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First Report of the Implementation Panel

Dear Judge Howard. Mr. Laney. and Mr. Westbrook:

Introduction

We are providing this first report of the Implementation Panel based on the initial site visit to the South Carolina Department of Corrections from May 2-5, 2016, pursuant to the Settlement Agreement in T.R. et all v S.C.D.C. et.al. As you will recall. the Implementation Panel is comprised of Raymond Patterson MD, and Emmitt Sparkman. with Tammie Pope as the Implementation Panel Coordinator. In addition, Subject Matter Expert, Jeffrey Metzner MD, has been retained for his expertise in this matter. All have contributed to this report.

The initial visit was scheduled with the anticipation that the Settlement Agreement would be finalized prior to the site visit. Further, our anticipation was that all of the policies and procedures would have been finalized prior to the initial site visit. However, as the parties are aware neither the Settlement Agreement nor the complete set of policies and procedures were finalized prior to the site visit. We, therefore, determined it would be more helpful to the process to provide consultative and technical assistance to SCDC for this initial site visit, tour a limited number of

facilities, and meet with their executive, clinical, and security staff to discuss their understanding of the process for implementation of the Settlement Agreement. This report will, therefore, be different from the anticipated upcoming reports which will focus on compliance with the provisions of the Settlement Agreement. Subsequent reports will be consistent with the essential requirements of the Implementation Goal including the 48 components identified in the Implementation Panel Report to a degree that satisfies the purposes and objectives of the goals, plans, and components in the Settlement Agreement, even if any particular formal requirement is not complied with in its entirety.

Overall, the site visit was very successful and in our view resulted with valuable assistance to SCDC at both the central and administrative levels as well as at the individual sites visited. In addition, we were able to tour various units at the sites to review the current processes and to explore the SCDC plans to expand their mental health programs to include the Crisis Intervention Unit, Behavioral Management Unit, and review space and other considerations for resource allocations, including clinical and custody staff and necessary space and physical plant proposals to accomplish the goals and objectives that we anticipate will be reflected in the Settlement Agreement.

We held an opening entrance conference with the SCDC administrative staff as well as an exit debriefing with the SCDC administrative staff to discuss the anticipated "road map" derived from the mediation as well as the results of the visit.

The baseline information provided by SCDC included the following:

Mental Health Classifications for Mentally Ill Institutional Population on May 2, 2016

SCDC Institutional Population = 20,427
SCDC Mentally Ill Population = 3,192

Mental Health Classification	Count	Percent of Mentally Ill Population	Percent of Total Population
L1	85	2.66%	.416%
L2	163	5.11%	.798%
L3	154	4.82%	.754%
L4	2,697	84.5%	13.2%
L5	54	1.69%	.264%
LC	13	.407%	.064%
MR	26	.815%	.127%

Explanation of Mental Health Classifications

(Code table pulled in directly from system and includes Non-Mentally Ill and retired codes. When an inmate returns, their previous Mental Health Classification is used until a new review is performed.)

CODE	DESCRIPTION
L1	MH-1 (HOSPITALIZATION)
L2	MH-2 (INTERMEDIATE CARE S
L3	MH-3 (AREA MENTAL HEALTH)
L4	MH-4 (OUTPATIENT)
L5	MH-5 (STABLE)
LC	SELF-INJURIOUS BEHAVIOR
M1	MI-1 (INPATIENT MENTAL HE
M2	MI-2 (MAJOR MENTAL ILLNES
M3	MI-3 (OUTPATIENT MENTAL H
M4	MI-4 (STABLE/MENTALLY ILL
MH	NMH (NO MENTAL HEALTH TRE
MI	MH-I (MENTALLY ILL)
MR	MH-R (MENTALLY RETARDED)
OK	MH-S (MENTALLY STABLE)
SA	SUBSTANCE ABUSE TREATMENT

Distribution by Institution

	Institutional Counts								Mentally Ill Inmates as Percent of				
Institution	L1	L2	L3	L4	L5	LC	MU	MR	Mentally Ill Inmates	Institution Total	Institution's Population	Agency's Mentally Ill Population	Agency's Total Population
ALLENDALE	0	0	0	159	6	0	0	0	**165**	1,147	14.4%	5.17%	.808%
BROAD RIVER	0	0	0	234	1	0	0	23	**258**	1,287	20.0%	8.08%	1.26%
CATAWBA	0	0	0	0	0	0	0	0	**0**	153	.000%	.000%	.000%
CENTRAL OFFICE ANNEX	0	0	0	0	0	0	0	0	**0**	1	.000%	.000%	.000%
EVANS	0	0	0	143	21	0	0	0	**164**	1,298	12.6%	5.14%	.803%
GILLIAM PSY	78	1	0	3	0	1	0	0	**83**	90	92.2%	2.60%	.406%
GOODMAN	0	0	0	0	0	0	0	0	**0**	226	.000%	.000%	.000%
GRAHAM CI	2	33	20	168	2	0	0	1	**226**	396	57.1%	7.08%	1.11%
GRAHAM R&E	0	4	2	33	0	0	0	1	**40**	183	21.9%	1.25%	.196%
KERSHAW	0	0	2	159	1	0	0	0	**162**	1,282	12.6%	5.08%	.79
KIRKLAND	1	125	3	74	1	12	0	0	**216**	1,503	14.4%	6.77%	1.06%
KIRKLAND INFRM	0	0	0	2	0	0	0	0	**2**	19	10.5%	.063%	.010%
KIRKLAND MAX	1	0	0	23	0	0	0	0	**24**	37	64.9%	.752%	.117%
LEATH	0	0	0	331	0	0	0	0	**331**	584	56.7%	10.4%	1.62%
LEE	1	0	33	225	10	0	0	0	**269**	1,423	18.9%	8.43%	1.32%
LIEBER	1	0	60	237	2	0	0	1	**301**	1,240	24.3%	9.43%	1.47%
LIVESAY	0	0	0	0	0	0	0	0	**0**	493	.000%	.000%	.000%
LOWER SAVANNAH	0	0	0	0	0	0	0	0	**0**	137	.000%	.000%	.000%
MACDOUGALL CI	0	0	0	81	0	0	0	0	**81**	606	13.4%	2.54%	.397%
MANNING	0	0	0	6	0	0	0	0	**6**	541	1.11%	.188%	.029%
MCCORMICK	0	0	1	157	1	0	0	0	**159**	1,090	14.6%	4.98%	.778%
PALMER	0	0	0	0	0	0	0	0	**0**	229	.000%	.000%	.000%
PERRY	0	0	33	219	0	0	0	0	**252**	899	28.0%	7.89%	1.2
RIDGELAND	1	0	0	157	0	0	0	0	**158**	1,171	13.5%	4.95%	.77
TRENTON	0	0	0	6	0	0	0	0	**6**	548	1.09%	.188%	.02

	Institutional Counts								Mentally Ill Inmates as Percent of				
Institution	L1	L2	L3	L4	L5	LC	MH	MR	Mentally Ill Inmates	Institution Total	Institution's Population	Agency's Mentally Ill Population	Agency's Total Population
TURBEVILLE	0	0	0	117	8	0	0	0	125	1,114	11.2%	3.92%	.612%
TYGER RIVER	0	0	0	163	1	0	0	0	164	1,277	12.8%	5.14%	.803%
WALDEN	0	0	0	0	0	0	0	0	0	630	.000%	.000%	.000%
WATEREE RIVER	0	0	0	0	0	0	0	0	0	823	.000%	.000%	.000%
TOTAL	85	163	154	2,695	4	13	0	26	[illegible]	[illegible]	[illegible]	100%	15.6%

Inmates in Lockup on April 27, 2016
by Institution and Mentally Ill vs. Non-Mentally Ill Population

Institution	Mentally Ill	Non-Mentally Ill	Total
ALLENDALE	24	92	116
BROAD RIVER	22	17	39
EVANS	18	70	88
GILLIAM PSY	8		8
GRAHAM R&E	15	16	31
KERSHAW	16	36	52
KIRKLAND	3	16	19
KIRKLAND MAX	23	13	36
LEATH	11	3	14
LEE	27	35	62
LIEBER	33	24	57
MANNING		18	18
MCCORMICK	9	32	41
MCLEOD REGIONAL		1	1
PERRY	27	69	96
RIDGELAND	6	26	32
TRENTON		41	41
TURBEVILLE	8	19	27
TYGER RIVER	7	36	43
WATEREE RIVER		6	6
Total	[illegible]	[illegible]	[illegible]

As a part of the consultative and technical assistance component of our site visit, our subject matter expert Jeffrey Metzner, MD provided a template as a potential model to SCDC administrative and compliance staff to assist them in the process of obtaining data and documenting the results pursuant to the requirements of the Settlement Agreement.

The specific details from this initial site visit are based on the clinical reviews and analysis by Drs. Patterson and Metzner, and security/operations reviews and analysis by Mr. Sparkman. In this report, "Panel" includes Dr. Metzner and Ms. Pope in terms of reviews and tours of facilities and programs.

Kirkland Correctional Institution (KCI)

During the morning of May 22, 2016 we had the opportunity to meet with the following staff:

Among the topics discussed was the method that would be used to calculate out of cell time to measure compliance with the GPH policy. Also with regard to out of cell time, Mr. Sparkman emphasized the need to determine the amount of security staff that will be required to provide the necessary hours. Dr. Metzner pointed out that in order to attain a level of 10 hours of structured therapeutic activities per week and 10 hours of unstructured therapeutic activities, SCDC would need to schedule 15 hours per week in order to allow for cancellations that inevitably will occur. He estimated it would take 6-12 months to begin to schedule 15 hours and to attain 10 per week per inmate. He emphasized that QI will be the key to reaching substantial compliance. He suggested if there were any questions about the methodology to employ, staff should call one of the panel members to make sure it is acceptable. He offered to provide the names of other agencies that have implemented ten hours of unstructured and ten hours of structured therapeutic activity ("10/10") so SCDC can get ideas from them about what has worked and what has not. According to Dr. Patterson, usually the time is tracked by number of hours offered, number of hours received, and number of hours that did not occur and why (refusals and cancellations). Dr. Metzner pointed out that as monitors, they will look at the amount of time offered and the amount of time used.

Gilliam Psychiatric Hospital (GPH)
The panel took a brief tour within the Gilliam Psychiatric Hospital and received a briefing by [redacted] regarding the plans for construction of a nursing station within each wing. The director of nursing had not yet been consulted in the context of the design and operation of the nursing station. We also toured the programming space that will include conversion of office space to two group therapy rooms that were off the housing unit. These rooms could likely accommodate 8 to 12 inmates in a group therapy setting if regular chairs were used.

The panel attended a GPH interdisciplinary treatment team, which was attended by a psychologist, [redacted] R.N., and mental health counselors (i.e., QMHPs). A psychiatrist was not at the meeting due to psychiatrist vacancy issues. Inmates being staffed were very briefly interviewed during the team meeting. Treatment plans were infrequently discussed during this meeting. We learned during our meeting with the treatment team staff that GPH inmates are currently offered about two group therapies per week.

Jeffrey Metzner, M.D. observed a group therapy for about eight GPH inmates that focused on substance abuse issues. This group was well run by the mental health clinician and the inmates, in general, were active participants.

GPH B Side was visited and activities observed. Discussions were held with Warden [redacted] and GPH Lieutenant [redacted] on the importance of developing security staffing necessary to provide revised activities that will include offenders' out of cell activities: 10 hours structured and 10 hours unstructured per week. The Implementation Panel offered that to accomplish 10 hours out of cell time normally took scheduling 15 hours.

Intermediate Care Services (ICS)
During the early afternoon we attended an intermediate care services interdisciplinary treatment team that was attended by a psychiatrist, lieutenant, classification officer, psychologist, and QMHPs. Inmates being reviewed by the treatment team were very briefly interviewed during the meeting. A treatment plan narrative was written during the meeting but the treatment plan was not discussed with the inmate.

Dr. Metzner observed the mental health rounding process in the segregation unit, which occurred on a monthly basis. The clinician would round on inmates who were in segregation following their disciplinary hearing. Inmates on lockdown in this housing unit, who were on pre-disciplinary hearing status, protective custody status, or youthful offenders on reception center status, were not rounded on by the mental health clinicians. Inmates reported they were not receiving one hour out of cell recreational time due to custody staffing shortages and complained that their food was routinely cold. The clinicians who performed the rounds did so in a competent manner.

Dr. Metzner also briefly toured the Self-Injurious Behavior Unit, which had three housing units based on the inmates' privilege level. The inmates were very complimentary of [redacted] M.D. and her mental health staff. They complained about lack of access to a reasonable outdoor

recreational area, which again appeared to be related to custody staffing issues. Inmates also complained about not being offered enough activities.

Mr. Sparkman provided additional information regarding his tour and discussions at Kirkland. A discussion was held with KCI Training Officer, Captain [redacted] KCI has not developed lesson plans for the new/revised Mental Health, Use of Force, Restricted Housing Unit, and Disciplinary Policies and Procedures. Feedback was provided to Captain [redacted] and other SCDC Officials that lesson plans needed to be developed for the aforementioned policies, Training Instructors needed to complete Train the Trainer on each of the policies and a roll out plan developed to ensure all SCDC staff were trained on the new/revised policies. Use of Force does not have a separate lesson plan and disciplinary is not offered for all staff at annual in-service.

Disciplinary Hearings were attended for two offenders. Each had a mental health designation. SCDC staff had completed a form identifying each offender could be held accountable for his behavior resulting in the rule violation. The offenders, due to their mental health designation, were assigned a staff Counsel Substitute to provide assistance at the disciplinary hearing. The Counsel Substitute was present at the disciplinary hearing with the offenders. SCDC officials advised offenders with a mental health designation, that are found unaccountable for a rule violation, can still be found guilty with no sanctions imposed or mitigated sanctions. Disciplinary Reports are reviewed by a Correctional Supervisor and graded (seriousness determined) by the Major or designee. The sanctions imposed by the Disciplinary Hearing Officer for offenders with a mental health designation are reviewed by the Disciplinary Treatment Team, which consists of the Warden and Treatment Staff. The Disciplinary Treatment Team reviews the sanctions recommended by the Disciplinary Hearing Officer for offenders with a mental health designation and determines the final sanctions. The Implementation Panel made a recommendation to consider revising the "guilty but not accountable" to the finding of guilty-mentally ill. SCDC officials were receptive to the recommendation. The revised disciplinary procedures that only allow 180 days maximum loss of privileges has not been fully implemented. The loss of privilege sanctions exceeding 180 days received prior to the revised disciplinary policies have not been adjusted by SCDC officials. It was reported this is in progress and should occur shortly.

Activities in ICS F Building B Side were observed. An offender was observed talking to himself and pacing in the housing unit. Other offenders reported the offender had decompensated over the last few days, was not sleeping and had discontinued personal hygiene. The information was reported to the ICS Treatment Team. A discussion was held between the Treatment Team and the Implementation Panel participants regarding the importance of identifying the medical/mental health and security staffing that would be necessary to provide increased services required by the Settlement Agreement.

Mr. Sparkman emphasized the issue of the mentally ill inmates being held in Security Detention ("SD") and the need to get them out of their cells. He asked when the Behavioral Management Unit ("BMU") would be up and running. Mr. [redacted] said they had to prioritize and were

focused on a high security ICS program before the BMU. Mr. Sparkman also raised the issue of the SSR policy being implemented and getting inmates out of that environment if they are behaving.

Dr. Metzner asked whether the inmates are not getting rec in RHU was accurate and Warden [redacted] said it was accurate and it's something they're working on. Dr. Metzner explained the recently approved position statement of the National Commission on Health Care (NCCHC) on solitary confinement and urged SCDC to have weekly mental health rounds, daily nursing rounds and rec time in RHU. Dr. Metzner said the quality of rounds was fine and he emphasized the same person should do them rather than rotating it. Dr. Patterson pointed out the harm in not doing the weekly mental health rounds (currently done monthly) is likely a contributor to the suicide rate which is currently three times the national rate. Mr. Sparkman pointed out that since the number of inmates in RHU has been cut in half, they can now send more resources to those who remain there.

Dr. Metzner also raised the fact that half of the inmates in RHU were not rounded because they were on protective custody, pre-hearing detention or were youthful offenders. Dr. Metzner pointed out that the greatest risk of suicide is in the first two weeks in RHU, and that weekly rounds on all inmates in all RHU's are necessary.

Self Injurious Behavior Unit (SIB)

With regard to the Self-Injurious Behavior (SIB) unit, Dr. Metzner suggested they focus on the quality of the treatment plan and look at outcome measures. He was concerned about the lack of access to a reasonable rec yard. He was impressed with Dr. [redacted] interactions with the inmates and the inmates' comments about the program, but he stressed the need to get them out on rec.

Mr. Sparkman also stressed the need to train on the new policies for use of force, disciplinary and restricted housing. Those are not policies that can just be handed to the training officers and expect them to train well on them. He suggested training the trainers because the new policies represent a huge culture change and controlling the message and explaining why the changes are being made is important for successful implementation. Nothing had been done in that area and it needs to be developed. He said when he returns in October, he will place a major emphasis on use of force implementation. He recommended having the training officers know the policies backward and forward and coming up with a plan to train the staff. Someone needs to be charged with that responsibility. It cannot be done overnight, but it will not ever get done without a plan.

Receiving and Evaluation

Areas visited during the morning of May 3, 2016 included the Receiving and Evaluation (R&E) and the Substantiated Security Risk (SSR) Units. The KCI R&E staff provided the Implementation Panel an overview of the Medical and Mental Health intake process for male offenders accepted to the South Carolina Department of Corrections. R & E areas involved in the medical/mental health intake process were toured by the Implementation Panel. The panel

toured the Men's R&E Unit during the morning of May 3, 2016. Issues identified included mental health evaluations not occurring in a confidential setting, which was related primarily to office doors being left open due to "safety concerns." We discussed potential remedies with key mental health and custody staff. Staff indicated approximately 60% of intake health care screenings result in a mental health care referral. We discussed with relevant staff tracking of this data and potential issues that may indicate a false positive rate. Dr. Patterson identified that Suicide Risk Screening is a component of the Mental Health Evaluation and not dependent on "clinical judgment."

Substantiated Security Risk (SSR)

After completing the KCI R&E Unit tour, the Implementation Panel proceeded to the KCI SSR Unit. The KCI SSR Unit is designated for the most dangerous and violent offenders identified in the SCDC. The SSR Unit has a capacity of 50 and the population on May 3, 2016 was 37. Offenders are classified SSR status that consist of three levels:

D-Disciplinary, poor behavior
I-Improved
R-Eligible for Release

Offenders entering the SSR Unit are initially placed on Improved Status; however, the first 72 hours the offender is on "stripped out" status in a suicide prevention smock and meals are finger foods. SCDC staff advised the initial harsh security procedures for 72 hours were policy but could not provide rationale for placing every offender in these harsh conditions upon arrival in the SSR. A review of SCDC records revealed the SSR population on May 3, 2016, was in the following levels;

Disciplinary-	5
Improved-	7
Eligible for Release-	22
Safe Keepers-	2
No Level-	3
Total-	39 (2 housed at Leiber Correctional Institution)

The panel interviewed inmates housed in the SSR. The census was 37 of 50 available cells. The conditions of confinement, including the recreation areas, which are inside the facility, with partially "open" (to sunlight), but covered by razor wire, and in which inmates remain shackled and cuffed were of great concern to the panel. Several inmates informed the panel they refused their one hour of out-of-cell time because of these conditions. The mental health professional (MHP) appeared to know the inmates well and engaged them effectively during rounds. Several inmates had been confined to the SSR, formerly MSU, for many years, including one inmate who had been there for 22 years, and Mr. Sparkman pursued clarification of the above designations and criteria for release from SSR with Mr. [redacted]

Before leaving Kirkland, the Panel and SCDC staff and leadership met in the warden's conference room to de-brief. Overall, Dr. Patterson described the day as good in that they were

able to see what they wanted to see and learned of areas in which work needs to be done. Areas of concern raised by the Panel included:

1. Inmates should always be a part of the treatment team at GPH rather than just at admission and discharge and a psychiatrist should be present;

2. GPH staff needs to assess how many long term residents they have because that affects their capacity for the rest of SCDC;

3. The GPH Treatment Team meetings did not focus on the treatment plan with the inmate and that should be the primary discussion;

4. If inmates are reluctant to leave GPH, that might indicate there are problems with treatment at the receiving institution, which should be investigated internally;

5. In the ICS, the mental health clinicians complained of not being able to get ICS inmates into GPH despite meeting the criteria for acute care which underscores the lack of capacity at GPH:

6. There should be joint meetings between ICS and GPH because if the two are at odds, bad things are going to happen:

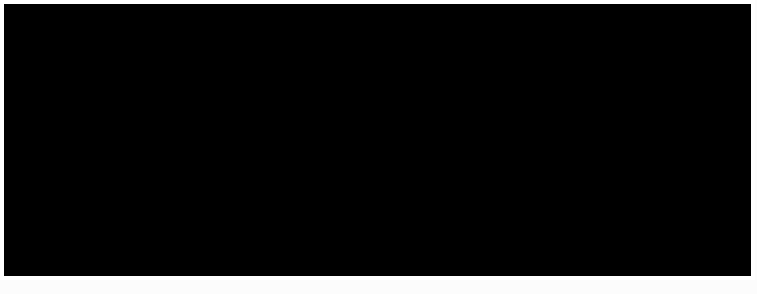
7. SCDC should look at what it would take to continue involuntary medications at institutions providing other levels of care (Dr. Metzner suggested looking at *Harper v. Washington*)

8. Programmatic activity is very low at the ICS—there was very little discussion in treatment team about what would happen with the inmate until the next meeting; and

9. The calculation of whether inmates are getting their 10/10 hrs will be labor-intensive, but it has to be done;

Camille Graham Correctional Institution (CGCI)

During the afternoon of May 3, 2016 we had the opportunity to meet with the following staff at Camille Graham Correctional Institution:



[redacted]

The basic overview of the mental health services at Graham was provided by Ms. [redacted] The ICS program is located in Blue Ridge dorm, which also houses some area mental health and some outpatient inmates. In R&E, there is one counselor now who does all of the screening and refers those in need of services to the psychiatrist. Treatment team is usually held on Fridays, but there was one planned that day so the Panel could sit in on it. Inmates in RHU are assessed within 30 days of arriving and every 90 days thereafter as long as they are in RHU. They were still working on the CI unit and currently had 3 women on CI. The average daily population at Graham was 579 and of those, 40 were ICS level of care ("LOC"), 23 were area LOC, 174 were outpatient LOC, 2 were L5 and 4 were at Geocare (3 for MH reasons and 1 for medical). There were a total of 36 women in RHU, 15 of whom were mentally ill. Dr. [redacted] is the psychiatrist who sees the women and she comes to Graham twice a week for 5 hours each time. There were 7 counselors including Ms. [redacted] and one Mental Health Tech. Ms. [redacted] provides administrative support for the mental health program. There are no psychiatric nurses or nurse practitioners.

Inmates currently have approximately 3-4 groups per week in the ICS. They are for the ICS and area LOC inmates. They also have crocheting, leisure and recreation and do physical activities on the yard 3 times per week. They have not been having community meetings recently. The overall capacity for Blue Ridge is 37 beds on the D-side and 48 beds on the C-side.

The R&E process for women is the same as for the men except they only receive women on Thursdays and Fridays and probably average about 30 per week, but the numbers vary from week to week.

The Panel was escorted to Blue Ridge Dorm to see the proposed location of the Women's CSU. [redacted] explained what renovations would be made to the rec yard to accommodate the CSU and the changes to the cells and the showers that would be used. He anticipated the work would begin in mid-June and had set September as a target completion date.

The Panel was then allowed to sit in on a treatment team meeting. Mr. Sparkman spent that time talking with the training officer and attended a DHO hearing. The usual attendees for their treatment team meetings are the warden, medical, the QMHPs, the administrative assistant, an Addictions Treatment Unit ("ATU") staff and security staff. The psychiatrist does not participate in the treatment team meetings due to staffing allocation/vacancy issues. A list of the women being staffed was handed out and each was discussed. Two of the inmates were called in to participate in the meeting. It was reported during the meeting that there were 135 inmates in R&E and some were being held in RHU because the R&E cells were full (despite being triple-celled).

After all of the inmates were discussed, Dr. Patterson asked the staff present if there were things they would like to have in order to be more effective. The MH tech said it would be helpful to have more recreational games and equipment for the recreational groups as she currently

provides supplies to inmates. The warden said she needs more staff so they could offer more structure and to have a full time psychiatrist. Dr. Patterson recommended they determine what staffing they need and what it will take to comply with the policies. The clinical supervisor noted that security often will not pull the inmates out of the cell and she believes it is unethical to yell through the cell door about private health matters. She also discussed how the diagnoses are not helpful because an inmate will retain a "rule out" or "unspecified" or "not otherwise specified" diagnosis for several months. The crisis beds are currently in the RHU. Mental health rounds in the RHU were not observed because they had been performed by staff earlier in the morning. They were reported to occur on a monthly basis. Dr. Patterson explained that RHU rounds should be once per week rather than once per month and the inmates should be pulled from their cells and assessed in a confidential setting as necessary or requested.

Dr. Metzner and Ms. Pope went to see where the R&E process occurs while Dr. Patterson observed a group. While at R&E, Dr. Metzner learned that the average length of stay in R&E was 3-4 months because it was taking that long to see the psychiatrist and/or medical. While in R&E, the women are triple-celled and are only allowed out of their cells to walk to meals and for one hour of rec and showers. About 30 female inmates are admitted on a once per week basis at Camille Graham CI. It was estimated that about 80% of the intakes result in a positive mental health screen.

During our afternoon tour. we visited the Blue Ridge Housing Unit, which houses predominantly ICS females inmates but also Area Mental Health Unit inmates. During the site visit there were 40 ICS inmates and 23 Area Mental Health inmates. The capacity was 37 inmates on D Unit and 48 inmates on C Unit. Mr. [redacted] showed us the plans for renovating space in this housing unit for purposes of creating programming space for group therapies and ten crisis cells. ICS inmates currently are offered 2-3 group activities per week.

Mr. Sparkman also stressed that health services (which include mental health services) have to continue. He explained that point will need to be stressed in training on the lockdown policy. Dr. Patterson added they will need to train the trainers on the new policies and explain why the policies are changing. Mr. Sparkman noted they have a good trainer in Lt. [redacted] and stressed that the trainers have to "walk the walk and talk the talk." In order for the policies and remedial plan to be successful. it will be important to train the trainers on the new policies and then let them train the staff on the new policies. Everyone has to be on message. As an example, he noted that when training on the new use of force policy, it would be important to teach new methods for handling situations. He recommended keeping the message simple so staff and inmates will understand.

Mr. Sparkman added that the intent of the DD policy was to limit DD time to 30 days, but allow for 60 days in extenuating situations. Instead, it seems 45-60 days has become the default. He said he is not blaming the DHO, but thinks the intent of the policy was not shared with the DHOs and it needs to be explained.

Mr. Sparkman interviewed Training Lieutenan[redacted]. Lieutenant [redacted] serves as the CGI and Goodman Correctional Institutions Training Officer and coordinator for the SCDC Columbia Midland Region consisting of six prisons. She directly reports to the CGI Warden

chain of command but also reports to the Training Academy chain of command. She and other Columbia Midland Region Training Officers have monthly two hour meetings. She reinforced previously provided information that SCDC staff had not received formal training on the revised Use of Force, Disciplinary, and Restrictive Housing Unit policies. She agreed that for consistency Training Officers needed "Train for Trainer" for these policies and the new/revised Medical and Mental Health policies before the training was offered to SCDC Staff. She reported staffing shortages made it very difficult for SCDC staff to receive the required annual training hours. She revealed SCDC correctional staff have difficulty meeting annual training hours to maintain their CLEE (Law Enforcement) certification. Staff availability results in approximately five attendees when class could be attended by twenty individuals. This results in having to offer additional classes to make courses available to staff further draining valuable SCDC resources. She estimated approximately 75 percent of the SCDC she is responsible for do not receive their required training hours. She provided information that correctional officers are required to attend 40 hours training before being assigned to an RHU Unit.

Both a Mental Health Disciplinary Treatment Team and Disciplinary Hearing were attended during the CGI site visit. The information received during KCI and CGI site visits indicates SCDC Hearing Officers are imposing the higher ranges for disciplinary detention (45-60 days). It is recommended that lower ranges (15-30 days) be considered by the Hearing Officers; unless, the violation is serious enough for security detention placement.

At the end of the day, everyone met back in the warden's conference room at Graham to discuss what the Panel had seen there. Dr. Patterson began by voicing two concerns. The first was a need to address the physical plant issues and to determine whether they will have space to accommodate the out of cell requirements necessary. The second was to assess and address the staffing needs at every level in every discipline. He recommended that non-mentally ill women not be placed in Blue Ridge. He noted that it would be important for future visits that staff be able to document what services are being provided at each LOC and they will need to distinguish between the structured and unstructured therapeutic activities. He explained they should only have mentally ill women in the mental health groups. For the ICS program, he suggested an itemized sheet demonstrating for each inmate that they are getting the 10/10 hrours and he added the services need to continue during periods of lockdown.

Dr. Metzner noted the Panel will be monitoring the compliance with policies and so the staff needs to know the policies. He also raised the issue of the length of stay in R&E especially since the women are triple-celled and not allowed dayroom time. The warden explained she does not allow the R&E women dayroom time because of the shortage of staff. Dr. Metzner discussed the NCCHC position statement and its implications for the situation in R&E. Due to the lack of out of cell time, he said the R&E women should be included in the mental health rounds once per week. He added the same would apply for the men if they are locked in their cells as much as the women. Mr. Sparkman noted even the American Correctional Association ("ACA") advocates that R&E should only take 4 weeks. Dr. Metzner offered that the ACA will also soon be coming out with a statement that any mentally ill inmates should be excluded from solitary confinement. Dr. Patterson added that if they cannot reduce the number of women per cell, they should at least make sure the women are allowed out of their cells for a decent amount of time per day.

Dr. Metzner encouraged the Graham staff that things will get better with time. He noted if the Panel prepared a report based on their visit, there would be criticisms despite the fact that they are doing the best they can with what they have. Dr. Patterson added that he understands it is difficult not to take the criticism personally, but the issue is the lack of resources, not poor performance.

Broad River Correctional Institution (BRCI)

During May 4, 2016 the Panel site visited the Crisis Stabilization Unit at the Broad River Correctional Institution, attended a treatment team meeting for this unit and observed the mental health rounds process within the RHU. We had the opportunity to meet with the following staff:

[redacted]

Crisis Stabilization Unit

The 32-cell crisis stabilization unit became operational during March 21, 2016. There were six inmates in this unit at the time of our site visit. The second floor of this unit, which also had about 32 cells. was used for permanent housing for the assigned inmate observers. Staff informed us that CSU inmates were receiving at least 10 hours of out of cell structured therapeutic activity per week in addition to another 10 hours of unstructured recreational time. The physical plant for this unit was impressive. CSU inmates did not have access to unstructured time in the dayroom area. Inmate observers are screened and selected by custody leadership staff and Dr. [redacted]

When general population inmates are participating in a group activity with higher security inmates such as RHU inmates, all inmates are cuffed during the group activity process. When higher security inmates are recreating in the outdoor yard in a congregate manner, they are all cuffed. Inmates are clothed in suicide smocks, without underwear, until the time of discharge.

Psychiatric time is provided on a three day per week basis by two different psychiatrists, which included coverage on at least one weekend day. The psychiatrists do not attend any of the daily treatment team staffing meetings.

The Panel observed a treatment planning team meeting, which involved team discussion of the inmates to be reviewed followed by each inmate being interviewed briefly in the team meeting. The healthcare records were not reviewed or available during the treatment team meeting and the conference room used for the staffing did not have computer access to the CRT.

There were 6 inmates staffed and of those, two had recently been admitted and four were nearing discharge. The inmates were a part of the staffing, but no treating psychiatrist was present. If they feel the need to include the psychiatrist, they can call and have them on the phone for a treatment team. Dr. Patterson advised Dr. [redacted] they need a full time psychiatrist for a 15 bed unit, so if they get to the capacity of 32 beds, they should have 2 full time psychiatrists. One inmate was ready to be taken off suicide precautions, but was not going to be discharged until there was a bed ready for him at the ATU. Ms. [redacted] asked whether the inmate's entire stay would count in determining the length of stay even though he was only being held there awaiting a bed in the ATU. Dr. Patterson said as long as the inmate is in the unit, his length of stay increases. He suggested that when the time comes when there is a waiting list for inmates to get into the unit and Dr. [redacted] has problems getting beds for discharges, he will need to track that so he can get the help he needs placing the discharged inmates.

Dr. Patterson asked those present in the treatment team meeting what they needed to do their jobs more effectively. QMHP [redacted] said she would like to have the complete medical record of the inmates who are admitted there. They also said computer access during treatment team meetings would be good. Dr. [redacted] said he would like to have a psychiatrist present at the treatment team meetings.

Drs. Metzner and Patterson encouraged Dr. [redacted] to tailor the clothing allowed to each inmate and use clinical judgment in assessing the risk. For example, Dr. Metzner suggested an inmate on constant observation probably doesn't need to be in a smock and almost certainly could at least have boxers under the smock unless he had a history of using boxers to try to hang himself. Dr. Patterson advised doing assessments all the way through and adjusting management of the inmates accordingly. He also cautioned they should be aware that what they do in the CSU may translate to outer institutions without a psychiatrist and incomplete treatment team.

With regard to discharge planning, Dr. Metzner suggested they coordinate their management plan with the receiving institution (mental health at the CSU communicating with mental health at the receiving institution). Operations staff may also need to know the management plan. He suggested they track inmates who have two or more admissions to the CSU during a 6 month period. That will indicate there is a problem with the discharge process.

The Panel was very impressed with the physical plant of the crisis stabilization unit and very encouraged by the enthusiasm of the staff and inmate access to out of cell programming. The lack of a psychiatrist during the treatment team meetings as well as the scarce number of hours of psychiatric time is very problematic and needs to be remedied.

The Panel discussed with staff issues related to inmate clothing restrictions. Specifically, inmates who are no longer on suicide precautions should not be in suicide smocks. We also recommended that inmates on suicide precautions, who are clothed in suicide smocks, should have underwear unless clinically contraindicated.

The Panel made specific suggestions related to the ADA cells from the perspective of further making them suicide resistant with specific reference to the toilets and the hand bar railings.

Correctional Staffing given for CSP was:

Unit Manager
Day Shift- Lieutenant and 4-5 Correctional Officers (minimum is 3 Correctional Staff)
Night Shift- Sergeant with 3 Correctional Officers (minimum is 3 Correctional Staff)

The CSP Unit has 32 offender observers. The observers shift are for a maximum of five hours

Groups are being held for offenders placed in the CSP Unit. A review of CSP Group roster found the following:

4/11/16	1 group
4/12/16	1 group
4/13/16	1 group (roster did not have the ending time for the group session)
4/17/16	1 group
4/18/16	1 group (roster did not have the start and ending time for the group)
4/19/16	1 group
4/20/16	1 group
4/21/16	4 groups
4/22/16	2 groups (2 rosters did not have the start and ending time for the group)
4/25/16	1 group (2 rosters were provided indicating offenders attended different groups at the same time)
4/26/16	3 groups
4/27/16	4 groups (2 rosters did not have the start and ending time for the group)
4/28/16	3 groups
4/29/16	2 groups (1 roster did not have the start and ending time for the group)
5/1/16	3 groups
5/2/16	3 groups (1 roster did not have the group end time)

SCDC staff holding the groups need to ensure roster forms are filled out correctly and completely.

Treatment Team meetings for CSP offenders were attended. Information was received from team members that a high number of CS offenders were coming from an identified SCDC Institution and something must be "going on". Team members acknowledged their perceptions about the increased number of offenders from this Institution had not been relayed to the

Institution or responsible SCDC Operations officials. The Implementation Panel stressed this type information should be communicated.

Restricted Housing Unit (RHU)

The Panel observed the mental health rounding process within the RHU, which was reported to occur on a monthly basis. This unit was very noisy and many inmates were disruptive during the process (e.g., banging on doors, flooding their cell). Inmates reported significant problems regarding access to mental health staff (e.g., not receiving timely responses to health care requests). Staff indicated that they had not received healthcare requests that were reportedly sent by several inmates.

Many of these cells appeared to be very dirty. Inmates did not appear to have access to daily outdoor recreation. At least one inmate, who appeared to be psychotic, was on the waiting list for admission to GPH. He flooded his cell during the rounding process.

RHU Correctional Staffing in the Saluda Unit is Day Shift- Lieutenant, Sergeant, Floor Officer, Control Room Officer and Night Shift Lieutenant, Sergeant, Floor Officer and Control Room Officer. Assigned staff acknowledged current staffing is insufficient to provide services to the assigned offenders. On a "good week" offenders only received three days per week recreation out of cell when policy requires five days per week. A provided RHU Roster indicated a number of offenders are being recreated in full restraints (4 out of 29 on the provided roster).

One inmate was released from SSR and was being held in the BRCI RHU after being cleared by an investigation. Reportedly, the offender had been observed by a staff member attempting to assault a Major during a disturbance but an investigation could not substantiate the attempted assault. Because of the conflict between the correctional staff eye witness account claiming to have observed the attempted assault and the investigation clearing the offender, no decision had been made to release the offender from RHU. The offender's version was he could not be released because he had a "separation requirement" from an offender at the General Population Step Down Program he had been initially recommended for by SCDC. The continued housing of the offender in RHU does not appear justified. Another offender complained he had threatened suicide and requested crisis stabilization but was denied by the Area Mental Health Supervisor. Mr. Sparkman requested the SCDC Director of Mental Health interview the offender. Empty cells in BRCI RHU cells were observed needing cleaning. The Implementation Panel recommended procedures and practice to clean cells after the release of offenders from RHU and the development of a cell inspection form to document the cleaning and condition of the cell. Common areas in RHU had peeling paint and needed general cleaning, particularly the shower areas.

The conditions of confinement within the RHU were very problematic, which exacerbated symptoms of inmates who were housed in this unit and on the mental health caseload. Mental health rounds on this unit should be performed on at least a weekly basis.

Behavioral Management Unit (BMU)
The Housing Unit proposed for the Behavior Management Unit (BMU) was toured. The BMU has 126 beds doubled celled. SCDC has not identified the number of offenders with a mental health designation currently in Restrictive Housing Unit beds that will be eligible for the BMU. The Implementation Panel stressed to responsible SCDC officials the actual BMU Program and number of beds could not be finalized until the projected number of BMU offenders were identified. Recommendations were made that the capacity of the proposed BMU Unit size should not have a capacity exceeding 50 beds. If more BMU beds are needed, after conducting an assessment of the RH offender with a mental health designation, an additional location will be needed for BMU.

Additional Meetings and Information

During the afternoon of May 4, 2016 we met with a large group of mental health providers (e.g. psychiatrists, nurse managers, pharmacy staff, PAs, etc.) from various institutions within SCDC in a group setting to discuss issues related to the proposed Settlement Agreement and the monitoring process.

We also met with key mental health and correctional staff leadership to discuss issues related to policies and procedures and again re-emphasized the need to develop a concrete plan relevant to the Behavioral Management Unit, with an emphasis on performing a needs assessment study.

Summary of Findings regarding Compliance

The final day of the visit, May 5, began with a meeting in the Director's Conference Room at SCDC Headquarters at 8am. Present for the meeting were Deputy Director of Operations [redacted] Dr. [redacted] and the Implementation Panel team members. The meeting began with Ms. [redacted], who spoke about the step down programs currently in existence at McCormick, Lee and Lieber. She discussed the pilot program at McCormick and the success they have had with it and provided anecdotal evidence of the difference it is making, as well as statistical evidence of the outcomes that have been measured. She also discussed plans to expand the step down programs and to include different specialized populations.

After remarks from Deputy Director [redacted] and Mr. [redacted] the floor was opened for final comments from the Implementation Panel members. Dr. Patterson began by explaining the purpose of the visit, which was largely consultative in nature. He acknowledged the needs in the areas of staffing, programs and construction. He noted that because the policies and settlement agreement are not yet final, the visit could not be a true monitoring visit. However, a template has been provided to the compliance staff for use at future visits to begin measuring compliance with the components of the agreement. He reported the feedback from staff was helpful and that the cultural change that will have to take place is major. He acknowledged the step down program is a really positive surprise. The Panel informed the participants that at the time of the site visit it is our view that based on review of Exhibit B provided by SCDC and reviewed by the

parties, SCDC mental health services would not be in compliance with any of the proposed Exhibit B criteria or what we anticipate to be the requirements of the Settlement Agreement.

Dr. Patterson noted the Panel did not review medical records or talk to many inmates, so their report will be shorter than usual. He suggested some priorities for moving forward. He advised finalizing the policies that have been the subject of negotiation and the settlement agreement. The next highest priority is getting the BMU up and running. An overall priority is to increase staffing. He noted that while the CSU is a promising program, it is incomplete without a full time psychiatrist who attends treatment team meetings and provides direct services. There should be a psychiatrist providing their expertise and recommendations regarding treatment and discharge planning and when inmates leave the CSU. He also encouraged communication between the operational staff in the CSU with the operational staff in the outlying institutions as they become aware of issues through interactions at the CSU. He noted that operational staffing issues are also important to compliance because the out of cell time required by the agreement can't be met without adequate security staff.

On the positive side, the team reported the CSU is a great improvement over how the CI inmates have been managed for years in SCDC. There are still some hiccups such as an inmate who had to stop over in the BRCI RHU before being taken to the CSU from Kershaw, but overall it is a huge improvement. He warned that with regard to the CSU, if there are 64 beds in the unit and only 32 are for CI, they will run out of beds. He also addressed the problems mentioned by staff about the staff at the CSU having been taken from GPH. He suggested explaining to the GPH staff why the CSU is a good thing for them also.

Dr. Patterson addressed the monthly rounds in the RHUs and said it is not sufficient. The rounds should be done weekly beginning immediately. This will allow staff to assess and meet the needs of inmates in segregation.

Mr. Sparkman reiterated the need for an overall mental health services plan and noted there should not be separate master plans, but one plan with optimistic goals. He said the best example he could provide about the problems with lack of planning is the BMU. It is still unclear how many beds are needed and without that basic piece of information there is no reason to move forward. He noted the plan can evolve, but there must be a plan. He recommended fast-tracking the development of the plan and shooting to have it completed within 30 days.

The next issue Mr. Sparkman addressed was the need for training. He emphasized that staff have to understand why the changes are being made to the way things are being done and have been done for a long time. He said he understands the tendency when staff is short to reduce or eliminate training, but he advised against it. He noted that everything in the new policies is a complete turn from what has been done for years and training is essential to making the changes. He warned that if the new policy is just handed to the trainers and they are told to train on it, there will be five different versions of the new policy being taught. He emphasized a roll-out plan for training including training for the trainers. He also suggested focus groups in some places to help understand where there are problems or a misunderstanding of the new policies.

He applauded SCDC for reducing the number of inmates in RHU from 1600 to 800 despite their lack of resources. With the reduction in numbers in RHU, he stressed the need to get the inmates still in RHU out of their cells for rec. He suggested focusing on those in SD who have been in RHU for over 60 days (of which there are approximately 300 inmates). He strongly advised starting with the provision of services for those approximately 300 even if they cannot do so for every inmate in RHU.

Mr. Sparkman also reiterated the need to expedite the opening of the BMU because it will help the RHU operations. He noted the BRCI RHU is a tough environment for staff to have to work in and he noted if the mentally ill inmates can be pulled out of the RHU that will help improve things for everyone. Another measure he recommended to help with RHU was to reduce the sentences in DD from 45-60 days to 0-30 days. He noted that additional days in RHU will not cure inmates. The main thing a stay in RHU will accomplish is to give the staff a break from an inmate's behavior. He also suggested when he returns in October if they have the behavior levels in RHU that will also mitigate the numbers because the inmates will not be in their cells 23-24 hours per day.

Mr. Sparkman observed that the staff need to follow the new policies—he observed many staff do not know how the new disciplinary policy works. When there is a staff shortage, it is taken for granted that the inmates will not get rec. That should not be the default position. The goal is to always provide rec especially for the SD inmates.

With regard to the use of force training. Mr. Sparkman emphasized the need to explain why the policy is better for the staff (i.e. what's in it for the staff as opposed to the inmates). Otherwise, staff will feel like there is no concern for their safety. He suggested reaching out to the NIC to look at defense tactics for safe crisis management. There are alternatives that should be used with the use of force training. He also recommended the use of force training be separated out by itself as part of the annual training to stress the importance. Deputy Director [redacted] noted he wished the training had been done prior to rolling out the policy and Mr. Sparkman agreed saying the staff still do not understand why he policy changed.

On a positive note. Mr. Sparkman commended SCDC for having completed the major re-write of the three policies (RHU. Disciplinary and Use of Force) and for reducing the population in RHU from 1600 to 800. He noted that because of that change. they really only have less than 300 inmates who have been in RHU for greater than 60 days and if they implement the reduction in sentences he suggested. the number will drop even more. SCDC Operations staff need to ensure only offenders in SSR and SD are in RHU for over sixty days. Reviewed records continue to identify offenders that are ST and DD status remain in RHU over 60 days. Lack of bed space is not acceptable justification for offenders on ST and DD status to remain in RHU beyond 60 days.

Dr. Metzner recommended that when the staff are trained on the new use of force policy, mental health staff should be there and be included in breakout sessions dispersed among the security staff. He recommended a contact at the DOC in California who has created some training videos with scenarios that would be useful to SCDC in their training efforts.

Mr. Sparkman also commended SCDC for the CSU and the huge improvement it means in the management of inmates on CI. Deputy Director [redacted] noted they are purposely moving slowly in getting it up and running so they can make adjustments it as it grows.

Mr. Sparkman explained that the staff at Lee initially wanted nothing to do with the character dorm. After they saw the environment in that dorm with the programming going on, they all wanted to work in there as opposed to an environment with no programming. Deputy Director [redacted] agreed and reiterated that it all comes down to a culture change.

Mr. Sparkman also discussed his findings in the SSR unit. He asked for the levels of the inmates there and learned that 22 of the 27 inmates there were in "R" status which indicates they are ready for release from there once approved by the Release Board. Referencing what has occurred in the step down programs discussed by Ms. [redacted], he said he believed 90% of those inmates could adjust to a similar program. He acknowledged there are 5-7 inmates who may not be, but stressed again that the unusual scary events should not dictate policy and the 99% successes should not be ignored.

Mr. Sparkman also commended SCDC for reducing the DD charges and being 99% of the way there in reducing the privilege restrictions. Finally, he is very pleased with the reduction in the use of the restraint chair noting there were no uses in January or February of 2016. He pointed out that with the changes that have been implemented, the violence has not gone up as many probably expected it would. Deputy Director [redacted] said inmate assaults have gone up, but not like it was before the changes.

Dr. Patterson's final issue was suicide prevention and management. He noted that SCDC's rate for the last year is three times the national average. He recommended looking at the problem in a self-critical way. It requires looking at the process, management and emergency response. The policy is written and the Columbia screen is being utilized to assess risk. He said the Panel will be focused on suicide prevention and management.

With regard to the master plan referenced earlier, Mr. Sparkman stressed that it has to be detailed and include all the disciplines. As an example, he said SCDC would need to determine how many security staff are needed in GPH in order to accomplish the out of cell time required and put that in the plan and then strive to achieve those numbers. Dr. Patterson added that the number of clinical staff will also affect the security staffing. Facilities Management also needs to be a part of the planning because the physical plant needs will be affected.

Mr. [redacted] noted that they need to find out where every mentally ill inmate in RHU is going. Mr. [redacted] added that they will need to prioritize their time on the things that they can accomplish by October. Dr. Patterson explained that 30 days should be the goal to have the plan and then begin implementing the goals. Mr. Sparkman encouraged them to include staff at all levels and to know they can change the plan, but everyone has to know about the change. Everyone needs to be at the table if there is a change because it could impact other areas.

Another issue is that the GPH and ICS clinical staff members need to work in collaboration for continuity of care. Mr. [redacted] said he can get the policies signed, but they are currently out of

compliance. There are things required in the policies that they cannot do now. Dr. Metzner pointed out that the agreement requires compliance with the policies. He strongly urged SCDC to finalize the policies in the next 30 days. He asked that Mr. [redacted] send a disc with copies of all of the final policies to Ms. Pope for her to distribute to the Panel members. He recommended that all of the staff be required to read the settlement agreement and the policies and have discussions with their supervisors. He suggested putting more emphasis on the particular policies staff will be working from, but staff should have familiarity with all of the policies. He noted that if there is a way to get CME credit for a presentation that could be done in which the policies are discussed, people are more likely to get on board with investing the time.

The Panel advised it would return October 31 thru November 4 and will probably be in Columbia for three days and at Lieber and Lee for the last two days. Lieber and Lee will be more consultative in nature. The Panel will want to see RHU rounds, treatment teams, DHO hearings, etc. similar to the current visit. Dr. Metzner noted the Panel had no problem with people shadowing them but not too many people because it affects the process.

Dr. Patterson noted that usually for the exit, both plaintiffs' and defendants' counsel are present in person or by conferen e call. That should be the case for the next visit. Dr. Metzner also asked that Dr. Patterson be n tified when there is a suicide. Dr. Patterson also added that the Panel needs to see the SL D report and the Suicide Prevention Committee ("SPC") reports. The Panel are not interested in making them public, but they need to see how the suicides are being managed and revi ed. [redacted] s sured the Panel the SPC is meeting and minutes are being kept. Dr. Patters rec n ended they be vigilant about the composition and scheduling of the committee.

[redacted] asked if there was anything they expected to see before their arrival that was not there. Dr. Patterson identified three things: final policies, an executed settlement agreement and training on the new policies. Dr. Metzner said when the Panel returns, they would like to see inmates in restricted cells (GPH. RHU, CSU) getting more out of cell time—the more the better. When they return to GPH. they would like to see twice as many groups as this time. RHU should at least be getting rec and showers 5 days per week mental health rounds weekly by the same person every week.

Mr. [redacted] also asked how the Panel viewed training being done by video. Dr. Patterson voiced a concern about whether there would be someone to ensure the trainees are paying attention to the video. Dr. Metzner said that type of training does not work well for use of force training. He recommends the security and mental health staff train together for that policy. Mr. Sparkman suggested they break down the policy and tweak the training when they train the trainers. He would expect the use of force training would take no less than 8 hours. Dr. Metzner reported his experience that videos that show scenarios of what to do and what not to do and then the trainees are broken into groups and have to determine how to handle different scenarios are helpful. Mr. Sparkman suggested in developing the training, SCDC should get some of the negative comments from staff and cover them during the training. He said it may be useful to have some focus groups on use of force. [redacted] reported they included myths and rumors in the first part of the training presentation done for key operational staff and trainers.

Mr. [redacted] asked about the outcome of the discussion concerning the Guilty But Not Accountable (GBNA) finding. Dr. Metzner suggested mental health input should include three questions: (1) is the inmate Mentally Ill; (2) if yes, was his Mental Illness related to his actions?; and (3) if yes. are there recommendations concerning mitigation? The most important thing is the determination of whether there are mitigating circumstances.

Dr. Patterson noted it is also important for security staff to hear what mental health staff has to offer as far as recommendations about how to manage the inmate. He advised mental health should not be endorsing punishment, but alternative interventions, such as a transfer to the BMU or the ICS would be appropriate. Dr. Metzner expressed concern about the term "not accountable" hurting the relationship between mental health and security staff. Mr. Sparkman's concern is that a finding of guilty affects future classification decisions for the inmate. Mr. [redacted] advised he is going to see how it factors into those decisions if the finding is guilty but not accountable. Dr. Metzner asserted that guilty with mitigating factors is still guilty and should be reported that way. Guilty but not accountable is different and if the inmate is truly not accountable, which is very rare. the disciplinary should be dismissed. Dr. Metzner suggested they get rid of GBNA because if the inmate is truly not accountable, he should not be found guilty.

The final issue discussed was the length of stay in R&E at Graham, which Mr. [redacted] acknowledged is four months for the women who are triple-celled and kept in their rooms except for 1 hour of rec. showers and meals. Dr. Metzner strongly urged that they be allowed out into the dayroom.

The Panel advised that the Panel will be sending a document request and would like to have the documents by October 15 for the next visit which will begin on October 31, 2016.

Respectfully submitted,

Raymond Patterson. M.D.,
Implementation Panel