F42*.
  - v. If the Mental Health Clinician is not a Licensed Clinical Psychologist or Psychiatrist, the *Mental Health Appraisal for Disability 730\_F42* must be signed (or emailed) by a Licensed Clinical Psychologist or Psychiatrist. The Mental Health Clinician will email the completed form within four months of the inmate's expected release to the inmate's assigned Case Management Counselor. For inmates assigned to designated MHUs, the Mental Health Clinician may provide the Case Management Counselor with other information in addition to the *Mental Health Appraisal for Disability 730\_F42*.
  - vi. A copy of the completed *Mental Health Appraisal for Disability 730\_F42* for the disability application packets should be provided to the community mental health and wellness services staff (MHCS, RMHC, and DMHC).
  - vii. Completion of SSI application should be coordinated with the Re-entry Counselor and then submitted to the local SSA Office. Disability claims may not be submitted more than 120 days (four months) prior to the release date. Age-based claims (i.e., for inmates age 65 and older) may not be submitted more than 30 days prior to release; see *SSA Blue Book Criteria*, and

*Mental Health Discharge Planning Guide on the DOC Intranet.*

## 2. Release Documentation

- a. Thirty to 45 days prior to the inmate's release from the DOC, the *Mental Health Release Summary to Community* 730\_F9 is to be completed by a Mental Health Clinician for inmates being released from an ACU or RTU or with a Mental Health Classification Code of two or higher; see Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*.
- b. For inmates released from licensed MHUs, a *Mental Health Discharge Summary* 730\_F7 should be completed within 14 days of release and forwarded to the appropriate Community Corrections Mental Health Clinician and Community Services Board (CSB) or another provider. The original *Mental Health Discharge Summary* 730\_F7 will be placed in Section IV of the inmate's health record.
- c. The original *Mental Health Release Summary to Community* 730\_F9 will be placed in Section IV of the inmate's health record. Copies of the *Mental Health Release Summary to Community* 730\_F9 will be emailed to the Chief P&P Officer of the receiving or sentencing P&P District, P&P District mailbox, Community Release mailbox, and appropriate Community Corrections Mental Health Clinicians (DMHC, MHCS, and RMHC). A copy of the *Mental Health Release Summary to Community* 730\_F9 should be faxed to the local CSB or health care provider where the inmate has an appointment.

## 3. Continuity of Care

- a. When screening for a disability and problematic release, facility mental health and wellness services staff should also talk with the inmate about post release plans, including whether the inmate intends to continue psychotropic medications and/or other mental health treatment in the community.
- b. The Mental Health Clinician will also meet with the inmate prior to release to review and explain the aftercare plan.
  - i. Community Appointments: Facility mental health and wellness services staff will schedule a follow up appointment with a community service provider or CSB in the area where the inmate is being released. An effort will be made to secure an appointment even at CSBs who have open access (walk-in hours). If there is any difficulty, the facility Mental Health Clinician will contact the DMHC or RMHC for assistance. The DMHC may also recommend another treatment provider in areas where CSB services are limited.
  - ii. Psychotropic Medication: If the inmate is prescribed psychotropic medication and specific criteria have been met; see Operating Procedure 720.5, *Pharmacy Services*, regarding psychotropic medication for inmates being released from the facility, the Mental Health Clinician will coordinate with facility health services staff and arrange for the inmate to leave the facility with up to a 90-day supply of medication.
    - (a) The Psychiatrist or Health Authority will contact the Senior Mental Health Clinician and provide written back-up prescriptions to be mailed to the assigned P&P District Chief P&P Officer upon release of inmates under P&P supervision. Copies of the prescriptions will be filed in Section IV of the inmate's health record. The Senior Mental Health Clinician will send an email to the Chief P&P Officer to inform them of the prescription, and this email will be copied to the community corrections mental health and wellness services staff (MHCS, RMHC, and DMHC). A cover memo will accompany the written prescription and will include the following:
      - Name and VACORIS number of the inmate
      - Name of the medication, strength, and directions for use
      - Prescriber
      - Name and phone number of the Senior Mental Health Clinician
    - (b) Inmates released without supervision obligations may contact the Senior Mental Health Clinician at the facility to request a backup prescription. Backup prescriptions will not be provided for inmates released to out of state home plans.



## I. Civil Commitment

1. Inmates being released from a DOC facility who meet involuntary admission criteria will be assessed for admission to the DBHDS through the Forensic Unit at Central State Hospital (CSH). CSH will determine the appropriate hospital placement within the DBHDS.
2. The Mental Health Clinician will contact the Forensic Unit's Admission Officer no less than 30 days after determining that involuntary commitment is indicated to plan for the transfer of the inmate. The Mental Health Clinician will also contact the Community Corrections Eastern RMHC and the DMHC assigned to Petersburg P&P District 7 and include them in all subsequent communication regarding the commitment and transfer to the DBHDS.
3. Admission under COV §37.2-814 et seq., *Commitment hearing for involuntary admission; written explanation; right to counsel; rights of petitioner* (not COV §53.1-40.2, *Involuntary admission of prisoners with mental illness*) is initiated by the Mental Health Clinician prior to the transfer of the inmate to the Forensic Unit. The local Court is petitioned to hold a civil admission proceeding for an inmate who is still incarcerated in the DOC and may make an appropriate order for civil admission upon the inmate's release. Per COV §53.1-40.9, *Civil admission proceeding prior to release*, an inmate whose release from the custody of the DOC is imminent and who may be mentally ill and in need of hospitalization may be the subject of an admission proceeding under COV §37.2-814 et seq., *Commitment hearing for involuntary admission; written explanation; right to counsel; rights of petitioner*, within 15 days prior to the anticipated release date, and any admission order entered in such proceedings will be effective upon the release of the inmate from the DOC.
4. The Mental Health Clinician will notify the appropriate Community Corrections Mental Health Clinicians (Regional and District) of the pending transfer. Community Corrections Mental Health Clinicians will serve as the point of contact for the appropriate P&P District and the DBHDS regarding treatment and discharge planning. DBHDS commitment forms are different than DOC forms, DBHDS commitment forms are as follows:
  - a. *Explanation of Involuntary Commitment Process-Description of Rights*
  - b. *Independent Examination, Certification and Recommendations for Placement, Care and Treatment*
  - c. *Order For Treatment*
  - d. *Petition For Involuntary Admission for Treatment*
5. Facility Mental Health Clinicians will notify the appropriate CSB regarding the pending transfer of the inmate to the DBHDS and document notification on the *Mental Health Release Summary to Community 730\_F9*. Mental Health Clinicians must notify the CSB that serves the inmate's *Home Plan* area; if the inmate is homeless, the CSB for the sentencing jurisdiction will be notified.
6. Transportation of the committed inmate will be coordinated and provided by the DOC.
7. The Forensic Unit staff evaluates the transferred, committed mentally disordered inmates to determine the appropriate least restrictive treatment setting. When clinically indicated, the Forensic Unit staff coordinates subsequent transfers to other regional hospitals or treatment settings.
8. The referring staff will provide the following information to the DBHDS upon the DOC discharge and admission of an inmate to the Forensic Unit:
  - a. If being released from a MHU, a *Mental Health Discharge Summary 730\_F7*
  - b. A *Mental Health Release Summary to Community 730\_F9*
  - c. A copy of the inmate's conditions of probation, parole and/or post release supervision
  - d. Whether or not the inmate's release was mandatory
  - e. The name and phone number of the P&P District to which the inmate is expected to ultimately return.
  - f. Any available information regarding the potential *Home Plan* for the inmate, i.e., what is planned or recommended for the inmate beyond their admission to a DBHDS hospital.
  - g. Medicaid and SSA (SSI/SSDI) applications, *Mental Health Appraisal for Disability 730\_F42*, and



the *DOC Referral Questionnaire for CSH*.

9. The mental health and wellness services staff can provide any information, which supplements the above, for example, a psychosocial history. Mental health and wellness services staff are not authorized to release copies of Pre-Sentence Investigations.

**J. Care in the Community**

1. Community Corrections Mental Health Clinicians will coordinate with facility Mental Health Clinicians, CSBs, local service providers, and other resources as necessary to assist in the transition of inmates from DOC facilities into the community.
2. P&P Officers may refer probationers/parolees to Community Corrections Mental Health Clinicians for assessment to determine their need for services and to facilitate access to the appropriate resources.
3. Community Corrections Mental Health Clinicians may perform mental health assessments to provide recommendations for special conditions of supervision related to mental health care and treatment. Note: Community Corrections Mental Health Clinicians are not authorized to perform court ordered psychological evaluations that require a Licensed Clinical Psychologist.
4. Community Corrections Mental Health Clinicians may assess a probationer/parolee for risk of harm to self or others, but they do not provide emergency services. Probationers/Parolees who meet either of these criteria will be referred to the local CSB, crisis services, or local hospital. Community Corrections Mental Health Clinicians can assist DOC staff in the process of obtaining emergency community services for probationers/parolees under community supervision.
5. Upon receiving an allegation from a probationer/parolee under community supervision that they were sexually abused while confined at a correctional facility, the head of the facility that received the allegation must notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. (§115.63[a], §115.263[a])
6. Such notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation. (§115.63[b], §115.263[b])
7. The Facility Unit Head must document that notification has been provided. (§115.63[c], §115.263[c])

## REFERENCES

COV §37.2-814 et seq., *Commitment hearing for involuntary admission; written explanation; right to counsel; rights of petitioner*

COV §53.1-40.1, *Medical and mental health treatment of prisoners incapable of giving consent*

COV §53.1-40.2, *Involuntary admission of prisoners with mental illness*

COV §53.1-40.4, *Appeal of order authorizing involuntary admission*

COV §53.1-40.9, *Civil admission proceeding prior to release*

12VAC35-105, *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*

Operating Procedure 720.5, *Pharmacy Services*

Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*

Operating Procedure 735.2, *Sex Offender Treatment Services (Institutions)*

Operating Procedure 820.2, *Inmate Re-entry Planning*

Operating Procedure 830.5, *Transfers, Institution Reassignments*

## ATTACHMENTS

Attachment 1, *Residential Treatment Admission Guidelines*

Attachment 2, *Individualized Treatment Planning Instructions*

## FORM CITATIONS



*Petition for Order for Involuntary Admission to a Licensed Correctional Mental Health Facility 730\_F4*  
*Affidavit in Support of Petition for Order for Involuntary Admission to A Licensed Correctional Mental Health Facility 730\_F4A*  
*Order for Involuntary Admission to a Licensed Correctional Mental Health Facility 730\_F4B*  
*Petition for Order Authorizing Involuntary Medical and/or Mental Health Treatment 730\_F5*  
*Affidavit in Support of Petition for Order Authorizing Involuntary Medical and/or Mental Health Treatment 730\_F5A*  
*Order Authorizing Involuntary Medical and/or Mental Health Treatment 730\_F5B*  
*Mental Health Transfer Request 730\_F6*  
*Mental Health Discharge Summary 730\_F7*  
*Application for Voluntary Admission to a Licensed Correctional Mental Health Facility 730\_F8*  
*Mental Health Release Summary to Community 730\_F9*  
*Master Treatment Plan 730\_F10*  
*Inactive Problem List 730\_F10A*  
*Objectives and Intervention Plans 730\_F10B*  
*Interdisciplinary Team Reassessment 730\_F10C*  
*Electronic Notification of Mental Health Inmate Transfer 730\_F11*  
*Mental Health Appraisal 730\_F17*  
*Mental Health Services Progress Note 730\_F30*  
*Mental Health Appraisal for Disability 730\_F42*  
*Serious Mental Illness Treatment Plan 730\_F46*  
*Request for Assistance - Problematic Release 820\_F9*  
*DOC Referral Questionnaire for CSH*  
*Explanation of Involuntary Commitment Process - Description of Rights*  
*Independent Examination, Certification and Recommendations for Placement, Care and Treatment*  
*Order for Treatment*  
*Petition for Involuntary Admission for Treatment*