REPORT OF THE
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

Evaluation of Inmate Mental Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

While the United States Supreme Court determined in the 1970s that inmates have a Constitutional right to mental health treatment, the Court has not provided direction on what constitutes adequate treatment. Therefore, questions remain as to what level and quality of mental health treatment should be available to inmates.

Item 15 of the 1992 Appropriation Act directed JLARC to examine the increasing cost of inmate health care within the Virginia Department of Corrections (DOC) and to determine appropriate levels of that care. This report examines mental health treatment. Other reports in this series address medical and dental care.

JLARC staff estimate that DOC expended approximately $4.9 million to provide mental health treatment in FY 1993. DOC provides three levels of mental health treatment: acute care for the most seriously mentally ill, sheltered care for inmates who are so mentally ill that they cannot function in the general population, and outpatient treatment for inmates who need periodic treatment but can function within the general population of inmates.

The recommendations in this report are directed at improving the department's performance in two major areas. First, the department has not developed a system for mental health treatment delivery. The lack of a system has resulted in a need for the department to improve the quality of treatment in its five sheltered care units, better utilize its psychologists providing outpatient treatment, and more efficiently utilize costly mental health treatment beds. The department has, however, made a significant commitment to provide acute mental health treatment for its male inmates and provides high-quality acute mental health treatment.

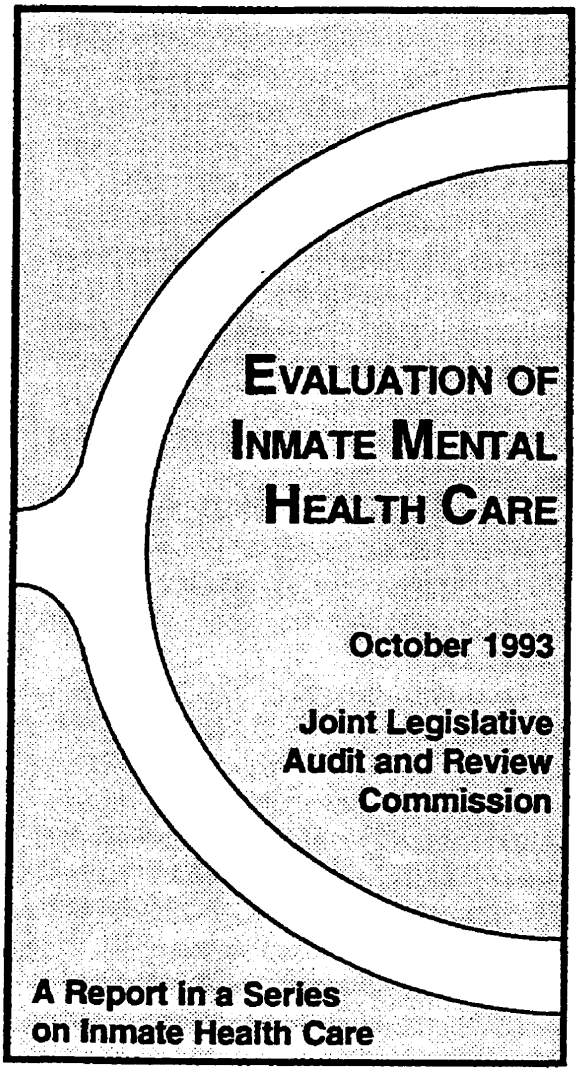
Second, the department has not developed adequate mechanisms for cost control. The department lacks adequate data on the costs of mental health treatment it is providing. Therefore, the department does not have a system of cost control for its delivery of mental health treatment. The department is planning a significant increase in staffing and mental health beds during FY 1994. It is important that the department use its existing resources and these new resources in a more cost efficient and effective manner.

On behalf of JLARC staff, I would like to thank the director and the staff of the Department of Corrections for their cooperation and assistance during the course of this review.

Philip A. Leone
Director

October 8, 1993

JLARC Report Summary



The U. S. Supreme Court determined in the 1970s that inmates have a Constitutional right to mental health treatment but the Court has not provided direction on what constitutes adequate treatment. Therefore, the level and quality of mental health care must be determined by treatment professionals within the corrections system.

JLARC staff estimate that the Virginia Department of Corrections (DOC) expended almost $4.9 million in FY 1993 to fund mental health treatment. The department employs 76.5 classified employees, 15 contract employees, and two temporary employees to provide mental health treatment in the institutions. One staff member within the central office is dedicated to mental health treatment and serves in an advisory capacity to the institutional staff.

DOC provides three levels of mental health treatment. Acute care for male inmates who are severely mentally ill and present a danger to self or others is provided at Marion Correctional Treatment Center. Acute care for female inmates is provided by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) at Central State Hospital. Sheltered care units at five facilities provide treatment and housing for inmates who are so mentally ill that they cannot function in the general population. Outpatient treatment is provided at 15 facilities for inmates who need periodic mental health treatment but are able to function within the general inmate population.

There are two major findings of this report. First, the department has not fully developed a system of comprehensive mental health care. Several problems with mental health service delivery appear to result from the lack of such a system. Second, the department has not developed adequate cost control mechanisms, in part because it lacks data on the costs of the mental health services it is providing. The department, which is planning to add new mental health staffing and beds during FY 1994, could also utilize its existing resources in a more cost-effective manner. While the new resources the department is adding should help it improve its mental health services, it is also important that DOC implement cost control mechanisms and operate more efficiently, in order to use its existing and new staff to their full potential.

DOC Lacks System for Mental Health Treatment

The department has made a significant commitment to the provision of acute mental health treatment for male inmates and provides quality mental health treatment at Marion. However, problems exist in the provision of sheltered care and outpatient treatment. The department has not provided a sufficient oversight role in guiding the development of the mental health programs at the facilities and identifying and correcting problems.

DOC Needs to Improve Treatment Provision in Sheltered Care Units. The department needs to address identified deficiencies in treatment planning, treatment implementation, and record-keeping in sheltered care units (see figure, top of next page). Individualized treatment plans, defined therapeutic interventions, and well-documented records are seen by mental health treatment professionals as necessary to help ensure quality treatment.

Individual written treatment plans document mental health staff recommendations for planned treatment interventions, and are used to monitor an inmate's progress during treatment. Written treatment plans are not prepared in three of the five sheltered care units. In the two units in which plans are prepared, the plans are too general to be used effectively in planning or monitoring treatment.

Treatment is usually provided in group settings, since this is the most cost-effective approach to dealing with the mental health problems of most inmates. However, two of the five units do not provide group therapy, relying instead on individual one-on-one therapy. None of the units providing group therapy have developed goals and objectives for the groups. Only one unit, Staunton's sheltered care unit, has developed outlines to describe issues which will be addressed in the groups.

Department operating procedures direct that an inmate's mental health files are to be included within the inmate's medical files. However, there are no department procedures which standardize the information which is to be included in mental health files. Including one unit which does not maintain mental health files, the quality of the mental health information is inadequate in four of the five sheltered care units.

Recommendation. *DOC should formalize its expectations regarding the need for and content of written, individual treatment plans. These treatment plans should include at a minimum: the active problems of the inmate, specific objectives and plans for treatment, and the expected behavioral results of the treatment.*

Recommendation. *DOC should direct mental health staff at Powhatan and Mecklenburg to develop groups to be used in the treatment of mentally ill inmates in the sheltered care unit.*

Recommendation. *DOC should direct mental health staff at each sheltered care unit to develop written program descriptions for all groups provided. In addition, DOC should direct mental health staff at each sheltered care unit to develop written contracts to be distributed to all inmates housed in the sheltered care units.*

Recommendation. *DOC should require that organized mental health files be maintained for each inmate by standardizing the contents of the files and the format to be utilized. Further, DOC should standardize the procedures for taking progress notes by providing directions on what the notes should include and the frequency that notations are to be made.*

Recommendation. *DOC should develop policies to ensure that copies of treatment plans, mental health histories, progress notes, and screening forms accompany inmates when they are transferred out of sheltered care units.*

Problems with Mental Health Service Delivery in Sheltered Care Units

	Problem	Facility				
		Greensville	Mecklenburg	Powhatan	Staunton	VCCW
Treatment Planning	No written treatment plans			X	X	X
	Treatment plans too general	X	X	n.a.	n.a.	n.a.
Group Therapy	No group therapy		X	X		
	No identified goals and objectives	X	n.a.	n.a.	X	X
	No contracts for therapeutic expectations	X	n.a.	n.a.		X
Record-Keeping	No mental health files					X
	Inadequate treatment notes	X	X	X		n.a.

Shaded Areas: Since treatment component is not provided, category does not apply, but problem needs to be addressed.

DOC Should Conduct Quality Assurance Reviews. Currently, DOC does not conduct quality assurance reviews of mental health treatment programs. Through effective quality assurance reviews, many of the problems addressed in this report could have been identified and addressed by the department.

Recommendation. *DOC should ensure that a quality assurance or continual quality improvement program for mental health treatment is established. The program that is instituted should focus on the quality, appropriateness, and scope of the treatment provided.*

DOC Needs to Provide Acute Care for Female Inmates. Access to acute care for female inmates is limited since women requiring acute care must be committed to Central State Hospital. Mental health staff indicated that some women needing this care are not receiving it. In response to this problem, DOC mental health staff have proposed a plan to house and treat acutely mentally ill women at Marion Correctional Treatment Center, the licensed psychiatric hospital operated by DOC to provide male inmates acute care.

Recommendation. *DOC should proceed with the mental health staff's plan to*

provide acute mental health treatment to women at the Marion Correctional Treatment Center.

DOC Should Address Security Issues in the Sheltered Care Units. Correctional officers working in mental health units must be able to relate to inmates in these units as mental health patients while maintaining a secure facility. Several of the units reported problems with the correctional officers assigned to the sheltered care units. Mental health staff in these units had no input into the correctional officers assigned to the units and indicated that many of the officers were not helpful in establishing the secure therapeutic environment necessary to provide treatment in a correctional setting.

Inmates in the sheltered care unit at Powhatan Correctional Center were locked in their cells for 20 hours per day and three correctional officers had to be present when mental health staff were conducting treatment in the cells. These procedures resulted in inmates receiving limited access to mental health treatment.

Recommendation. *DOC should develop written policy to ensure that mental health staff have input into correctional officer assignments to the mental health unit for all shifts. In addition, the department should ensure that all correctional officers working in mental health units have attended the Mental Health Basic Skills program.*

Recommendation. *DOC should ensure that the warden, or the assistant warden for programs, at Powhatan Correctional Center meet with mental health staff in the sheltered care unit to discuss appropriate policies regarding the amount of time inmates in the sheltered care unit spend in their cells and the number of security officers required to escort the inmates when out of their cells.*

DOC Should Use Mental Health Expertise Available at DMHMRSAS To Improve Quality of Care. When DOC assumed responsibility for mental health treatment of inmates in 1984, a plan was prepared to direct the transfer of responsibility from DMHMRSAS to DOC. The plan outlines a continuing role for DMHMRSAS staff in the mental health treatment of inmates. Expertise available at DMHMRSAS should further help DOC improve the quality of its mental health treatment through the Interdepartmental Mental Health Advisory Committee. Important functions the committee was to have conducted, as outlined in the original plan, have not been completed or accomplished. These functions include establishing standards for mental health services, developing mechanisms for quality assurance reviews, and assisting in mental health program services design and development. In addition, DOC needs to pursue DMHMRSAS licensure of its five sheltered care units. Licensure would provide DOC an additional mechanism to improve the quality of treatment.

Recommendation. *DOC should work with DMHMRSAS to begin the licensure process for the mental health units operated by DOC. DOC should establish a timeline and planning process whereby all DOC mental health units are licensed within five years or by 1998.*

Recommendation. *The Department of Corrections should reconvene the Interdepartmental Mental Health Advisory Committee.*

DOC Lacks Adequate Mechanisms to Ensure Cost-Effectiveness

The department is not currently utilizing its resources in the most cost-effective manner. Given the pending increase in mental health staff and beds, it is especially important that the department take action to ensure that existing resources are used to their

full potential and additional resources are used effectively. There are four cost control or cost-effectiveness issues that DOC needs to address, including the utilization of beds, the use of psychologists to perform routine administrative duties, the lack of a distinct mental health budget, and the need to monitor costs at Greensville.

DOC Does Not Utilize Costly Mental Health Beds Efficiently. Inefficient use of costly sheltered and acute care beds is due in large part to the current practice of requiring mental health staff at the major institutions to arrange all transfers out of sheltered and acute care beds. This limits the amount of time mental health staff spend on treatment provision and causes delays in the transfer of inmates, clinically ready for discharge, out of sheltered and acute care units. Therefore, inmates no longer requiring these services are remaining in costly treatment beds longer than necessary.

Recommendation. *DOC should address the problems with delays in the transfer process by centralizing the responsibilities within the central classification board. Written policy should instruct mental health staff to notify the designated contact person at CCB when a bed will be opening or when a bed is needed.*

Psychologists Providing Outpatient Treatment Are Not Used Cost-Effectively. Many psychologists providing outpatient services spend large amounts of time on administrative duties such as filing and scheduling appointments. Consequently, there is limited time being spent providing mental health treatment. These administrative duties could be more efficiently performed by existing, lower-paid clerical staff.

Recommendation. *DOC should examine the administrative duties being conducted by mental health staff to determine if all these duties are necessary. If so, the department should take steps to provide access to clerical staff from within the institutions, which would provide mental health staff more time to provide treatment.*

DOC Should Examine Cost-Effectiveness of Mental Health Treatment. There is no separate distinct budget for mental health treatment within the Department of Corrections. Mental health staff are therefore limited in their understanding of the cost of mental health services and the reasons for the increase or decrease in those costs.

DOC should isolate the costs of the various types of health care by establishing individual "cost centers" dedicated to each type of inmate health care. Subsequently, DOC would be able to identify and control mental health treatment costs, take system-wide cost containment actions, and conduct and use cost comparisons to monitor cost effectiveness of the various units. Further, the Department should conduct analyses comparing the cost of renovating existing DMHMRSAS facilities to the cost of new construction as standard aspects of planning for capital expansion.

Recommendation. *DOC should establish cost centers which differentiate mental health treatment expenditures from dental and medical expenditures.*

Recommendation. *The mental health program director should review mental health cost data at least quarterly. The cost data should be used in evaluating alternative means of providing mental health treatment and in making and justifying budgetary decisions.*

Recommendation. *DOC should ensure that the analysis of mental health cost data is used to the fullest extent possible in identifying efficient and inefficient mental health units.*

Recommendation. *DOC should ensure that cost-effectiveness is the basis for deciding whether to employ mental health staff as classified, salaried employees or on a contract basis.*

Recommendation. *DOC should conduct a cost analysis which compares the costs of renovating the existing DMHMRSAS structures to the cost of new construction. The information from this cost analysis should be included with all capital outlay requests presented to the Senate Finance and House Appropriations Committees.*

DOC Should Increase Its Monitoring of the Sheltered Care Unit at Greensville. The Department of Corrections contracts with Correctional Medical Services, a private corporation, to provide mental health treatment at Greensville. As discussed previously, this review identified problems with the quality of treatment provided at Greensville. Further, comparison of the cost of the Greensville sheltered care unit to the acute care facility at Marion indicated that Greensville's care is more costly than might be expected. Therefore, DOC should thoroughly review both the costs and quality of the treatment provided under the contract with Correctional Medical Systems.

Recommendation. *DOC should thoroughly review the cost effectiveness of the current contract with Correctional Medical Systems for mental health services.*

Table of Contents

I. Introduction

Mental health treatment is one of three components of inmate health services provided by the Virginia Department of Corrections (DOC). The other components are medical care and dental care. This report presents JLARC staff findings on the mental health services provided by the department. JLARC staff findings on dental care services were reported earlier, and the next report in the series will be on medical services.

Nationally, the number and proportion of inmates determined to be seriously mentally disordered and in need of mental health treatment is increasing. Two explanations have been given by several respected criminologists for the increase: overcrowding may increase tensions in prisons and cause mental illness; and the increasingly narrow criteria for civil commitment of the mentally ill and the general policy of deinstitutionalization may result in higher rates of conviction and imprisonment of persons who before would have been in the mental health system.

Item 15 of the 1992 Appropriation Act directed JLARC to examine the increasing costs of health care in corrections and to determine the appropriate level of inmate health care. The mandate further directed JLARC to develop mechanisms to restrain the growth of costs for inmate health care.

OVERVIEW OF MENTAL HEALTH TREATMENT

The legal question about the rights of inmates to mental health care was addressed in the late 1970s by the Supreme Court, when it held that inmates have a Constitutional right to care. However, the difficult questions about the level and quality of that care must be addressed by correctional administrators and mental health staff.

Broad standards have been developed for mental health treatment by several associations as part of their overall medical treatment standards. Generally, the adequacy of these standards has not been addressed by the courts.

Legal Issues

The mental health treatment provided inmates must be conducted in accordance with the federal and State laws addressing treatment, transfer, and rights to refuse treatment. The case law and statutory provisions outline a right to treatment for serious psychological needs or when sentencing is based on the mental condition of the inmate. Several key decisions have served to establish that treatment services must be provided. However, the courts have been silent on the level and quality of the mental health treatment which must be provided inmates.

The Supreme Court established in the late 1970s that inmates have a Constitutional right to mental health care. Failure to provide timely access to care violates the inmates' Constitutional rights under the Eighth Amendment protections against cruel and unusual punishment. Therefore, departments of corrections have a duty to provide care for inmates remanded into their custody.

The Supreme Court in *Estelle v. Gamble*, 429 U.S. 98,97 S.Ct.285 (1976), established that inmates have a right to care for serious needs. However, the decision in *Estelle* also established the standard of "deliberate indifference," which must be proven in cases challenging the adequacy of treatment. Mere negligence in providing care is not sufficient to result in a claim under *Estelle*. Deliberate indifference indicates knowledge by corrections officials that (a) a real problem exists which can benefit from treatment, and (b) there is a strong likelihood that failure to provide care would result in harm to the inmate. Deliberate indifference could occur in a facility with excellent mental health resources if even one inmate with serious known mental health needs were denied access to needed care, or if a prescribed course of treatment were ignored by officials. Deliberate indifference might also occur if an inmate with serious mental health treatment needs were assigned to a facility which could not provide the necessary mental health treatment.

The Fourth Circuit Federal Court of Appeals extended the standard in *Estelle* to inmates with psychiatric problems in *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977). In this Virginia case, the court found that inmates are entitled to mental health treatment if a condition exists which can become harmful if not treated and can improve if treated.

Another area where the Court has been active is in the protection of inmates' due process rights regarding transfers from one type of facility to another. The Supreme Court addressed this issue and set up certain due process safeguards for the inmate. In 1980, the Court decided in *Vitek v. Jones* (445 U.S. 480, 1980) that inmates, found by a psychologist or psychiatrist to be mentally ill or retarded and not able to be treated in a correctional facility, could not be transferred from a correctional facility to a mental hospital, even if the hospital was operated by the corrections department, without due process being followed. Due process was defined by the Court to be the following: "written notice of the proposed transfer, a hearing, the right to be heard, the right to present witnesses, an independent decision maker, and access to State-furnished qualified and independent assistance if the prisoner cannot furnish his own." Virginia requires that hearings consistent with the *Vitek* decision be held when a male inmate is committed to Marion Correctional Treatment Center or a female inmate is committed to Central State Hospital.

DOC requires that the inmate be transferred to either Marion or Central State Hospital if forced medication is necessary for the treatment of mental illness, although there is no formal written departmental policy on this. Currently, DOC allows prisoners the right to refuse medication. However, a 1990 Supreme Court decision appears to not require transfer to a mental health facility to force medication. The Court held in *Washington v. Harper*, 110 S.Ct. 1028 (1990) that treatment of a prisoner against his or

her will did not violate due process where the prisoner was found to be dangerous to self or others and treatment was in the prisoner's medical interest.

Standards for Inmate Mental Health Treatment

Professional associations have developed general standards which address inmate mental health treatment. The associations are:

- the American Correctional Association (ACA),
- the American Public Health Association (APHA),
- the National Commission on Correctional Health Care (NCCHC) and
- the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

ACA, APHA, and NCCHC each provide one general standard for mental health treatment as part of their set of standards for inmate medical treatment (Exhibit 1). JCAHO has the most comprehensive standards for mental health treatment which mental hospitals must comply with in order to be accredited. Currently, Marion Correctional Treatment Center is the only DOC facility which is JCAHO accredited.

In Virginia, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) licenses mental health facilities. Marion Correctional Treatment Center is the only DOC facility which is licensed by DMHMRSAS.

JLARC REVIEW

Item 15 of the 1992 Appropriation Act directed JLARC to:

> examine the increasing costs of inmate health care in the state correctional system. The objective of the study will be to determine the appropriate level of inmate health care while developing mechanisms for restraining the growth of costs.

This is the second report in the inmate health series. The first report, which covered dental care services, was released in January 1993.

Exhibit 1

Mental Health Standards Proposed by Professional Associations

ACA	APHA	NCCHC
Specifically referred inmates should have a comprehensive evaluation within 14 days of the date of referral; arrangements should be made for inmates that are severely disturbed and/or retarded; such inmates should be afforded due process; there should be a policy governing the use of restraints for medical and psychiatric purposes; psychotropic drugs should be ordered by a physician; and there should be a suicide prevention and intervention program.	Diagnostic and therapeutic services should be available; special training should be conducted for health and correctional staff; a program on suicide prevention should be available; specific rules should be followed if restraints are used; and mental health staff should work to enhance the mental health services of the institution.	All inmates should have a mental health evaluation within 14 days of admission; treatment and referral sources should be available, and care should be provided for inmates who are mentally ill or retarded; correctional staff should be trained to recognize and respond to mentally ill, develop-mentally disabled or suicidal inmates; specific rules should be followed when medical restraints are used; there should be a policy governing the use of forced psychotropic medications; and there should be a suicide prevention plan addressing a variety of issues.

Source: *Prison Health Care: Guidelines for the Management of an Adequate Delivery System*, National Institute of Corrections, March 1991.

Study Issues

Five major study issues have been developed to address the study mandate as it pertains to mental health treatment. The issues are:

- to determine if the mental health services provided by DOC meet the current legal requirements for such services,
- to determine if access to adequate mental health treatment is provided to inmates,
- to identify the major cost components of mental health services,

- to evaluate if the department is providing mental health services in a cost-effective manner, and

- to identify and evaluate options which the Department of Corrections has to contain costs of inmate mental health treatment which will not jeopardize the quality of care or incur additional legal liability for the State.

Research Activities

A number of research activities were undertaken to address the study issues. These activities included mail surveys, site visits to acute and sheltered care units, structured interviews, cost estimates, and document reviews.

Mail Surveys. JLARC staff conducted a survey of mental health services provided within the department. Due to the variance in the type of mental health services provided in each facility, surveys were customized. Different surveys were sent to each of the following respondent groups:

- Marion Correctional Treatment Center,

- the five facilities with sheltered care units,

- Staunton's developmental disabilities unit,

- three reception and classification centers at the major institutions which do not receive parole violators,

- the 13 facilities with outpatient mental health treatment services, and

- the 22 field units.

The 45 surveys were mailed to the highest ranking mental health professional at the major institutions and reception and classification centers, and to the head nurses at each field unit. Forty-four surveys were completed and returned, resulting in a response rate of 98 percent. The Chesterfield Work Release Unit did not respond to the survey.

Site Visits. Site visits were conducted at six prisons with inpatient mental health treatment: Greensville, the Marion Correctional Treatment Center, Mecklenburg, Powhatan, Staunton, and the Virginia Correctional Center for Women (VCCW). During the visits, JLARC staff conducted interviews with mental health staff, reviewed inmate files, and toured the facilities including the mental health units.

Structured Interviews. In addition to interviews during the site visits, structured interviews were conducted with the following:

- central office DOC staff with responsibilities for mental health treatment, sex offender treatment, substance abuse treatment, and the classification and transfer of mentally ill inmates;

- DMHMRSAS staff who work on forensic issues;

- legislators with special interest in mental health issues for inmates;

- individuals representing associations in Virginia (such as VA CURE and Offender Aid and Restoration) with knowledge of, and an interest in, mental health issues for inmates; and

- individuals who are currently federal grant or contract recipients for research on issues pertaining to mentally disordered criminal offenders.

Cost Estimates. Estimates of the primary costs involved in providing mental health care (for staffing and psychotropic medication) were made for fiscal years 1991 through 1993. These costs had to be estimated because mental health care expenditures are not reported separately from dental and medical care expenditures.

The actual salaries paid to the mental health care staff working on June 30 of 1991 and 1992 and on April 30, 1993 were extracted from a DOC personnel data base. The associated benefit costs were calculated based on figures supplied by Department of Planning and Budget staff.

The cost of psychotropic medication was estimated based on what was paid by DOC's Central Pharmacy and the Marion Correctional Treatment Center. The Central Pharmacy supplies all of the correctional institutions, except Marion and Greensville, with the vast majority of their pharmaceuticals.

Document Reviews. JLARC staff reviewed documents to assess legal issues related to correctional mental health treatment, and to determine the Virginia Department of Corrections' policies in response to the legal requirements. The staff reviewed pertinent sections of the *Code of Virginia,* and all federal Supreme Court, federal Circuit Court of Appeals, and State court decisions relating to mental health. To assess the department's compliance, department and institutional operating procedures relating to mental health were reviewed. Further, JLARC staff reviewed the standards relating to mental health of the Joint Commission on Accreditation of Healthcare Organizations, the American Correctional Association, the American Public Health Association, and the National Commission on Correctional Health Care.

Internal DOC reports were also reviewed. These include reports written for Board of Corrections audits and internal affairs investigation reports.

Report Organization

This chapter has provided a brief overview of the legal issues which apply to mental health treatment and the JLARC review. Chapter II describes the mental health treatment services currently provided by the Department of Corrections. The study findings about those services are contained in Chapter III.

II. Inmate Mental Health Treatment in Virginia

The Virginia Department of Corrections (DOC) began providing mental health services for its inmates in 1950 when the department hired its first full-time psychiatrist. However, up until about 1984, staff from the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) provided most of the mental health treatment for inmates. In 1984, DOC became the primary provider of mental health treatment to its inmate population when Governor Robb transferred 57 positions from DMHMRSAS to DOC. At that time, DOC was allocated approximately $1.5 million for mental health treatment services.

JLARC staff estimate that the department expended almost $4.9 million in FY 1993 for mental health services. During this same period, DOC mental health treatment staff reported that they provided in-patient mental health services to inmates in 312 beds. Due to recent General Assembly appropriations, the department began adding 25 additional mental health treatment staff and 105 in-patient beds in July 1993.

The organization of mental health services within DOC is consistent with the traditional structure in corrections, with central office staff serving as advisors to mental health staff working in the major institutions. One staff member is dedicated to mental health services within the central office. Within the facilities, 76.5 full-time equivalent (FTE) positions provide mental health treatment.

OVERVIEW OF MENTAL HEALTH TREATMENT SERVICES

Each inmate entering the DOC system is screened for mental health treatment needs as part of the routine reception and classification procedures. If the screening indicates mental health problems, the testing will continue in order to determine the level of mental health functioning, which helps decide inmate placement.

DOC provides three types of mental health treatment: acute care, sheltered care, and outpatient mental health services. Each of the three types is reflective of the treatment provided and the level of inmate functioning. The most seriously mentally ill inmates receive treatment in acute care facilities. Those who are so ill that they cannot function in the general inmate population receive treatment in sheltered care units. Mentally ill inmates who can function in the general inmate population receive outpatient services. The department provides all mental health treatment within the system with the exception of treatment for women in need of acute mental health care. Acute care for women is still provided by the Department of Mental Health, Mental Retardation, and Substance Abuse Services at Central State Hospital.

DOC does not maintain comprehensive data on the number of inmates receiving outpatient services within the department. Unlike acute and sheltered care services,

outpatient services are provided to inmates who continue to function in the general inmate population setting. Mental health staff estimate that they provided individual and group therapy to an average of approximately 350 inmates each week in 1992.

Inmate Classification and Placement for Mental Health Needs

There are ten reception centers for inmates entering the State correctional system — one for female inmates and nine for male inmates. VCCW receives and classifies all female inmates. The Fairfax, Tazewell, and Tidewater field units receive minimum security inmates with short sentences that will be served exclusively within a field unit. Bland, Brunswick, and Buckingham serve as reception centers for inmates returning to prison for parole violations. All other male inmates go to the Powhatan Reception and Classification Center, the Southampton Reception and Classification Center, or Deep Meadow.

Inmates entering major institutions except those sent directly to infirmaries are screened for mental illness. Mentally ill inmates will receive a mental health diagnosis using the *Diagnostic and Statistical Manual of Mental Illness IIIR*. Further, all inmates receive one of six mental health classification codes at the reception centers. The six codes and a brief description of each code are shown in Exhibit 2.

In determining the inmate's placement, a central classification board staffed by four employees at DOC's central office, considers the inmate's mental health classification, as well as other factors such as security classification and the presence of any enemies within the system. If the inmate is in need of immediate acute care for mental health, commitment procedures will be initiated so male inmates can be committed to the Marion Correctional Treatment Center and female inmates committed to Central State Hospital.

Mental Health Treatment Levels

Three levels of mental health treatment — acute, sheltered, and outpatient — are provided within the correctional system. Table 1 indicates the treatment levels available within each of the major institutions (excluding institutions which operate solely as reception centers). Mental health treatment is not provided within field units. Any field unit inmate in need of mental health treatment would be transferred to a major institution. Figure 1 shows the location of mental health beds within DOC's major institutions.

Acute Care. Acute mental health treatment is provided for inmates who are so severely mentally ill that they meet the civil commitment criteria of being dangerous to themselves or others or are incapable of self-care. Generally, inmates who are provided acute care are actively psychotic or suicidal. Inmates may be identified as being in need of acute mental health care at the time they are taken into the correctional system or at any time during their incarceration. Once an inmate is identified as possibly needing

Exhibit 2

Mental Health Classifications Used By The Virginia Department of Corrections

Classification	Description
MH-4	**Severe Impairment** The inmate may be a danger to self and/or to others and/or may be substantially unable to care for self as a result of mental illness. Assignment to an acute care mental health setting is required.
MH-3	**Moderate Impairment** The inmate has a condition of an on-going nature and is chronically unstable. The individual cannot function in the general inmate population for any extended period of time and requires mental health treatment. The inmate may move into and out of sheltered care mental health units as his or her condition deteriorates and then improves.
MH-2	**Mild Impairment** The inmate has a chronic psychological or psychiatric condition with symptoms which are usually mild but stable. Monitoring by a qualified mental health professional is required.
MH-1	**Minimal Impairment** The inmate has a history of instability and/or prior mental health treatment but is capable of functioning without mental health services or psychotropic medication.
MH-0	**No Documented History of Mental Health Services Needs** Neither history nor current behavior suggests any need for mental health services.
MH-X	**No Mental Health Classification Code Assigned** This category includes inmates housed in field units or other facilities with no qualified mental health professional available to assign a mental health classification code. The category includes inmates assigned directly from a jail to a facility with no qualified mental health professional.

Source: Department of Corrections Department Operating Procedure 776, Attachment B.

Table 1

Level of Mental Health Treatment Provided Within Major Institutions

Institution	Level of Treatment Provided		
	Acute	Sheltered	Outpatient
Augusta			
Bland			●
Brunswick			●
Buckingham			●
Deep Meadow			●
Greensville		●	●
Keen Mountain			●
James River			●
Marion	●		
Mecklenburg		●	●
Nottoway			●
Powhatan		●*	●
Southampton			●
Staunton		●	●
St. Brides			●
VCCW	●**	●	●

*Unit provides short-term stabilization and treatment.

**Treatment actually provided at Central State Hospital.

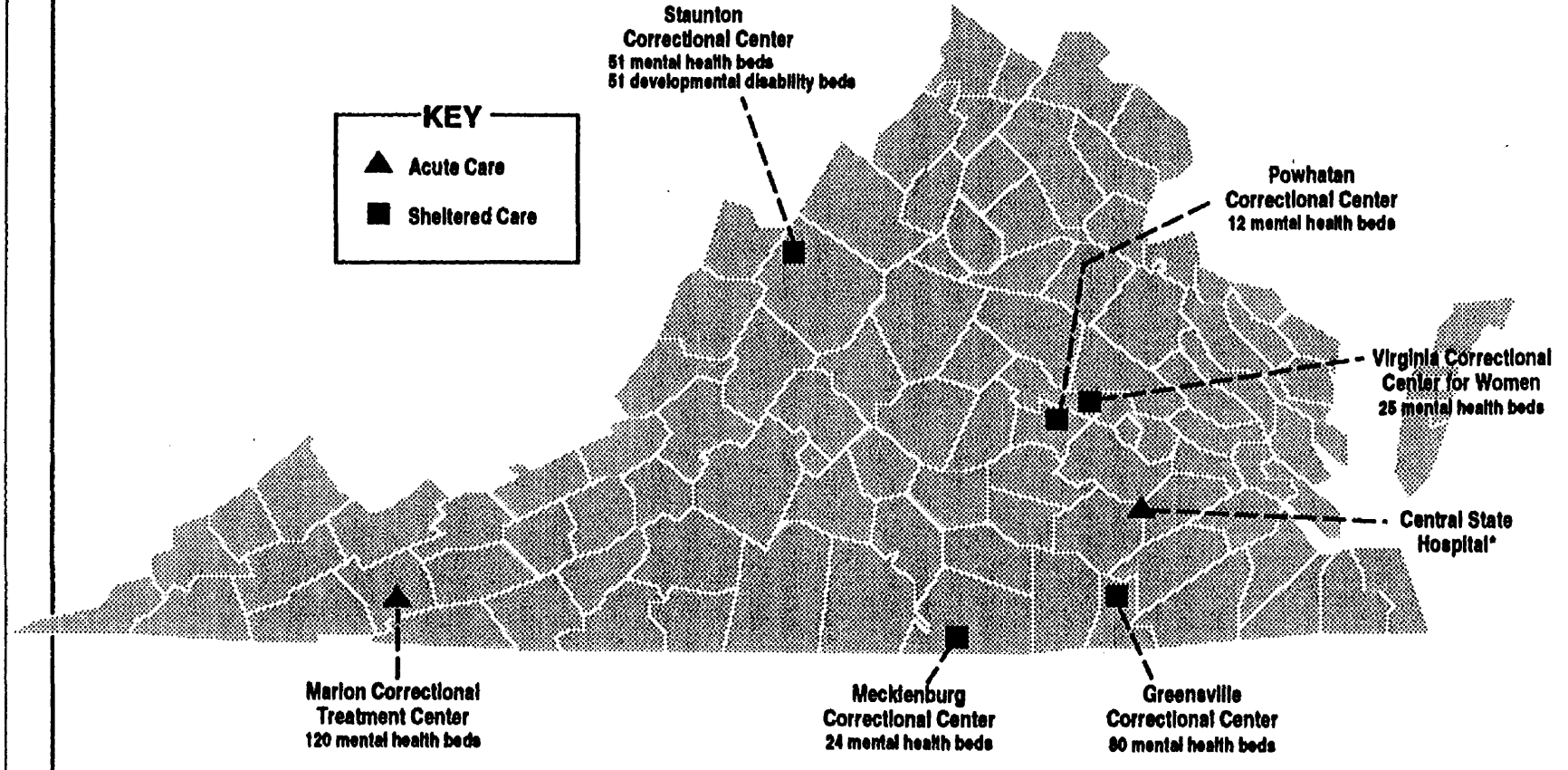
Source: JLARC analysis of Department of Corrections data on mental health treatment provided, March 1993.

acute care, an evaluation by a psychiatrist is completed. If the psychiatrist's evaluation indicates the inmate meets the commitment criteria, a commitment hearing will be held within the institution using the due process standards established by the *Vitek* decision. Due process proceedings have been incorporated into Section 53.1-40.2 of the *Code of Virginia*. Male inmates are committed to Marion Correctional Treatment Center for acute mental health treatment while female inmates are committed to Central State Hospital.

The Marion Correctional Treatment Center is licensed by DMHMRSAS and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a psychiatric treatment center. Any male inmate in need of acute mental health treatment may be voluntarily or involuntarily committed to Marion for treatment. Marion is a costly operation which maintains a low inmate-to-staff ratio by employing a relatively large number of mental health staff. The equivalent of 3.5 psychiatrists (classified as mental health physician Cs) are employed at Marion at pay grade 23 in addition to 14 other mental health staff. Currently Marion has bed space for 167 inmates,

Figure 1

Location of Mental Health Beds



* The number of beds available for women at Central State Hospital varies, but is usually between 1 and 3.

Source: JLARC staff graphic.

of which 120 beds are designated as treatment beds. A variety of therapies are provided at Marion, including groups on topics such as coping with schizophrenia, horticultural therapy, and victim empathy/sensitivity. Additional information on the groups offered by staff at the Marion Correctional Treatment Center is provided in Appendix B.

Acute care for female inmates is provided at Central State Hospital. Female inmates must be committed to Central State Hospital. DOC has a memorandum of understanding with DMHMRSAS which provides the acute care to female inmates at no charge to DOC. Generally, one to two female inmates will be in Central State at any given time.

Sheltered Care. Sheltered care beds are provided for inmates who have mental disorders which are serious enough to preclude their placement in the general inmate population but are not serious enough to require hospitalization. Often these inmates suffer from schizophrenia or severe organic impairment, need "step down" care following acute care, or are awaiting civil commitment to Marion or Central State Hospital.

Each sheltered care unit has its own individual approach to mental health treatment. The approaches do not appear to be coordinated in a way to produce a system of care within the department. Information on the topics for group treatment in each facility with a sheltered care unit is provided in Appendix C.

The sheltered care unit at Greensville is operated as part of the medical contract that the Department of Corrections has with Correctional Medical Systems (CMS). CMS is a private company based in St. Louis, Missouri. The unit has 80 single bed cells arranged in two pods of 40 cells each. Each pod is a locked area with a dayroom as part of the pod. The unit houses B and C custody inmates. DOC classifies maximum security inmates as C custody, medium security inmates as B custody, and minimum security inmates as A custody.

According to the mental health director at Greensville, the unit is operated on a system of levels of increased responsibility, functioning, and privileges for the inmates. When inmates enter the unit they are at the lowest level and are locked in their cells for a maximum of 23 1/2 hours per day. Levels 2 and 3 allow inmates increasingly greater time out of their cells. Inmates on level 4 are allowed to participate in some activities with the general population inmates at Greensville, and are only locked in their cells at night and following the scheduled lock-downs of the institution.

CMS staff report that they conduct several types of groups each week, including stress management and pre-discharge planning. In addition, work with individual inmates is conducted mainly through daily rounds and meetings between mental health staff and inmates in the pods.

The two mental health units at Mecklenburg house 24 B and C custody inmates in single cells. Each unit has 12 beds. One unit is primarily for inmates diagnosed as schizophrenic, paranoid, or clinically depressed. The other unit is referred to as the

sheltered care unit and houses inmates who, mental health staff indicate, would not function well in the general inmate population because of chronic mental illness. Each unit has an open area or "pod" with two metal picnic tables, a television, and an adjoining room with books, tables, and chairs. Inmates are locked in their cells for an average of nine hours per day. Treatment is primarily by individual contact, as the only group conducted is art therapy led by a psychiatric nurse.

The mental health unit at Powhatan is a 12 bed unit. The 12 beds are in single cells that are configured much like isolation and segregation cells. The unit houses inmates that are B and C custody. Mental health staff have recently decided that the unit will be an "acute care" unit for those inmates who can be treated and returned to the general inmate population, or for inmates who are waiting to be transferred to Marion or who have recently been transferred out of Marion. Thus, Powhatan mental health staff define acute care as short-term mental health treatment, rather than the Marion definition of acute care as treatment of the severely mentally ill.

At the time of the JLARC site visit, inmates at Powhatan were locked in their cells for 20 hours per day and allowed out only for showering and recreation for no more than four hours per day. No mental health groups were being conducted in the unit. In addition, it was required that three correctional officers be present whenever any mental health staff were conducting individual sessions with an inmate. Therefore, due to other responsibilities of the officers, they were frequently unavailable. Consequently, mental health staff provided limited mental health treatment.

Staunton has two treatment units. One serves as a sheltered care unit for mentally ill inmates. The other is a developmental disability (DD) unit which houses mentally retarded inmates. Both units house inmates in dormitories. The units are not locked and inmates can enter and leave the housing units as they please.

The primary treatment goal for inmates in Staunton's sheltered care unit is to have the inmates remain stable and function at the highest possible level. Treatment is largely conducted in groups. For example, there are psychoeducational groups on identifying criminal thoughts and coping with schizophrenia. Psychoeducational groups teach the inmate about the topic and how to deal with it. All inmates in the 51 bed sheltered care unit are B custody.

The developmental disability unit consists of 51 beds, and houses A and B custody inmates classified as having a low mental retardation impairment. According to DD unit staff, more severely mentally retarded inmates are not in the system, as they would generally be found incompetent to stand trial. Treatment is largely conducted in groups which are structured around the theme of enhancing the inmates' life skills capabilities, and include personal hygiene, nutrition, communication, stress management, finding a place to live, and money management.

The sheltered care unit at VCCW consists of a locked floor with 25 beds for A, B, and C custody female inmates. Each inmate has a single cell and a dayroom serves as a group area for the inmates. The only time inmates are locked in their cells is from

midnight to 4:45 a.m. Treatment is largely conducted individually, as the only groups provided are a group for stress management and a group for survivors of sexual abuse.

Outpatient Care. Outpatient care is provided to inmates who can function within the general inmate population but need to regularly see a mental health professional or take medication. Outpatient services are provided at all of the major institutions except the institutions which operate solely as reception centers and the Southampton Intensive Treatment Center.

Outpatient treatment consists of crisis intervention, daily rounds, individual therapy, group therapy, and monitoring of psychotropic medications. Groups provided for outpatients vary among institutions, as few topics are offered by more than one institution. Group topics include anger control, stress management, and coping with depression. Information on the groups offered by outpatient mental health staff is in Appendix D.

The department does not keep data on the number of inmates receiving outpatient services. However, based on the JLARC survey of mental health staff, approximately 640 inmates in major institutions who are not in sheltered care units require mental health treatment. These 640 inmates have been classified by the department as being either mildly, moderately or severely impaired (MH2, MH3 or MH4).

Field Units. Since there are no mental health professionals in the field units, department policy indicates that mentally ill inmates are not to be sent to field units. Field unit nurses report that if an inmate misbehaves due to mental illness, or attempts or threatens suicide or self-mutilation, or requires psychotropic medication, the inmate will be placed under close observation until the inmate can be transferred to a major institution.

MENTAL HEALTH TREATMENT COSTS

The primary costs involved in providing mental health treatment result from employing the mental health staff and providing the pharmaceuticals used in treatment. Except for the acute care provided for female inmates at Central State Hospital, DOC provides mental health treatment within its major institutions. Since Central State Hospital does not charge DOC for the treatment it provides, acute care costs for female inmates are not included in DOC's mental health care costs.

In order to examine mental health care costs, JLARC staff developed cost estimates for approximately a three-year period. These estimates were based on the DOC data available on mental health staffing and the pharmaceuticals used to treat mental health problems. Estimates were necessary because expenditures for mental health are reported within expenditure codes that also include dental and medical expenses. Generally the cost estimates were made for fiscal years 1991 through 1993 because

pharmaceutical costs prior to FY 1991 were not available. These cost estimates indicate that staffing costs accounted for approximately 95 percent of the mental health care costs while pharmaceuticals account for about 5 percent. Pharmaceutical costs have been increasing at a faster rate; however, this is partly due to the deflationary effect of the salary freeze that has applied to State employees.

A cost estimate of all direct mental health care costs was also made for FY 1993. In addition to the staffing costs for classified salaried employees and psychotropic pharmaceutical costs, the payments made to contract and temporary mental health staff and the cost of the mental health portion of the contract at Greensville were estimated. There may be additional indirect costs to DOC such as the employment of additional security personnel or additional laundry charges, but these costs should be relatively minor and were not estimated. The estimated cost of all direct mental health services during FY 1993 was almost $4.9 million.

Estimated Historical Expenditures for Mental Health Care Staffing

Costs related to the employment of classified, salaried mental health employees within the major institutions have been estimated (Table 2). These estimates were based on historical information regarding the number and actual salaries of mental health care staff employed on June 30 of 1991 and 1992, and on April 30, 1993.

As shown in Table 2, from June 1991 to April 1993 the cost in salaries and benefits to employ mental health care staff increased from $3,110,365 to $3,273,183, or about five percent. The number of mental health staff increased from 68.5 full-time equivalents (FTEs) to 76.5 FTEs, or by approximately 12 percent. During the same time period, the number of inmates housed in the major institutions increased from 11,825 to 13,303, or by 12.5 percent.

Table 2

Estimated Mental Health Staffing Costs Within Major Institutions

	June 30, 1991	June 30, 1992	April 30, 1993
Salaries*	$2,441,316	$2,564,456	$2,608,659
Benefits	669,049	711,156	664,524
Total	$3,110,365	$3,275,612	$3,273,183
Number of Staff	68.5	72.5	76.5

*Salaries include only the costs related to classified, salaried Department of Corrections employees. Contract and temporary positions are not included since historical data on their employment were not available.

Source: Department of Corrections Masterfile Reports, and personnel benefit costs supplied by the Department of Planning and Budget.

Estimated Historical Expenditures for Psychotropic Medication

Pharmaceutical expenditure data were readily available from two sources — the department's central pharmacy and the Marion Correctional Treatment Center. All of the correctional institutions, except Marion and Greensville, order the vast majority of the pharmaceuticals used either directly or indirectly from the central pharmacy. Marion orders pharmaceuticals from Southwestern State Hospital and the private contractor at Greensville uses a private source for pharmaceutical needs.

The costs and types of pharmaceutical purchases made by the central pharmacy were available for time periods which approximated fiscal years 1991 and 1992 and the first three quarters of FY 1993. Table 3 shows the estimated cost of psychotropic medications purchased by Marion during fiscal years 1991 and 1992 and the first three quarters of FY 1993. It was not possible to specifically separate the psychotropic medications from other medications purchased by Marion. However, medical staff at Marion estimate that at least 90 percent of all medication is psychotropic in nature, and this percentage was used to estimate the costs. Table 3 contains the estimated cost of the medications typically used to treat mentally ill patients, and the cost of all medications purchased by the central pharmacy (from the primary wholesaler) and by Marion during those time periods.

As the table illustrates, while the expenditures for all medications were relatively stable between FY 1991 and FY 1992, the expenditures for psychotropic medications grew by 31 percent from $147,172 to $193,252. A projection of data from the first three quarters of 1993 (assuming expenditures at the same rate during the final quarter) indicates that while expenditures for all medications may increase by 48 percent over FY 1992 expenditure levels, expenditures for psychotropics may increase by less than one-half that rate, or by about 21 percent. Thus, the percentage of all medication expenditures that are accounted for by psychotropics has shown no consistent pattern — increasing from 10.6 percent in FY 1991 to 13.9 percent in FY 1992, and then decreasing to 11.6 percent in FY 1993.

Estimated Cost of Direct Mental Health Care Services for FY 1993

An estimate of the direct costs involved in providing mental health care services during FY 1993 was also made (Table 4). This estimate required projecting the likely costs of psychotropic pharmaceuticals for FY 1993, estimating the amount of the payments made to contract and temporary mental health care staff, and requesting from CMS an estimate of the cost for providing mental health care services at Greensville. These three sets of figures were added to the previously determined salary and benefit estimates for a sum of almost $4.9 million in total costs.

MENTAL HEALTH STAFFING AND ORGANIZATION

The organization of DOC's mental health services parallels that of the other health services within the department. That is, a limited number of central office staff are dedicated to mental health treatment while the majority of staff are located within

Table 3

Estimated Pharmaceutical Expenditures Fiscal Years 1991 and 1992 and Year to Date 1993*

	FY 1991	FY 1992	July 1992 - March 1993	Projected FY 1993**
Psychotropic Medication				
Central Pharmacy	$79,107	$100,362	$101,168	$135,000
Marion Correctional Treatment Center	68,065	92,890	73,457	98,000
Total	**$147,172**	**$193,252**	**$174,625**	**$233,000**
All Medication				
Central Pharmacy	$1,318,142	$1,286,181	$1,429,157	$1,906,000
Marion Correctional Treatment Center	75,628	103,211	81,619	109,000
Total	**$1,393,770**	**$1,389,392**	**$1,510,776**	**$2,015,000**

Note: Pharmaceutical expenditures for Greensville Correctional Center are not included in the figures shown.

*The months included in the printouts supplied by the Department of Corrections' central pharmacy approximated the fiscal years cited.

**Year end figures were projected based on the assumption that medication expenditures were made at the same rate during the final quarter of FY 1993 as during the first three quarters.

Source: Computer printouts showing the cost of pharmaceuticals ordered by the Department of Corrections' Central Pharmacy and spreadsheets from the Marion Correctional Treatment Center's Business Manager.

the institutions (in this case within the major institutions). Central office staff function in an advisory capacity over the institutional staff, who are typically supervised by the assistant warden for programs.

Staffing and Organization within the Central Office

The mental health program director is the only employee within DOC's central office dedicated to mental health treatment on a full-time basis. The director position is relatively new as it was created in 1986. The current role of the program director is to establish departmental policy related to mental health treatment, to develop budget requests that address mental health staffing needs, and to address problems in the

Table 4

Estimated Cost of Mental Health Care Fiscal Year 1993

Salaries	Benefits	Psychotropic Medication	Contract and Temporary Staff Wages	Greensville Contract Payments	Total
$2,608,659	$664,524	$233,000*	$608,114	$750,222	$4,864,519

*FY 1993 costs were projected on the basis of expenditures made during the first three quarters of that fiscal year.

Source: JLARC staff analysis of Department of Corrections Masterfile Reports, personnel benefit costs supplied by the Department of Planning and Budget, JLARC staff survey data, an estimate supplied by CMS and data from the Department of Corrections Budget Office, and computer printouts showing the cost of pharmaceuticals ordered by the Department of Corrections Central Pharmacy and the Marion Correctional Treatment Center.

provision of mental health treatment. The mental health program director reports to the chief of operations for programs, and unlike the chief physician, chief dentist, chief pharmacist, and registered nurse manager B, is not considered to be a part of the Office of Health Services. The director does not supervise staff within the institutions and there is no discrete budget for mental health to be managed.

The mental health program director is assisted by a psychologist senior on the central classification board (CCB) and a clerical position. The CCB is staffed with five employees at DOC's central office who are responsible for making decisions on custody classifications, work release, furloughs, and inmate transfers. The CCB psychologist assists in moving inmates who have mental health treatment needs and have been difficult to place.

Staffing and Organization at the Institutional Level

Mental health staff are located in each of the major institutions except the Southampton Intensive Treatment Center. As noted previously, mental health staff are not employed within field units. The number of classified mental health staff working within the major institutions varies ranging from one at Bland, Deep Meadow, James River, Keen Mountain, Southampton, and St. Brides to 17.5 mental health staff at Marion (Table 5). The differences in staffing levels are generally related to the different levels of mental health treatment provided and the number of inmates treated. As of April 30, 1993, 76.5 full-time equivalent mental health positions were employed by the department. Table 6 illustrates the distribution of these 76.5 FTEs by position classification. (The mental health care staff employed by CMS at Greensville are not shown in Table 6). The highest ranking mental health professionial in all but one institution reports to the assistant warden for programs. All of the mental health staff at one reception and classification center report to the treatment program supervisor. Contract and tempo-

Table 5

Filled Mental Health Positions Within Major Institutions April 30, 1993

Facility	Mental Health Staff	Mental Health Services Provided
Marion	17.5	Acute (120 beds)
Greensville	12*	Sheltered (80 beds), Outpatient
Mecklenburg	2	Sheltered (24 beds), Outpatient
Powhatan	10	Sheltered (12 beds), Outpatient
Staunton	10	Sheltered (51 beds), Outpatient
VCCW	3	Sheltered (25 beds), Outpatient
Augusta	3	Outpatient
Bland	1	Outpatient
Brunswick	2	Outpatient
Buckingham	3	Outpatient
James River	1	Outpatient
Keen Mountain	1	Outpatient
Nottoway	2	Outpatient
Southampton	1	Outpatient
St. Brides	1	Outpatient
Deep Meadow	1	Outpatient, Reception and Classification
Powhatan R&C	9	Reception and Classification
Southampton R&C	4	Reception and Classification

*Greensville staff total includes seven employees paid by the contractor, CMS.

Source: Department of Corrections Masterfile Reports, April 30, 1993; Memo from the CMS administrator, June 24, 1993; and the Bed Utilization Report, March 1, 1993.

Table 6

Mental Health Positions Within Major Insitutions April 30, 1993

Type of Position	Number of Filled Positions
Mental Health Physician C	4.5
Psychologist Supervisor	1
Psychologist Senior	19
Psychologist	24
Psychologist Assistant	2
Clinical Social Worker Supervisor	2
Clinical Social Worker	5
Social Worker	1
Registered Nurse*	5
Psychiatric Forensic Services Aide	5
Psychiatric Practical Nurses	8
Total	**76.5**

*These registered nurses directly support the mental health staff and are considered to be members of the institutional treatment teams.

Source: Department of Corrections Masterfile Reports, April 30, 1993 and interviews with institutional staff.

rary staff are also employed within the major institutions to supplement the work of the classified mental health staff. As shown in Table 7, 14 psychiatrists and one psychologist are employed by contract and two psychiatrists are employed temporarily within 13 major institutions. The cost of employing the 17 contract and temporary staff during FY 1993 was estimated to be $608,114. The department projects that the number of inmates incarcerated in State correctional institutions will increase from the current population of 17,000 to 30,000 by the year 2000, or by 76 percent. While no recent attempts have been made to specifically project the number of mentally ill inmates this population will include, clearly that number will increase substantially also. Preliminary plans to increase mental health staffing and the number of mental health beds have already been formulated by DOC.

Appropriations from the 1992 and 1993 General Assembly sessions will be used to employ additional staff to assist in the mental health units beginning July 1, 1993. Themental health program director stated that the department plans to employ 25 new staff (Exhibit 3).

The director also plans to add 105 mental health beds in the short term and at least 71 more beds within five years (Exhibit 4). Fifty-seven mental health beds will be added at VCCW and Brunswick. The department has not yet decided where the remaining additional mental health beds will be located. The mental health beds at

Table 7

Contract and Temporary Mental Health Staff Wages

Facility	Position	Average Hours per Week	Hourly Wage (dollars)	Estimated FY 1993 Salary (dollars)
Augusta	Psychiatrist	8	110.00	45,760
Bland	Psychiatrist	15	83.80	65,364
Brunswick	Psychiatrist	8	75.00	31,200
Buckingham	Psychiatrist	8	105.00	43,680
James River	Psychiatrist	8	100.00	41,600
Keen Mountain	Psychiatrist	2	125.00	13,000
Mecklenburg	Psychiatrist	8	100.00	41,600
Nottoway	Psychiatrist	16	100.00	83,200
Powhatan R&C	Psychiatrist	9	94.86	44,394
Southampton	Two Psychiatrists	5	135.00	35,100
Staunton	Two Psychiatrists*	28	53.17	77,416
St. Brides	Psychiatrist	2	150.00	15,600
VCCW	Two Psychiatrists	12	100.00	62,400
	Psychologist	2.5	60.00	7,800
Total		**131.5**		**608,114**

*These two psychiatrists are employed on a temporary (P-14) rather than contract basis.

Source: JLARC survey of Department of Corrections mental health staff, May 1993.

Brunswick will be the first beds specifically designed for long-term mental health care. The long-term plans entail including sheltered care beds within a special needs facility involving the rebuilding of Deerfield Correctional Center and sheltered care beds for female inmates within the new women's prison.

The need to continue to expand mental health care beds in the future underlines the importance of making effective use of existing resources and taking cost containment actions that can help to control current and future costs and improve the overall quality of mental health services provided by the department. This can be accomplished by taking immediate actions internally to address deficiencies in the provision of mental health treatment; identify, monitor, and control the cost of providing care; and by taking additional actions that require working with other State agencies. These actions are discussed in detail in the following chapter.

Exhibit 3

Department of Corrections Plans for Increasing the Number of Staff Supporting Mental Health Units

Institution	Additional Staffing Planned
Augusta	1 psychologist
Bland	1 psychologist
Brunswick	0.5 psychiatrist 1 psychologist 1 clinical social worker 1 registered nurse 1 rehabilitation counselor 1 office services specialist 2 correctional officers
Buckingham	1 psychologist
Deep Meadow	1 psychologist
Nottoway	1 psychologist
Powhatan	1 psychologist
St. Brides	1 psychologist
Virginia Correctional Center for Women	1 psychiatrist 1 psychologist senior 1.5 psychologists 1 clinical social worker 1 rehabilitation counselor 1 office services specialist 4 correctional officers

Source: Interview with the mental health program director, May 5 and June 23, 1993.

Exhibit 4

Department of Corrections Plans for Increasing the Number of Mental Health Treatment Beds

Short-Term Plans for Increasing the Number of Mental Health Treatment Beds

Type of Mental Health Unit	Location	Number of Beds
Sheltered care for male inmates who need long-term mental health treatment	Brunswick	32
Sheltered care for female inmates	VCCW	25
Undecided	Undecided	48

Long-term Plans for Increasing the Number of Mental Health Treatment Beds

Type of Mental Health Unit	Location	Number of Beds
Sheltered care for male inmates	Deerfield (rebuild)	Undetermined
Sheltered care for female inmates	New Women's Prison	71*

*Although 120 beds will be devoted to mental health treatment, the increase in the number of beds will only be 71 since the 49 beds at VCCW will become general population beds.

Source: Interviews with DOC staff, spring 1993.

III. Assessment of Inmate Mental Health Services and Cost Restraint Mechanisms

The provision of mental health services for Virginia's inmate population has gradually evolved, with responsibility for those services being increasingly shifted from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to the Department of Corrections. DOC assumed primary responsibility for the provision of inmate mental health care in 1984 when funding and staffing for that care were transferred from DMHMRSAS to DOC. A plan developed in 1986 by the staff of the Secretaries of Public Safety and Human Resources, DOC, and DMHMRSAS, entitled Services for the Mentally Disordered Offender Within the Virginia Department of Corrections, was expected to serve as the blueprint for structuring a system of mental health care within DOC. The 1986 study designed a mental health care system with established standards for treatment and a mechanism for ongoing quality assurance reviews.

Currently, DOC provides all levels of mental health treatment except acute care for female inmates. However, DOC has not fully developed a system of comprehensive mental health care. There is little consistency in the treatment provided across facilities for similar levels of care. Two primary factors appear to be responsible for the inconsistencies. First, it appears that the development of a system of mental health treatment has been given a low priority by DOC. Only one person within DOC has been assigned full-time responsibility for overseeing and directing mental health care. DMHMRSAS staff time and expertise, which have been available to DOC and could have helped to compensate for DOC's limited oversight role, has been little-utilized. Second, correctional institutions have been allowed to be relatively autonomous in developing their own mental health programs. Without effective central office oversight of the mental health care programs, this autonomy may affect the quality of care provided by DOC.

In addition to deficiencies in the provision of mental health services, the department has not developed sufficient cost control mechanisms. This has resulted in the department not utilizing its existing resources in the most cost-effective manner. DOC is planning to add 25 new staff and 105 mental health care beds during FY 1994. It is especially important, therefore, that the department operates more efficiently and uses the existing and new staff to their full potential.

ASSESSMENT OF MENTAL HEALTH TREATMENT PROVISION

This review of inmate mental health care found that DOC is providing quality care to male inmates needing acute mental health treatment. DOC has provided mental health treatment at Marion Correctional Treatment Center since 1980. During the time DOC has been operating the facility, the department has made the successful operation

of Marion a departmental priority. This has included making financial and staffing resources available, achieving State licensure, obtaining accreditation by the Joint Commission on Accreditation of Healthcare Organizations, conducting a national recruitment effort for staff, and achieving the balance between security and treatment necessary for a treatment facility.

However, many deficiencies exist in the department's provision of the other types of mental health treatment — sheltered care and outpatient treatment. According to the mental health program director, many of the problems in mental health treatment will not be solved by adding staff. Instead, the director indicated that more needs to be done to define the role and purpose of mental health treatment within the department. In addition, this review found that the department needs to increase the central office oversight and control of the provision of mental health care. This oversight should result in resolving inconsistencies among the sheltered care units in treatment planning, quality of treatments offered, record-keeping practices, and security issues in the facilities. Many of these inconsistencies could be addressed by DOC through the conduct of effective quality assurance reviews. In addition, the department needs to proceed with its plan to begin providing acute care for its female inmates.

Further, the department should fully utilize the mental health expertise available to it within State government. Specifically, the department should pursue licensure by DMHMRSAS of its sheltered care units. In addition, DOC should reconvene the interdepartmental advisory committee and use the expertise available to supplement its internal knowledge and capabilities.

Problems in Implementing Comprehensive Mental Health Services

An evaluation of DOC's progress toward the system of mental health care envisioned in the 1986 study indicates that a number of deficiencies exist, particularly in the sheltered care units. Shortcomings were noted in treatment plan development, treatment provision (particularly related to therapy groups), mental health records and data, acute care provision for female inmates, and input into security-related decisions. These problems indicate the need for the department to conduct effective quality assurance reviews of the programs. Such reviews could be used by the department to monitor the treatment activities occurring in the facilities and to make any necessary improvements.

The Content and Quality of Treatment Plans Needs Improvement in Most of the Sheltered Care Units. Individual treatment plans provide written documentation of the recommendations made by institutional treatment teams for each inmate in acute or sheltered care. JLARC staff found that written mental health treatment plans are prepared by Marion, Greensville and Mecklenburg. Staunton, Powhatan, and Virginia Correctional Center for Women (VCCW) mental health staff do not prepare written treatment plans. Staffs at the three sheltered care facilities that are without written treatment plans indicate that they meet to orally discuss inmate progress and plans for future treatment.

While the treatment plans for Marion are comprehensive, the treatment plans developed by Greensville and Mecklenburg staff are very general and do not appear to be sufficient to direct treatment interventions on an individualized basis. For example:

> *Marion has detailed individual treatment plans which vary according to inmate needs. Every treatment plan includes the following categories: active problems, strengths, objectives and plans, and discharge/ aftercare planning. Every active problem has an objective and a plan. The objectives and plans include which groups the inmate should attend, which mental health staff should work with the inmate on an individual basis, whether or not medications should be administered, and what should be the results of therapy. The results of therapy refer to specific behaviors the inmate should demonstrate following reception of therapy. For example, one inmate was expected to stop claiming to be a famous figure or claiming to have been attacked by imaginary forces.*
>
> * * *
>
> *Greensville mental health staff maintain treatment plans for all inmates in the sheltered care unit. Each treatment plan lists a series of objectives to be accomplished, followed by a list of interventions to accomplish each objective. The interventions, however, are not detailed and contain notations such as "individual and group therapy," without outlining the specific types of individual and group therapy that should be attended to accomplish the objectives. Further, the goal indicated on each treatment plan is the same: "To discharge the inmate to appropriate placement." Expected behavioral results of therapeutic intervention are not included.*
>
> * * *
>
> *Mecklenburg mental health staff also complete treatment plans for all inmates in the sheltered care unit. Each treatment plan includes goals for the following categories: academic skills, vocational skills, recreational skills, arts and crafts, individual therapy, group therapy, substance abuse, and medications. The treatment plans also include an overall recommendation. However, the inmates' problems are not outlined, nor are the expected results of therapeutic intervention. While the goals for individual and group therapy are defined, the means to achieve these goals are not. Further, the goal for group therapy is the same for every inmate: "participate in health-self care; socialization."*

Written mental health treatment plans should be developed for each inmate within the sheltered care units. Powhatan, Staunton, and VCCW should begin preparing written mental health treatment plans, while Greensville and Mecklenburg should prepare better-developed plans.

Recommendation (1). **The Department of Corrections should formalize its expectations regarding the need for and content of written, individual mental health treatment plans. These treatment plans should include, at a minimum: the active problems of the inmate, specific objectives and plans for treatment, and the expected behavioral results of the treatment.**

Variations in Treatment Structure, Planning, and Delivery Raise Questions About Overall Quality. Mental health staff in all of the units visited reported that psychotropic medication is prescribed as needed and that individual treatment of inmates is provided. However, the use, content, and structure of group therapies is dependent on the preferences and interests of the mental health staff within the institutions. JLARC staff examined the types of treatment offered, the descriptions and outlines developed for therapy groups, and any contracts developed to delineate therapeutic expectations for inmates.

As would be expected, Marion Correctional Treatment Center, the acute care facility, offers the most comprehensive array of treatment interventions. These interventions include individual therapy as needed, four psychotherapeutic groups, and 14 psychoeducational groups. The four psychotherapeutic groups allow the inmates to discuss thoughts and feelings on topics such as substance abuse and victim empathy. The 14 psychoeducational groups deal with issues such as understanding and coping with schizophrenia, coping with anger, and human sexuality. Psychoeducational groups teach the inmate about the topic and how to deal with it.

The types of treatment interventions offered in the sheltered care units vary. While Greensville and Staunton each provide a number of groups in addition to individual therapy, Powhatan's mental health staff rely completely on individual therapy and provide no therapy groups. Mecklenburg and VCCW staff report that they conduct few groups, and they base treatment mainly on informal meetings with inmates in the pod or in their cells. They attribute the limited treatment opportunities to staffing limitations. Groups conducted at Mecklenburg and VCCW are generally limited to those provided by psychiatric nurses, although a psychologist at VCCW conducts a survivors of sexual abuse group which includes two or three sheltered care inmates. VCCW and Mecklenburg staff, however, indicate that when they receive additional staff in July 1993, providing group therapy will be a priority. Powhatan mental health staff indicate they are in the process of developing groups.

Marion mental health staff have developed extensive descriptions for all groups provided, depicting the goals and objectives of the groups and the topics that will be covered. Staunton is the only sheltered care unit to have developed written descriptions for all groups for the sheltered care inmates, prior to the JLARC request for such descriptions. VCCW staff developed a program description for JLARC staff. Program descriptions developed by Staunton and VCCW include general descriptions of program content and length. However, they do not include items such as the program objectives and participant eligibility. For example:

The program description for the psychoeducational group at Marion on "coping with anger" indicates that the objective is to have the patients gain knowledge of the origins and consequences of their own experiences of anger. The description specifically states that the patient will appropriately resolve at least one anger-related situation during the group. An additional goal is that a decrease in the frequency of overt aggression by participants will occur. The program description also describes group activities, including the subjects to be covered and the methods used, such as role-playing and structured exercises. Further, participant eligibility criteria outlines that those eligible for the group include patients who are identified by treatment teams as having impaired impulse control, and patients identified as internalizing anger.

* * *

Staunton's description for its psychoeducational group on schizophrenia indicates that the group addresses the causes, symptoms, and treatment of schizophrenia and societal perceptions and misconceptions. The description indicates that there is a heavy emphasis on the prevention of relapses through medication compliance and the avoidance of substance abuse. The description also indicates that the groups usually number between ten and 15, and the material is primarily taught from a planned format using lectures, handouts, and class participation.

* * *

The program description for VCCW's stress management/relaxation group for sheltered care inmates was prepared specifically for JLARC staff because the program had been operated without one. The description indicates that the group runs for four weeks for 1.5 hours per session. The topics listed include the signs of stress; general management tips; an introduction to relaxation therapy; and aids to improving sleep, positive affirmations, and communication.

In addition to outlines of program content, contracts inform inmates of the content of the groups and what is expected of them during and after group completion. For example:

Inmates in Staunton's developmental disabilities unit must sign a contract to participate in the life skills program. The contract stipulates that attendance to all assigned groups is mandatory, additional programs that may be of benefit may be required, and all floor rules and regulations will be adhered to at all times.

It does not appear that mental health staff in the other sheltered care units provide outlines or contracts to the inmates during the course of group treatment.

The absence of written goals and objectives for all groups by mental health staff in the sheltered care units limits DOC and institutional mental health staff in their ability to evaluate group success. Generally, the only documented outcome of the groups provided in the sheltered care units involves class attendance lists and notations in the inmates' record regarding attendance. Each sheltered care unit should develop written goals and objectives for all groups provided. These goals and objectives should be modeled after those developed by Marion mental health staff.

Recommendation (2). **The Department of Corrections should direct mental health staff at Powhatan and Mecklenburg to develop therapy groups to be used in the treatment of mentally ill inmates in the sheltered care units. Mental health staff in these units should consult with the mental health program director on aspects of program design.**

Recommendation (3). **The Department of Corrections should direct mental health staff at each sheltered care unit to develop written program descriptions for all groups provided. These program descriptions for each group should include the goals and objectives, the subject matter, the method of instruction, the participant eligibility criteria, the group size and length, and the required qualifications of the group leader. Outlines that summarize the goals, objectives, and subject matter of the groups should be distributed to inmates participating in the groups.**

Recommendation (4). **The Department of Corrections should direct mental health staff at each sheltered care unit to develop written contracts to be distributed to all inmates housed in the sheltered care units. The contracts should list what is expected of the inmate during the inmate's stay in the unit and should be signed by each inmate participating in group therapy.**

Mental Health Record-Keeping Practices Need To Be Improved. While department operating procedures define the format for the medical files and the place for the mental health files within the medical file, there are no guidelines standardizing the practice of recording mental health treatment among facilities. Consequently, the quality of the progress notes kept by a number of sheltered care unit staff is inadequate. The absence of standard record-keeping procedures also makes it difficult for institutions receiving a new inmate to determine the inmate's mental health status. Since inmates are often transferred, knowledge and understanding of the inmates' mental health and treatment history are critical to ensuring the continuity of care at the receiving institution.

JLARC staff reviewed mental health files for all five sheltered care units and Marion Correctional Treatment Center. While all facilities have separate mental health files, only three develop individual treatment plans, as previously mentioned, and only

Marion completes a monthly progress report (Table 8). In addition to the individual treatment plans, a major part of the mental health files is the weekly progress notes taken by mental health staff based on the inmates' group activities and one-on-one sessions with the inmate in the cell or on the pod. Marion's progress notes are the most organized, comprehensive, and useful.

Table 8

JLARC Staff Review of Acute and Sheltered Care Unit Files

	Number of Inmates in Unit	Number of Files Reviewed	Separate Mental Health File	Individual Treatment Plan	Monthly Progress Report	Frequency of Notations
Greensville	80	12	Yes	Yes	No	2/week
Marion	120	19	Yes	Yes	Yes	4-5/week
Mecklenburg	24	12	Yes	Yes	No	1/week
Powhatan	12	11	Yes	No	No	2/week
Staunton	51	11	Yes	No	No	1/week
VCCW	24	24	Yes	No	No	0*

*Notes taken during therapy groups at VCCW are kept in a separate file. However, they are currently unorganized.

Source: JLARC staff review of acute and sheltered care unit files, March-May 1993.

Staunton's notes are the most extensive and detailed of the sheltered care units. In addition to noting the physical appearance of the inmate and summarizing the conversation with the therapist, Staunton's mental health files include detailed notes on the inmates' thought content, mood, interpersonal interactions, defensive structure, mental status, and patient history. Notes at Powhatan, Mecklenburg, and Greensville are generally limited to the visual condition of the inmate, the conversation held with the inmate, and the psychotropic medications administered. At the time of JLARC review, VCCW sheltered care unit notes were incomplete and unorganized. However, VCCW staff indicate they are in the process of developing a system for organizing the mental health notes for sheltered care inmates.

The DOC mental health program director acknowledged problems in record-keeping and the importance of improving the process. The program director indicated that an internal mental health advisory committee that the director had reconvened would be discussing what should be in the mental health files at their summer meeting. Procedures should be developed specifying that progress notes should include the therapeutic content of inmate meetings, rather than simply a description of the appearance of the inmate. Standardizing and enhancing note-taking procedures would facilitate the receiving facilities' ability to determine the inmates' mental health history and enable more effective monitoring of mental health treatment provided.

In addition to improving the processes for record-keeping, the department needs to ensure that receiving facilities are provided with all necessary documentation of an inmate's mental history. This would better enable staff to take the proper precautions and provide necessary treatment. Currently, there appear to be some problems in ensuring that complete mental health histories accompany the inmates to receiving facilities. For instance, in response to the JLARC survey, several field unit staff report that mental health histories are often not in the files when inmates arrive from major institutions. Complete mental history information does not always follow inmates transferring out of sheltered care units either. For example:

> *An internal affairs investigation was conducted based on the poor physical and mental condition of an inmate that had arrived at Marion from Greensville's sheltered care unit. Marion staff were unable to utilize the files to determine what had happened to the inmate. During the investigation, the medical director at Marion noted that when the inmate arrived at Marion, "very little documentation" existed on the inmate's treatment at Greensville, and the records that did exist were a "treat to decipher."*

The department is also experiencing problems with ensuring that the mental health screening form is forwarded with inmates as they transfer to new institutions. Outpatient mental health staff estimate that approximately 17 percent of their inmates do not have a mental health classification. However, reception and classification staff report that all inmates sent to major institutions are screened for mental illness except those that are sent directly to an infirmary for medical emergencies. Therefore, it appears that the mental health screening form is not always being forwarded with the inmates to each of their new institutions. Institutional staff should ensure that all necessary treatment and history information from the mental health files is forwarded, including the screening form, to enable receiving staff to more adequately monitor incoming inmates.

Recommendation (5). **The Department of Corrections should require that organized mental health files be maintained for each inmate by standardizing the contents of the files and the format to be utilized. At a minimum, the following items should be included in the mental health files: individual treatment plans, treatment team review summaries, screening forms, and progress notes.**

Recommendation (6). **The Department of Corrections should standardize the procedures for taking progress notes by providing directions on what the notes should include and the frequency that notations are to be made. The department should require that progress notes include the therapeutic interventions taken.**

Recommendation (7). **The Department of Corrections should develop policies to ensure that copies of treatment plans, mental health histories,**

progress notes, and screening forms accompany inmates when they are transferred out of sheltered care units.

DOC Should Conduct Quality Assurance Reviews of the Mental Health Units. DOC does not currently conduct a rigorous, ongoing quality assurance program for mental health treatment. Quality assurance is nominally provided in annual Board of Corrections audits and sporadic monitoring conducted by the mental health program director. The Board of Corrections audits focus on the presence of written policies, procedural requirements, and records management. These audits are conducted by a group of DOC staff which typically does not include a mental health professional. The sporadic monitoring conducted by the mental health program director is not a regularly scheduled, comprehensive review of all programs but an ad hoc review of selected programs and is usually to resolve some crisis or emergency situation. Mental health staff in several institutions stated that these visits were usually to orient the program director to what they were doing rather than for the program director to examine them.

The mental health program director stated that quality assurance is the "biggest gap" in mental health service provision at this time. While the director was comfortable stating that quality is good at Marion, the director was not confident that the care provided in all other institutions was high quality care. In fact, the director indicated that the definition of quality mental health care as it relates to DOC has not been determined. Quality assurance is an important function in the oversight of mental health services and it should be given a higher priority by DOC.

Recommendation (8). **The Department of Corrections should ensure that a quality assurance or continual quality improvement program for mental health treatment is established. The program that is established should focus on the quality, appropriateness, and scope of the treatment provided.**

DOC Needs to Provide Female Inmates Better Access to Acute Care. Female inmates at VCCW receive acute care at Central State Hospital. These women must be committed to Central State Hospital, where they are usually stabilized fairly quickly and then returned to VCCW. According to the mental health staff at VCCW, a few women who are non-compliant in taking medication are frequently admitted to Central State Hospital, quickly stabilized, and then returned to VCCW.

As of May 1993, two women were committed to Central State Hospital. However, VCCW mental health staff indicate that approximately seven women at VCCW needed acute treatment at that time. Although the memorandum of agreement between DOC and DMHMRSAS does not place any restrictions on the number of inmates who can be treated at Central State Hospital, VCCW staff indicate that they have never had more than five inmates there at any one time.

Acutely mentally ill inmates at VCCW are often kept in segregation in the basement of the institution's maximum security building. VCCW mental health staff

indicate that this building has the additional security needed to handle acutely mentally ill inmates. However, the mental health staff to inmate ratio within the maximum security building is not sufficient to treat inmates needing this type of care. The mental health program director acknowledged that this is not a good situation and that these mentally ill women need to be in an acute care facility.

Although DMHMRSAS does not charge DOC for treating female inmates at Central State Hospital, DOC staff are exploring options for treating women in need of acute care within the department. This is primarily due to the limited number of female inmates admitted, the repeated admissions of certain female inmates to Central State Hospital, the short stays at Central State Hospital, and the current practice of frequently housing acutely mentally ill women in the maximum security segregation unit at VCCW.

DOC mental health staff have proposed a plan to house and treat acutely mentally ill women at Marion Correctional Treatment Center. This appears to be a sound approach for several reasons:

- Marion is the only licensed and accredited mental health treatment facility within DOC,
- Marion has a high staff-to-inmate ratio,
- Marion provides high quality mental health treatment,
- Marion has two 20-bed wings that will soon be available to house acute patients, and
- Marion conducts extensive mental health training of its correctional officers.

Recommendation (9). **The Department of Corrections should proceed with the mental health staffing plan to provide acute mental health treatment to women at Marion Correctional Treatment Center.**

DOC Needs to Address Security-Related Issues which Impact Mental Health Treatment. Correctional officers working in mental health units have added responsibilities due to the nature of working in units housing mentally ill inmates. Mentally ill inmates often misbehave due to their mental illness. In order to preserve a therapeutic environment, correctional officers must relate to the inmate as a mental health patient while at the same time maintaining a secure facility. Further, correctional officers must be aware of procedures to take when inmates threaten or attempt suicide or self-mutilation. Correctional officers working in mental health units must be trained for this purpose and must cooperate with mental health staff.

A basic mental health training program is provided for security staff working within the department. The "Mental Health Basic Skills" program is provided at the Academy for Staff Development to train correctional officers to work with mentally ill

inmates. This two- to three-day program is offered three times per year, and is not mandatory, but is recommended for officers working in facilities with mental health units. Marion conducts additional training for its security staff, which is mandatory for all officers. This training includes suicide prevention, pain control, and de-escalating conflict. In addition, Marion's security staff must receive additional training every two years.

Mental health staff at Marion, Staunton, and Mecklenburg also have significant input into which security officers work in their mental health units, and are generally satisfied with their correctional officers. All three mental health staffs indicate that maintaining a therapeutic environment would be impossible if they did not have control over security staff assignments.

Powhatan, VCCW, and Greensville mental health staff, however, have indicated problems in the provision of mental health treatment due to security issues. Powhatan mental health staff indicate that security policies in the mental health unit hamper their ability to treat inmates. For example:

> *According to mental health staff at Powhatan Correctional Center, inmates in the mental health unit are locked in their cells for 20 hours a day and an unwritten security policy specifies that three correctional officers must be present when an inmate is seen by mental health staff. Mental health staff indicate that the policy negatively affects the inmate's mental status and restricts staff's ability to provide therapy. In fact, one staff member indicated that the situation results in the staff member "being paid to provide mental health treatment full-time but only being able to provide it half-time." Powhatan mental health staff and the DOC mental health program director indicate they have attempted to have these policies changed, but as of the time of this review they were unsuccessful.*

There appears to be no compelling reason for this policy. An examination of security classifications does not explain the policy (Table 9). For example, 67 percent of Powhatan's sheltered care inmates are C custody (maximum security) while 75 percent of Mecklenburg's sheltered care inmates are C custody. However, Powhatan's mental health unit has mandatory lock down 20 hours per day, while Mecklenburg inmates are locked in their cells for nine hours, usually at night.

VCCW mental health staff are satisfied with the correctional officers assigned to the mental health unit during regular hours (daytime Monday through Friday). However, VCCW mental health staff indicate that officers who work off-hours, or substitute for those on the regular shift, often have not received mental health training and are not interested in working in the mental health unit.

Mental health staff at Greensville also indicate that during off-hours, the assigned security staff change and are not always trained in mental health. For example,

Table 9

Number and Percentage of Maximum, Medium, and Minimum Security Inmates in Mental Health Units

Facility	C Custody (maximum)		B Custody (medium)		A Custody (minimum)	
	Number	Percent	Number	Percent	Number	Percent
Greensville	62	78	18	23	0	0
Marion	67	57	48	41	2	2
Mecklenburg	18	75	6	25	0	0
Powhatan	8	67	4	33	0	0
Staunton	0	0	51	100	0	0
VCCW	12	48	11	44	2	8

Source: JLARC survey of Department of Corrections mental health staff, May 1993.

one mental health professional at Greensville indicated that some of the officers will taunt an inmate if the inmate behaves inappropriately due to mental illness.

The department should address problems related to security issues within the mental health units. Greater consultation with mental health staff regarding the correctional officers that are assigned to the mental health unit could help reduce the possibility for future conflicts and enhance the inmates' ability to respond to therapy. Further, the department should make it a priority to have correctional officers who are assigned to sheltered care units receive the department's mental health care training.

Recommendation (10). **The Department of Corrections should develop a written policy to ensure that mental health staff are consulted about correctional officer assignments to the mental health units for all shifts. In addition, the department should ensure that all correctional officers working in mental health units have attended the "Mental Health Basic Skills" program given by the Mental Health Curriculum Advisory Committee.**

Recommendation (11). **The Department of Corrections should ensure that the warden, or the assistant warden for programs, at Powhatan Correctional Center meets with mental health staff in the sheltered care unit to discuss appropriate policies regarding the amount of time inmates in the sheltered care unit spend in their cells, and the number of security officers required to escort the inmates when out of their cells. Agreements reached in this meeting should be reported to the mental health program director in the central office and documented in the Institution Operating Procedures.**

Additional Mechanisms Available to Address Deficiencies in Service Provision

In addition to addressing specific deficiencies identified during the study review, DOC should undertake two broad initiatives to enhance the overall quality of mental health treatment in the department. First, DOC should pursue licensure of all of its mental health units. Currently none of the sheltered care units are licensed by DMHMRSAS. Second, the Inter-Departmental Mental Health Advisory Committee should be reconvened. This committee is composed of staff from DMHMRSAS and DOC, and could be a valuable resource for DOC in improving mental health care.

DOC Should Pursue Licensure of Mental Health Units. In 1986, regulations for licensure of correctional psychiatric facilities were developed and promulgated by DMHMRSAS. Facilities which comply with the regulations may be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Marion Correctional Treatment Center is the only mental health unit or facility operated by DOC that has pursued licensure as a correctional psychiatric facility.

Sections 37.1-179 et. seq. of the *Code of Virginia* require licensure for "any facility or institution ... which provides care or treatment for mentally ill or mentally retarded persons, or persons addicted to the intemperate use of narcotic drugs, alcohol, or other stimulants including the detoxification, treatment or rehabilitation of drug addicts." The regulations state that they apply to all correctional facilities that propose to establish treatment programs for mentally ill inmates. The regulations further state that they apply to a "psychiatric unit of a correctional institution under the management and control of the Department of Corrections, devoted to the care and treatment of the mentally ill." Based on these definitions, it seems that DOC should be applying for licensure of its mental health units at Greensville, Mecklenburg, Powhatan, Staunton, and VCCW.

The regulations promulgated by DMHMRSAS cover 22 areas applicable to the management of psychiatric hospitals in correctional institutions. Many of the topics covered in the regulations would address weaknesses in DOC's mental health treatment programs which have also been identified earlier in this report. Areas addressed by the regulations which could help address weaknesses in DOC's current program include requirements for:

- Client rights — specifies that procedures should be developed for providing forced medication of an inmate for mental illness.
- Organization and management — covers requirements for staffing, and the appointment of a clinical director and a governing body.
- Psychiatric services — sets out the primary function and definition of a psychiatric facility, and describes the types of services which should be provided.

- Rehabilitation services — establishes and identifies the responsibility and authority for these services within the broader context of psychiatric services.

- Personnel practices — requires staff development and personnel policies.

- Diagnosis and treatment — requires a written treatment plan for each inmate which provides a mechanism for appropriate coordination, communication, and collaboration among all staff members involved in an individual's treatment.

- Medical records — outlines the required written policies and procedures, as well as the contents of the medical files and appropriate information for adequate documentation for all types of treatment received by the inmate.

Compliance with the licensure requirements should result in improvements in the quality of treatment being provided in the units. Further, licensure may produce efficiencies within the system in the long term. Interviews with sheltered care staff indicated that the primary reason for transferring an inmate to Marion was that the inmate refused needed medications. The recent Supreme Court decision, *Washington v. Harper,* 110 S.Ct. 1028 (1990), allows correctional facilities to force medication when the medication is in the inmate's best interest and the inmate is dangerous to self or others. In Virginia, institutional staff and DOC administration have been reluctant to implement a policy allowing forced medication in the sheltered care units. If DOC units were able to institute this policy to force medications safely, and the staffing and programmatic requirements of licensure should allow for this, then inmates who only need medication stabilization would not have to be transferred to Marion. Marion could then be used solely for the care and treatment of the most seriously mentally ill within the system.

Recommendation (12). **The Department of Corrections should work with the Department of Mental Health, Mental Retardation, and Substance Abuse Services to begin the licensure process for the mental health units operated by DOC. DOC should request that the Department of Mental Health, Mental Retardation, and Substance Abuse Services conduct readiness visits to the sheltered care units. These visits should begin at the largest units and work back to the smallest unit. DOC should establish a timeline and planning process whereby all DOC mental health units are licensed within five years or by 1998.**

DOC Should Reconvene the Interdepartmental Mental Health Advisory Committee. When DOC assumed full responsibility for the mental health treatment of inmates, an interdepartmental advisory committee was formed. The committee, which was composed of staff from DMHMRSAS and DOC, was to be the focus for the collaborative efforts between the two departments. According to DMHMRSAS staff, the committee met infrequently and has not met since December 1991. Increased advisory

involvement of DMHMRSAS staff in the mental health treatment of inmates would be beneficial to the State. DOC's central office has assigned one individual responsibility for mental health treatment, which limits what can be accomplished. Mental health treatment is the express mission of DMHMRSAS, which has an established resource of staff expertise. These staff, through the interdepartmental advisory committee, would be an available resource to DOC for improving its mental health treatment services.

In the 1986 plan, *Services for the Mentally Disordered Offender Within the Virginia Department of Corrections*, developed by the staffs of the Secretaries of Public Safety and Human Resources, DOC, and DMHMRSAS, collaboration with DMHMRSAS was seen as key to the success of having DOC responsible for the provision of mental health treatment for inmates. Several actions were called for in that plan which have not yet been implemented. As a result, the mental health treatment being provided by DOC has been adversely affected.

The plan recommended that DMHMRSAS collaborate with DOC on the following activities:

- develop standards for sheltered care programs and outpatient services;
- develop a mechanism for quality assurance reviews;
- establish a mechanism for evaluating, promoting, and improving mental health/mental retardation services within DOC;
- assist DOC in mental health program services design and development; and
- coordinate the efforts of DOC in developing a network of post release services for inmates with the local community services boards.

None of these activities have been completed, and the continued lack of these mechanisms and standards continue to produce weaknesses within the mental health services provided by DOC. Therefore, the Advisory Committee needs to be reconvened and to meet on a schedule which will allow these needs to be addressed in the near future.

Recommendation (13). **The Department of Corrections should reconvene the Interdepartmental Mental Health Advisory Committee. The committee should meet at regularly scheduled intervals. Initial topics to be addressed by the committee should include, but not be limited to: developing standards for sheltered care programs and outpatient services; developing a mechanism for quality assurance reviews; establishing a mechanism for evaluating, promoting, and improving mental health/mental retardation services within DOC; improving mental health program design and development; and coordinating the efforts between DOC and the community service boards for the development of a network of post-release services for inmates.**

MECHANISMS FOR COST RESTRAINT

The General Assembly has appropriated funding to employ additional staff to assist in mental health treatment beginning in July 1993. Using these funds, the department plans to add 25 new staff and 105 mental health care beds. This review of inmate mental health treatment has indicated that the department is not utilizing its existing resources in the most cost-effective manner. Therefore, given the pending increase in mental health staff and beds, it is especially important that the department take action to ensure that existing resources are employed to their full potential and the additional resources are used effectively. Specifically, the department needs to operate more efficiently in four major areas.

First, the department needs to refine the transfer process of mentally ill inmates to minimize using costly sheltered and acute care beds for inmates who no longer require such services. DOC could accelerate the transfer process by placing the responsibility for transfer in the central office rather than the current decentralization of the responsibility to the acute and sheltered care units. This would enable DOC to utilize costly sheltered and acute care beds more efficiently.

Second, DOC needs to examine the large amount of time outpatient mental health staff in several facilities spend on administrative duties, thereby limiting the time spent on provision of treatment. These administrative duties could be performed more cost-effectively if mental health staff had greater access to administrative support from lower-salaried clerical staff in the facility.

Third, the department needs to isolate and track mental health costs on an ongoing basis. DOC staff are hampered in their ability to analyze or control mental health care costs since they are not separately budgeted or reported. Once these costs are isolated, DOC staff should determine why certain mental health units are particularly cost-effective, or more costly, in their operation.

Fourth, the department needs to examine options for limiting capital expansion. Specifically, the department should conduct cost and space analyses comparing the costs of adding mental health beds through renovation of existing structures to the cost of new construction. These analyses may limit the amount of capital expansion necessary to meet the needs of an increasing population.

Sheltered and Acute Care Beds Are Not Utilized Cost-Effectively

The inefficient use of sheltered and acute care beds is due in large part to the current practice of requiring mental health staff at the major institutions to arrange all transfers into and out of the mental health units. Since receiving institutions are reportedly reluctant to accept mentally ill inmates into their facilities, many inmates remain in sheltered and acute care beds long after they have been clinically diagnosed as ready for discharge to general population. DOC could utilize sheltered and acute care beds more efficiently by centralizing the transfer function in the central classification

board (CCB). The CCB is staffed with five employees at DOC's central office who are responsible for making decisions on custody classifications, work release, furloughs, and inmate transfers.

Department operating procedures direct that inmates treated in sheltered care units are to be transferred back to the institution from which they came unless the inmate has an enemy at that facility. However, sheltered and acute care staff indicate that institutions will often refuse to take the inmate back. They must then call other institutions until they find one that will accept the inmate.

The transfer process has resulted in excessive waiting times for transfers out of sheltered care units. For example:

> *On March 31, 1993, four of the 12 inmates housed in Powhatan's sheltered care unit were diagnosed as clinically ready to be discharged and were waiting to be transferred out of the unit. One inmate had been waiting 63 days to be discharged, two inmates had been waiting about 40 days, and the fourth inmate had been waiting two weeks.*

Mental health staff in acute and sheltered care units report that the waiting time for inmates who are clinically ready for discharge to another major institution ranges from four days for Mecklenburg inmates to 300 days for Greensville inmates (Table 10). At Marion, which provides the expensive acute care, inmates clinically ready for discharge are not transferred until an average of 59 days later. Therefore, costly sheltered and acute care beds are occupied by inmates who no longer require treatment in these units. As Table 10 indicates, mental health staff at the facilities reported that in May 1993, 10 inmates at Greensville and 11 inmates at Marion had been diagnosed as ready for discharge, but had not been transferred. Maintaining inmates who no longer need acute or sheltered care in those types of beds does not efficiently utilize costly space and staff.

Further, access is restricted for inmates waiting for assignment to sheltered care beds from reception and classification centers. Mental health staff at one reception and classification center indicated frustration over difficulties in placing inmates in sheltered care beds. For example, one mental health professional indicated:

> *Mental health patients waiting in the reception and classification unit are not in an ideal situation. For example, all inmates are in double cells, regardless of whether they are mentally ill. A few of the more seriously mentally ill inmates are temporarily placed in a sheltered care unit pending permanent transfer; however, there is only room for three or four reception and classification unit inmates. Currently, six inmates are waiting for transfer to a sheltered care unit. The average waiting time for placement in a sheltered care unit for inmates from this reception and classification center is five months. None of the mentally ill inmates in the reception and classification unit are receiving any mental health treatment other than psychotropic medications.*

Table 10

Average Time Inmates Wait to be Transferred Out of Sheltered and Acute Care Units and into Other Institutions

Facility	Average Time Until Transfer (days)	Inmates Ready for Discharge
Greensville	300	10
Marion	59	11
Mecklenburg	4	1
Powhatan	39	3
Staunton	14	0
Total		**25**

*VCCW is not included because it is the only women's prison; therefore, women are not transferred to other institutions.

Source: JLARC survey of Department of Corrections mental health staff, May 1993.

The CCB senior psychologist responsible for assisting institution mental health staff in transferring inmates in and out of sheltered care beds currently spends less than 40 percent of the time on this function. The majority of the senior psychologist's time is spent making security classifications at major institutions and field unit reception and classification centers. The psychologist acknowledged that there are some weeks that insufficient time is devoted to mental health.

Further, the decentralized nature of transfer results in the CCB psychologist generally not being informed when inmates are ready to transfer out of an acute or sheltered care bed. For example, as of May 1993, the CCB psychologist was aware of only four cases systemwide who were ready to be discharged from acute or sheltered care units at that time. However, as Table 10 indicates, at that time there were actually 25 inmates in acute and sheltered units systemwide waiting to be transferred.

It appears that DOC should address the problems with the transfer process by directing that CCB staff serve as the administrative focal point for all acute and sheltered care units that have inmates waiting to be discharged, all sheltered care units with bed openings, and all facilities with inmates waiting for a bed. Decisions could then be made at the central office as to when and where inmates are to be transferred. This would eliminate the need for mental health staff to make numerous phone calls to different institutions in search of a facility that will take a acute or sheltered care inmate, and would better utilize the costly acute and sheltered care beds.

Recommendation (14). **The Department of Corrections should address the problems with delays in the transfer process by centralizing the responsibilities in the central office central classification board. Written policy should instruct mental health staff to notify the CCB when a bed will be opening or**

when a bed is needed, rather than having institutional mental health staff arrange acceptance and then notify the CCB.

Outpatient Treatment is Limited Due to Time Spent on Other Duties

The department has 24 psychologists providing outpatient services in the major institutions. Along with part-time psychiatrists assigned to the institutions, these psychologists are generally the staff responsible for providing outpatient services. Psychologists' duties currently include providing individual and group therapy; conducting evaluation examinations; preparing individual treatment plans; and performing administrative duties, which include items such as filing, making appointments, answering telephones, and doing paperwork.

According to the estimates reported by the highest ranking mental health professional at each of the facilities, the psychologists providing outpatient services at most institutions spend less than one-half of their time providing individual and group therapy (Table 11). Limited time spent providing individual and group therapy appears to be due to large amounts of time some psychologists spend on administrative duties. As Table 11 indicates, psychologists at six facilities estimated that they spend 50 percent or more of their time on administrative and other duties.

Table 11

Reported Percentages of Time Psychologists Spend on Duties

Institution	Evaluation Examinations	Treatment Plan Preparation	Verbal Therapy and Group Counseling	Administrative/ Other Duties*
Augusta	5	3	30	62
Bland	20	15	45	20
Brunswick	10	2.5	35	52.5
Buckingham	12	13	23	52
Deep Meadow	80	5	5	10
Greensville	20	0	60	20
James River	40	10	40	10
Mecklenburg	6	0	30	64
Nottoway	5	1.5	53	41.5
Powhatan	25	10	15	50
Southampton	4	1	30	65
Staunton	13	5	41	41
St. Brides	45	5	35	15
VCCW	20	0	50	30

*These duties include items such as answering telephones, making appointments, and doing paper work.

Note: Keen Mountain is not included because the psychologist recently began employment at this facility.

Source: JLARC survey of Department of Corrections mental health staff, May 1993.

Several institutional psychologists indicate that the need to perform administrative and other duties reduces the amount of time they spend providing direct treatment. For example:

> *One psychologist indicated that using psychologists to perform clerical tasks takes time away from direct services to inmates. The psychologist indicated that administrative procedures they are required to complete include: data-keeping, file building, record circulation between institutions, file organization, appointment-making, and tracking of inmates arriving and leaving the institution.*
>
> * * *
>
> *Another psychologist reported spending 65 percent of his time on administrative duties. This psychologist stated, "I am an extremely well-paid typist and file clerk." In addition, the psychologist remarked that these administrative duties are duties that a high school graduate could perform.*

Since psychologists are generally the only mental health staff providing outpatient treatment, the inefficient use of psychologists limits the amount of therapy inmates are receiving.

However, some psychologists have access to clerical support from staff who are assigned to different units within the institution. For example:

> *The warden at one correctional institution has allowed mental health staff access to a clerical position for approximately 50 hours per month. This clerical position is assigned to the treatment counselors. The warden has authorized that this position be loaned to mental health staff on a part-time basis. The part-time clerical assistance has permitted mental health staff to perform monthly reviews of the progress of mentally ill inmates, which were not conducted when no clerical support was provided. Further, this clerical support has enabled the mental health staff at this facility to spend a lower percentage of time on administrative duties and a greater percentage of time on treatment.*

Based on the percentages of time reported for administrative duties by approximately 50 percent of the outpatient treatment staff, it appears that some facilities are not providing sufficient access to existing clerical staff support. Therefore, the department should look for ways to systematically ensure that mental health staff have access to the existing clerical support staff in facilities where it is problematic.

Recommendation (15). **The Department of Corrections should examine the administrative duties being conducted by mental health staff to determine if all these duties are necessary. If so, the department should take steps to**

provide access to clerical staff support from within the institutions which would provide mental health staff more time to conduct treatment.

Mental Health Costs Are Not Effectively Maintained and Monitored

DOC staff are hampered in their ability to analyze or control mental health care costs since they are not separately budgeted or reported. Both central office and institutional staff lack data on what the components of mental health services currently cost, what these components have cost in the past, and how the cost of these components is increasing or decreasing. In addition to the fact that DOC has established little capacity to understand and track mental health care costs, DOC also has little incentive to control costs when there is no accounting for what has been expended.

Cost Data Specific to Mental Health Treatment Should Be Maintained. The focus of the financial division of DOC is to ensure that expenditures are appropriately reported within the correct program area and do not exceed the allotted amounts available within that program area. This level of analysis is consistent with the expectations of the Department of Planning and Budget (DPB) for a financial division. However, this level of analysis does not allow for identifying the primary determinants of cost increases, a first step in controlling mental health treatment costs.

Although mental health treatment is budgeted as part of the overall medical care program, DOC could institute "cost centers" that would allow for separate reporting of mental health, dental, and medical expenditures. Cost centers allow agencies to internally track expenditures in a manner that is more useful for that agency. Currently, DOC does not have a cost reporting system that effectively isolates the cost of providing mental health treatment from dental or medical care. Providing a separate accounting for mental health treatment costs would encourage mental health staff to take cost containment actions, such as ordering less costly medications and limiting the use of contract personnel when possible.

Recommendation (16). **The Department of Corrections should establish cost centers which differentiate mental health treatment expenditures from dental and medical expenditures. Detailed instructions regarding the coding of these cost centers should be promulgated, explained, and distributed to all staff involved in coding expenditure data.**

Cost Data Specific to Mental Health Treatment Should Be Monitored. Since comprehensive, statewide cost data on mental health services are not maintained, no one in the central office can effectively monitor mental health treatment costs. Central oversight of meaningful cost data is needed if mental health treatment costs are to be identified and controlled. Currently no system-wide cost containment actions are being taken for mental health treatment in part because of the lack of reliable cost data. No cost comparisons between the mental health care provided in various major institutions

are made, again in part because of the lack of reliable cost data. Monitoring mental health cost data will allow the department to complete these types of cost comparisons and allow for more cost-effective operations to be identified. This will assist DOC in making and justifying budgetary decisions.

Recommendation (17). **The Department of Corrections should ensure that the mental health program director reviews mental health cost data at least quarterly. The cost data should be used in evaluating alternative means of providing mental health treatment and in making and justifying budgetary decisions.**

The Cost-Effectiveness of Mental Health Units Should Be Addressed. Once mental health-specific cost data are monitored, the mental health program director will be able to identify mental health units which are particularly cost-effective or inexplicably costly in their operation. The director should seek to determine the reasons for the efficient or costly operations and ensure that any necessary actions are taken. This may entail informing other mental health units of cost containment ideas or assisting an inefficient unit in reducing costs.

Because of the substantial limitations in DOC's data, JLARC staff were only able to isolate mental health costs for the operations of Marion Correctional Treatment Center and the mental health care provided by Correctional Medical Systems Services (CMS), the private contractor at Greensville. This analysis of mental health care costs revealed the need for close scrutiny by DOC of the cost-effectiveness of the mental health care provided by CMS.

A comparison of the estimated mental health care costs for the acute care provided at Marion and the sheltered care unit at Greensville indicated that the cost on a per-inmate basis at Marion is only 33 percent greater than CMS' costs for the Greensville sheltered care unit (Table 12). It seems reasonable to expect that the difference would be greater since Marion provides acute care for the most seriously mentally ill inmates. For example, Marion spends approximately 59 percent more on psychotropic medications ($817 per inmate compared to Greensville's $513 per inmate). However, while Marion's staff per inmate ratio is 29 percent higher than Greensville's, Greensville's average compensation for its mix of staffing is 2.5 percent higher than the average compensation for the staffing mix at Marion.

Privatization of mental health care services at Greensville is part of a pilot project to determine the cost-effectiveness of this alternative means of providing inmate health care services. Considering the high cost of the CMS contract for mental health sheltered care and the programmatic problems previously noted, DOC should carefully review and monitor both the cost-effectiveness and the quality of the service provision at Greensville. Further, once the department establishes a mechanism to isolate mental health costs, comparisons of the costs involved in operating all the sheltered care units should be conducted and used to monitor the cost-effectiveness of these units.

Table 12

Comparison of Costs for Greensville's Sheltered Care Unit and Acute Care at the Marion Correctional Treatment Center

Facility	Salaries and Benefits	Psychotropic Medications and Supplies	Total Cost	Cost Per Inmate
Greensville	$470,430	$41,022	$ 511,452	$6,393
Marion	$924,512	$98,000	$1,022,512	$8,521

Source: Data supplied by the Marion Correctional Treatment Center, Department of Corrections Masterfile Reports, personnel benefit costs supplied by the Department of Planning and Budget, and CMS estimated mental health services costs.

Recommendation (18). **The Department of Corrections should ensure that the analysis of mental health cost data is used to the fullest extent possible in identifying efficient and inefficient mental health units. Potential cost containment ideas that are identified should be shared with other units. Inefficient operations should be assisted in reducing costs.**

Recommendation (19). **The Department of Corrections should thoroughly review the cost-effectiveness of the current contract with Correctional Medical Systems for mental health care services. In addition to analyzing the cost components of mental health care services, the review should examine the types of services being provided and the quality of those services.**

Employment Decisions Should Be Made On the Basis of Cost-Effectiveness. One cost containment action that appears to have cost savings potential involves hiring mental health staff, psychiatrists in particular, as classified, salaried employees whenever that is possible instead of relying on contract staff. During FY 1993, ten psychiatrists worked within 14 major institutions on a contract or temporary basis. (Four of these psychiatrists actually worked in two or more institutions.) Contract and temporary psychiatrists are typically paid on a per-hour basis for working a relatively limited number of hours each week. The current charges range from $50 to $150 per hour and the psychiatrists work for between one and 16 hours each week.

It appears that the department is spending too much for the limited hours contract psychiatrists work. For example:

> *One contract psychiatrist works a total of 32 hours per week for the department. This psychiatrist is paid $100 per hour. These hours are*

divided among three institutions: James River, Mecklenburg, and Nottoway. Mental health staff at these institutions estimate that this psychiatrist will earn $166,400 for these hours worked during FY 1993. However, if the psychiatrist worked full-time and were paid as a full-time state employee, the salary and benefit expenses would be no more than $120,000 per year.

DOC should attempt to hire psychiatrists as full- or half-time classified employees whenever that would be the more cost-effective course of action and qualified applicants can be attracted. In cases in which an institution is not close to other institutions and a limited number of psychiatric hours are needed, employing a salaried psychiatrist even on a half-time basis may not be cost-effective. In other instances, particularly if a psychiatrist can be employed to serve at two or more institutions, better psychiatric coverage may be achieved at a cost savings to the State if the psychiatrist is hired as a classified employee.

Recommendation (20). **The Department of Corrections should ensure that cost-effectiveness is the basis for deciding whether to employ mental health staff as classified, salaried employees or on a contact basis. Only in cases in which a qualified mental health professional cannot be recruited or a special circumstance exists (such as services being needed for a limited period of time) should the less cost-effective alternative of hiring on contract be used.**

Capital Expansion for Mental Health Beds Could Be Limited

As stated earlier, national experts have speculated that nationally the number of mentally ill inmates is increasing. In addition, mental health staff within DOC indicate that they are seeing more inmates who are chronically mentally ill and need to be in separate environments throughout their incarceration. Therefore, the need for expanding the number of available mental health treatment beds is almost a certainty for the department. However, DOC needs to take certain steps prior to considering the need for additional capital expansion. These steps may limit the amount of capital expansion necessary to meet the needs of an increasing population.

The first step, which has been discussed earlier in this chapter, is for more efficient and effective use of existing mental health beds. This can be achieved through better management by the Central Classification Board, which will help ensure more timely transfer of inmates who are clinically ready for transfer. Centralizing this function will also help to ensure that mental health professionals are able to provide more clinical treatment time, which should reduce the average length of stay for those inmates who are not chronically mentally disordered.

Second, prior to any proposals for capital expansion, the department should examine existing, vacant buildings on the grounds of DMHMRSAS facilities located throughout the State. Following deinstitutionalization, DMHMRSAS reduced both

capacity and daily census of some facilities. Therefore, DMHMRSAS has vacant buildings which could possibly be used by DOC to house mentally disordered offenders.

As of April 1993, DMHMRSAS had 23 vacant buildings, of which, ten were built after 1950. (Additional information on the vacant buildings is provided in Appendix E). DOC needs to compare the costs of converting and operating these buildings to the cost of building and operating new prisons for additional mental health beds.

DOC currently occupies two buildings which were previously occupied by DMHMRSAS — Staunton Correctional Center was a State psychiatric hospital, and Marion Correctional Treatment Center was a building operated by DMHMRSAS and is on the grounds of Southwestern Virginia Mental Health Institute. Given that DOC has previously acquired and is using DMHMRSAS facilities to house and treat inmates, a determination should be made, prior to any additional new construction, as to whether some of these other vacant buildings could be converted to accommodate prisoners. DOC should conduct a comparative cost analysis of the options, including the associated operating costs, and present that analysis as part of their capital outlay proposal.

Recommendation (21). **The Department of Corrections should examine creative alternatives to new construction for inmate mental health beds. The examination should include, at a minimum, the buildings which are vacant on the grounds of DMHMRSAS facilities. DOC should conduct a cost analysis which compares the costs of renovating these existing structures to the cost of new construction analysis. The cost analysis should include a comparison of the operating costs associated with each of the options. The analysis should be conducted routinely as part of the preliminary planning process for each addition of mental health beds which require capital additions. The information from this cost analysis should be included with all capital outlay requests presented to the Senate Finance and House Appropriations Committees.**

Appendixes

Appendix A

Item 15-A, 1992 Appropriation Act

The Joint Legislative Audit and Review Commission shall examine the increasing costs of inmate health care in the state correctional system. The objective of this study shall be to determine the appropriate level of inmate health care while developing mechanisms for restraining the growth of costs. The Commission shall report on its progress to the 1993 General Assembly and to each succeeding session until its work is completed. In carrying out this review, Virginia Commonwealth University, the Departments of Corrections, Health, Medical Assistance Services, and Mental Health, Mental Retardation and Substance Abuse Services, and the Auditor of Public Accounts shall cooperate as requested and make available all records, information and resources necessary for the completion of the work of the Commission and its staff.

Appendix B

Therapy Groups Provided at Marion Correctional Treatment Center

Psychotherapeutic	Psychoeducational
Coping with losses	AIDS education
Substance abuse	Alcohol and drug education
Victim empathy (sex offenders)	Basic social skills training
Victim empathy (non-sex offenders)	Understanding co-dependent relationships
	Communication skills
	Coping with anger
	Enhancing self-esteem
	Human sexuality
	Medical education and health care skills
	Pre-release program
	Re-entry skills for transfer to general population or parole
	Relapse prevention strategies
	Understanding and coping with schizophrenia

Source: JLARC staff analysis of Marion Correctional Treatment Center Annual Program Descriptions, May 1993.

Appendix C

Therapy Groups Provided by Mental Health Staff for Inmates in Sheltered Care Units*

Group	Greensville	Mecklenburg	Powhatan	Staunton	VCCW
Arts and crafts		●			
Aspects of male identity	●				
Chemical dependency				●	
Community meeting	●				●
Identifying criminal thoughts				●	
Improving living skills	●				
Interpersonal skills				●	
Level transition	●				
Preparation for discharge	●				
Schizo-phrenia education				●	
Stress management	●				●
Survivors of sexual abuse					●

* Only groups conducted by mental health staff are included. Alcohol, substance abuse, and sex offender groups conducted by counselors or volunteers are not included.

Source: JLARC survey of Department of Corrections mental health staff, May 1993.

Appendix D

Outpatient Mental Health Groups

	Self Awareness	HIV Support	Stress Management	Survivors of Sexual Abuse	Problem Solving	Anger Control	Family Issues	Violent Offenders	Coping With Depression	Post Traumatic Stress	Psycho-educational*	None
Augusta												●
Bland				●				●	●	●	●	
Brunswick												●
Buckingham					●	●						
Deep Meadow												●
Greensville									●			
James River												●
Keen Mountain												●
Mecklenburg												●
Nottoway												●
Powhatan			●				●					
Southampton												●
Staunton	●	●										
St. Brides												●
VCCW			●	●								

*Psychoeducational groups in depression, stress, and rational emotive therapy conducted by masters level practicum students under supervision of psychologist senior.

Note: Only groups conducted by mental health staff are included. For example, alcohol, substance abuse, and sex offender groups conducted by counselors or volunteers are not included.

Source: JLARC survey of Department of Corrections mental health staff, May 1993.

Appendix E

Vacant Buildings at DMHMRSAS Facilities*

Location	Name of Facility	Number of Vacant Buildings on Facility Campus	Approximate Dates of Construction	Approximate Square Footage
Burkeville	Piedmont Geriatric Hospital	4	1918/1924/1944/1952	15,600/2,200/2,100/ 2,400
Catawba	Catawba Hospital	4	1924/1939/1952/1954	1,900/2,100/14,800/ 4,500
Lynchburg	Central Virginia Training Center	2	1915/1955	7,500/19,900
Marion	Southwestern Virginia Mental Health Institute	3	1930/1952/1967	49,000/87,800/25,400
Petersburg	Petersburg Campus: Central State Hospital, Southside Virginia Training Center, and Hiram W. Davis Medical Center	6	1904/1910/1929/1930/ 1951/1951	4,000/7,400/30,000/ 110,300/2,900/2,900
Staunton	Western State Hospital	1	1950	30,400
Williamsburg	Eastern State Hospital	3	1940/1951/1951	1,900/60,800/60,800

* The buildings listed are currently vacant and are scheduled to remain vacant.

Source: Department of Mental Health, Mental Retardation, and Substance Abuse Services listing of vacant DMHMRSAS facilities, April 27, 1993.

JLARC Staff

RESEARCH STAFF

Director

Philip A. Leone

Deputy Director

R. Kirk Jonas

Division Chiefs

Glen S. Tittermary
● Robert B. Rotz

Section Managers

John W. Long, Publications & Graphics
Gregory J. Rest, Research Methods

Project Team Leaders

Linda E. Bacon
● Charlotte A. Kerr
Susan E. Massart
Wayne M. Turnage

Project Team Staff

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Julia B. Cole
Mary S. Delicate
Joseph K. Feaser
Joseph J. Hilbert
Jack M. Jones
Brian P. McCarthy
Laura J. McCarty
Deborah L. Moore
William L. Murray
Rowena R. Pinto
● Ross J. Segel
Anthony H. Sgro
● E. Kim Snead

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Section Manager

Joan M. Irby, Business Management & Office Services

Administrative Services

Charlotte A. Mary

Secretarial Services

Rachel E. Gorman
Becky C. Torrence

SUPPORT STAFF

Technical Services

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Betsy M. Jackson, Publications Assistant

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