

Mental Health Services – General Provisions (SCDC Policy HS-19.04)

Included in the Department of Corrections' (SCDC) May 24, 2019 letter to the House Legislative Oversight Committee (LOC). This information was provided in response to the following questions in LOC's May 16, 2019 letter to the Department of Corrections: "30. Please describe different types of housing units within SCDC that incorporate programs into the day to day living, including the requirements for an inmate to qualify for placement in the unit."

In addition to providing the information in this document, SCDC provided the following response:

- Structured Living Unit – policy is in draft form.
- Transition Unit – General Population - criteria: behavior compliant, waiting on job, education, vocational assignment.
- Work/Program Unit – General Population – criteria: behavior compliant, assigned a job, education, vocational, etc.
- Character Unit – General Population – Criteria can be reviewed in PS.10-17, Attachment A, Item 3, please see attached.
- Re-Entry Unit (Kershaw/Manning) – Criteria: can be reviewed in PS-10.14, please see attached.
- Addictions Treatment Unit YOA (Turbeville)– General Population – Criteria can be reviewed in OP-22.39, Section 2 and see definition of young offender.
- Addictions Treatment Unit Adult (Turbeville)– General Population – Criteria: approved/assigned by Mental Health.
- Shock Unit (Turbeville/Camille) – General Population – Criteria can be reviewed in PS-10.12, Section 1.2, please see attached.
- Restoring Promise (Lee/Turbeville) – General Population – Criteria is being developed by Young Offender Parole and Reentry Services.
- Restrictive Housing Unit – Restricted Population – Criteria can be reviewed in OP.22.38, please see attached.
- Death Row – Restricted Population/Managed as General Population – Criteria must be sentenced to death.
- Diversionary Housing Unit – Restricted Population – Criteria: Inmates assigned to Security Detention with a Mental Health classification of 3, awaiting assignment to a Behavior Management Program or Step-Down Program, for further information see HS-19.10, Section 3 will amended, please see attached.
- HLBMU – Restricted Population – Criteria can be reviewed in HS-19.10, Section 2, please see attached.
- LLBMU – Restricted Population – Criteria can be reviewed in HS-19.10, Section 3, please see attached.
- ICS – Restricted Population – Criteria can be reviewed in HS-19.04, Section 16, please see attached.
- Choices – Restricted Population – Criteria is - pending addition to policy HS-19.04 & HS- 19.12, please see attached.
- Crisis Stabilization Unit – Restricted Population – Criteria can be reviewed in HS-19.04, Section 6 &7, please see attached.
- Step Down – Restricted Population – Criteria can be reviewed in OP-22.38B, please see attached.
- Adjustment Unit – General Population – Criteria: SP inmates with unsubstantiated protective concerns refusing to live in General Population.
- Restorative Unit – General Population - Criteria: SP inmates (majority with Mental Health designation) with unsubstantiated protective concerns refusing to live in General Population.

- Special Concerns Unit - General Population – Criteria: SP inmates with unsubstantiated protective concerns refusing to live in General Population.
- Statewide Protective Custody – Restricted Population/Managed as General Population – Criteria can be reviewed in OP-22.23, please see attached.
- Mental Health Units (BRCI-Murray, Lee F1A,) – General Population – Criteria: Inmates with Mental Health designation.
- Infirmary – Medical – Criteria: Medical.



SCDC POLICY

This policy has been developed in response to and as a portion of the Remedial Plan agreed upon by the parties in the settlement of T.R. V. South Carolina Department of Corrections, No. 2005-CP-40-02925. As agreed by the parties in the Settlement Agreement, it is the understanding and agreement of the parties that implementation and effectuation of the provisions of this policy as a portion of the Remedial Plan shall be phased in over time and all aspects shall not become effective immediately. (See Section 2 - Summary of Agreement and Section 4 (f) - Implementation Phase-In of Settlement Agreement effective May 2, 2016).

NUMBER: HS-19.04

TITLE: MENTAL HEALTH SERVICES - GENERAL PROVISIONS

ISSUE DATE: August 31, 2016

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

OPERATIONS MANUAL: HEALTH SERVICES

SUPERSEDES: SCDC POLICY HS-19.02 (dated July 1, 2008) - NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES: 19-11, 19-29, M-53, M-107, M-120, M-152

ACA/CAC STANDARDS: 4-ACRS-4C-03, 4-ACRS-4C-06, 4-ACRS-4C-15, 4-ACRS-5A-08, 4-ACRS-7D-07, 4-4095, 4-4098, 4-4099, 4-4256, 4-4277, 4-4285, 4-4286, 4-4295, 4-4296, 4-4305, 4-4348, 4-4351, 4-4368, 4-4370, 4-4371, 4-4372, 4-4373, 4-474, 4-4399, 4-4404, 4-4429-1, 4-4431, 4-4433, 4-4434, 4-4435, 4-4437, 4-4438, 4-4439, 4-4440, 4-4441, 4-4442, 4-4446

STATE/FEDERAL STATUTES: SC Code Ann. §24-1-130; SC Code Ann. §44-115-10 through 150; SC Code Ann. §44-22-10 through 220; SC Code Ann. §44-11-20; Americans with Disabilities Act; HIPAA; Pub.L. 104-191, 110 Stat. 1936; C.F.R. §T. 42, Ch. I, Subch. A, Pt. 2; 42 U.C. Code § 12101

PURPOSE: To provide information and assurance for the care and management involving inmates in need of mental health services within the South Carolina Department of Corrections (SCDC).

POLICY STATEMENT: SCDC is committed to providing all inmates access to mental health care based on documented policies and procedures. Provisions of mental health services include inmate assessment and evaluation, suicide prevention, special needs care, referrals for care, ongoing care, and discharge planning. Unless otherwise noted, policy information is applicable to both male and female inmates.

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SPECIFIC PROCEDURES:

1. GOAL AND INTENT:

1.1 The goal of SCDC is to diagnose and treat mentally ill inmates, and to work with inmates in developing plans of care designed to minimize symptoms and reduce adverse effects of mental illness, maximize wellness, and promote recovery. The Agency intends to achieve the goal through the establishment and operation of programs promoting recovery oriented, individualized approaches to care that utilize evidence-based practices and maximize an inmate's abilities; minimize symptoms, adverse effects, and/or consequences of mental illness; and maintain and promote inmate integration into the general population and/or the community.

1.2 Mental Illness at SCDC: SCDC recognizes a mental disorder as outlined in the most recent edition of the Diagnostic and Statistical Manual (DSM) by the American Psychiatric Association. A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (*An expectable or culturally approved response to a common stressor or loss, such as death of a loved one, is not a mental disorder.*) Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

1.3 Serious mental illness can include diagnoses such as schizophrenia spectrum and other psychotic disorders, bipolar disorders, depressive disorders, and anxiety disorders, trauma and stress related disorders, neurodevelopmental disorders, neurocognitive disorders, and severe personality disorders that result in significant dysfunction and the inability to function in the general population. Inmates who experience significant functional impairment involving acts of self-harm or other behaviors that have a serious adverse effect on life may also fall into this category.

1.4 Mental health services at SCDC include, but are not limited to: assessment, case management, treatment, and discharge planning. Mental health services are provided to all inmates classified as mentally ill. Inmates classified as non-mentally ill receive mental health services if clinically warranted.

2. INSTITUTIONS - IDENTIFY LEVELS OF CARE:

2.1 The following SCDC institutions currently provide mental health care for mentally ill inmates:

- | | |
|---|--|
| 1) Kirkland Reception and Evaluation (L2, L3, L4) | 10) Manning Correctional Institution (L4, L5) |
| 2) Broad River Correctional Institution (L4) | 11) Lee Correctional Institution (L3, L4) |
| 3) Camille Graham Correctional Institution (L2, L3, L4) | 12) Evans Correctional Institution (L4) |
| 4) Perry Correctional Institution (L3, L4) | 13) Kershaw Correctional Institution (L4) |
| 5) Tyger River Correctional Institution (L4) | 14) Turbeville Correctional Institution (L3, L4) |
| 6) McCormick Correctional Institution (L4) | 15) Ridgeland Correctional Institution (L4) |
| 7) Leath Correctional Institution (L4) | 16) Lieber Correctional Institution (L3, L4) |
| 8) MacDougall Correctional Institution (L4) | 17) Allendale Correctional Institution (L4) |
| 9) Gilliam Psychiatric Hospital (L1) | 18) Contract Hospital Facility/females (L1) |

3. RECEPTION AND EVALUATION (R&E) - See Health Services Procedure 700.10 "Reception and Evaluation Center (R&E)":

3.1 Upon entry, inmates committed to SCDC have access to mental health services. As part of SCDC's intake process, **ALL** inmates receive an initial mental health screening to identify any mental health needs. If warranted, inmates may also receive supplementary psychiatric screenings and evaluations. The information obtained will determine an inmate's level of care needs and the inmate's mental health classification.

4. REFERRALS:

4.1 A mental health referral can occur at any time during the inmate's incarceration and may come from a variety of sources to include, but is not limited to:

- P-SERC process;
- Sick call;
- Request from staff;
- Correctional personnel or legal representation; and
- Friends and family members.

4.2 When mental health staff receive a referral, the inmate is screened and evaluated for determination of clinically indicated services.

5. CLINICAL ADMINISTRATION:

5.1 Staffing: SCDC mental health staff is comprised of a diverse group of licensed, credentialed, and qualified mental health professionals that include Psychiatrists, Clinical Supervisors, QMHPs, Mental Health Technicians, and others who offer on-site mental health care and case management on a daily basis to all SCDC inmates as needed. Services include, but are not limited to:

- Mental health screening at intake;
- Psychological evaluation;
- Psychiatric evaluation, medication, and management;
- Psychological assessment;
- Suicide prevention and intervention;

- Crisis intervention;
- Individual and group treatment; and
- Cognitive behavioral treatment.

5.1.1 Qualified Mental Health Professionals (QMHPs) are available either onsite or on call 24 hours a day for every institution.

5.1.2 Psychiatrists, Clinical Supervisors, and other QMHPs are available to provide diagnostic impressions, evaluations, treatment, and other therapeutic mental health services.

5.1.3 Other Qualified Mental Health Professionals (QMHPs) hold a Masters degree in counseling or a counseling related field, and are licensed in the state of South Carolina. They provide treatment and case management services to all inmates classified as mentally ill and any inmate receiving suicide precaution (SP) or crisis intervention (CI) services. QMHPs assist inmates in meeting and maintaining mental health treatment goals and objective through advocacy, on-going assessment and evaluation, planning, communication, education, resource management, and service facilitation. Those mental health providers who are not licensed to practice independently as mental health professionals will be supervised with monthly documentation.

5.1.4 Nurses provide a wide range of duties including caring for and educating inmates about their medical and mental health needs. They administer medications and provide other medical and mental health treatment interventions as authorized or credentialed.

5.1.5 Mental Health Technicians are individuals who have a Bachelor's level degree in counseling or other mental health related area. They are considered to be clinical, non-uniformed staff who assist with care and treatment of the mentally ill inmates.

5.1.6 Activity Therapists are clinical staff members with a degree in recreational therapy, physical education, art therapy, music therapy, or associated area who provide treatment planning, education, supervision, and oversight of therapeutic activities for inmates with a mental health classification.

5.1.7 An annual staffing needs assessment is performed by the Deputy Director of Health Services, Division Director of Behavioral/Mental Health and Substance Abuse Services, Chief Psychiatrist, Director of Nursing, Medical Director, and Quality Management Director in order to ensure that adequate coverage, licensure/credentialing requirements are maintained and service gaps and trends are identified.

5.2 Inmate Screening/Evaluation/Treatment:

5.2.1 Screening: All inmates receive mental health services orientation and mental health screening upon commitment to SCDC (*see Health Services Procedure 700.10, "Reception and Evaluation Center (R&E)"*), and again at any time during the inmate's prison term as needed or requested. Mental health screening can be expedited based on the results of intake screenings conducted by case management and medical staff. Mental health screenings are completed as follows:

- Routine: completed within three (3) business days;
- Urgent: completed within twenty-four (24) hours;
- Emergent: completed within four (4) hours, and the inmate is kept under direct observation until the evaluation is completed.

5.2.2 Evaluation: Inmates who present with mental health concerns as identified through screening may receive routine, urgent, or emergent referral for further evaluation (dependent on their symptom presentation and/or history). Further evaluation includes a confidential clinical evaluation, suicide risk assessment, psychiatric assessment, and psychological testing, when necessary:

- Routine evaluations are completed within fourteen (14) days;
- Urgent evaluations are completed within twenty-four (24) hours;
- Emergent evaluations are completed within four (4) hours, and the inmate is kept under direct observation until the evaluation is completed.

5.3 Classification: Classification will determine inmate placement in accordance with an inmate's level of care, risks, and security requirements. Identifying existing mental health problems and potential mental health concerns will allow Classification to provide proper placement of inmates classified as mentally ill. Inmates are considered admitted to Mental Health Services after the Health Summary has been revised to indicate LOC status. They will subsequently be assigned to institutions that provide the appropriate level of mental health care.

5.3.1 Psychiatrists will complete a mental health evaluation to render a diagnostic impression, make treatment recommendations, and determine need for further psychological, neurological, medical, and laboratory testing to ensure that an inmate receives the proper level of care. A psychiatric evaluation is completed prior to a mental health classification being assigned. The classification is determined by the evaluating psychiatrist with input from other QMHPs.

5.3.2 Psychotropic medications are generally prescribed by a psychiatrist or a psychiatric mid-level practitioner. Psychiatric medication may also be initiated or monitored on a shorter term or interim basis as needed by a general medical physician or mid-level practitioner with appropriate experience and training. Informed consent is required for any inmate voluntarily taking psychiatric medication. Inmates receive medication, education, compliance monitoring, and drug toxicity monitoring by psychiatrists, mid-level practitioners, nursing staff, and pharmacy staff as dictated by their treatment regimen.

5.3.3 Individual counseling services are private through confidential sessions between the inmate and his/her assigned QMHP, Clinical Supervisor, Psychiatrist, or other mental health professional. Counseling sessions provide a supportive environment for the inmate to address feelings, thoughts, and behaviors associated with his/her mental illness and identify goals, objectives, and strategies that foster changes in thinking patterns, an understanding of self-actualization, learning new skills, and/or ways to diminish problem behavior.

5.3.4 All inmates identified as mentally ill (Mental Health Classification L1, L2, L3, L4, or L5) must be monitored by mental health staff, regardless of whether or not psychotropic medication is prescribed, or whether or not the inmate is compliant with his/her prescription medication.

- **L1 Hospitalization** - Male inmates are placed in Gilliam Psychiatric Hospital. Female inmates are placed in a contract facility. Mental health professionals see the inmate at least weekly or more routinely if clinically indicated.
- **L2 Intermediate Care Services (ICS)** - Inmates' ability to function is severely impaired due to mental illness. There are active symptoms of major mental illness with impaired reality testing or multiple failures to conform behavioral functions in a lowered level of care. Inmates are seen at a minimum of twice per month by a QMHP, or more routinely if clinically indicated.
- **L3 Higher Intensity Outpatient Treatment** - Inmates' ability to function in a general population is moderately impaired due to mental illness. They are easily overwhelmed by everyday pressures, demands, and frustrations, resulting in disorganization, impulsive behavior, poor judgment, delusions, hallucinations, or other exacerbations. They are seen by QMHPs at least monthly, or more routinely if clinically indicated, and require a treatment plan update every three (3) months.
- **L4 Outpatient** - Inmates may be housed in general population or structured living unit. Inmate's ability to function in general population is mildly impaired or needs monitoring due to change in medication, recent move from higher level of care, or history of self-injurious behavior. They are seen by QMHPs at least every ninety (90) days, or more often if clinically indicated, and require a treatment plan update every six (6) months.
- **L5 Work Release Eligible** - Inmates carry a mental health diagnosis, symptoms in remission, eligible for KOP (carry on person) medication. Inmates' ability to adjust and function in general population is not impaired due to mental illness. They are seen by QMHPs at least every six (6) months, or more if clinically indicated, and require a treatment plan annually.

5.4 Case Management: The lead QMHP at the receiving institution will ensure that inmates classified as mentally ill are assigned a QMHP. QMHPs will provide appropriate treatment/services based on an inmate's individual clinical need(s). Both routine and significant contacts will be documented in the AMR. QMHPs will keep the treatment team informed of each inmate's progress or lack of progress, and will request any additional support as needed.

5.4.1 With the exception of Incidental/Non-Contact notes, all mental health professionals document mental health care services in Data, Assessment, Plan (DAP) format or Subjective, Objective, Assessment, Plan (SOAP) format. See Health Services Procedure 700.5, "Mental Health Clinical Documentation." Types of contact documented include:

- **Routine Contact:** Documentation for regular contact rather than for a special reason (ex.: individual therapy progress note);
- **Significant Contact:** Documentation of matters that require immediate attention/action (ex.: initial assessments, suicide prevention/precaution);
- **Incidental:** Brief explanation of changes, concerns, and/or problems that may or may not involve contact with the inmate;
- **Group Sessions:** Documenting individual progress for participants in group sessions.

5.4.2 Treatment Planning: Once an inmate has been screened, evaluated, and classified to receive mental health services, mental health staff will determine an effective course of action by establishing an individualized treatment plan in conjunction with the inmate. An individual treatment plan provides treatment recommendations that will help the inmate develop the necessary skills for successful adjustment while incarcerated and upon release to the community. Individual Treatment Plans (ITPs) are completed for each mentally ill inmate. The ITP ensures that treatment remains focused on goal attainment and ensures that resources are effectively utilized to meet the needs of the inmate who is actively receiving mental health care and services. (See SCDC Policy HS-19.05, "Mental Health Services - Treatment Plans and Treatment Team Meetings.")

5.4.3 Treatment Team meetings are conducted regularly and on an as needed basis at all facilities with inmates classified as being in need of mental health care. Inmates are included in the initial treatment planning process, as well as subsequent treatment plan reviews and discussion, and plans reflect any updates/changes. Inmates are encouraged to attend and participate in their individual treatment team session(s). (See SCDC Policy HS-19.05, "Mental Health Services - Treatment Plans and Treatment Team Meetings.")

5.4.4 Group counseling services address the mental health needs of the SCDC population by instruction and discussion of topics such as anger management, medication management, victim impact, etc. Mentally ill inmates are encouraged to participate in group counseling as part of the treatment process. Some groups are limited to participation of mentally ill inmates

only. Others are open and welcome to all inmates. Groups may be closed or open ended in structure. (See Health Services Procedure 700.5, "Mental Health Clinical Documentation.")

5.4.5 Restraints - See SCDC Policy HS-19.08, "Mental Health Services - Clinical Use of Restraints for Mental Health Purposes".

- Restraints are used only when there is imminent danger of the inmate harming him/herself or others that cannot be resolved by a less restrictive method;
- Prior to using restraints, all other less intrusive methods are utilized/considered to protect the individual(s) from harm. Restraints are used as a last resort;
- Restraints are not used for the purpose of punishment or discipline;
- Use of restraints requires a physician's order;
- Any inmate placed in restraints is kept under constant observation. The order for continued restraints will be reviewed at least every four (4) hours;
- The inmate is assessed for circulatory problems, onset of medical concerns, and toileting needs every two (2) hours or more often if needed and has meals served on a regular schedule.

6. LEVEL OF CARE (LOC) CLASSIFICATION AND PROGRAM CODES:

6.1 Classification: SCDC mental health level of care classification and coding system is hierarchical, ranging from (L5), representing inmates who are able to function with minimal assistance from mental health staff, to (L1), representing hospitalization and the greatest need for mental health care. Inmates not requiring current mental health care are classified as NMH.

6.1.1 Hospitalization: Male inmates are placed in Gilliam Psychiatric Hospital. Female inmates, and occasionally male inmates, are placed in a contract facility (*LOC Classification Code: L1*).

6.1.2 Residential Care: Residential mental health services are provided for inmates with moderate to severe symptoms who need frequent, ongoing mental health care and services in a therapeutic environment. Each Residential Care Program has its own LOC identifier:

- Substance Abuse Treatment - LOC Classification Code: SA
- Habilitation Program - LOC Classification Code: ID
- Behavior Management Unit - LOC Classification Sub: BU
- Intermediate Care Services - LOC Classification Code: L2
- Self Injurious Behavior Program - LOC Classification Code: LC

6.1.3 Outpatient: Inmates who have the ability to function in general population may be housed in general population or structured living units. Outpatient inmates are mildly to moderately impaired and/or need monitoring due to a need for medication management, recent move from higher level of care, history of self injurious behavior or mild/moderate symptoms present and/or to maintain stability. There are two (2) levels of outpatient care:

- Higher Intensity Outpatient Treatment: LOC Classification Code: L3; and
- Lower Intensity Outpatient Treatment: LOC Classification Code: L4.

6.1.4 Assignment will be based on review of treatment needs. Inmates who are on more complex medication regimens, or viewed as being less stable or more needy, are classified as Higher Intensity. Institutions designated as suitable for housing Higher Intensity Outpatients will be staffed at a higher level to accommodate additional mental health programming.

6.1.5 Work Release Eligible: Inmate has one or more mental health diagnoses; however, the individual's symptoms are in remission and/or well controlled with treatment. If a mentally ill inmate is considered eligible for work release, his/her case is reviewed on an individual basis by the Treatment Team and the chief psychiatrist to determine if his/her treatment plan can be continued in a work release program (LOC Classification Code: L5).

6.1.6 Non-Mental Health: Designated code for inmates who have no current need for mental health services (LOC Classification Code: NMH).

6.2 Special Program Codes: Program and service codes help to identify and track the progress of mentally ill inmates who participate in several programs, services, and opportunities provided to assist in psychiatric rehabilitation, substance abuse treatment, sex offender treatment, and therapeutic group sessions designed to educate inmates in several areas of life management. Inmates may be assigned one or more of the following codes:

- Sex Offender Treatment Program Code: 310;
- Crisis Intervention Services Code: 079;
- Individual Therapy Services Program Code: 080;
- Group Therapy Services Program Code: 081.

7. PROGRAMS AND SERVICES:

7.1 Inpatient Psychiatric Care:

7.1.1 An inmate experiencing significant, acute, or severe psychiatric or emotional difficulties, whose care requires a healthcare setting and it cannot be accomplished in a less intensive treatment setting, may be admitted to the hospital for further evaluation and care. Admission is voluntary, by court order, or considered emergency while the court order process is being initiated.

7.1.2 Routine referrals for inpatient care will be made to the chief psychiatrist or designee. Emergency referrals will be handled by the psychiatrist on call.

7.1.3 A medical examination, including updated physical exam and clinically appropriate laboratory studies, will be conducted within twenty-four (24) hours of admission.

7.1.4 Voluntary Admission - Institutional medical staff and/or QMHP will coordinate admission for inmates who voluntarily agree to inpatient treatment. Males requiring in-patient psychiatric care will generally be admitted to Gilliam Psychiatric Hospital. Females requiring in-patient psychiatric care will be admitted to a contract facility. Voluntary participants sign a consent form informing them of their right to withdraw from hospitalization at any time. However, if the need for continued treatment is warranted, a psychiatrist will file a petition with Richland County Probate Court for involuntary judicial commitment.

7.1.5 Involuntary Admission - If an inmate refuses a referral for inpatient treatment, the psychiatrist will determine if the inmate is best served by either completing an application for emergency hospitalization to secure inpatient hospitalization on an involuntary basis or filing a petition with Richland County Probate Court for involuntary judicial commitment. Women requiring inpatient psychiatric care will be admitted to a contract facility for involuntary admission. Males requiring psychiatric care are admitted to Gilliam Psychiatric Hospital.

7.1.6 Inmates who are hospitalized have access to short-term and long-term inpatient psychiatric care with the goal of stabilization for transition to a less restrictive environment within SCDC.

7.2 Crisis Intervention (CI)/Suicide Precaution (SP) - See SCDC Policy HS-19.03, "Inmate Suicide Prevention and Intervention":

7.2.1 Any inmate arriving with or developing a condition that warrants an immediate response due to being a danger to him/herself or others is placed in a healthcare setting and receives suicide precaution/crisis intervention services immediately. This level of care is prescribed and discontinued by order of a licensed independent practitioner credentialed to order CI/SP status (psychiatrist, mid-level psychiatric practitioner, or doctoral level Clinical Supervisor).

7.2.2 Emergency intervention and prevention measures are utilized when inmates display suicidal tendencies/actions, homicidal tendencies/actions, self-injurious behaviors, or other conditions that may cause harm to themselves or others.

7.2.3 Each institution has designated specific safe cells that are appropriately secure and suicide resistant to allow inmates, at least temporarily, to be placed on special status under direct observation by uniformed staff with qualified health and mental health professionals performing scheduled and unscheduled observation and evaluation. Inmates placed in safe cells will be subject to the same conditions, restrictions, and privileges set forth for CI/SP inmates in SCDC Policy HS-19.03, "Inmate Suicide Prevention and Intervention."

7.2.4 The Chief Clinical Supervisor will coordinate the CI/SP program within SCDC.

7.3 Residential Mental Health Care:

7.3.1 Intermediate Care Services (ICS) - See SCDC Policy HS-19.12, "Mental Health Services - Intermediate Care Services (ICS)":

- A therapeutic environment is provided for mentally ill inmates with serious, persistent mental illness who need frequent or ongoing mental health services, including monitoring due to potential medication management issues and/or a condition or circumstance requiring more extensive monitoring, treatment, or case management short of hospitalization.
- Inmates meeting specific program admission criteria for ICS may be identified during R&E processing or at any time during his/her period of incarceration. A mental health services referral packet is completed for review by the Program Supervisor/Coordinator to determine suitability for program participation.
- If the inmate is accepted into the program, then s/he can either be transferred from R&E upon completion of the intake process, or from their current living unit upon completion of the designation process by the Division of Classification and Inmate Records.
- The inmate's Health Summary must be updated by a physician, psychiatrist, or nurse practitioner to reflect assignment of the most recent diagnoses.

7.3.2 Habilitation Program (Hab Program):

- Social, vocational, and academic skills programming is provided to inmates who demonstrate significant intellectual impairment limiting their ability to adjust to or function in a general correctional environment.
- The inmate's condition is expected to continue indefinitely. The Hab Unit is a mandatory LOC assignment, but participation in the treatment programs and services is voluntary.

- Inmates are evaluated for program admission during R&E processing or may be identified and referred from any SCDC institution. Various testing instruments that measure intellectual and cognitive functioning, adaptive behavior, and other clinical issues will be utilized in the evaluation process with any inmate suspected of intellectual impairment.
- Referrals are reviewed by the Habilitation Services Program Manager and program Treatment Team. When approval is granted, LOC is updated to reflect the Hab Unit assignment.

7.3.3 Self-Injurious Behavior (SIB) Services:

- Services are provided in a therapeutic environment for mentally ill inmates who 1) display chronic self-injurious behavior; 2) have a documented history of acute self-injurious behavior; and/or 3) are identified by a Psychiatrist/Clinical Supervisor as needing placement in the SIB Program (*Males Only*) or provided other SIB specific services.
- **Males:** QMHPs complete a referral package for review by the SIB Program Manager and program Treatment Team who decide to accept, reject, or refer the inmate to another mental health program. If approval is granted, LOC is updated to reflect SIB program assignment.
- **Females:** Inmates identified by a Psychiatrist/Clinical Supervisor as needing more intensive mental health treatment for self injurious behavior will be referred to a contract facility for inpatient services, if necessary. An individual treatment plan to address follow-up needs in response to continued risk for SIB will be developed.

7.3.4 Substance Abuse Treatment Program:

- Services are provided to any inmate with an addiction to drugs and/or alcohol.
- Mentally ill inmates who are dually diagnosed with a substance abuse problem must be cleared psychologically by their current Mental Health Treatment Team to participate in the Substance Abuse Treatment program.
- Inmates dually diagnosed with a mental illness and substance abuse issues must be psychologically and medically stabilized prior to beginning the Substance Abuse Treatment program.
- Referrals for substance abuse services are outlined in SCDC Policy PS-10.02, "Inmate Substance Abuse Programs."

7.3.5 Behavior Management Unit (BMU): Additional assessment and treatment are provided in a therapeutic environment to mentally ill inmates who display or have displayed serious, ongoing behavioral problems resulting in significant lockdown time due to disciplinary infractions.

7.3.6 Sex Offender Treatment Program (SOTP) - See SCDC Policy PS-10.11, "Sex Offender Treatment Program (SOTP)":

- Voluntary or court ordered services including educational groups, treatment groups, and relapse prevention groups are provided for inmates with a history of deviant sexual behavior.
- The SOTP Coordinator completes individual evaluations on inmates who are court ordered, referred, or request entry into the Sex Offender Treatment Program.
- Mentally ill inmates will retain their current LOC classification and evidence of program assignment, and participation will be indicated/coded in the Program Services Summary. Mental health care will not be interrupted due to program assignment.

7.4 Outpatient Care:

7.4.1 Intensive Outpatient Mental Health Services (IOP) - Higher Intensity Outpatient Care:

- The inmates classified as intensive outpatient are inmates who present with moderate symptoms needing frequent or ongoing mental health care, who are being prescribed psychotropic medication that requires close monitoring, and whose condition or circumstances require a higher level of evaluation, treatment, and/or case management but does not arise to the level of the need for hospitalization or residential care programming.
- When a Psychiatrist indicates IOP services are needed, a QMHP will update the inmate's medical classification information in the AMR to reflect the current mental health status.
- Inmates requiring IOP care are assigned to an institution with full time mental health staff.

7.4.2 Outpatient Mental Health - Lower Intensity Outpatient Care:

- Inmates classified as Lower Intensity Outpatients must be able to function with limited supervision from mental health staff.
- When a Psychiatrist indicates outpatient mental health services are needed, a QMHP will update the inmate's medical classification information in the AMR to reflect the current mental health status.

- Inmates requiring outpatient care are assigned to an institution with full time mental health staff.

7.5 Services for Non-Mentally Ill Inmates:

7.5.1 Inmates designated as NMH are individuals with no current identified mental health needs.

7.5.2 Mental health services, including suicide precaution/crisis intervention, continue to be available to non-mentally ill inmates. Non-mentally ill inmates can request access to mental health services by utilizing the medical referral/sick call process. Any staff member can also bring concerns about any inmate's mental health to the attention of any mental health staff member who will initiate a formal referral for evaluation.

7.6 Mental Health Services for Death Row Inmates - See SCDC Policy OP-22.16, "Death Row":

7.6.1 Male inmates on death row are admitted directly to Lieber Correctional Institution (Lieber) and complete the intake process at Lieber. Female death row inmates are admitted directly to Camille Graham Correctional Institution (Graham) and also receive intake services at Graham.

7.6.2 During the intake process, an incoming death row inmate is placed on precautionary SP/CI status and remains there until he/she completes initial R&E mental health screenings and any identified mental health assessments.

7.6.3 Death row inmates receive the same screening, assessments, and LOC classification as inmates housed in the general population. Mental health treatment will be individualized. All death row inmates are routinely assessed monthly by a QMHP. If at any time a death row inmate appears to need additional mental health services, a referral is completed to begin supplementary mental health services as clinically indicated.

7.6.4 QMHP is present during the reading of an inmate's death warrant after which the inmate is automatically placed on CI/SP. Mental health personnel monitor the inmate during CI/SP and develop and provide mental health treatment as necessary.

7.7 Specialized Mental Health Care Services:

7.7.1 Beyond the traditional mental health services provided, mental health staff will collaborate with various specialized program areas to provide mental health services as required. Since many inmates receiving specialized program services also have a mental illness and/or a medical diagnosis, their program(s) will be located at a facility that can provide their medical, psychiatric, and mental health care management as required. Mental health and medical personnel will coordinate with program staff to ensure the inmate receives concurrent services in order to maintain continuity of care.

7.7.2 Inmates receiving specialized program services who also require mental health services shall have individualized care plans created to ensure that such specialized program services situations do not prevent the inmate from receiving mental health care as clinically indicated. Examples of specialized programs or services that may present mitigating circumstances and/or require the creation of an individual care plan include, but are not limited to, the following:

- Prison Rape Elimination Act (PREA) - Refer to SCDC Policy OP-21.12, "Prevention, Detection, and Response to Sexual Abuse/Sexual Harassment;"
- Infirmary Services - Refer to Health Services Procedure 400.1, "Infirmary Services";
- Shock Incarceration - Refer to SCDC Policy PS-10.12, "Shock Incarceration";
- Guilty But Mentally Ill (GBMI) - Refer to SCDC Policy OP-22.14, "Inmate Disciplinary System," and Health Services Procedure 700.2, "Inpatient Psychiatric Admission";
- Protective Custody - Refer to SCDC Policy OP-22.23, "Statewide Protective Custody";
- Young Offender Parole and Reentry Services - Refer to SCDC Policy OP-22.39, "Young Offender Parole and Reentry Services (YOPRS)";
- Pregnancy-related Health Care Services - Refer to SCDC Policy HS-18.15, "Levels of Care";
- Disability Services (Handicapped Unit) - Refer to SCDC Policy HS-18.15, "Levels of Care";
- Hospice Care - Refer to SCDC Policy HS-18.15, "Levels of Care";
- Chronic/Palliative and Convalescent Care - Refer to SCDC Policy HS-18.15, "Levels of Care";
- Substantiated Security Risk (SSR) - Refer to SCDC Policy OP-22.38, "Restrictive Housing Unit (RHU);" and
- Restrictive Housing Unit (RHU) - Refer to SCDC Policy OP-22.38, "Restrictive Housing Unit (RHU)."

8. DISCHARGE:

8.1 Mental Health Services Discharges:

8.1.1 From Hospitalization: Inmates discharged to a lower level of care after being hospitalized are assigned to an appropriate institution and/or program to meet their level of functioning. Inmates receive a mental health assessment within 48 hours of arriving at the receiving institution. Hospital discharge information including treatment recommendations, medication, etc., is added to the inmate's treatment plan.

8.1.2. From Mental Health Treatment: Inmates can request removal from mental health services at any time. Inmates can also be recommended for removal from mental health services by their Treatment Team. Inmates who are requesting or are recommended for discharge from mental health services will have their case reviewed by the institutional Treatment Team, with input from the Regional Manager, Clinical Supervisor, and Chief Psychiatrist.

8.2 Mental Health Discharge Upon SCDC Release:

8.2.1 QMHPs work diligently to provide as many resources as possible to assist inmates in continuing their treatment upon release. Inmates are fully advised of potential assistance programs and program eligibility requirements. Inmates receive assistance completing applications/enrollment for disability, Medicaid/Medicare, etc. A psychiatrist reviews all psychiatric medications prior to discharge, and an appointment for follow-up care and management of psychiatric medications will be coordinated to occur within five (5) days of the inmate's release date. The inmate will routinely receive a five (5) day supply and one (1) 30-day refill prescription for medication, if clinically indicated, upon the inmate's release. Exceptions can be made on a case by case basis if follow-up care is not scheduled within five (5) days of release.

9. DISCIPLINARY - See SCDC Policy OP-22.14, "Inmate Disciplinary System," and SCDC Policy HS-19.06, "Disciplinary Detention for Inmates Classified as Mentally Ill":

9.1 All inmates classified as mentally ill and receiving higher levels of care (Classifications L1, L2, L3, and LC) and any inmate who suffers from or presents with a serious mental illness, regardless of classification, who is to come before a Disciplinary Hearing Officer (DHO) due to an infraction that could result in a level one or two formal charge, will be assessed by a QMHP. The QMHP will determine what impact, if any, the inmate's mental health state should carry in regard to disciplinary sanctions. The QMHP completing the disciplinary statement will not, whenever possible, be the primary counselor assigned to the inmate.

9.2 An inmate who is or has been on the mental health caseload within the last six (6) months and who is charged with a major disciplinary infraction will have an evaluation completed within three (3) business days by a QMHP with the assistance of a Psychiatrist and/or a Clinical Supervisor as needed. This evaluation will include a formal review of mental health history, diagnosis, and current treatment. The inmate's competency to understand and any impact that his/her mental health issues may have had on his/her behavior at the time of the offense is assessed. The evaluation will be completed by a QMHP who is not assigned to the case.

9.3 A Disciplinary Hearing Officer (DHO) will examine investigatory findings and case study information to fairly adjudicate the inmate. If a mentally ill inmate receives a "guilty" verdict, an institutional Mental Health Disciplinary Treatment Team (MHDTT) consisting of a Clinical Supervisor, Psychiatrist, and QMHP or Regional/Program Manager, as well as a Warden, Associate Warden, and/or Major, will review the nature of the offense to determine an appropriate penalty or other resolution for the inmate after taking into consideration the mitigating factors reflected in the inmate's mental health assessment.

9.4 The MHDTT will review the status of a mentally ill inmate's disciplinary sanctions to determine if the inmate's privileges can be restored or if the inmate can return to the institution's general population or other suitable housing.

9.5 Mentally ill inmates receiving a disciplinary conviction are provided ongoing care and services to assure that corrective measures remain fair and humane. Every effort is made to ensure that inmates classified as mentally ill who commit a disciplinary infraction are:

- granted access to needed levels of mental health care;
- afforded consistent, timely access to a clinical correctional counselor;
- secured in safe and sanitary housing units; and
- considered for alternative sanctions that are conducive to positive therapeutic change.

10. USE OF FORCE:

10.1 Authorized, trained staff members will use the minimum mechanical security restraints and/or minimum reasonable force necessary to gain control of an inmate, after reasonable means of intervention have been exhausted, and use of force will be discontinued when the inmate is under control. The purpose of the appropriate use of force is never to punish but to protect and ensure the safety of the public, staff, inmates, and others; and to prevent injury, prevent serious property damage, and ensure institutional security and good order.

11. HUNGER STRIKE/EXTENDED FAST - See SCDC Policy OP-22.33, "Hunger Strike/Extended Fast Plan," HSP 4000.4, "Medical Management of Malnourished Inmates and Hunger Strike," and HSP 200.6, "Management of Inmate Hunger Strike/Extended Fast":

11.1 Mental health clinicians assist uniformed staff and medical staff in the management of an inmate on a hunger strike, including the provision of counseling with the inmate to resolve the problem.

11.2 Subsequent mental health evaluations will continue for the duration of the failure to eat behavior.

11.3 Psychiatric hospitalization will be considered if the inmate meets the civil commitment criteria.

12. PRISON RAPE ELIMINATION ACT (PREA) / SEXUAL VICTIMIZATION - See SCDC Policy OP-21.12, "Prevention, Detection, and Response to Sexual Abuse/Sexual Harassment":

12.1 Sexual victimization reports are accepted in multiple ways: request to staff, in person to any uniformed or non-uniformed staff member, PREA Compliance Manager, inmate self report, and inmate third party reporting.

12.2 Once a sexual victimization report has been received, mental health staff will follow procedures set forth in the mental health sexual victimization screening procedure and will follow protocol outlined in federal PREA standards.

13. DUTY TO WARN:

13.1 If any mental health staff person, in the course of treating an inmate, has reason to conclude that the inmate poses a threat to a third person, the mental health staff member is obliged by law to take appropriate action to prevent the occurrence of harm.

13.2 If an inmate makes a specific verbal or written threat against an identifiable potential victim and the employee believes that the inmate intends harm to that identifiable potential victim, the employee will immediately inform his/her supervisor and complete SCDC Form 19-29A, "Incident Report," so that all appropriate warning steps can be carried out by the Division of Victim Services. (See SCDC Policy GA-01.13, "Duty to Warn.")

14. INFORMED CONSENT - See *Health Services Procedure 200.3, "Informed Consent"*:

14.1 The Psychiatrist/Nurse Practitioner must clarify the treatment, alternatives, possible benefits, and risks of a treatment to an inmate before starting a psychiatric procedure or treatment. In lay terms, the Psychiatrist/Nurse Practitioner/Medical Doctor must explain the following:

- the treatment, rationale, and possible benefits;
- the nature and severity of material risks, and the likelihood of their occurrence;
- reasonable alternative treatment; and
- possible consequences of withholding consent.

14.2 Informed consent is given when an inmate fully understands treatment, alternatives, and risks, is considered competent to give consent, and then voluntarily agrees to a recommended psychological or psychiatric treatment. The process will be documented in the Automated Medical Record (AMR).

14.3 If an inmate is placed on antipsychotic medication, the inmate will be given SCDC Form M-107, "Consent for Neuroleptic Medications," to sign. The form will be signed by the inmate and witnessed by the Psychiatrist/Nurse Practitioner/Medical Doctor. The form will then be filed in the hard copy of the inmate's medical record. In the event the inmate is being evaluated via tele-psychiatry, the form will be provided by a QMHP at the time of discussion. The QMHP will note the process, and then forward the form for signature by the Nurse Practitioner or Physician.

15. REFUSAL OF MENTAL HEALTH TREATMENT:

15.1 An inmate has the right to refuse any or all proposed mental health treatment.

15.2 An inmate does not waive his or her right to subsequent mental health care by refusing treatment at a particular time.

15.3 If an inmate has a documented history of prior episodes of mental health care, the following steps should be followed:

- document the refusal in the medical record;
- provide a description of the service being refused;
- provide evidence that the inmate has been made aware of any consequences to his/her mental health that may occur as a result of the refusal; and
- obtain the signature of the inmate and the date on any applicable form, along with the signature of any required witness.

15.4 An inmate's refusal of mental health treatment does not equate to a lack of classification for mental health services.

15.5 If an inmate refuses treatment but his/her mental health deteriorates to the point that the inmate is no longer stable, the inmate will be evaluated for involuntary treatment and/or inpatient hospitalization.

15.6 When an inmate refuses a recommended treatment, the inmate must sign SCDC Form M-53, "Refusal of Medical Advice." Once the form is signed, the form will be forwarded to Mental Health Services to ensure they are made aware.

15.7 If an inmate classified as mentally ill wishes to be removed from Mental Health Services, the QMHP will inform the treating Psychiatrist who will see the inmate face to face to determine a plan of action, including a decision about how to handle any current prescriptions. The inmate will continue to be monitored for 90 days. If, at the end of the 90-day monitoring period, the inmate is stable, and with the concurrence of the treating Psychiatrist, Treatment Team, and Regional Manager/Program Manager, the inmate can be removed from Mental Health Services.

15.8 Consequences of the refusal are explained to the inmate. The form will be filed in the hard copy of the inmate's medical record, and the refusal will be documented in the Automated Medical Record.

15.9 If the inmate refuses to sign the Refusal of Medical Advice form, the verbal refusal will be witnessed by two employees, and the verbal refusal will be documented in the Automated Medical Record.

15.10 If the inmate is unable to sign, the verbal refusal or the inmate's mark will be witnessed by two employees, and the verbal refusal will be documented in the Automated Medical Record.

16. ASSESSMENTS FOR INMATES IN RESTRICTIVE HOUSING UNIT (RHU):

16.1 Classification Review Assessments (CRA) will be completed for inmates in RHU. The institution's classification manager will provide the CRA list to the lead QMHP at least thirty (30) days in advance of the review date. The lead QMHP will ensure that the CRA list is completed and returned to the classification manager one (1) week before the Institutional Classification Committee (ICC) hearing.

16.2 All inmates, as part of the intake and initial case management review at RHU, will be administered SCDC Form M-183, "Suicide Precaution/Crisis Intervention Screening Form." Nursing will serve as the primary administrator of the screening form. In places where 24-hour nursing is not available, then appropriate security staff will administer the tool. Security staff will be trained on how to use the tool to arrive at a decision as to whether the inmate needs crisis precautions upon entering into RHU or are housed as normal in RHU. If the screening document indicates the inmate needs crisis precautions, mental health staff will be contacted 24-hours per day, seven days per week, and given the results of the assessment. Crisis precautions will be taken with the inmate to include being placed on a 15-minute watch, as well as having all clothing removed and given a suicide smock. If the assessment does not result in crisis precautions inmates will be assigned as normal. Medical/nursing staff will see each inmate assigned to RHU within 24 hours of admission if the screening document indicated no crisis concerns. Mental health staff will see each inmate assigned to RHU within four (4) hours for emergent or 24 hours for routine if the screening document indicates crisis precautions. The screening document will be kept in a secure place in the RHU control room for 24 hours and then filed in the inmate's medical record. For positive responses other than acute suicidal concerns inmates will receive Q-15 minute checks and will be allowed to keep their property. For inmates responding "yes" to acute suicide behavior, the inmate will be stripped out and placed on 1:1 observation. This observation status will be considered as an emergent referral to mental health constituting evaluation within four (4) hours.

16.3 All inmates will be assessed/monitored weekly while in RHU. All mentally ill inmates will be assessed and evaluated in accordance with their level of care classification, or more frequently if deemed necessary. Assessments will be documented in the Mental Health Clinic (CCC) section of the Automated Medical Record.

16.4 Mental status rounds will be performed on all inmates housed in RHU weekly. These will be done at cell front to identify inmates who are decompensating or having a difficult time adjusting to being isolated.

16.5 Inmates identified as MI/DD or handicapped and housed in an RHU, regardless of the reason, will not be denied services due to their status. These inmates will have a treatment plan developed that reflects services offered while in an RHU. These services will be provided based on the diagnoses, and the treatment/service plan. Services in addition to weekly rounds will be provided as clinically indicated and will be documented in the AMR. Limitations on services will be based on documentable security concerns and/or limitations (e.g., inability to attend groups).

17. CONFIDENTIALITY:

17.1 Every reasonable effort will be made to ensure that an inmate's Mental Health Treatment/Records remain confidential.

17.2 Only authorized Health Services employees will have access to an inmate's Mental Health Records. In the event that Mental Health Records are transported by security, the record will be placed in a sealed envelope to ensure confidentiality.

17.3 Information regarding an inmate's treatment cannot be released to any outside agency or person to include family members without written consent of the inmate. If the inmate agrees to give consent for the information to be released, the inmate must complete SCDC Form M-152, "Release of Information." This form includes the type of information and to whom it can be released.

18. TRAINING ON MENTAL HEALTH SERVICES ISSUES:

18.1 All newly hired SCDC personnel and contract providers receive orientation and training on mental health services and working with mentally ill inmates.

18.1.1 Mental health, medical, and uniformed personnel receive annual training on suicide prevention strategies, self injurious behavior, mentally ill inmate care, and mentally ill inmate security management. Areas of training also include:

- interpreting and responding to symptomatic behaviors, and communication skills for interacting with inmates with mental illness;
- recognizing and responding to indications of suicidal thoughts;
- conducting proper suicide prevention observation;
- responding to mental health crises, including suicide intervention and cell extractions;
- recognizing common side effects of psychotropic medications;
- professional and humane treatment of inmates with mental illness;
- trauma informed care;
- de-escalation techniques;
- alternatives to discipline and use of force when working with inmates with mental illness and more; and
- CPR and First Aid.

18.1.2 All mental health staff, whether full-time or contract, will be specifically trained regarding the function and structure of mental health services including:

- mental health policies and procedures;
- nature of special programs; and
- unique missions of various facilities.

18.1.3 Each mental health staff member will verify understanding of the above by signing an acknowledgement form that will be kept on record.

19. CONTINUOUS QUALITY MANAGEMENT - See SCDC Policy HS-19.07, "Mental Health Continuous Quality Management (CQM)":

19.1 The Division of Behavioral/Mental Health and Substance Abuse Services provides systematic and ongoing comprehensive quality management processes for monitoring, evaluating, and improving the quality and appropriateness of mental health care provided for inmates.

19.2 The process identifies indicators that quantify quality and appropriateness of the multiple aspects of care, and organizes the data collected to help facilitate identification of areas in need of administrative change, training, program revision, or other modifications.

19.3 Continuous Quality Management indicators examine high risk/high volume activities, self-injurious behavior, and special treatment procedures including, but not limited to, the utilization of mental health watches, restraints, and treatment.

20. DEFINITION(S):

Activity Therapist refers to a Clinical staff member with a degree in recreational therapy, physical education or associated area, art therapy, or music therapy, who provides treatment planning, education, supervision, and oversight of therapeutic activities for inmates with a mental health classification.

Case Management refers to assisting inmates in meeting and maintaining mental health treatment goals and objectives through advocacy, ongoing assessment and evaluation, planning, communication, education, resource management, and service facilitation.

Clinical Supervisor refers to a Qualified Mental Health Professional (QMHP) supervising/managing mental health professionals in a program and/or region ensuring quality clinical care.

Continuity of Care refers to the process of ensuring care from the point of admission to discharge to transition into the community.

Crisis Intervention (CI)/Suicide Precaution (SP) refers to the process designed to address immediate acute distress and associated behaviors when an inmate is a danger to him/herself or others. If it is determined that the inmate requires CI or SP status, the inmate may be transferred to a designated CI bed space. The usual length of stay in CI will be ten (10) days or less. The licensed Clinical Supervisor, psychiatrist, physician, physician's assistant, or nurse practitioner who ordered CI or SP will complete SCDC Form M-120, "Crisis Intervention Form."

Developmental Testing refers to administration, interpretation, and reporting of screening and assessment instruments for inmates to assist in the determination of developmental levels for the purpose of facilitating mental health services, placement, and treatment planning.

Discharge Planning refers to preparation for program or institutional dismissal to assure continuity of care and effective aftercare planning prior to an inmate's expected release date.

Duty to Warn refers to the obligation to warn an identifiable individual, organization, or entity of a specific threat of harm.

Evidence-based Treatment refers to intervention with consistent scientific evidence demonstrating improved recipient outcomes.

Healthcare Setting refers to a clean, safe, therapeutic environment with a nursing station that is staffed 24/7.

Hunger Strike/Extended Fast refers to a situation in which an inmate communicates to an SCDC staff member that s/he is on a hunger strike/extended fast, or when an SCDC staff member observes the inmate not consuming an adequate amount of food or liquid for 72 hours or more.

Individual Treatment Plan (ITP) refers to a document that details a client's current mental health problems and outlines the goals and strategies that will assist the client in overcoming his or her mental health issues.

Initial Assessment refers to face-to-face interaction between a mental health staff member and inmate designed to gather information that enables the clinician to evaluate and assess for mental health services.

Inmate refers to a male or female convicted of an offense against the State of South Carolina, sentenced to imprisonment for more than three months, and serving a criminal sentence under commitment to the State Department of Corrections, including persons serving sentences in local detention facilities designated under the provisions of applicable laws and contractual agreements.

Inpatient Care refers to a voluntary or involuntary commitment to a psychiatric hospital.

Level of Care (LOC) refers to a hierarchical coding system that reflects an inmate's current medical and mental health classification, mental health service need(s), and the intensity of treatment an individual will receive. All inmates receive a Level of Care classification.

Medical Record, Automated (AMR) refers to a multidisciplinary, computerized network that links mental health professionals and medical professionals to information. The AMR tracking system helps to maintain continuity of care and allows for timely and efficient access to information.

Medical Record, Hard File refers to a paper-based system of recordkeeping that stores medical, mental health information, and other documents/information not stored in the AMR. Hard files are stored in the medical record area of the inmate's assigned institution. When an inmate transfers to a different institution, the hard file follows the inmate.

Mental Health Disciplinary Treatment Team (MHDTT) was established to review and provide case guidance for inmates with a mental health classification who are found guilty of a disciplinary offense.

Mental Health Screening consists of observation and structured inquiry into each inmate's mental health history and symptoms. Structured inquiry includes questions regarding suicide history, ideation, and potential, prior psychiatric hospitalizations and treatment, and current and past medications, both those prescribed and what is actually being taken.

Mental Health Technician refers to a staff member with at least a Bachelor's Degree and two (2) years' experience in a mental health related field, or an Associate's Degree and four (4) years of experience in a mental health related field, who provides adjunct mental health services to mentally ill inmates under the supervision of licensed clinical staff.

Mental Status Examination refers to a confidential, structured assessment of behavioral and cognitive functioning that describes the mental state of the individual receiving the evaluation. It includes both objective observations by the clinician and subjective descriptions given by the inmate.

Outpatient Care refers to the level of care intended for mentally ill inmates who are able to function satisfactorily in a general population setting for extended periods of time. This includes two subsets of inmates: Higher Intensity Outpatients and Lower Intensity Outpatients.

P-SERC refers to a service delivery process involving psychiatric screening, evaluation, resolution, and classification.

Potential Victim refers to an identifiable individual, organization, or entity who/which is the target of a specific threat of harm.

Psychiatric Assessment/Evaluation consists of a face-to-face interview of the inmate and review of all reasonably available healthcare and mental health records and collateral information. It includes a diagnostic formulation and, at least, an initial treatment plan.

Psychiatrist refers to an individual licensed to practice medicine in the State of South Carolina, who is (1) certified by the American Board of Psychiatry and Neurology or eligible for certification by that Board, or (2) certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by the Board.

Psychological Testing refers to psychological evaluation using standard assessment methods and instruments to assist in mental health assessments and treatment planning processes.

Psychologist refers to a mental health practitioner licensed by the State of South Carolina as a psychologist.

Psychotropic Medication refers to any medication (i.e., anti-depressant, anti-anxiety, anti-psychotic or mood stabilizing) prescribed for treating various mental health symptoms.

Qualified Healthcare Practitioner (QHP) refers to a physician, physician's assistant, or nurse practitioner.

Qualified Mental Health Professional (QMHP) refers to a mental health practitioner licensed by the State of South Carolina such as a psychiatrist, licensed psychologist, licensed professional counselor, licensed professional counselor-supervisor, licensed independent social worker, licensed marital and family therapist (LMFT), or psychiatric nurse practitioner. It also includes a licensed master social worker and licensed professional counselor-intern and LMFT-intern with appropriate supervision.

Referral (Mental Health) refers to a request for mental health services.

Residential Care is reserved for mentally ill inmates unable to function in a general population setting due to a mental disorder, but who typically do not meet the criteria for admission to a psychiatric hospitalization. Residential care options, situated in a therapeutic environment, are available to inmates who present with mental health issues likely to affect their ability to function effectively while incarcerated.

Sick Call refers to a system that allows an inmate to report health and mental health concerns and receive individualized and appropriate medical or mental health services for non-emergency illness or injury, to include non-emergency mental health complaints and requests to see counselors.

Specific Threat refers to a written or verbal declaration of intended harm toward an identified potential victim(s).

Suicide Precaution (SP) refers to intervention measures to reduce physical self-harm by an inmate identified as a risk for suicidal behavior. These measures include placement of the inmate into a safe cell under constant observation.

Tele-Psychiatry refers to a process that uses video conferencing to assist in providing psychiatric services to inmates residing in remote institutions.

Therapeutic Environment refers to mental health treatment provided in a setting that is conducive to the achievement of its goals. This includes the physical setting and the social-emotional setting, in which an atmosphere of empathy and respect for the dignity of the patient is maintained. Mental health services are conducted in private and carried out in a manner that encourages the inmate's subsequent use of services. A therapeutic environment implies the following conditions:

- a sanitary and humane environment;
- written procedures;
- adequate medical and mental health staffing;
- adequate allocation of resources for the prevention of suicide, self-injury, and assault;
- adequate observation, treatment, and supervision; and
- social interactions that foster recovery.

Treatment Team refers to a multidisciplinary group including, but not limited to, mental health staff (QHP's, QMHPs, medical personnel, and uniformed staff) who discuss integrated therapeutic services, collaborate, and share appropriate information based on the inmate's level of care, for the purpose of treatment of mentally ill inmates and continuity of care.

SIGNATURE ON FILE

s/Bryan P. Stirling, Director

Date of Signature

ORIGINAL SIGNED COPY MAINTAINED IN THE OFFICE OF POLICY DEVELOPMENT.