

Exhibit 51



VIRGINIA DEPARTMENT OF CORRECTIONS

Institutional Classification Authority Hearing

DOC IH

DOC Location: Red Onion State Prison

Report generated by Shepherd, J W

Report run on 3/10/2017 at 4:09 PM

Offender Name: Cavitt, Brian K	DOC#: 18 [REDACTED]	DOC Location: Red Onion State Prison	Bed Assignment: C-1-SLS-120-B
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Part I: ICA Referral Notice

You were scheduled to appear before the Institutional Classification Authority on or after 02/01/2017 for Internal Status

Comments: 90 day appropriate housing review

Authorizing Staff

Date & Time

Hearing Date: 2/3/2017

Offender Statement: I don't belong in here

Reporting Staff Comments: Remain in segregation, offender has not met all the requirements of the step down program.

Part II: Hearing Disposition

Internal Status Review:

The ICA recommends: Internal status change to Intensive Management 0

Rationale: Remain in segregation, offender has not met all the requirements of the step down program.

ICA: Stanley,
Carroll R

Date: 2/3/2017

Administrative Review:

Decision: Approve

Internal status change to Intensive Management 0

Duncan, Amee B

Date: 2/6/2017

Comments: Remain segregation, has not completed all the requirements of the Step-Down Program.

Exhibit 52



VIRGINIA DEPARTMENT OF CORRECTIONS

Institutional Classification Authority Hearing

DOC-11H

DOC Location: Red Onion State Prison

Report generated by Brace, R

Report run on 11/13/2019 at 12:36 PM

Offender Name: Cornelison,
Derek M

DOC#: 11

DOC Location: Red Onion State
Prison

Bed Assignment: C-1-SLS-
126-B

Part I: ICA Referral Notice

You were scheduled to appear before the Institutional Classification Authority on or after 07/12/2017 for Internal Status

Comments: 90 day appropriate housing hearing

Authorizing Staff

Date & Time

Hearing Date: 7/12/2017

Offender Statement: I want to go to GP

Reporting Staff Comments: Remain segregation. Offender has not met all the requirements of the step-down program.

Part II: Hearing Disposition

Internal Status Review:

The ICA recommends: Internal status change to Intensive Management 1

Rationale: Remain segregation. Offender has not met all the requirements of the step-down program.

ICA: Kiser, Justin
W

Date: 7/13/2017

Administrative Review:

Decision: Approve

Internal status change to Intensive Management 1

Duncan, Ameer B

Date: 7/19/2017

Comments: Remain segregation, Cornelison has not completed the required criteria of the Step-Down Program.

EXHIBIT 53
(Filed Under Seal)

EXHIBIT 54
(Filed Under Seal)

Exhibit 55



Virginia Department of Corrections

Mental Health Services

Operating Procedure 730.3

MHS: Levels of Service

Authority:

Directive 730, *Mental Health Services*

Effective Date: December 1, 2020

Amended: 9/1/21

Supersedes:

Operating Procedure 730.3, March 1, 2018

Access: ☐ Restricted ☒ Public ☐ Inmate

ACA/PREA Standards: 5-ACI-6A-07, 5-ACI-6A-08, 5-ACI-6A-33, 5-ACI-6A-34, 5-ACI-6A-37, 5-ACI-6A-38, 5-ACI-6A-39, 5-ACI-6C-04, 5-ACI-6C-12; 4-ACRS-4C-03, 4-ACRS-4C-15; §115.63, §115.263

**Content
Owner/
Reviewer:**

Denise Malone
Chief of Mental Health Services

Signature Copy on File

11/10/20

Signature

Date

Signatory:

Scott Richeson
Deputy Director of Programs, Education,
Reentry

Signature Copy on File

11/16/20

Signature

Date

REVIEW

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

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, ACA standards, PREA standards, and DOC directives and operating procedures.

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DEFINITIONS

Acute Care Unit - A designated treatment unit licensed to provide inpatient mental health services for inmates whose functioning is so severely impaired by a mental disorder that they meet the criteria for involuntary admission.

Aftercare Services - Services provided by community mental health professionals to inmates who still require mental health 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 §53.1-67.7 and COV §53.1-67.8.

Facility - Any institution or Community Corrections Alternative Program.

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.

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.

Mental Health Residential Treatment Unit - A designated treatment unit where mental health services are provided to inmates who are unable to function in a general population setting due to mental disorder but who typically do not meet the criteria for admission to an Acute Care unit.

Inmate with Serious Mental Illness (SMI) - Inmate diagnosed with a Psychotic Disorder, Bipolar Disorder, Major Depressive Disorder, PTSD or Anxiety Disorder, or any diagnosed mental disorder (excluding substance abuse 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.

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.

Psychology Associate - 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 Psychiatric Provider, Social Worker or Registered Nurse.

Secure Diversionary Treatment Program (SDTP) - A residential programming unit with bed assignments designated for eligible inmates who are classified as Seriously Mentally Ill (SMI), 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.

Shared Allied Management (SAM) Unit - A residential programming unit operated at designated DOC 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/ or medical staff.

Treatment Team - An interdisciplinary team typically comprised of a psychiatrist, psychologist or psychology associate, clinical social worker, and nurse who has a psychiatric background; the team works in conjunction with other support staff, including medical, counseling, and security personnel, 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 services system with appropriate levels of care for mentally disordered inmates/probationers/parolees housed in Department of Corrections (DOC) facilities or under DOC supervision in the community.

PROCEDURE

I. Services

- A. The DOC offers a range of mental health services including Acute Care, 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 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 [I])
 1. Facilities with full-time Psychology Associates have a Psychology Associate on call at all times to provide emergency mental health services through consultation and, if needed, crisis intervention.
 2. Facilities without full-time Psychology Associates request emergency mental health services by contacting the assigned Mental Health Clinical Supervisor or designated Psychology Associate at another facility; see *Guidelines to Access Emergency Mental Health Services*, Operating Procedure 730.2, *Mental Health Services: Screening, Assessment, and Classification*.
- D. Community Corrections Psychology Associates provide assessment and referral services for probationers/parolees under Probation and Parole supervision in the community and in CCAP facilities. (4-ACRS-4C-15 [CC])

II. Levels of Care

A. Acute Care

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 Acute Care Unit (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; 4-4404).
- c. Male inmates who are in need of acute care may be admitted to Marion Correctional Treatment Center (MCTC) ACU. Female inmates who are in need of acute care 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 Psychology Associate will first contact and discuss the referral with the ACU (MCTC or FCCW) Admissions Coordinator and the Psychology Associate Senior at Central Classification Services (CCS) or designee before petitioning a judge or special justice for admission of an inmate. The Psychology Associate will then complete an assessment documented on a [Mental Health Transfer Request - MH 6 730_F6](#).
 - b. The 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 Health Record and copies forwarded to the ACU and the Psychology Associate Senior at CCS or designee via electronic messaging or fax.
 - i. If the ACU agrees to accept the transfer, the Psychology Associate of the referring facility will petition the court for the involuntary admission.
 - ii. If the ACU does not agree to accept the transfer, the Psychology Associate Senior at CCS or designee will be contacted for placement options.
 - c. In emergencies when there is insufficient time for the Psychology Associate 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 Psychology Associate may contact the Acute Care 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 Psychology Associate determines that the referral is appropriate, the ACU staff will initiate involuntary admission proceedings as soon as possible after transfer and notify the Psychology Associate Senior at CCS or designee. (5-ACI-6C-12)
 - ii. If the assessing Psychology Associate, in consultation with the Acute Care Admissions Coordinator, determines that the referral is inappropriate, they will contact the Psychology Associate Senior 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 Psychology Associate.
 - 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 Psychology Associate will contact the Psychology Associate Senior at CCS or designee and the Acute Care Admissions Coordinator for transfer arrangements.
 - d. If the petition for involuntary admission is not granted, the referring Psychology Associate will notify the Acute Care Admissions Coordinator and will consult with the Psychology Associate

Senior 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 - DOC MH 1](#) 730_F4, [Affidavit in Support of Petition for Order for Involuntary Admission to A Licensed Correctional Mental Health Facility - DOC MH 1A](#) 730_F4A, and the [Order For Involuntary Admission To A Licensed Correctional Mental Health Facility - DOC MH 1B](#) 730_F4B. An original set of these documents must be sent to the Acute Care 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 *Acute Care* 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 - DOC MH 2](#) 730_F5, [Affidavit in Support of Petition for Order Authorizing Involuntary Medical and/or Mental Health Treatment - DOC MH 2A](#) 730_F5A, [Order Authorizing Involuntary Medical and/or Mental Health Treatment - DOC MH 2B](#) 730_F5B.
6. Voluntary Admission – qualifying inmates may submit an [Application for Voluntary Admission to a Licensed Correctional Mental Health Facility - DOC MH 3](#) 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 RTU and bed availability is expected within the next 30 days.
7. Discharge from an ACU to a DOC non-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 - DOC MH 7 730_F7](#) will be completed within 14 days before the discharge. The Discharge Summary should include placement recommendations.
 - c. The original will be filed in Section IV of the inmate Health Record and a copy of the Discharge Summary will be sent to the Psychology Associate Senior at CCS for completion of required classification processing. The Psychology Associate Senior at CCS or designee will review the request for transfer, execute the required classification paperwork, and provide a copy to the Senior Psychology Associate or MHU Director at the receiving facility.
 8. Discharge to a Mental Health Residential Treatment Unit (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 Psychology Associate Senior at CCS or designee for such a transfer.
 - c. When staff at an ACU recommends inmate discharge, a [Mental Health Discharge Summary - DOC MH 7 730_F7](#) will be completed within 14 days before the discharge. The 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 Discharge Summary will be sent to the Psychology Associate Senior at CCS for completion of required classification processing. The Psychology Associate Senior at CCS or designee will review the request for transfer, execute the required classification paperwork, and provide a copy to the Senior Psychology Associate or MHU Director at the receiving facility.
 9. Discharge to the Community; see *Discharge to the Community* section below.
- B. Mental Health RTU's (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 Psychology Associate will contact and discuss the referral with the Mental Health RTU Director and the Psychology Associate Senior at CCS or designee. The Psychology Associate will complete an assessment documented on a [Mental Health Transfer Request - MH 6 730_F6](#). The 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 Psychology Associate Senior at CCS or designee.
 - b. If the Mental Health RTU agrees to accept the transfer, the Psychology Associate Senior at CCS or designee will coordinate the transfer.
 - c. If the Mental Health RTU does not agree to accept the transfer, the Psychology Associate Senior 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 - DOC MH 7 730_F7](#) will be completed within 14 days before the discharge and placed in Section IV of the inmate's Health Record. The *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 *Discharge Summary* will be sent to the Psychology Associate Senior at CCS or

designee for completion of required classification processing. The Psychology Associate Senior at CCS or designee will review the request for transfer, execute the required classification paperwork, and provide a copy to the Senior Psychology Associate 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 Acute Care or RTU. A written ITP is encouraged but not required for inmates receiving Outpatient services. (5-ACI-6A-07)
2. In general, treatment planning is the process of:
 - a. Intake
 - i. Orientation to the Mental Health Unit (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 Acute Care RTU 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 staff may consider an inmate for transfer from one facility to another to meet the inmate's specific identified mental health needs.
2. The referring Psychology Associate will contact and discuss the referral with the Psychology Associate Senior at CCS or designee and the Psychology Associate Senior of the receiving facility; see *Acute Care* and *RTU's* sections above for transfers to DOC MHU's.
3. Within 14 days before the referral request, the referring Psychology Associate will complete an assessment documented on a [Mental Health Transfer Request - MH 6](#) 730_F6, file the original in Section IV of the inmate's Health Record, and send copies via electronic messaging or fax to the Psychology Associate Senior at CCS or designee and the Psychology Associate Senior of the receiving facility. (5-ACI-6A-33)
4. If the request for transfer is approved, the Psychology Associate Senior at CCS or designee will complete the necessary classification processing.
5. Whenever an inmate that is receiving mental health services outside a MHU is transferred from one DOC facility to another, the sending Psychology Associate should complete and send an [Electronic Notification of Mental Health Inmate Transfer](#) 730_F11 to the receiving Senior Psychology Associate. 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 Psychology Associate who was completing the *Notification*, 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 Seriously Mentally Ill (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
3. The interdisciplinary treatment team will conduct a formal ICA 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/ or medical staff.
2. 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 Acute Care, 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 MHU's for disruptive behavior, which may be related to their mental health diagnoses and symptoms which may include:
 - a. A Mental Health Code 2 or 2S and are housed in RHU with a history of repeated misbehavior due to their mental illness
 - b. Recently released from an ACU or other MHU's
 - c. Had suicidal/ self-harm incidents and/ or thoughts in the last three months
 - d. 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
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 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 Psychology Associates provide mental health services to probationers/ parolees on Probation and Parole supervision in the community and at CCAP facilities. The Community Mental Health 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 facility under the supervision of the RMHC in their respective regions. A full-time Psychology Associate 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 Psychology Associate 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 facility:
 - i. The Superintendent, Senior Probation Officer, or nurse at the facility will contact the appropriate Community Corrections Psychology Associate to discuss the situation.
 - ii. Typically, the Community Corrections Psychology Associate will meet with and assess the probationer/parolee at the referring facility and will make recommendations for further action and/or follow up services.
 - iii. The Community Corrections Psychology Associate will document the intervention/assessment on an external note uploaded to VACORIS or via a [Mental Health Services Progress Notes 730_F30](#) filed in the probationer's/parolee's Health Record at the facility.
 - iv. If the assigned Community Corrections Psychology Associate determines that mental health services are warranted, the Psychology Associate will relay this to the referring individual so that the appropriate follow up action(s) can occur.
 - v. If the Community Corrections Psychology Associate 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 facility:
 - i. The Superintendent, Senior Probation Officer or nurse at the facility will contact the assigned Community Corrections Psychology Associate 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 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 Notes 730_F30](#) filed in the probationer's/parolee's Health Record at the facility.

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 staff and the Re-entry Counselor.
- 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, *Re-entry Planning*. 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 Psychology Associate reviewing available mental health information.
 - 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 Psychology Associate will complete a [Mental Health Appraisal for Disability \(DOC MH 17-D\)](#) 730_F42.
 - iv. The Psychology Associate will confer with the medical staff at the facility to ensure that the inmate's medical problems or physical limitations are documented on the [Mental Health Appraisal for Disability \(DOC MH 17-D\)](#) 730_F42.
 - v. If the Psychology Associate is not a licensed clinical psychologist or psychiatrist, the [Mental Health Appraisal for Disability \(DOC MH 17-D\)](#) 730_F42 must be signed (or emailed) by a licensed clinical psychologist or psychiatrist. The Psychology Associate 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 MHU's, the Psychology Associate may provide the Case Management Counselor with other information in addition to the [Mental Health Appraisal for Disability \(DOC MH 17-D\)](#) 730_F42.
 - vi. A copy of the completed [Mental Health Appraisal for Disability \(DOC MH 17-D\)](#) 730_F42 for the disability application packets should be provided to the Community Mental Health 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 - DOC MH 9](#) 730_F9 is to be completed by a Psychology Associate 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 Services: Screening, Assessment, and Classification*.
 - b. For inmates released from licensed mental health units, a [Mental Health Discharge Summary - DOC MH 7](#) 730_F7 should be completed within 14 days of release and forwarded to the appropriate Community Corrections Psychology Associates and Community Services Board (CSB) or other provider. The original [Mental Health Discharge Summary - DOC MH 7](#) 730_F7 will be placed in Section IV of the inmate's Health Record.
 - c. The original [Mental Health Release Summary to Community - DOC MH 9](#) 730_F9 will be placed in Section IV of the inmate's Health Record. Copies of the [Mental Health Release Summary to Community - DOC MH 9](#) 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 Psychology Associates (DMHC, MHCS, and RMHC). A copy of the [Mental Health Release Summary to Community - DOC MH 9](#) 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 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 Psychology Associate will also meet with the inmate prior to release to review and explain the aftercare plan.
 - i. Community Appointments: Facility mental health staff should schedule a follow up

appointment with a community service provider or CSB in the area where the inmate is being released. An effort should be made to secure an appointment even at CSB's who have open access (walk-in hours). If there is any difficulty, the facility Psychology Associate should 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 Psychology Associate will coordinate with facility medical staff and arrange for the inmate to leave the facility with up to a 30-day supply of medication.
 - (a) The psychiatrist or Health Authority will contact the Senior Psychology Associate and provide written back-up prescriptions to be mailed to the District Chief P&P Officer upon release of inmates under probation and parole supervision. Copies of the prescriptions will be filed in Section IV of the inmate's Health Record. The Senior Psychology Associate will send an email to the Chief P&P Officer to inform them of the prescription, and this email should be copied to the Community Corrections 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 Psychology Associate
 - (b) Inmates released without supervision obligations may contact the Senior Psychology Associate 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

- a. Inmates being released from a DOC facility who meet involuntary admission criteria will enter the DBHDS through the Forensic Unit at Central State Hospital or another hospital determined by DBHDS.
- b. The Psychology Associate will contact the Forensic Unit's Admission Officer as soon as possible after determining that involuntary commitment is indicated to plan for the transfer of the inmate.
- c. 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 Psychology Associate 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.
- d. The Psychology Associate will notify the appropriate Community Corrections Mental Health Clinicians (Regional and District) of the pending transfer. Community Corrections Psychology Associates 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:
 - i. [*Explanation of Involuntary Commitment Process-Description of Rights*](#)
 - ii. [*Independent Examination, Certification and Recommendations for Placement, Care and Treatment*](#)
 - iii. [*Order For Treatment*](#)

- iv. [Petition For Involuntary Admission for Treatment](#)
- e. Facility Psychology Associates 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 - DOC MH 9](#) 730_F9. Psychology Associates 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.
- f. Transportation of the committed inmate will be coordinated and provided by the DOC
- g. 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.
- 2. 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 - DOC MH 7](#) 730_F7
 - b. A [Mental Health Release Summary to Community - DOC MH 9](#) 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 Office 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
- 3. The mental health staff can provide any information, which supplements the above, for example, a psychosocial history. Mental health staff are not authorized to release copies of Pre-Sentence Investigations.
- J. Care in the Community
 - 1. Community Corrections Psychology Associates will coordinate with facility Psychology Associates, CSB's, 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 Psychology Associates for assessment to determine their need for services and to facilitate access to the appropriate resources.
 - 3. Community Corrections Psychology Associates may perform mental health assessments to provide recommendations for special conditions of supervision related to mental health care and treatment. Note: Community Corrections Psychology Associates are not authorized to perform court ordered psychological evaluations that require a licensed clinical psychologist.
 - 4. Community Corrections Psychology Associates may assess a probationer/parolee for risk of harm to self or others but they do not provide emergency services. Probationer's/Parolee's who meet either of these criteria should be referred to the local CSB, crisis services, or local hospital. Community Psychology Associates can assist DOC staff in the process of obtaining emergency community services for probationer's/parolee's 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

Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition), American Psychiatric Association, Washington, D.C.

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 Services: Screening, Assessment, and Classification*

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

Operating Procedure 820.2, *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 - DOC MH 1 730_F4](#)

[Affidavit in Support of Petition for Order for Involuntary Admission to A Licensed Correctional Mental Health Facility - DOC MH 1A 730_F4A](#)

[Order For Involuntary Admission To A Licensed Correctional Mental Health Facility - DOC MH 1B 730_F4B](#)

[Petition for Order Authorizing Involuntary Medical and/or Mental Health Treatment - DOC MH 2 730_F5](#)

[Affidavit in Support of Petition for Order Authorizing Involuntary Medical and/or Mental Health Treatment - DOC MH 2A 730_F5A](#)

[Order Authorizing Involuntary Medical and/or Mental Health Treatment - DOC MH 2B 730_F5B](#)

[Mental Health Transfer Request - MH 6 730_F6](#)

[Mental Health Discharge Summary - DOC MH 7 730_F7](#)

[Application for Voluntary Admission to a Licensed Correctional Mental Health Facility - DOC MH 3 730_F8](#)

[Mental Health Release Summary to Community - DOC MH 9 730_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 DOC MH-17 730_F17](#)

[Mental Health Services Progress Notes 730_F30](#)

[Mental Health Appraisal for Disability \(DOC MH 17-D\) 730_F42](#)

[Request for Assistance- Problematic Release 820_F9](#)

[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*](#)



EXHIBIT 56
(Filed Under Seal)

Exhibit 57

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
BIG STONE GAP DIVISION**

WILLIAM THORPE, *et al.*,

4. I applied standard data management techniques in both Excel and the statistical programming software “R” to organize the data in VADOC-00037970 in a manner that would allow certain analysis to be performed. I also incorporated information from the other documents mentioned in the prior paragraph to the same Excel spreadsheet to permit analysis of the information together.

5. I have prepared summary charts, attached hereto as Exhibits A-C, showing the number of, and other statistical calculations for, prisoners classified as Security Level-S or Level-6 at Red Onion and Wallens Ridge State Prisons. All assumptions underlying the summaries I prepared are clearly stated in each Exhibit.

6. Attached as Exhibit A is a summary showing (1) the number of unique incarcerated individuals at Security Level-S, (2) the number of unique incarcerated individuals at Security Level-S or Level-6, (3) the average length of stay at a Security Level, (4) the length of stay at a Security Level broken down by time intervals and by year.

7. Attached as Exhibit B is a summary of (1) the number of unique incarcerated individuals assumed to have a currently active security Level-S, (2) the number of unique incarcerated individuals assumed to have a currently active Security Level Segregation or Level-6 at the Red Onion and Wallens Ridge State Prisons, (3) the average length of their current stay period, (4) the length of their current stay period broken down by time intervals.

8. Attached as Exhibit C is a summary of (1) the number of unique incarcerated individuals with mental health issues assumed to have a currently active security Level-S, (2) the number of unique incarcerated individuals with mental health issues assumed to have a currently active Security Level Segregation or Level-6 at the Red Onion and Wallens Ridge State Prisons,

(3) the average length of their current stay period, (4) the length of their current stay period broken down by time intervals.

9. I am being compensated at my usual rate of \$120/hour for my work in this case.

I declare under penalty of perjury that the foregoing is true and correct. Executed this June 20, 2022.

A handwritten signature in black ink, appearing to read "Peter Graham", written over a light gray rectangular background.

Peter Graham

EXHIBIT A

Base Summary Statistics

Assumptions:

- Security Level Classifications that occurred at **Wallens Ridge State Prison** or **Red Onion State Prison** were also included, if there was not a gap between the end date and the start date of a subsequent security level at Red Onion or Wallens Ridge.
- Security Level Periods that started in October of 2020 or after are excluded from this analysis. October 2020 through July 2021 represents the expected nine. month period for the step-down program. We do not feel comfortable with creating artificial end dates for individuals within this nine month period.

SECURITY LEVEL PERIODS are defined as the first classification start date and the end date of the last consecutive Security Classification of Segregation or Level 6. A gap of less than 15 days between an end date and the next start date does not constitute a break in Security Classification Period. However, any gap of 15 or more days would generate a new Security Classification Period.

ANALYSIS 1: SECURITY LEVEL = SEGREGATION ONLY				
480 <- Unique Incarcerated Individuals				
638 <- Unique Security Level Periods				
Average Length of Security Level Periods-				
1,192 <- Days				
3.26 <- Years				
Length	Days	# of Security Levels		
Under 6 months	Less than 183	74		
6 months - a year	183-364	74		
1 to 1.5 years	365-546	99		
1.5 to 2 years	547-728	79		
2 - 3 years	729-1,092	81		
3 - 5 years	1,093-1,820	99		
5 - 10 years	1,821-3,640	115		
10+ years	3,641+	17		
Security Level Periods				
Year	Unique in Year	# Starting	# Ending	
2007	72	72		
2008	86	14		
2009	108	22		
2010	151	43		
2011	201	50		
2012	229	28	6	
2013	297	74	143	
2014	231	77	66	
2015	210	45	51	
2016	245	86	64	
2017	225	44	72	
2018	180	27	93	
2019	111	24	44	
2020	99	32	23	
2021	76	N/A	76	

ANALYSIS 2: SECURITY LEVEL = SEGREGATION OR LEVEL 6				
550 <- Unique Incarcerated Individuals				
600 <- Unique Security Level Periods				
Average Length of Security Level Periods-				
3,452 <- Days				
9.45 <- Years				
Length	Days	# of Security Levels		
Under 6 months	Less than 183	67		
6 months - a year	183-364	22		
1 to 1.5 years	365-546	60		
1.5 to 2 years	547-728	42		
2 - 3 years	729-1,092	66		
3 - 5 years	1,093-1,820	100		
5 - 10 years	1,821-3,640	168		
10+ years	3,641+	75		
Security Level Periods				
Year	Unique in Year	# Starting	# Ending	
2007	72	72		
2008	86	14		
2009	108	22		
2010	151	43		
2011	201	50		
2012	229	28	6	
2013	340	117	73	
2014	333	66	57	
2015	313	37	45	
2016	333	65	41	
2017	315	23	46	
2018	292	23	61	
2019	247	16	58	
2020	213	24	25	
2021	188	N/A	188	

Updated 6.3.2022

DATA NOTES/ASSUMPTIONS:

- Original data provided reflect individuals placed in Security Levels of Segregation or Level-6 on or after 8/1/2012 through July 2021.
- It is assumed that all security level assignments for the population identified above were provided, regardless of when those classifications started or ended. This means that Security Classification assignments extend well before the date parameters of the Internal Assignment.
- Individuals with more recent security classification assignments are more likely to not have any "end dates" associated with their classification. When a release date was available, that was used as a proxy end date. When an end date was not available, July 30, 2022 was used as an end date in order to calculate Security Classification Periods.
- It is assumed that Security Level Assignments with the location of "Conversion" or "Central Office, Administration" identify security classifications that were adjusted due to data system or program changes that did not allow the appropriate location to be represented in the data.

EXHIBIT B

Base Summary Statistics - All Individuals Assumed Current/Active Segregation or Level-6

Assumptions:

- Security Level Classifications that occurred at **Wallens Ridge State Prison** or **Red Onion State Prison**
- Security Level Classification where the location was identified as "Conversion" or "Central Office, Administration" were also included, if there was not a gap between the end date and the start date of a subsequent security level at Red Onion or Wallens Ridge.
- Only those Security Level Classifications and Security Level Periods that did not have a specified end date are included in this analysis. For purposes of calculated length of stay, an artificial end date of July 30, 2021 was
- Security Level Periods starting in or after October of 2020 are included in this analysis. This is to ensure that more recent entries are included in the Current/Active statistics.

SECURITY LEVEL PERIODS are defined as the first classification start date and the end date of the last consecutive Security Classification of Segregation or Level 6. A gap of less than 15 days between an end date and the next start date does not constitute a break in Security Classification Period. However, any gap of 15 or more days would generate a new Security Classification Period.

ANALYSIS 1: SECURITY LEVEL = SEGREGATION ONLY			
89 <- Unique Incarcerated Individuals			
89 <- Unique Security Level Periods			
Average Length of Security Level Periods-			
1,064 <- Days			
2.91 <- Years			
Length	Days	# of Security Levels	
Under 6 months	Less than 183	30	
6 months - a year	183-364	5	
1 to 1.5 years	365-546	16	
1.5 to 2 years	547-728	2	
2 - 3 years	729-1,092	2	
3 - 5 years	1,093-1,820	12	
5 - 10 years	1,821-3,640	19	
10+ years	3,641+	3	
Facility			
S - Segregation			
Red Onion State Prison	79		
Wallens Ridge State Prison	10		
Total	89		

ANALYSIS 2: SECURITY LEVEL = SEGREGATION OR LEVEL 6			
209 <- Unique Incarcerated Individuals			
209 <- Unique Security Level Periods			
Average Length of Security Level Periods-			
893 <- Days			
2.44 <- Years			
Length	Days	# of Security Levels	
Under 6 months	Less than 183	80	
6 months - a year	183-364	23	
1 to 1.5 years	365-546	21	
1.5 to 2 years	547-728	6	
2 - 3 years	729-1,092	8	
3 - 5 years	1,093-1,820	30	
5 - 10 years	1,821-3,640	38	
10+ years	3,641+	3	
Facility			
Security Level			
6 - Level 6			
Red Onion State Prison	120	79	199
Wallens Ridge State Prison		10	10
Total	120	89	209

DATA NOTES/ASSUMPTIONS:

- Original data provided reflect individuals placed in Security Levels of Segregation or Level-6 on or after 8/1/2012 through July 2021.
- It is assumed that all Security Level assignments for the population identified above were provided, regardless of when those classifications started or ended. This means that Security Classification assignments extend well before the date parameters of the Internal Assignment.
- Individuals with more recent security classification assignments are more likely to not have any "end dates" associated with their classification. When a release date was available, that was used as a proxy end date. When an end date was not available, July 30, 2022 was used as an end date in order to calculate Security Classification Periods.
- It is assumed that Security Level Assignments with the location of "Conversion" or "Central Office, Administration" identify security classifications that were adjusted due to data system or program changes that did not allow the appropriate location to be represented in the data.

Updated 6.3.2022

EXHIBIT C

Base Summary Statistics - All Individuals Assumed Current/Active Segregation or Level-6 with Mental Health Issues

Assumptions:

- Security Level Classifications that occurred at **Wallens Ridge State Prison** or **Red Onion State Prison**
- Security Level Classification where the location was identified as "Conversion" or "Central Office, Administration" were also included, if there was not a gap between the end date and the start date of a subsequent security level at Red Onion or Wallens Ridge.
- Only those Security Level Classifications and Security Level Periods that did not have a specified end date are included in this analysis. For purposes of calculated length of stay, an artificial end date of July 30, 2021 was given.
- Security Level Periods starting in or after October of 2020 are included in this analysis. This is to ensure that more recent entries are included in the Current/Active statistics.
- Individuals with Mental Health Issues are identified as being represented on the ROG1, ROG5, or ROG6 Disability Subclass Lists.

SECURITY LEVEL PERIODS are defined as the first classification start date and the end date of the last consecutive Security Classification of Segregation or Level 6. A gap of less than 15 days between an end date and the next start date does not constitute a break in Security Classification Period. However, any gap of 15 or more days would generate a new Security Classification Period.

ANALYSIS 1: SECURITY LEVEL = SEGREGATION ONLY				
6 <- Unique Incarcerated Individuals				
6 <- Unique Security Level Periods				
Average Length of Security Level Periods-				
1,531 <- Days				
4.19 <- Years				
		Length	Days	# of Security Levels
		Under 6 months	Less than 183	0
		6 months - a year	183-364	1
		1 to 1.5 years	365-546	2
		1.5 to 2 years	547-728	1
		2 - 3 years	729-1,092	0
		3 - 5 years	1,093-1,820	2
		5 - 10 years	1,821-3,640	0
		10+ years	3,641+	0
		S - Segregation		
Facility				
Red Onion State Prison		4		
Wallens Ridge State Prison		2		
Total		6		

ANALYSIS 2: SECURITY LEVEL = SEGREGATION OR LEVEL 6				
22 <- Unique Incarcerated Individuals				
28 <- Unique Security Level Periods				
Average Length of Security Level Periods-				
1,045 <- Days				
2.86 <- Years				
		Length	Days	# of Security Levels
		Under 6 months	Less than 183	3
		6 months - a year	183-364	3
		1 to 1.5 years	365-546	2
		1.5 to 2 years	547-728	2
		2 - 3 years	729-1,092	1
		3 - 5 years	1,093-1,820	9
		5 - 10 years	1,821-3,640	2
		10+ years	3,641+	0
		Security Level		
Facility		6 - Level 6	S - Segregation	Total
Red Onion State Prison		16	4	20
Wallens Ridge State Prison		0	2	2
Total		16	6	22

DATA NOTES/ASSUMPTIONS:

- Original data provided reflect individuals placed in Security Levels of Segregation or Level-6 on or after 8/1/2012 through July 2021.
- It is assumed that all Security Level assignments for the population identified above were provided, regardless of when those classifications started or ended. This means that Security Classification assignments extend well before the date parameters of the Internal Assignment.
- Individuals with more recent security classification assignments are more likely to not have any "end dates" associated with their classification. When a release date was available, that was used as a proxy end date. When an end date was not available, July 31, 2022 was used as an end date in order to calculate Security Classification Periods.
- It is assumed that Security Level Assignments with the location of "Conversion" or "Central Office, Administration" identify security classifications that were adjusted due to data system or program changes that did not allow the appropriate location to be represented in the data.

Updated 6.20.2022

Exhibit 58

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
BIG STONE GAP DIVISION**

WILLIAM THORPE, *et al.*,

Plaintiffs,

v.

VIRGINIA DEPARTMENT OF
CORRECTIONS, *et al.*,

Defendants.

CASE NO. 2:20-cv-00007-JPJ-PMS

AFFIDAVIT OF GERALD McNABB

I, Gerald McNabb, declare the following under penalty of perjury pursuant to 28 U.S.C. §1746:

1. My name is Gerald McNabb. I am one of the named plaintiffs in *William Thorpe et al. v. Virginia Department of Corrections et al.*, No. 2:20-cv-00007. I am over the age of twenty-one 21, and I am competent to give this affidavit and to testify regarding the matters in this affidavit.
2. I am a prisoner at Wyoming State Penitentiary in the general population and have been incarcerated there since November 19, 2021. I was transferred from Virginia to Wyoming on interstate compact on May 4, 2021. Prior to that, I had been a prisoner at Red Onion State Prison (“ROSP”) since 2012 and was imprisoned as Security Level-S in long-term solitary confinement.
3. Before being imprisoned at ROSP, I was incarcerated at Sussex I State Prison and Powhatan Correctional Facility. Earlier, I was incarcerated at Mecklenburg Correctional Center from 1983 to 1990. At Mecklenburg, I participated in levels 1, 2, and 3 of the Phase Program. I remember receiving an opt-in notice for the ACLU’s original suit against Mecklenburg and later hearing about the settlement agreement.

4. While confined at ROSP, I was subject to long-term solitary confinement. I spent approximately 22 to 24 hours a day in a single 8' x 10' cell alone. Nearly all of my limited personal interactions were with prison staff.
5. The only time I was permitted to leave my cell was for a 15-minute shower three times per week, or for one hour of "outdoor recreation" per day. These opportunities to leave my cell were revoked regularly at the discretion of prison guards, or inconsistently provided.
6. During outdoor recreation, I was taken out to the "yard" in shackles connected a leash. I was then placed in a "recreation cage" that resembles a dog kennel. The cage was entirely empty.
7. Each time I was permitted to leave my cell, I was forced to endure daily cavity searches. This required me to strip naked before two officers, who would then inspect my head, hair, mouth, torso, pelvic area, legs, and feet. I was also required to open my mouth, raise my arms, turn around, spread my legs, raise my penis and testicles, turn around to face the back of the cell, spread my buttocks, bend over so that guards could inspect my anus, squat, and cough. The experience of daily cavity searches was dehumanizing.
8. Upon arrival at ROSP in 2012, I was not given any guidance about how the Step-Down Program works. I had to request the operating procedures myself.
9. The Step-Down Program has two pathways—the IM pathway and the SM pathway. I was initially assigned the IM Pathway. I was initially never told about the possibility of a pathway change.
10. To complete each level of the Step-Down Program, prisoners have to finish workbooks and also meet behavior and hygiene standards. Whether a prisoner has met these standards is up to prison staff.
11. The *Challenge Series* is a component of the Step-Down Program that includes workbooks and classes. I completed the *Challenge Series* several times. The first time I finished the *Challenge Series* was in 2016. I completed it for the second time in 2017. I completed the seven books of the *Challenge Series* for the third time over the course of 2018 and 2019.

12. I was status IM-0 in July 2018. I completed the first two books of the *Challenge Series* and my status was changed to IM-1 in January 2019. I completed books three, four, and five over the next few months and my status was upgraded to IM-2 in July 2019. My status was upgraded to SM-2 in November 2019. Even though my status was upgraded from IM-1 to IM-2 in July 2019, I did not receive the increased commissary allowance associated with IM-2 status until mid-September. I was unable to purchase items from commissary in the interim and had to brush my teeth with soap. I was finally able to purchase IM-2 commissary items nine weeks after I first raised the issue. I believe this delay was retaliation for my continued filing of complaints about conditions at ROSP. I filed multiple informal complaints and was told that there was nothing VDOC could do to correct this error because my status still showed as IM-1 in the system, even though my official record and cell door placard showed that I was IM-2. I did not receive productive responses to these complaints. Additionally, I was denied complaint forms and was forced to buy them from other prisoners, or have copies made and sent to me via mail.
13. In my experience, filing informal complaints or regular grievances was rarely productive. Sometimes guards would refuse to give me the informal complaint forms, steal forms from me or shred them in front of me. When I submitted an informal complaint, prison administration took longer than the allowed time period to respond, and backdated their responses so it looked like they replied on time.
14. The responses often did not address the substance of the informal complaints or grievances. I had regular grievances rejected because they raise a slightly different issue than the issue I raised in the informal complaint. I had grievances rejected because they raised more than one issue. These non-substantive responses, combined with the limited period in which one may submit and appeal grievances, make using the grievance procedure incredibly difficult.
15. I had to re-start the *Challenge Series* most recently in June 2018 because I received a disciplinary charge for refusing programming. On the day of the incident, Officer Martin subjected me to a humiliating and invasive strip search before I could go to an anger management class. Once I was completely naked, Officer Martin told me to walk around

my cell. I knew this was not part of the procedure, so I demanded my clothes back and became angry. I had to demand my clothes back a number of times before Officer Martin finally gave me my clothes back so I could get dressed. Officer Martin then wrote me up for refusing to attend the anger management class. I felt like that was a tactic to make me angry and to allow Officer Martin to write me up for refusing programming.

16. There were other times when I refused to participate in the strip search procedure, but did not receive a charge for it.
17. Throughout my time at ROSP, I was subjected to repeated sexual humiliation by correctional officers in retaliation for participating in this case or to provoke me in order for me to fail in the Step-Down program.
18. Correctional officers also willfully provided incomplete food trays or included meat despite the fact that I do not eat it.
19. I feel that charges were selectively leveled against myself and other people incarcerated in Level S to erase our progress and keep us from progressing to general population. I believe correctional officers were taught to use the disciplinary system to push back our statuses. It was hard to motivate myself to proceed through the Step-Down Program because I believed that no matter how far I progressed, I would just get set up again and sent back to the beginning.
20. At one point, Officer Messer told me that it was not worth it for me to participate in the Step-Down Program. That was even more disheartening because Counselor Gilliam told me that if I refuse the program, I will probably be in solitary confinement for the rest of my life.
21. I was supposed to have ICA hearings every 90 days to review my status. The ICA hearings were supposed to occur either at my cell door or in a counselor's office, and I was supposed to have the option of attending. And I was supposed to receive 48 hours' notice before an ICA hearing takes place.

22. However, I only recall one ICA hearing where I actually was able to attend in the counselor's office. That was in August 2019. The hearing took between five and ten minutes.
23. For example, in March 2019, Lieutenant Lambert and Counselor Kegley approached me while I was showering in the C1 pod and asked me if I wanted to do my ICA hearing there. I replied that I wanted to have it in the counselor's office because I had a written statement I wanted to provide. I also refused to waive my 48 hours' notice. Later that day Counselor Kegley came by my cell and I gave her my written statement.
24. About a week later, I received a written decision for the ICA hearing. The hearing decision referred to the written statement I had provided. The ICA committee recommended keeping me at IM-1 because I had not yet completed the Step-Down Program and because I still had time to serve in IM-1.
25. But the ICA hearing was held without my presence, despite my request to attend. The written decision listed the hearing date as the day Lieutenant Lambert and Counselor Kegley came to me in the shower. When I filed an informal complaint about this incident, they falsely claimed that I refused to come out of my cell for the ICA hearing.
26. In May 2019, Lieutenant Lambert and Counselor Kegley again attempted to hold an ICA hearing without the required notice at my cell door. The written ICA decision stated that I was offered the opportunity to come to the office but that I refused to leave my cell. This was not true.
27. I asked to attend my October 2019 ICA hearing but never received a response.
28. Having experienced both the Phase Program at Mecklenburg and the Step-Down Program at ROSP, I do not feel that there is a real difference between the two. Long-term solitary confinement is not over; VDOC has just changed its name.
29. As a direct and proximate result of my being held in long-term solitary confinement, I have experienced a number of physical and psychological harms, including anxiety, anger, bouts

of disorientation, an inability to concentrate, weight loss, shortness of breath, headaches or migraines, paranoia, and restlessness.

30. I agreed to be a Plaintiff in this lawsuit because I do not agree with the Step-Down Program's effectiveness and believe that the program amounts to an unconstitutional violation of prisoners' rights.
31. I understand that this lawsuit is brought by me and others on behalf of everyone at Red Onion or Wallens Ridge who have had to go through the Step-Down Program and that I am seeking the same relief as my fellow class members.
32. I intend to represent everyone in this lawsuit and understand and accept my responsibilities in that regard.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge.

Signature Gerald McNabb #33538

Dated this 20 of June, 2022

Gerald McNabb
Wyoming State Penitentiary

Exhibit 59



Virginia Department of Corrections

Mental Health Services

Operating Procedure 730.2

Mental Health and Wellness Services: Screening, Assessment, and Classification

Authority:

Directive 730, *Mental Health Services*

Effective Date: June 1, 2021

Amended: 9/1/21, 10/1/21, 3/1/22

Supersedes:

Operating Procedure 730.2, January 1, 2019

Access: ☐ Restricted ☒ Public ☐ Inmate

ACA/PREA Standards: 5-ACI-5B-11, 5-ACI-6A-31, 5-ACI-6A-32; §115.21, §115.41, §115.42, §115.61, §115.62, §115.81, §115.82, §115.83, §115.221, §115.241, §115.242, §115.261, §115.262, §115.282, §115.283

Content Owner/Reviewer: Denise Malone
Chief of Mental Health and Wellness
Services

Signature Copy on File

3/31/2021

Signature

Date

Signatory: H. Scott Richeson
Deputy Director - Programs, Education,
Re-entry

Signature Copy on File

5/10/2021

Signature

Date

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 February 2022 and necessary changes have been made.

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, ACA standards, PREA standards, and DOC directives and operating procedures.

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DEFINITIONS

Acute Care Unit - 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.

Annual Review - A uniform yearly review of an inmate's classification, needs, and objectives. The Initial Classification Date (ICD) is used to establish the review date for an inmate received on or after February 1, 2006. The Custody Responsibility Date (CRD) is used to establish the review date for an inmate received prior to February 1, 2006.

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*.

District Mental Health Clinician (DMHC) - A Community Corrections Psychology Associate assigned to P&P Offices and Community Corrections Alternative Programs (CCAP).

Facility - Any institution or Community Corrections Alternative Program.

Health Trained Staff - A DOC employee, generally a Corrections Officer, who has been trained to administer health screening questionnaires, including training as to when to refer to health care staff and with what level of urgency.

High Risk Sexual Aggressor (HRSA) - As identified by the Classification Assessment and Psychology Associate assessment, any inmate/probationer/parolee at high risk of being sexually abusive.

High Risk Sexual Victim (HRSV) - As identified by the Classification Assessment and Psychology Associate assessment, any inmate/probationer/parolee confirmed as a sexual victim or identified as being at high risk of being sexually victimized.

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

Intersystem Transfer - Transfer of an inmate from one distinct correctional system into another i.e., from a jail or out-of-state institution into a DOC institution.

Intrasystem Transfer - Transfer of an inmate/probationer/parolee from one institution to another, from an institution to a Community Corrections Alternative Program, or for transfer from one Community Corrections Alternative Program to another within the Department of Corrections.

Mental Health Classification Code - A numeric code assigned to an inmate by a Psychology Associate 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-4 representing the greatest need for mental health and wellness services.

Mental Health Residential Treatment Unit - A designated treatment unit where mental health and wellness services are provided to inmates who are unable to function in a general population setting due to mental disorder but who typically do not meet the criteria for admission to an Acute Care Unit.

Psychology Associate - 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.

Psychotropic Medication - Medication prescribed for the treatment of a documented mental health disorder, e.g., thought, mood, or behavioral disorder.

Qualified Mental Health Professional (QMHP)-Adult - An individual employed in a designated mental health and wellness services position who meets Department of Health Professions (DHP) Board of Counseling regulatory standards including at least a bachelor's degree in human services or a related field, supervised experience, registration with DHP as a QMHP, and ongoing education in mental health topics.

Serious Mental Illness (SMI) - An individual diagnosed with a Psychotic Disorder, Bipolar Disorder, Major Depressive Disorder, Posttraumatic Stress Disorder (PTSD) or Anxiety Disorder, or 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.

Sexual Assault Assessment - A clinical assessment completed by a Psychology Associate to determine the need for crisis intervention or other mental health and wellness services related to sexual assault victimization and/or protection from further victimization.

Telehealth - The provision of remote medical and/or mental health care by a two-way, real-time electronic interactive communication between the patient and the practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio equipment.

PURPOSE

This operating procedure establishes a standard protocol for the screening, assessment, and determination of the mental health status and mental health service needs of inmates/probationers/parolees in DOCs facilities.

PROCEDURE

I. Telehealth

A. Telehealth may be used for inmate/probationer/parolee mental health and wellness services encounters.

1. Mobile video telehealth devices may include the following:

- a. iPads
- b. Tablets
- c. Microsoft Surfaces
- d. Telehealth cell phones
- e. Telehealth MiFi's
- f. Webcams

i. All mobile video telehealth devices must be stored in a secure location. When not in use, these devices must be stored in a locked cabinet/drawer in a locked Psychology Associate II office.

ii. All mobile video telehealth devices and components must be inspected and accounted for by each unit with each shift change and documented on [Telehealth Electronic Device Control Record](#) 720_F42.

iii. The Health Authority or designee and the Chief of Security must inventory and inspect all mobile video telehealth devices monthly and document on [Telehealth Electronic Device Control Record](#) 720_F42.

iv. See Operating Procedure 720.2, *Medical Screening, Classification, and Levels of Care*, Attachment 2, *Mobile Telehealth Device Information* and Attachment 3, *Overview: Telehealth Mobile Device Storage, Access, and Use* for further guidance.

II. Transfer Screening (5-ACI-5B-11, 5-ACI-6A-31)

A. Each inmate/probationer/parolee will receive an initial mental health screening at the time of admission to a DOC facility to identify those with mental health and wellness services needs.

B. The mental health screening will include:

1. Inquiry into whether an inmate/probationer/parolee:

- a. Has present suicide ideation
- b. Has a history of suicidal behavior or self-directed violence
- c. Is presently prescribed psychotropic medication
- d. Has a current mental health complaint
- e. Is being treated for mental health symptoms
- f. Has a history of inpatient or outpatient mental health treatment
- g. Has any recent use of alcohol or addictive substance use, to include frequency of use, amount used, and last time used
- h. Has a history of substance use disorder treatment

2. Observation of inmate/probationer/parolee:

- a. General appearance and behavior
- b. Level of consciousness (alertness, orientation)
- c. Evidence of abuse or trauma



- d. Current symptoms of psychosis, depression, anxiety, or aggression
- 3. Disposition of inmate/probationer/parolee:
 - a. To the general population
 - b. To the general population with appropriate referral to mental health care service
 - c. Referral to appropriate mental health care service for emergency treatment
- C. The Psychology Associate will notify facility staff responsible for making housing and programming assignments for transgender or intersex inmates of any relevant screening results that would present management or security considerations so staff, on a case-by-case basis, can make a determination that best ensures the inmate's health and safety. (§115.42[c], §115.242[c])

III. Intersystem Transfers: Intake at Reception and Classification Centers, Parole Violator Units, and Community Corrections Alternative Programs

- A. An intake mental health screening will be performed by health/mental health trained or qualified health care personnel upon the inmate's/probationer's/parolee's arrival at a DOC facility. All findings will be recorded on the [Preliminary Medical Screening \(C&R 7b\)](#) 720_F8; see *Transfer Screening* section of this operating procedure.
 - 1. All data collected by qualified health care personnel on admission to the facility will be recorded on [Intrasystem Transfer Medical Review \(DOC 726-B\)](#) 720_F9.
 - 2. Facilities without 24-hour health care staff will have Corrections Officers trained to screen inmates/probationers/parolees when qualified health care personnel are absent.
 - a. These health trained staff will complete the [Health Screening - Health-Trained Staff](#) 720_F10 immediately upon the arrival of the inmate/probationer/parolee to the facility.
 - b. The screener will send the *Health Screening - Health-Trained Staff* to the facility medical department for review by health care staff and inclusion into the inmate's/probationer's/parolee's Health Record.
- B. If mental health concerns arise from the screening, health trained staff and qualified health care personnel will follow Attachment 1, *Guidelines to Access Emergency Mental Health and Wellness Services*.
- C. Mental Health Initial Screening and Appraisal (Institutions only) (5-ACI-6A-32)
 - 1. In addition to the mental health screening, all intersystem (i.e., new to DOC) transfers into DOC institutions will also undergo a mental health appraisal by a Psychology Associate.
 - 2. Inmates will be interviewed within the following time frames:
 - a. New inmates on psychotropic medications will be interviewed by the Psychology Associate within one working day of admission for a face to face [Mental Health and Wellness Services Screening](#) 730_F12 or a [Mental Health Appraisal](#) 730_F17.
 - b. The full [Mental Health Appraisal](#) 730_F17 will be completed on all inmates within 14 calendar days of admission.
 - 3. If there is documented evidence of a mental health appraisal within the previous 90 days, a new appraisal is not required, except as determined by the Psychology Associate.
 - 4. The Psychology Associate will document the results of the mental health appraisal on the [Mental Health Appraisal](#) 730_F17 and assign the inmate a Mental Health Classification Code. Instructions for completing the *Mental Health Appraisal* can be found on Attachment 2, *Mental Health Appraisal Instructions*. The mental health appraisal includes:
 - a. Assessment of current mental status, symptoms, condition, and response to incarceration.
 - b. Assessment of current suicidal potential and person-specific circumstances that increase suicide potential.
 - c. Assessment of violence potential and person-specific circumstances that increase violence

potential.

- d. Review of available historical records of inpatient and outpatient psychiatric treatment.
 - e. Review of history of treatment with psychotropic medication.
 - f. Review of history of psychotherapy, psycho-educational groups, and classes or support groups.
 - g. Review of history of substance use and treatment.
 - h. Review of educational and special education history.
 - i. Review of history of sexual or physical abuse-victimization and predatory behavior and/or sexual offenses.
 - j. Review of history of suicidal or violent behavior.
 - k. Review of history of cerebral trauma or seizures.
 - l. Assessment of drug and alcohol use or addiction.
 - m. Use of additional assessment tools, as indicated.
 - n. Referral to treatment, as indicated.
 - o. Development and implementation of a treatment plan, including recommendations concerning housing, job assignment, and program participation.
5. When an inmate is assigned a Mental Health Classification Code of MH-2 or higher, and has received previous mental health treatment services, the Psychology Associate may request recent and pertinent mental health records from the appropriate psychiatric hospitals, Community Services Boards (CSB), community mental health practitioners, etc.
 6. Based on the results of the mental health appraisal, the Psychology Associate will determine if further assessment is needed to address mental health issues. When clinically indicated, the Psychology Associate should consider testing or other appropriate interventions before the inmate is transferred from the Reception and Classification Center. When testing is utilized, the results will be documented on the [*Psychological Summary \(C&R 8\)*](#) 730_F23 within 60 days of the inmate's admission to the institution.
 7. All original mental health documentation, including information received from outside agencies as well as testing data, will be filed in Section IV of the inmate's Health Record. The original [*Mental Health Appraisal*](#) 730_F17 will be filed, in its entirety, in Section IV of the inmate's Health Record.
 8. Clinical decisions involving these inmates awaiting transfer to a permanent institution will be the responsibility of the mental health staff at the reception center until the actual transfer. Upon transfer, the receiving institution will review the inmate's record in accordance with this operating procedure.

IV. Intrasystem Transfers: Inmates Transfer from One DOC Facility to Another

- A. All inmates will receive a medical and mental health screening by health trained staff or qualified health care personnel upon arrival to a facility; see *Transfer Screening* section of this operating procedure.
- B. If mental health concerns arise from the screening, qualified healthcare personnel will follow Attachment 1, *Guidelines to Access Emergency Mental Health and Wellness Services*.
- C. Record review and screening interview completed by the Psychology Associate (Institutions only)
 1. The receiving institution Psychology Associate will review the inmate's health records for all intrasystem transfers and conduct an interview as indicated by the inmate's Mental Health Classification Code.
 - a. The Psychology Associate's record review must be completed and documented within three working days of the inmate's admission to the institution.
 - b. Inmates with a Mental Health Classification Code 2 or above will be interviewed by a Psychology Associate and documented on a [*Mental Health and Wellness Services Screening*](#) 730_F12, within five working days of the inmate's admission to the institution.

- c. The Psychology Associate will use a [Mental Health and Wellness Services Screening](#) 730_F12 or licensure approved form for screening at the time of transfer.
 2. If the newly received inmate has a Mental Health Classification Code of MH-0, assigned within the past 12 months, no further review or evaluation by the Psychology Associate is required when the code remains the same.
 - a. If a staff member (e.g., medical staff or Case Management Counselor) believes that the MH-0 is not accurate, the staff member will contact the Psychology Associate to request a review of the Mental Health Classification Code.
 - b. The Psychology Associate will review the inmate's Health Record to determine the accuracy of the current Mental Health Classification Code and based on results of their review, the Psychology Associate may conduct a face-to-face interview with the inmate.
 - c. The Psychology Associate will determine if the assigned Mental Health Classification Code reflects the current mental health status and needs of the inmate, or if it requires updating.
 - d. The results of this review will be documented on the [Mental Health Coding Classification Review/Update](#) 730_F18.
 3. If a newly received inmate has a Mental Health Classification Code of MH-1, the Psychology Associate will review the inmate's Health Record to determine the accuracy of the current Mental Health Classification Code.
 - a. Based on the results of the record review, the Psychology Associate may conduct a face-to-face interview with the inmate.
 - b. The Psychology Associate will determine if the assigned Mental Health Classification Code reflects the current mental health status and needs of the inmate, or if it requires updating.
 - c. The results of this review will be documented on a [Mental Health Coding Classification Review/Update](#) 730_F18 even if the Mental Health Classification Code remains the same.
 4. If a newly received inmate has a Mental Health Classification Code of MH-2, MH-2S, MH-3, or MH-4, the Psychology Associate will review the inmate's Health Record and conduct a face-to-face interview with the inmate to determine the accuracy of the current Mental Health Classification Code.
 - a. Based on the inmate's behavior, review of the record, and any additional information obtained since the last Mental Health Classification Code assignment or review, the Psychology Associate will determine if the assigned Mental Health Classification Code reflects the current mental health status and needs of the inmate or if it requires updating.
 - b. The results of this review will be documented on a [Mental Health Coding Classification Review/Update](#) 730_F18 even if the Mental Health Classification Code remains the same.
 5. If a newly received inmate has not been assigned a Mental Health Classification Code, the Psychology Associate will review the inmate's Health Record, conduct a mental health appraisal, and determine the appropriate Mental Health Classification Code in accordance with the *Intersystem Transfer, Mental Health Appraisal* section of this operating procedure.
 6. When an inmate refuses to cooperate with the face-to-face interview, the Psychology Associate will, at a minimum, directly observe the inmate, review available records, and document findings on the [Mental Health Appraisal](#) 730_F17 or [Mental Health Coding Classification Review/Update](#) 730_F18, as appropriate.
- D. Transfer of inmates to obtain mental health and wellness services - If an inmate requires mental health and wellness services not available at the institution, a transfer will be initiated in accordance with Operating Procedure 730.3, *Mental Health Services: Levels of Care*.

V. Evaluations and Assessments

- A. In addition to assessment and screening procedures set forth in this operating procedure, an outside evaluation or assessment referral of an inmate may be submitted at any time as considered necessary by



the Psychology Associate Senior.

- B. For challenging cases, Psychology Associates will seek consultation, supervision, and when warranted refer for an evaluation.
- C. If a referral for an outside evaluation is needed:
1. All assessment referrals should be reviewed and approved by the Psychology Associate Senior.
 2. The Psychology Associate Senior will review the referral with the Mental Health Clinical Supervisor (MHCS).
 3. If approved, the Psychology Associate Senior will get the [Consent for Release of Confidential Health and/or Mental Health Information](#) 701_F8 signed and send along with the [Referral for Psychological Evaluation](#) 730_F35, and the [Mental Health Serious Mental Illness \(SMI\) Determination](#) 730_F34, if applicable, to the Mental Health Initiatives Administrator (MHIA).
 4. The MHIA will review and forward to the vendor.
 - a. The Psychology Associate Senior will schedule the appointment, set up the area, make any unit notifications and arrangements, and will communicate directly with the vendor.
 - b. Any changes in the scope or nature of the evaluation must be approved by the MHIA.
 5. Within 90 days, the vendor will send the report to the MHIA who will forward the report to the Psychology Associate Senior and copy the MHCS.
 6. After consultation with the MHCS, the Psychology Associate Senior will discuss the results of the evaluation with the inmate.
- D. All inmates designated as a High Risk Sexual Aggressor (HRSA) or High Risk Sexual Victim (HRSV) are referred to Psychology Associate staff for assessment and follow-up in accordance with Operating Procedure 810.1, *Offender Reception and Classification*, and Operating Procedure 810.2, *Transferred Offender Receiving and Orientation*.
1. The Psychology Associate should review the inmate's most recent *Classification Assessment* in VACORIS and any other relevant information to determine if the inmate's designation is appropriate or if an override is warranted.
 - a. Relevant information includes but is not limited to:
 - i. Completion of relevant treatment
 - ii. Demonstrated period of stability
 - iii. Completion of monitoring period with no evidence of mental health issues or symptoms related to abuse/victimization history
 - iv. Extended amount of time has elapsed since abuse or victimization event without current symptoms or behavior related to the event
 - b. When the inmate is a "known" victim or "known" aggressor and there is sufficient data to support an override, the Psychology Associate may indicate that further monitoring is warranted and the inmate may be stepped down to a "potential" designation.
 - c. The Psychology Associate must document the use of an override on the [Prison Rape Elimination Act \(PREA\) Psychology Associate Follow-Up](#) 730_F28 and update the inmate's designation on the *Classification Assessment*.
 2. In institutions, within 14 days of completion of the *Classification Assessment*, the Psychology Associate will notify those inmates, identified as HRSA or HRSV, of the availability for a follow-up meeting with a mental health practitioner and inform the inmate of available relevant treatment and programming. Notification will be documented on the [Prison Rape Elimination Act \(PREA\) Psychology Associate Follow-Up](#) 730_F28. (§115.81[a, b])
 - a. Any information related to sexual victimization or abusiveness that occurred in an institutional setting will be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing,

- bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. (§115.81[d])
- b. Before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the inmate is under the age of 18, the Psychology Associate must obtain informed consent from the inmate ([Consent for Release of Information](#) 050_F14 or [Consent for Release of Confidential Health and/or Mental Health Information](#) 701_F8). (§115.81[e])
3. HRSA and/or HRSV codes must be documented in the mental health section of the inmate's Health Record and reviewed annually thereafter by a Psychology Associate at the assigned facility.
 - a. Mental Health staff will pull a custom report in VACORIS in the month of January in order to complete an annual follow-up to monitor and assess current level of functioning, risk, and needs for inmates who are designated HRSA or HRSV.
 - b. The Psychology Associate will meet with the inmate upon their request, upon referral by the staff, and/or annually to offer available services, encourage participation in relevant programming, and monitor progress for a period of no less than one year.
 - i. These individuals may or may not have a documented mental health diagnosis, but demonstrate behavior or report complaints that may be appropriate for mental health monitoring or intervention.
 - ii. During that time, the inmate's Mental Health Classification Code will be determined by a Psychology Associate as is clinically appropriate. (Institutions only).
 4. An inmate's risk level must be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness. (§115.41[g], §115.241[g])
 - a. The Psychology Associate will immediately consult with the Facility Unit Head or designee and recommend housing interventions or other immediate action to protect an inmate when it is determined that the inmate is subject to a substantial risk of imminent sexual abuse, or is considered at risk for additional sexual victimization. (§115.62, §115.262)
 - b. Psychology Associates will attempt to conduct a mental health evaluation of all known inmate on inmate abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate. (§115.83[h], §115.283[h])
 - i. Other than routine monitoring (e.g., in Restorative Housing Unit), mental health and wellness services are not automatically offered to the alleged/founded perpetrator of the sexual assault.
 - ii. If mental health and wellness services are provided, e.g., if the alleged/founded perpetrator requests such services, a Psychology Associate other than the Psychology Associate who assessed and/or provided services to the alleged/founded victim of the assault should follow up.
- E. In institutions, all inmates will be screened before the inmate's placement or within in one working day after placement in General Detention so any "at risk" inmates may be identified and monitored as provided in Operating Procedure 730.5, *Mental Health Services: Behavior Management*.
- F. Sexual Assault Assessment
1. All incidents or alleged incidents of sexual assault on an inmate/probationer/parolee assigned to a DOC facility must be reported and investigated, to include notification to a facility Psychology Associate; see Operating Procedure 038.3, *Prison Rape Elimination Act (PREA)*.
 2. Any Psychology Associate, who has knowledge, suspicion, or information regarding an incident or alleged incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against inmates or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation, must immediately notify the Facility Unit Head of the allegation, unless the referral is from the Facility Unit Head. (§115.61[a], §115.261[a])
 3. Psychology Associates may be made aware of the incident or alleged incident from health services staff, investigators, a MHCS, directly from the inmate/probationer/parolee, inmate/probationer/parolee

family members, PREA Hotline, or other contacts and facility staff. (§115.82[a], §115.83[a], §115.282[a], §115.283[a])

- a. If the incident or alleged incident is a recent sexual assault (i.e., having occurred within the past two weeks), the Psychology Associate will immediately notify the facility medical department unless the referral is from medical.
- b. The Psychology Associate will initiate contact with the victim as soon as possible but no later than two working days after receiving notification of the incident or alleged incident (unless the inmate/probationer/parolee is unavailable, e.g., hospitalized).
 - i. The evaluation and treatment of the victim will include, as appropriate, follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to, or placement in, other facilities or their release from custody. (§115.83[b], §115.283[b])
 - ii. The Psychology Associate should offer services and, based on the inmate's/probationer's/parolee's mental and physical status, set an initial time as soon as possible to meet with the inmate/probationer/parolee.
 - iii. If, prior to seeing the inmate/probationer/parolee, the Psychology Associate learns that the inmate/probationer/parolee has been transported to another DOC facility, the Psychology Associate will contact the Senior Psychology Associate at the receiving facility to ensure follow up.
- c. If indicated, the examining Psychology Associate will offer the inmate/probationer/parolee information on ways to avoid or reduce the probability of sexual victimization to include providing the inmate a copy of the *Zero Tolerance for Sexual Abuse and Sexual Harassment* attachment to Operating Procedure 038.3, *Prison Rape Elimination Act (PREA)*.
- d. The Psychology Associate will conduct a [Sexual Assault Assessment](#) 730_F25 and recommend subsequent services as indicated. The *Sexual Assault Assessment* may be conducted by any Psychology Associate identified by their immediate supervisor as competent to conduct such assessments. (§115.83[a], §115.283[a])
 - i. Before beginning the *Sexual Assault Assessment*, the Psychology Associate will advise the inmate/probationer/parolee of the practitioner's duty to report, and the limitations of confidentiality and that such information may be available to the facility administration in the context of an investigation in accordance with Operating Procedure 730.6, *Mental Health Services: Confidentiality*. (§115.61[c], §115.261[c])
 - ii. The *Sexual Assault Assessment* involves a clinical interview which will be conducted in as confidential a setting as possible. Ideally, such assessments will not be conducted at a cell door and will not be conducted in the direct presence of non Psychology Associate staff.
 - iii. At facilities with no assigned Psychology Associate, the Facility Unit Head will notify the MHCS of the allegation and the MHCS will coordinate the assessment of the inmate/probationer/parolee.
 - iv. The Psychology Associate will file the *Sexual Assault Assessment* in Section IV of the inmate/probationer/parolee Health Record.
4. If the alleged victim of sexual assault refuses to speak to the Psychology Associate or refuses to cooperate with the assessment interview, at least one additional attempt to conduct the assessment will be made by a different Psychology Associate within two working days of the inmate's/probationer's/parolee's initial refusal.
 - a. If the inmate/probationer/parolee continues to refuse, they will be reminded of the availability of mental health and wellness services upon request.
 - b. These attempted interventions will be documented in Section IV (Mental Health and Wellness Services) of the inmate/probationer/parolee Health Record.
5. Results of the *Sexual Assault Assessment* will determine the nature and extent of recommended follow-up mental health and wellness services offered to the inmate/probationer/parolee. §115.83[a], §115.283[a])

- a. The Psychology Associate provides victims with follow up mental health and wellness services consistent with the community level of care. (§115.83[c], §115.283[c])
 - b. If the inmate/probationer/parolee refuses recommended follow up services, the Psychology Associate will advise the inmate/probationer/parolee that they can change their mind at any time and that the Psychology Associate will check back with them (within a week) to monitor their status.
 - c. If the inmate/probationer/parolee agrees to accept services, the Psychology Associate will follow up and provide services to the inmate/probationer/parolee as deemed appropriate.
6. The DOC will attempt to make a victim advocate available from a rape crisis center. If a rape crisis center is not available to provide victim advocacy services, the DOC must make these services available by a qualified staff member from a community-based organization or a qualified agency staff member. (§115.21[d], §115.221[d])
 7. All case records associated with claims of sexual abuse, including medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling become part of the inmate's/probationer's/parolee's Health Record and are retained in accordance with schedules referenced in Operating Procedure 025.3, *Public Records Retention and Disposition*.
- G. Screening for inmate participation in Victim/Offender Dialogue (VOD)
1. If an inmate agrees to participate in a VOD, the institutional Senior Psychology Associate will meet with the inmate to determine suitability. If there is no Senior Psychology Associate on site, the MHCS will determine who will complete the screening. The screening will:
 - a. Determine whether the inmate accepts responsibility for the offense, and document the inmate's response to the proposed VOD.
 - b. Determine if the inmate is compliant with medication, programs and other treatment.
 - c. Determine if the inmate has a mental illness and their diagnosis to include their Mental Health Classification Code, current mental status, and clinician's opinion as to whether the information gathered in the screening will have an adverse impact on the inmate's current level of stability.
 - d. Determine if the inmate has a history of predatory or stalking behavior.
 2. The screening will be emailed to the Facility Unit Head and victimservices@vadoc.virginia.gov, with a printed copy of the screening filed in section IV of the inmate's Health Record.
 3. If the inmate declines to participate in a VOD, or the screening determines that the inmate is not appropriate at this time, the Psychology Associate who completed the screening will notify the VOD Coordinator.
- H. In addition to assessment and screening procedures set forth in this operating procedure, an evaluation or assessment of an inmate/probationer/parolee may be completed at any time as considered necessary by the Psychology Associate.
- I. DOC and Virginia Parole Board staff may request an assessment by forwarding a [Referral: Mental Health Status Update](#) 730_F26 to the appropriate institutional Senior Psychology Associate, or Mental Health Residential Treatment Unit Director. The receiving Psychology Associate will determine the appropriate means to address the referral.
- J. Inmates admitted to a Mental Health Residential Treatment Unit will receive a comprehensive evaluation by a Psychology Associate; see Operating Procedure 730.3, *Mental Health Services: Levels of Care*. The evaluation will be completed within 15 working days of admission to the Mental Health Residential Treatment Unit and include at least the following:
1. Review of mental health screening and appraisal data.
 2. Direct observation of behavior.
 3. Collection and review of additional data from individual diagnostic interviews and tests assessing

personality, intellect, and coping abilities.

4. Compilation of the inmate's mental health history.
5. Development of an overall treatment or management plan with appropriate referral to include transfer to mental health facility for inmates whose mental health and wellness services needs exceed the treatment capability of the institution.

VI. Mental Health Classification Coding System (Institutions only)

- A. In DOC institutions, the Mental Health Classification Coding system provides a standard approach through which the mental health status and services needs of individual inmates may be examined.
 1. Such classification provides information regarding inmates who have special treatment needs or who may present special management concerns.
 2. This classification system provides information that can be used for program planning and administrative purposes, as well as in the allocation of current and future resources.
 3. Probationers/parolees in Community Corrections Alternative Programs are not assigned a Mental Health Classification Code.
- B. When a Mental Health Classification Code is assigned, it should reflect the inmate's current mental status and services needs and not be based solely on a history of treatment (which may include psychotropic medication) for:
 1. Substance abuse
 2. Sleep disturbance
 3. Medical conditions
 4. Psychotropic medication prescribed for medical conditions (i.e. pain management)
 5. Sex offenses
- C. The Mental Health Classification Coding system criteria are as follows:

MH-4 Severe Impairment

The inmate is seriously mentally ill and is considered a danger to self or to others or may be substantially unable to care for self. The inmate may be prescribed psychotropic medication.

Inmates coded as MH-4 must have a documented significant DSM diagnosis with Serious Mental Illness (SMI) designation or diagnosis of a severe personality disorder that is manifested with breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment or has consistently demonstrated dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior etc., as a consequence of any diagnosis set out in the definition of serious mental illness.

Assignment to an acute care mental health treatment unit is required.

MH-3 Moderate Impairment

The inmate has an on-going mental disorder and may be chronically unstable. The inmate typically cannot function in the general population for extended periods of time and requires on going mental health monitoring or mental health monitoring and treatment. The inmate may be prescribed psychotropic medication.

This category typically includes:

- Inmates previously coded as MH-4 who have been stabilized and are discharged from an acute care treatment unit, or
- Inmates assigned to a designated DOC Mental Health Residential Treatment Unit
- Inmates whose level of disturbance is such that admission to an Acute Care Unit (ACU) or other designated DOC mental health unit is a probable periodic occurrence.

Inmates coded as MH-3 must have a documented significant DSM diagnosis with SMI designation or diagnosis of a severe personality disorder that is manifested with breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment; or has consistently demonstrated dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior etc., as a consequence of any diagnosis set out in the definition of serious mental illness.

Inmates coded as MH-3 will be assigned to institutions with full time mental health and wellness services staff.

MH-2S Substantial Impairment

The inmate must have a documented significant DSM diagnosis that meets SMI criteria which requires monitoring by a Psychology Associate and may require medication intervention.

- Inmates coded as MH-2S must be assigned to institutions with full time mental health and wellness services staff.
- Inmates whose level of disturbance is such that admission to an ACU or other designated DOC mental health unit is a probable periodic occurrence.
- A [Mental Health Serious Mental Illness \(SMI\) Determination](#) 730_F34 is completed upon reception into the DOC, upon transfer to each new institution, at the annual MH Classification Code review, and upon assignment to the Restorative Housing Unit and Secure Diversionary Treatment Program if the [Mental Health Serious Mental Illness \(SMI\) Determination](#) 730_F34 is more than one year old.

MH-2 Mild Impairment

The inmate must have a documented significant DSM diagnosis or diagnosis of a personality disorder with symptoms that are usually mild to moderate but stable. The individual can typically function satisfactorily in a general population setting for extended periods. Monitoring by a Psychology Associate may be necessary. The inmate may be prescribed psychotropic medication.

Inmates coded as MH-2 will be assigned to institutions with full time mental health and wellness services staff.

Inmates for whom treatment services are recommended or treatment needs are anticipated will be coded at least MH-2 to ensure assignment to an institution with full time mental health and wellness services staff.

MH-1 Minimal Impairment

The inmate does not currently require mental health treatment but has a history of self-directed violence, suicidal gestures or attempts, or mental health treatment within the past two years. The inmate is not prescribed psychotropic medication and can function satisfactorily in a general population setting. Inmates coded as MH-1 may be assigned to any institution.

This code is the minimum code assigned to an inmate with a diagnosis of Gender Dysphoria. Higher codes may be assigned based on level of associated symptomatology and behavior.

MH-0 No Mental Health and Wellness Services Needs

The inmate has no documented history of mental health treatment within the past year (this does not include treatment for alcohol or substance abuse alone, nor for evaluation purposes alone). There is no documented or reported behavior that currently indicates any mental health and wellness services needs. No monitoring or treatment by a Psychology Associate is currently required.

Inmates coded as MH-0 may be assigned to any institution.

MH-X Designated Field Unit and Work Center

This category includes mental health inmates on psychotropic medications housed in designated Field Units and Work Centers who have been screened and approved in accordance with Attachment 3, *Designated Field Unit and Work Center - Psychiatric Services Guidelines*.

D. Changing the Mental Health Classification Code

1. When a change occurs in an inmate's mental health status or mental health service needs, the current assigned Mental Health Classification Code will be reviewed by a Psychology Associate and updated as necessary.
2. Any time an inmate's Mental Health Classification Code is changed, the Psychology Associate will complete a [Mental Health Coding Classification Review/Update](#) 730_F18. The original *Mental Health Coding Classification Review/Update* will be filed in Section IV of the inmate's Health Record.
3. Mental Health Classification Codes may be reduced one level at a time (i.e. MH-3 to MH-2S and MH-2 to MH-1, but not MH-3 to MH-1). The following guidelines apply when lowering a Mental Health Classification Code:
 - a. Inmates coded as MH-4 are eligible to have their code lowered to MH-3 when they have been stabilized or discharged from an ACU. Symptomatology and level of functioning are key factors that must be considered prior to the code being changed.
 - b. Inmates coded as MH-3 are eligible to have their code lowered to MH-2S if they have demonstrated six months of stability. Symptomatology and level of functioning are key factors that must be considered prior to the code being changed. A Psychology Associate must have interviewed the inmate within the past 30 days prior to lowering the code from MH-3 to MH-2 S.
 - c. Any change to or from MH-2S status requires consultation and a co-signature from a licensed mental health clinician. Symptomatology and level of functioning are key factors that must be considered prior to the Mental Health Classification Code being changed.
 - d. Inmates coded as MH-2 are eligible to have their code lowered to MH-1 when they have demonstrated six months of stability or when clinically justified, as determined by the Psychology Associate Senior at that site. Symptomatology and level of functioning are key factors that must be considered prior to the code being changed. A Psychology Associate must have interviewed the inmate within the past 30 days prior to lowering the code from MH-2 to MH-1.
 - e. Inmates coded as MH-1 are eligible to have their code lowered to MH-0 if there has been no documented history of mental health treatment within the past year or when clinically justified, as determined by the Psychology Associate Senior at that site. If the Psychology Associate can demonstrate that the current Mental Health Classification Code was assigned in error, the Psychology Associate Senior at that site can authorize correction of the code outside of the time periods noted above with the reasons noted in the medical record.

E. Annual review of the Mental Health Classification Code (Institutions only)

1. Inmates who have a Mental Health Classification Code of MH-1 or greater, and who are assigned to an institution with Psychology Associates, will have their Health Record reviewed at least one time per year at the time of the scheduled annual review.
2. When the inmate is due for their annual review, the Psychology Associate will complete a record review verifying the correct Mental Health Classification Code.
 - a. The results of the review will be documented on the [Mental Health Coding Classification Review/Update](#) 730_F18.
 - b. If the Psychology Associate is considering lowering the Mental Health Classification Code, the guidelines in the *Changing the Mental Health Classification Code* section of this operating procedure will be followed.
3. Inmates who have a Mental Health Classification Code of MH-0 do not have to be reviewed by a Psychology Associate at the time of the inmate's annual review.
 - a. If the inmate's Case Management Counselor questions the accuracy of a current Mental Health Classification Code of MH-0, the Case Management Counselor will send a written request to the Senior Psychology Associate for a review of the Mental Health Classification Code.
 - b. When such a request is received, a Psychology Associate will complete a record review verifying

or updating the current Mental Health Classification Code and document the results of the chart review on the [Mental Health Coding Classification Review/Update](#) 730_F18.

F. Mental Health Classification Codes for parole eligible inmates (institutions only)

1. Upon written request from a Parole Examiner or Case Management Counselor, the Psychology Associate will complete a record review verifying that the current Mental Health Classification Code is accurate or requires updating for an inmate being reviewed for parole.
2. The results of the chart review will be documented on the [Mental Health Coding Classification Review/Update](#) 730_F18.
3. If the Psychology Associate is considering lowering the Mental Health Classification Code, the guidelines in the *Changing the Mental Health Classification Code* section of this operating procedure will be followed.

VII. Mental Health Classification Coding System (Community Corrections and CCAP Only)

- A. The District Mental Health Clinicians (DMHC) or Regional Mental Health Clinicians (RMHC) will review each probationer/parolee released from a facility, jail, or sentenced directly to community supervision from the Court in order to identify the probationer's/parolee's mental health status and services needs and assign a Community Mental Health Classification Code.
- B. The Community Mental Health Classification Coding system criteria are as follows:

CMH-4 Severe Impairment

The probationer/parolee has a DSM diagnosis that may include SMI designation and/or is considered a danger to self or to others or may be substantially unable to care for self. The probationer/parolee may require inpatient hospitalization and/or be prescribed psychotropic medication. This status includes probationers/parolees who tend to be chronically unstable, marginally compliant with treatment and/or supervision, and at risk in the community.

CMH-3 Moderate Impairment

The probationer/parolee has a DSM diagnosis that may include SMI designation with significant impairment and/or chronic instability. The probationer/parolee typically cannot function in the community for extended periods of time and requires ongoing mental health monitoring or mental health monitoring and treatment. The probationer/parolee may be prescribed psychotropic medication. This category typically includes probationers/parolees previously coded as MH-4 who have been stabilized and are discharged from a hospital or inmates whose level of disturbance is such that admission to a hospital is a probable periodic occurrence. General guidelines for assigning this code include:

- DSM diagnosis with SMI designation with significant impairment and/or chronic instability.
- Currently in a hospital or transferred between hospitals (i.e., state or private hospitalizations).
- Recently released from hospital and/or receiving intensive community services, such as Program Assertive Community Treatment or mental health skill building.
- Receiving or history of receiving disability for mental health issues, including intellectual disability or traumatic brain injury.
- Mental health issues severe enough to interfere with amenability to supervision.
- Requires assistance with daily living due to mental health issues.
- History of at least one psychiatric hospitalization/commitment.
- History of a suicide attempt within the past six months.

CMH-2 Mild to Moderate Impairment

The probationer/parolee may have a DSM diagnosis that includes SMI designation with symptoms that are usually mild to moderate but stable. The individual can typically function satisfactorily in a community setting for extended periods. Monitoring by a DMHC may be necessary and the

probationer/parolee may be prescribed psychotropic medication. Probationers/parolees for whom treatment services are recommended or treatment needs anticipated will be coded at least CMH-2. General guidelines for assigning this code include:

- May be taking psychotropic medication prescribed during incarceration.
- Receiving mental health and wellness services or programming from external provider (e.g., CSB case manager, psychiatrist, clinics, Primary Care Physician (PCP)).
- Receiving or history of receiving disability for mental health issues, including intellectual disability.
- Dually diagnosed with mental health and substance abuse issues.
- Diagnosed with intellectual disability or traumatic brain injury with moderate functional impairment.
- May fluctuate in stability and amenability to supervision.
- Chronic suicidal ideation or recent suicidal thoughts without plan or intent.
- Recent situational stressor causing a disruption in functioning and/or treatment adherence.

CMH-1 Minimal Impairment

The probationer/parolee may or may not require mental health treatment currently but has a history of self-directed violent behavior, suicidal gestures or attempts, or mental health treatment within the past two years. This is the minimum code assigned to probationer/parolee designated as a HRSA or a HRSV if mental health intervention is indicated. General guidelines for assigning this code include:

- May be referred for or receiving services from an external provider (e.g., CSB case manager, psychiatrist, mental health clinic, PCP) and has been functioning well for the past six months.
- May have history of mental health and wellness services but no treatment for the past six months.
- Maintaining stability on psychotropic medications with no significant functional impairment.
- Mental health issues do not substantially interfere with amenability to supervision.

CMH-0 No Mental Health and Wellness Services Needs

There is no documented or reported behavior that currently indicates any mental health and wellness services needs. No monitoring or treatment by a DMHC is currently required.

- No referral to RMHC/DMHC, CSB, treatment program, or other outside provider.
- No known history of mental health and wellness services in the past year.
- Stable in the community for the past six months.
- Probationer/parolee may have adjustment or mood disturbance associated with substance use, but has no other mental health and wellness services needs.

C. Changing the Community Mental Health Classification Code

1. When a change occurs in a probationer's/parolee's mental health status or mental health service needs, the current assigned Community Mental Health Classification Code will be reviewed by a DMHC and updated as necessary.
2. Any time a probationer's/parolee's Community Mental Health Classification Code is changed, the DMHC will document this change in a VACORIS note.
3. Community Mental Health Classification Codes may be reduced one level at a time (i.e. CMH-3 to CMH-2 and CMH-2 to CMH-1, but not CMH-3 to CMH-1). The following guidelines apply when lowering a probationers/parolees Community Mental Health Classification Code:
 - a. CMH-4 are eligible to have their code lowered to CMH-3 when they have been stabilized or discharged from a hospital. Symptomatology and level of functioning are key factors that must be considered prior to the Community Mental Health Classification Code being changed.
 - b. CMH-3 are eligible to have their Community Mental Health Classification Code lowered to CMH-2 if they have demonstrated six months of stability. Symptomatology and level of functioning are key factors that must be considered prior to the Community Mental Health Classification Code

being changed. A DMHC must have interviewed the probationer/parolee within the past 30 days prior to lowering the Community Mental Health Classification Code from CMH-3 to CMH-2.

- c. CMH-2 are eligible to have their Community Mental Health Classification Code lowered to CMH-1 when they have demonstrated six months of stability or when clinically justified, as determined by the DMHC. Symptomatology and level of functioning are key factors that must be considered prior to the Community Mental Health Classification Code being changed. A DMHC must have interviewed the probationer/parolee within the past 30 days prior to lowering the Community Mental Health Classification Code from CMH-2 to CMH-1.
- d. CMH-1 are eligible to have their Community Mental Health Classification Code lowered to CMH-0 if there is no documented history of mental health treatment within the past year or when clinically justified, as determined by the DMHC.

VIII. Information Technology Code Entry

The Psychology Associate will enter the Mental Health Classification Code into VACORIS within two working days of the completion of the [Mental Health Appraisal](#) 730_F17, or [Mental Health Coding Classification Review/Update](#) 730_F18, as appropriate.

REFERENCES

Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition)
 Operating Procedure 025.3, *Public Records Retention and Disposition*
 Operating Procedure 038.3, *Prison Rape Elimination Act (PREA)*
 Operating Procedure 720.2, *Medical Screening, Classification, and Levels of Care*
 Operating Procedure 730.3, *Mental Health Services: Levels of Service*
 Operating Procedure 730.5, *Mental Health Services: Behavior Management*
 Operating Procedure 730.6, *Mental Health Services: Confidentiality*
 Operating Procedure 810.1, *Offender Reception and Classification*
 Operating Procedure 810.2, *Transferred Offender Receiving and Orientation*

ATTACHMENTS

Attachment 1, *Guidelines to Access Emergency Mental Health and Wellness Services*
 Attachment 2, *Mental Health Appraisal Instructions*
 Attachment 3, *Designated Field Unit and Work Center-Psychiatric Services Guidelines*

FORM CITATIONS

[Consent for Release of Information](#) 050_F14
[Consent for Release of Confidential Health and/or Mental Health Information](#) 701_F8
[Preliminary Medical Screening \(C&R 7b\)](#) 720_F8
[Intrasystem Transfer Medical Review \(DOC 726-B\)](#) 720_F9
[Health Screening - Health-Trained Staff](#) 720_F10
[Telehealth Electronic Device Control Record](#) 720_F42
[Mental Health and Wellness Services Screening](#) 730_F12
[Mental Health Appraisal](#) 730_F17
[Mental Health Coding Classification Review/Update](#) 730_F18
[Psychological Summary \(C&R 8\)](#) 730_F23
[Sexual Assault Assessment](#) 730_F25
[Referral: Mental Health Status Update](#) 730_F26

[Prison Rape Elimination Act \(PREA\) Psychology Associate Follow-Up](#) 730_F28

[Mental Health Serious Mental Illness \(SMI\) Determination](#) 730_F34

[Referral for Psychological Evaluation](#) 730_F35



Exhibit 60

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
BIG STONE GAP DIVISION**

WILLIAM THORPE, *et al.*,

Plaintiffs,

V.

VIRGINIA DEPARTMENT OF
CORRECTIONS, *et al.*,

Defendants.

Case No. 2:20-cv-00007-JPJPMS

DECLARATION OF TARA LEE

I, Tara Lee, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am an attorney duly admitted to practice law in this Court, the State of Virginia, the Fourth Circuit, and multiple Federal Districts in Virginia and other states.

2. I am a partner at White & Case LLP (“White & Case”), and have personal knowledge of the facts contained in this declaration, or knowledge based on my review of documents in the possession of White & Case. White & Case is counsel for Plaintiffs in the above-captioned litigation, and I submit this declaration in support of Plaintiffs’ Motion for Class Certification.

3. White & Case seeks appointment as class counsel for the proposed classes in this action under Rule 23(a)(4) and 23(g) of the Federal Rules of Civil Procedure. My declaration states facts related to White & Case's appointment and myself. As set forth below, White & Case possesses the class action experience, knowledge of the relevant substantive areas of law, and resources necessary to fairly and adequately represent the interests of the proposed classes in this action.

4. I am a 1996 graduate of the University of San Diego School of Law, where I received my Juris Doctor degree. I was admitted to the Maryland State Bar in 1996, California State Bar in 1999, Virginia State Bar in 2005, New York State Bar in 2013, and District of Columbia State Bar in 2015. I am also a member in good standing of several federal bars.

5. I have maintained an active litigation practice for over 25 years. Since 2020, I have worked at White & Case. My practice includes litigating complex class action suits.

6. White & Case is a global law firm headquartered in New York. Attorneys from White & Case, including myself and Michael Gallagher who is also counsel in this case, have significant experience litigating class action suits, including to jury verdict. Those class action suits include: *Brink v. XE Holding, LLC*, No. 11-1733 (EGS) (D.D.C.); *Darrough v. SOC LLC*, No. 2:20-cv-01951-CDS-BNW (D. Nev.); *In re Asacol Antitrust Litig.*, No. 15-cv-12730-DJC (D. Mass.); *In re Brand Name Prescription Drugs Antitrust Litig.*, No. 94 C 897, MDL 997 (N.D. Ill.); *In re Loestrin 24 FE Antitrust Litig.*, No. 1:13-md-2472-S-PAS; MDL No. 13-2472-S-PAS (D.R.I.); *In re USC Student Health Center Litigation*, No. 2:18-cv-04258-SVW (C.D. Cal.); *Risinger v. SOC LLC*, No. 2:12-cv-00063-MMD-PAL (D. Nev.). As one of the largest international law firms, White & Case has more than sufficient resources to prosecute this case vigorously.

7. The White & Case team also includes Daniel Levin, Kelly Newman, and Matthew S. Leddicotte, all of whom have extensive class action experience.

8. White & Case has devoted thousands of hours of attorney time into prosecuting this case. Michael Gallagher and I supervise approximately 25 associates working on this case, as well as paralegals and secretaries who have also been assisting. White & Case has been heavily involved in the investigation and litigation of this matter since 2018. White & Case is familiar

with the laws applicable to this case and with the state and local rules; it is ready, willing, and able to prosecute this case on behalf of Plaintiffs and the proposed classes.

9. I am aware of no conflicts of interest between myself, White & Case, and any members of the proposed classes.

I declare under penalty of perjury that the foregoing is true and correct. Executed this June 20, 2022.

/s/ Tara Lee
Tara Lee

Exhibit 61

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
BIG STONE GAP DIVISION**

WILLIAM THORPE, *et al.*,

Plaintiffs,

V.

VIRGINIA DEPARTMENT OF
CORRECTIONS, *et al.*,

Defendants.

Case No. 2:20-cv-00007-JPJ-PMS

DECLARATION OF EDEN B. HEILMAN

I, Eden B. Heilman, counsel for Plaintiffs in the above-captioned case, and pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am an attorney duly admitted to the practice of law in this Court, the Commonwealth of Virginia, the Eastern District of Virginia, the Fourth Circuit, the Fifth Circuit, the Supreme Court of the United States, and multiple Federal Districts in Louisiana as well as the State of Louisiana.

2. I am the legal director of the American Civil Liberties Union Foundation of Virginia (“ACLU of Virginia”) and have personal knowledge of the facts contained in this declaration, or knowledge based on my review of documents in the possession of the ACLU of Virginia. The ACLU of Virginia is counsel for Plaintiffs in the above-captioned litigation, and I submit this declaration in support of Plaintiffs’ Motion for Class Certification.

3. The ACLU of Virginia seeks appointment as class counsel for the proposed classes in this action under Rule 23(a)(4) and 23(g) of the Federal Rules of Civil Procedure. As set forth below, the ACLU of Virginia and its legal staff possess the class action experience, knowledge of

the relevant substantive areas of law, and resources necessary to fairly and adequately represent the interests of the proposed classes in this action.

4. The ACLU of Virginia is a nonprofit, nonpartisan organization which promotes civil liberties and civil rights for everyone in the Commonwealth of Virginia through litigation, public education and advocacy with the goal of securing freedom and equality for all. Founded in 1969, the ACLU of Virginia has extensive experience litigating landmark civil rights cases, including *Loving v. Virginia* (challenging Virginia's anti-miscegenation statute) and *Harris v. Rainey/Bostic v. Schaefer* (challenging Virginia's ban on marriage by same-sex couples), as well as dozens of cases involving the rights of individuals incarcerated in Virginia's prisons and jails.

5. I lead the team of ACLU of Virginia attorneys working on this matter. I graduated with my Juris Doctor from Loyola University New Orleans College of Law in 2006, my Master of Social Work from Tulane University in 2002, and my Bachelor of Arts from the University of Florida in 2000.

6. I have maintained an active litigation practice for approximately 16 years. I spent the majority of my legal career at the Southern Poverty Law Center, from July 2007 to March 2018, where I worked exclusively on civil rights litigation, first as a staff attorney, then as a senior staff attorney, managing attorney, and the director of the organization's Louisiana office.

7. As an attorney for the Southern Poverty Law Center, I gained deep experience representing individuals in carceral settings as well as experience litigating claims under the Americans with Disabilities Act ("ADA") and the Rehabilitation Act, including serving as lead counsel on the class action *Berry v. Pastorek*, No. 2:10-cv-04049 (E.D. La.) (representing plaintiff class).

8. As managing attorney and director of the Louisiana office of the Southern Poverty Law Center, I oversaw our litigation on issues involving criminal justice reform, prison conditions, economic justice, juvenile justice, and disability rights, among other issues, which included complex class action litigation.

9. Since June 2018, I have served as legal director for the ACLU of Virginia. As the legal director, I oversee the organization's litigation docket on issues such as prison conditions, gender equity and sex discrimination, free speech and religious liberty, voting, and privacy and technology. The vast majority of the ACLU of Virginia's litigation is before the federal courts of Virginia and the Fourth Circuit. Much of our work since 2018 has included cases involving incarcerated individuals in the custody of the Virginia Department of Corrections (VDOC) such as: *Reyes v. Clarke*, No. 3:18CV611 (W.D. Va.) (representing plaintiff); *Whorley v. Northam*, No. 3:20-cv-002555 (E.D. Va.) (representing plaintiffs); *Hawkins v. Stallard*, No. 7:20-cv-00675 (W.D. Va.) (representing plaintiff); *Burke v. Clarke*, No. 7:16-cv-00365 (W.D. Va.) (representing plaintiff); *Law, Jr. v. Zook*, No. 3:22-cv-00295 (E.D. Va.) (representing plaintiff); *Porter v. Clarke*, No. 18-6257 (4th Cir.) (as amici); *Latson v. Clarke*, No. 18-2457 (4th Cir.) (as amici); *Hardin v. Hunt*, No. 21-7195 (4th Cir.) (as amici); *Mathena v. Malvo*, 18-217 (U.S. 2019) (as amici).

10. Since 2018, we have also been involved in a number of other notable cases in Virginia's federal courts and before the Fourth Circuit Court of Appeals, such as *Grimm v. Gloucester Cty. Sch. Bd.*, 400 F. Supp. 3d 444 (E.D. Va. 2019), 972 F.3d 586 (4th Cir. 2020); *Seaman v. Virginia*, No. 3:22-cv-00006, 2022 WL 872023 (W.D. Va. Mar. 23, 2022); *League of Women Voters of Virginia v. Virginia State Bd. of Elections*, 458 F. Supp. 3d 442 (W.D. Va. 2020); *Falls Church Med. Ctr., LLC, v. Oliver*, 412 F. Supp. 3d 668 (E.D. Va. 2019); *Coalition for T.J.*

v. Fairfax Cty. Sch. Bd., No. 22-1280 (4th Cir.) (as amici); *Updegrove v. Miyares*, No. 21-1506 (4th Cir.) (as amici); and *Stinnie v. Holcomb*, No. 21-1756 (4th Cir.) (as amici).

11. The ACLU of Virginia team working on this case also includes senior staff attorney Vishal Agraharkar and senior staff attorney Matthew Callahan.

12. Vishal Agraharkar received his Juris Doctor degree from Columbia Law School in 2010, and his Bachelor of Arts from Williams College in 2005. He has maintained an active litigation practice for approximately 11 years. Since 2018, he has been a senior staff attorney at the ACLU of Virginia, where he has had extensive experience in civil rights litigation in federal court, including by serving as lead counsel or counsel on multiple cases involving the rights of incarcerated persons in Virginia prisons in particular. Prior to working at the ACLU of Virginia, Mr. Agraharkar was the Cochran Fellow at the law firm of Neufeld Scheck & Brustin in New York, where he litigated several wrongful conviction civil rights lawsuits in federal courts around the country. Before that, Mr. Agraharkar served as counsel at the Brennan Center for Justice in New York, where he had extensive experience litigating voting rights lawsuits in federal court.

13. Matthew Callahan is a 2015 graduate of the New York University School of Law, where he received his Juris Doctor degree. He was admitted to the California bar in 2015, the District of Columbia bar in 2019, and is admitted *pro hac vice* in this matter. He is also a member in good standing of numerous federal bars. Mr. Callahan has extensive litigation experience. He has served as lead counsel in multiple successful civil rights and prisoners' rights cases, both his current role and his previous four years at the non-profit Muslim Advocates. He also worked on class action defense in multiple cases as an associate at the firm Schiff Hardin LLP.

14. The ACLU of Virginia is the Virginia affiliate of the national ACLU, a nationwide, nonprofit, nonpartisan organization with nearly 2 million members dedicated to the principles of

liberty and equality embodied in the Constitution and this nation's civil rights laws. The ACLU of Virginia, with approximately 28,000 members and over 240,000 supporters, has sufficient funding available to finance the costs of this litigation.

15. The ACLU of Virginia has devoted significant hours of attorney time into prosecuting this case. We have been heavily involved in the investigation and litigation of this matter since early 2019. We are familiar with the laws applicable to this case and with the state and local rules. The ACLU of Virginia is ready, willing, and able to prosecute this case on behalf of Plaintiffs and the proposed class.

16. I am aware of no conflicts of interest between myself, the ACLU of Virginia, and any members of the classes.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed this 20 day of June 2022 in Richmond, Virginia.

/s/ Eden B. Heilman
Eden B. Heilman