**South Carolina Department of Corrections**
**Implementation Panel Report of Compliance**
**November 30, 2016**

Executive Summary

This second report of the Implementation Panel ("IP") is provided as stipulated in the Settlement Agreement in the above-referenced matter, and it is based on the first and second site visits to the South Carolina Department of Corrections facilities and our review and analysis of SCDC's compliance with the Settlement Agreement criteria. The first site visit by the IP was from May 2 thru May 5, 2016. During the course of this visit the IP including their subject matter expert made onsite inspections at Camille Graham C.I., Kirkland C.I. and Broad River C.I. including reviews of specific units and mental health related programs. The second site visit by the IP was October 31 thru November 4, 2016 to those same facilities and also included Perry C.I. and Lee C.I. We have received a plethora of documents, including policies and procedures and additional reports as noted in this report. In addition, we have had conference calls with the plaintiffs and defendants as well as discussions with SCDC staff, inmates, and plaintiffs, and we reviewed additional documents during the onsite visits. We conducted an Exit Conference on November 4, 2016, which was attended by Director Bryan Sterling and the administrative, operations, and clinical staff of SCDC; plaintiffs' counsel Daniel Westbrook and Stuart Andrews; defendant's counsel Roy Laney; and the mediator, Judge William Howard. During the Exit Conference we provided our preliminary findings based on the two site visits and addressed questions and concerns offered by any of the participants.

This Executive Summary is a brief overview of the SCDC analysis and the IP's findings regarding SCDC's compliance with the Settlement Agreement. The specific Settlement Agreement criteria (with the exception of Policies and Procedures) are described in detail in this report, and the compliance levels, i.e., noncompliance, partial compliance, or substantial compliance in each of the elements along with the basis for those findings and recommendations of the IP are also included. Appended to this report is Exhibit B to the settlement agreement, which is a summary of the IP's assessment of compliance with the remedial guidelines. Exhibit B does not include a separate component for the development of overall policies and procedures that will address implementation of the components set forth in Exhibit B, but the IP wants to acknowledge the work that has gone into development of the policies while also noting that training and implementation have yet to be accomplished and will be monitored closely. As Exhibit B reflects, the IP determined the following levels of compliance:

1. Substantial Compliance – one component
2. Partial Compliance – thirty components
3. Noncompliance – twenty-eight components

As discussed during the site visits and during our Exit Conference with the parties, the IP's primary concerns regarding SCDC's failure to demonstrate substantial compliance with the Settlement Agreement have to do with the following issues: (1) Staffing, including, clinical, operations, administrative, and support staff; (2) Conditions of Confinement including specifically the Restrictive Housing Units (RHU), segregation of any type; (3) prolonged stays in Reception and

Evaluation and the quality/appropriateness of evaluation and treatment components; (4) lack of timely assessments and adequate treatment at the mental health programmatic levels; and (5) operations practices and adherence to policies and procedures.

Despite the ongoing efforts during mediation to finalize policies, we were apprised during the site visits that several policies were still being developed or were under revision, as the finalization of specific policies did not comport with the necessary requirements of the Settlement Agreement and/or the needs of inmates for adequate mental health care. The first step in policy and procedural development and implementation is the actual writing of the policies and finalization within SCDC. The other necessary components including training staff regarding the policies and procedures, implementation, supervision regarding those policies and procedures, and quality management review via the quality assurance/improvement mechanisms within SCDC are currently incomplete and inadequate.

A major achievement has been development of the Quality Assurance Risk Management (QARM) component within SCDC as an essential oversight and analysis component and mechanism. The IP was very positively impressed by their efforts and strongly encourages the continuation and expansion of their efforts at the central levels. However, as we have emphasized repeatedly during our discussions and on-site reviews, the data collection component of the quality management program must be accomplished at the facility level and relate to policies and procedures, and specific facility parameters and mental health programs, operations, support, and ultimately inmate mental health needs. This has not been accomplished, and the dire need for staffing (as noted in this report) and active on-site and central support for instituting, developing, and/or maintaining adequate services and support functions at the facility level has not been achieved.

Another major achievement has been the progress towards closing the SSR unit and plans for the High Intensity/Level Behavioral Management Unit. In addition, closure of the Super Max unit at Lee is recognized as another major achievement.

During this calendar year, SCDC has reported two deaths by suicide, and while the IP has received notice of these and other deaths, the establishment of an adequate and effective Mortality and Morbidity Review process including psychological autopsies has not been developed. SCDC central offices have requested that the IP provide direction and actual documents regarding a "Master Plan" for compliance with the Settlement Agreement by SCDC, as well as a model formal "Psychological Autopsy" format. In addition, SCDC requested the IP coordinator (Ms. Tammie Pope) participate in ongoing meetings with SCDC staff to facilitate this process.

While the IP has provided technical assistance and suggestions regarding how obtaining compliance with the Settlement Agreement criteria and its requirements could be accomplished, the IP has also emphasized repeatedly that these processes should be developed within SCDC by the appropriate staff within the SCDC and consultants, if necessary, who are responsible for their implementation, training, and supervision of staff on the actual requirements. SCDC must continue to develop and implement an internal process that supports and assures effective quality management so that the process will be developed and sustained beginning with the Settlement Agreement monitoring process and continuing after the settlement agreement has been satisfied

and/or otherwise resolved. The timely development and implementation will also facilitate transition to the anticipated Electronic Health Record (EHR).

Accordingly, the following description and appendices are reflective of our overviews of the specific facilities that were inspected during this site visit, namely Camille Graham Correctional Institution, Kirkland Correctional Institution, Broad River Correctional Institution, Perry Correctional Institution, and Lee Correctional Institution. As reported during our Exit Conference, the IP considers the conditions at Perry Correctional Institution to be at a severe crisis level that requires immediate correction. Not only are the staffing levels for clinicians, as well as operations staff, unacceptably low, preventing the implementation of effective treatment measures, but also based on the operations staffing this facility has experienced frequent lockdowns since at least February 2016 and has been unable to provide adequate recreation or showers, and inmates who have been cleared from restrictive housing remain in restrictive housing status because of the lack of available beds to which to transfer those inmates. These conditions must be corrected immediately, and plans to address the multiple factors contributing to the crisis at Perry must be developed and implemented.

Below are the specific findings followed by the appendices that provide overview information on the system as a whole as well as the individual facilities within the system. As noted, Policies and Procedures are in Partial Compliance.

1. **The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**

    a. **Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs.**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* Policy H.S.-19.11: Mental Health Services - Reception and Evaluation: Mental Health Screening, Evaluation, and Classification has stated goal of referring inmates to the appropriate treatment programs. "*Based on the initial, secondary, and/or psychiatric evaluation, mental health personnel will resolve to identify a program or service provided by the SCDC Division of Mental Health Services suitable for the mentally ill inmate's individual mental health care needs.*"

At R&E, there are 3 opportunities for screening/evaluation of inmates to ensure those with SMI are accurately diagnosed and referred to appropriate treatment programs.

- Intake Assessment Interview
- Medical Intake Screening
- Mental Health Screening

*Note: to increase compliance percentage, an internal monitoring process will be implemented by Division of Mental Health.*

In a review of 202 (100%) of females entering SCDC from April – May 2016:

| Process | Average (Days) | Min | Max | Standard (Days) |
|---|---|---|---|---|
| Days elapsed from intake to Mental Health Screen (3 days) | [redacted] | 2 | 17 | 3 |
| Days elapsed from MH screen date to QMHP assessment | 10 | 0 | 65 | Emergent 4 hours; Urgent 24 hours; Routine 14 days |
| Days elapsed from MH screen to Psychiatric evaluation | [redacted] | 3 | 45 | Emergent 4 hours; Urgent 24 hours; Routine 14 days |
| Days elapsed from intake to Physical Exam | 6 | 0 | 13 | 7 |
| Days elapsed from intake to Medical Classification | 23 | 6 | 46 | 30 |
| Days elapsed from intake to transfer out of R&E (45 days) | 36 | 3 | 81 | 45 |

In a review of 270 (20%) of males entering SCDC from June-July 2016:

| Process | Average | Min | Max | Standard |
|---|---|---|---|---|
| Days elapsed from intake to Mental Health Screen (3 days) | [redacted] | 1 | 45 | 3 |
| Days elapsed from MH screen date to QMHP assessment | [redacted] | 2 | 47 | Emergent 4 hours; Urgent 24 hours; Routine 14 days |
| Days elapsed from MH screen to Psychiatric evaluation | [redacted] | 1 | 49 | Emergent 4 hours; Urgent 24 hours; Routine 14 days |
| Days elapsed from intake to Physical Exam | 3 | 0 | 30 | 7 |
| Days elapsed from intake to Medical Classification | [redacted] | 10 | 68 | 30 |
| Days elapsed from intake to transfer out of R&E (45 days) | 45 | 0 | 111 | 45 |

*November 2016 Implementation Panel findings:* Implementation of the relevant policy and procedure has been problematic, especially in meeting the required timeframes as demonstrated by the SCDC status update data. We discussed with staff the need to determine the percentage of inmates receiving evaluations by the QMHPs and/or psychiatrists in the required timeframes. In addition, a summary should be provided, when compliance is not present, regarding the identified obstacles in achieving compliance and the plan to achieve compliance.

We also emphasized that the data needs to be gathered and analyzed locally in contrast to being the responsibility of the central office QARM, although it should be reviewed by the QARM. We

met with the central office IT staff to discuss the use of a web based data system to collect the needed information.

We met with R&E staff during the morning of November 2, 2016. One of the three FTE staff allocations assigned to this unit has been vacant for many months with partial coverage provided by a clinician from the ICS. Staff reported the need for additional staff, although they would have office space issues if additional staff was provided. It was not uncommon that their efficiency was significantly hampered due to the lack of available custody officers for escort purposes. A psychiatrist provided coverage on a two-day per week basis, which resulted in significant delays for inmates referred to the psychiatrist to be seen.

Staff also indicated that they over-referred inmates for both QMHP evaluations and psychiatric assessments based on screening results due to instructions received from supervisory staff regarding the threshold for such referrals. As a result there was a significantly high percentage of "false positives" being referred.

R & E staff were also responsible for reception center inmates referred for a crisis stabilization level of care. Such inmates were housed in unit F-1 for weeks at a time and were not transferred to the CSU at the Broad River Correctional Institution. We briefly inspected the crisis stabilization unit cells in unit F-1, which were not suicide resistant.

*Recommendations:* Work with IT staff to develop a web based data collection system. Work with the local prisons to implement a process for collecting and analyzing the pertinent data.

Clinicians should be allowed to exercise reasonable clinical judgment relevant to mental health referrals following the mental health screening assessment process.

The "crisis stabilization cells" in unit F-1 should only be used when beds are not available at the Broad River CI CSU.

**a. (continued) Accurately determine and track the percentage of the SCDC population that is mentally ill.**

*Implementation Panel Assessment:* partial compliance

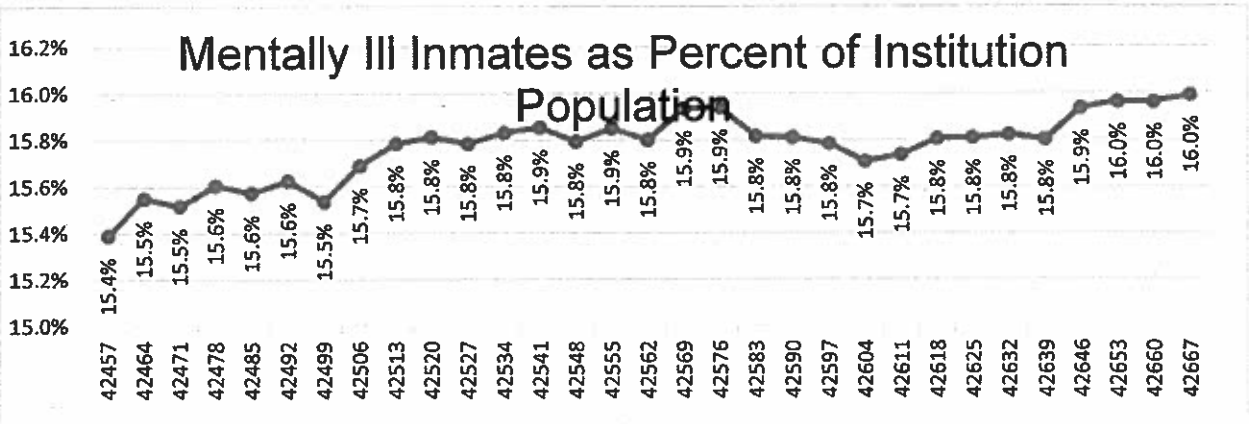
*November 2016 SCDC Status Update:* The Division of Resources and Information Management generates a weekly report of Mental Health Classifications for Mentally Ill Institutional Population. This report includes the numbers of mentally ill inmates by classification, the percentage of mentally ill by classification as a percentage of the mentally ill population, and the percentage of mentally ill inmates as a percentage of the total population. In addition, this information is provided by institution.

Mental Health Classifications for Mentally Ill Institutional Population

| Date | SCDC Institutional Population | SCDC MI Population | Mentally Ill Inmates as % of Institution Population |
|---|---|---|---|
| 3/28/2016 | 20,603 | 3,171 | 15.4% |
| 4/4/2016 | 20,328 | 3,161 | 15.5% |
| 4/11/2016 | 20,410 | 3,167 | 15.5% |
| 4/18/2016 | 20,511 | 3,201 | 15.6% |
| 4/25/2016 | 20,689 | 3,222 | 15.6% |

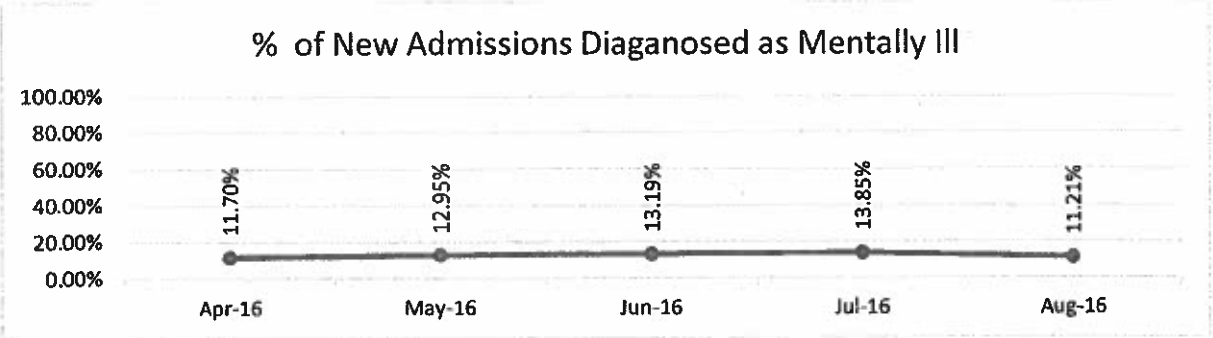
| 5/2/2016 | 20,427 | 3,192 | 15.6% |
|---|---|---|---|
| 5/9/2016 | 20,506 | 3,186 | 15.5% |
| 5/16/2016 | 20,541 | 3,223 | 15.7% |
| 5/23/2016 | 20,721 | 3,271 | 15.8% |
| 5/30/2016 | 20,831 | 3,294 | 15.8% |
| 6/6/2016 | 20,398 | 3,220 | 15.8% |
| 6/13/2016 | 20,497 | 3,245 | 15.8% |
| 6/20/2016 | 20,619 | 3,269 | 15.9% |
| 6/27/2016 | 20,793 | 3,284 | 15.8% |
| 7/4/2016 | 20,498 | 3,249 | 15.9% |
| 7/11/2016 | 20,487 | 3,237 | 15.8% |
| Date | SCDC Institutional Population | SCDC MI Population | Mentally Ill Inmates as % of Institution Population |
| | | | |

| 7/18/2016 | 20,509 | 3,268 | 15.9% |
|---|---|---|---|
| 7/25/2016 | 20,690 | 3,298 | 15.9% |
| 8/1/2016 | 20,771 | 3,285 | 15.8% |
| 8/8/2016 | 20,492 | 3,240 | 15.8% |
| 8/15/2016 | 20,660 | 3,261 | 15.8% |
| 8/22/2016 | 20,773 | 3,263 | 15.7% |
| 8/29/2016 | 20,871 | 3,284 | 15.7% |
| 9/5/2016 | 20,577 | 3,252 | 15.8% |
| 9/12/2016 | 20,667 | 3,267 | 15.8% |
| 9/19/2016 | 20,807 | 3,292 | 15.8% |
| 9/26/2016 | 21,004 | 3,319 | 15.8% |
| 10/3/2016 | 20,686 | 3,296 | 15.9% |
| 10/10/2016 | 20,605 | 3,289 | 16.0% |
| 10/17/2016 | 20,749 | 3,312 | 16.0% |
| 10/24/2016 | 20,823 | 3,330 | 16.0% |




The following chart illustrates the number of diagnoses for new admissions from April-September 2016:

| Admission Month | Total # Admissions | Total # Mentally Ill or Retarded | Total % Mentally Ill or Retarded |
|---|---|---|---|
| 04 Apr | 863 | 101 | 11.70% |
| 05 May | 718 | 93 | 12.95% |
| 06 Jun | 864 | 114 | 13.19% |
| 07 Jul | 657 | 91 | 13.85% |
| 08 Aug | 812 | 91 | 11.21% |
| 09 Sep | 932 | 10 | 1.07% |
| | | | |




*November 2016 Implementation Panel findings:* As per SCDC status update. It is very likely that the percentage of inmates within SCDC that are on the mental health caseload is underrepresented based on national statistics.

*Recommendations:* The "accurate determination" element needs to be assessed via a quality improvement study.

**b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* The Division of Quality Assurance and Risk Management (QARM) conducts an audit of R & E intakes at Camille Graham and Kirkland R&E Centers for quarterly reporting. Because the number of females entering the system is significantly less than males entering the system, the sample from the first audit included 100% of CGCI R&E intakes in April and May 2016. A sample of 20% per month of the June and July intakes at KCI R&E were reviewed, as the intakes can average 800-900 per month.

During the review QARM staff assessed the days elapsed from intake to:

- MH initial screening
- QMHP assessment
- Psychiatric evaluation
- Physical exam
- Transfer from R & E to an institution

The purpose of the review was to ensure timeliness of services, based on restraints as dictated by the R & E policy. As deficiencies were identified, QARM staff immediately reported findings to counselors, the Division Director for Behavioral/Mental Health and Substance Abuse Services and other staff as identified, with directives to provide updates and corrections as completed.

Since the Division of QARM was established, approximately 34 individual cases of deficiencies were identified during the auditing of SCDC R&E Mental Health Services. When these deficiencies were identified, the auditor sent the findings to the QMHP or supervisor responsible for the area, notifying him/her of the deficiency and asking that it be corrected. At least 12 of

those have been corrected to date, and QARM will follow up to ensure compliance. Significant to the findings are multiple times that:

- A MEDCLASS is entered incorrectly at R&E (e.g., the psychiatrist orders "L-4", but the MEDCLASS is entered as "NMH" or "SA")
- A psychiatrist evaluates a NMH patient and starts him/her on psychiatric medication, but the MEDCLASS is not updated to reflect the new level of care.

The following chart captures defectives as noted during the QARM review of the R&E process:

| **R&E Deficiencies** | |
|---|---|
| MEDCLASS at R&E does not match psyche recommendations | 45% |
| Referral from R&E Medical not done timely | 3% |
| At R&E Psyche ordered observe for a time, MEDCLASS entered as NMH | 3% |
| R&E MEDCLASS entered before I/M sees psyche | 5% |
| Transfer from R&E causes the process to not be completed, and is not picked up at next institution. | 3% |
| Improper MH Triage | 3% |
| **At the institutions** | |
| Psyche starts on psychiatric meds but MEDCLASS is not updated | 16% |
| Referral not done in timely manner | 0% |
| Psyche ordered observe for 90 days, MEDCLASS does not reflect L4 | 5% |
| No-show not followed up | 3% |
| Self-referral not seen timely | 3% |
| **Classification Issues** | |
| Old SCDC # vs. New SCDC # | 3% |
| Institutional classification issues | 3% |
| **Other** | 5% |

*November 2016 Implementation Panel findings:* Staff have made an initial start in complying with this provision. Issues remain regarding the need for a more accurate and efficient database as described earlier in addition to producing quality improvement reports. In general, quality improvement reports should be "stand-alone" documents that include the following subsections:

- Description of the issue being reviewed;
- Methodology used in the study;
- Results;
- Assessment of the results; and
- Planned actions, if any.

*Recommendations:* See 1(a).

**c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* SCDC recently created the Division of Quality Assurance

and Risk Management (QARM) within the Office of Legal and Compliance to develop and implement an agency quality assurance and risk management system to track and measure agency compliance with the sixteen new or amended policies referenced in the settlement agreement. The division is developing data collection tools to capture information relating to screening, timeliness, and continuity of care for inmates identified as needing mental health services as well as data relating to other matters such as use of force, discipline, and restrictive housing with a focus on inmates classified as mentally ill.

The QARM team members will visit SCDC institutions, request information, and conduct ongoing audits similar to that of the outside monitors. It is the goal of SCDC's QARM staff to provide monitoring reports to the compliance team as requested, advise the agency on the status of its progress in implementing the requirements of the Remedial Plan, to make recommendations to assist staff in accomplishing compliance, and to prepare the agency and institutions for the outside monitors and their audits. Unfortunately, this left a vacuum internal to Health Services, as the internal QA monitors were moved out of Health Services so the Agency would have a centralized, independent means of monitoring and assessing.

SCDC Policy HS-19.07 was written prior to these changes, and while it addresses the aforementioned component relative to enforcement of timeliness of assessment and treatment, the specifics need to be updated to reflect actual practice and structure. To address these concerns, QARM is drafting an Agency CQI policy to reflect its activities and practices.

As a lack of compliance was found in the timeliness of assessment and treatment for intakes of inmates determined to be mentally ill at R&E, per section 3.3.10 of Policy HS-19.07, improvement action plans will be initiated and documented for each area for improvement as identified. If the findings are determined to be related to an individual, the clinician and the regional manager/program supervisor will develop and implement an improvement action plan. If the findings are determined to be systemic, the division director will develop and implement an investigatory review and corrective action process plan.

Though policy dictates the CQM Director in part develop and implement the investigatory review and corrective action process plan, it has been recommended that a change be made to allow the QARM Division Director to complete this action.

An additional recommendation has been made for an internal CQI Team to be established to fulfill the role of the ARC team.

Currently there is no documentation relative to enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill.

However, based on the initial review, the following report highlights compliance with timely review of screenings and assessments for 100% females entering Camille Graham R&E April-May 2016 (n=202). Areas not in compliance with the standard as outlined in policy included

1) days elapsed from intake to MH screen and
2) days elapsed from date of screening to psychiatric evaluation.

Based on the initial review, the following report highlights compliance with timely review of screenings and assessments for a 20% sample of males entering Kirkland R&E June-July 2016 (n=270). Areas not in compliance with the standard outlined in policy included:

1) days elapsed from intake to MH screen,
2) days elapsed from MH screen date to QMHP assessment,
3) days elapsed from MH screen date to psychiatric evaluation, and
4) days elapsed from intake to medical classification.

These reports have been distributed to the Division of Mental Health.

*November 2016 Implementation Panel findings:* As per the SCDC status report.

*Recommendations:* See provision 1(a).

**d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* SCDC does not have a program to regularly assess general population inmates for developing mental illness; however, when inmates transfer from one institution to another, nursing or other trained personnel provide screening that includes questions assessing mental health changes (SCDC Form M-14). This assessment does not capture all inmates, as not every inmate transfers regularly.

A recommendation has been made by the QARM staff for screenings to be done in conjunction with the annual TB testing, as this would cover all inmates annually.

Information to substantiate the effectiveness of identifying inmates in the general population as they transfer from institution was not available at the time this report was completed. A request has been submitted to the Division of Resource Information Management to begin generating this data. It will include information identifying all inmates who have a MEDCLASS change within 30 days of a transfer. From this list a sample will be assessed to determine if the MEDCLASS change was as a result of the mental health screen done at the time of transfer.

*November 2016 Implementation Panel findings:* See SCDC status update. We discussed with key staff various options for meeting the requirements of this provision. It appeared that the most practical solution was to perform a mental health screening at the time of the inmate's annual classification review. Such a screening would be very similar to the reception center mental health screening process.

*Recommendations:* Develop and implement the required program.

**2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved**

**treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC.**

**a. Access to Higher Levels of Care**

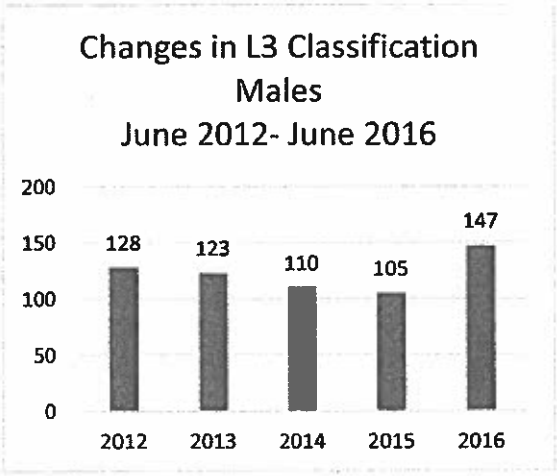
**i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;**

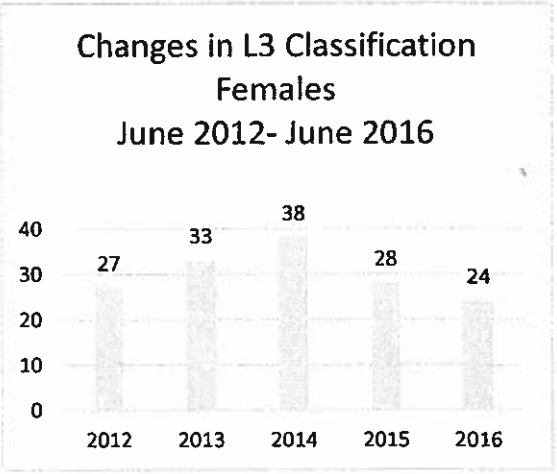
*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* During the 90-day psychiatric appointments, the MEDCLASS should be reviewed to determine if an inmate needs a higher level of care. QARM has not been able to evaluate this practice effectively as this is not recorded as discreet data and there are inconsistences in how this information is documented. It has been recommended that Mental Health receive training on how to document this information consistently. Post training, QARM staff will begin to track these reviews.

Although a specific plan has not been articulated, QARM staff are currently tracking the Area Mental Health numbers to determine changes in the data.

No documentation is available to support this MEDCLASS review; however, from June 2012-June 2016, male inmates receiving Area Mental Health Services has increased 14.8%. From June 2012-June 2016, female inmates receiving Area Mental Health Services has decreased 11.1%.




*November 2016 Implementation Panel findings:* as per SCDC status update that indicates a decrease in female inmates receiving area mental health services.

We suggested that QI studies be performed on target populations to assess the appropriateness of the level of care being offered to inmates within these target populations. These target populations include, but are not limited to, the following:

1. Inmates with two or more CSU admissions within the past six months.

2. Inmates with two or more GPH admissions within the past six months.
3. Inmates discharged from GPH directly to outpatient services (in contrast to an ICS level of care).
4. Mental health caseload inmates receiving multiple disciplinary reports.

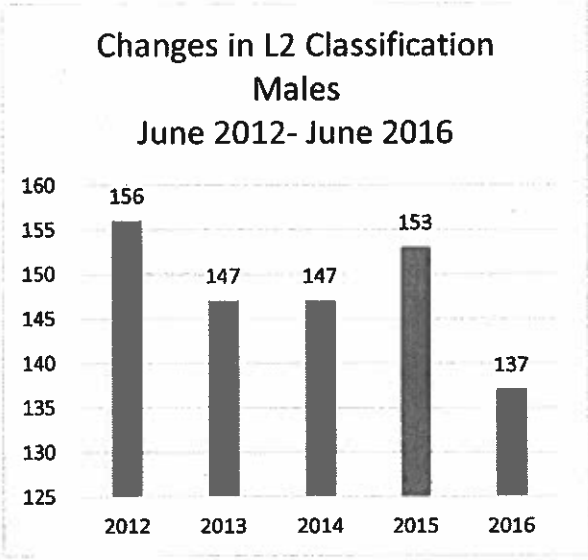
*Recommendations:* as above.

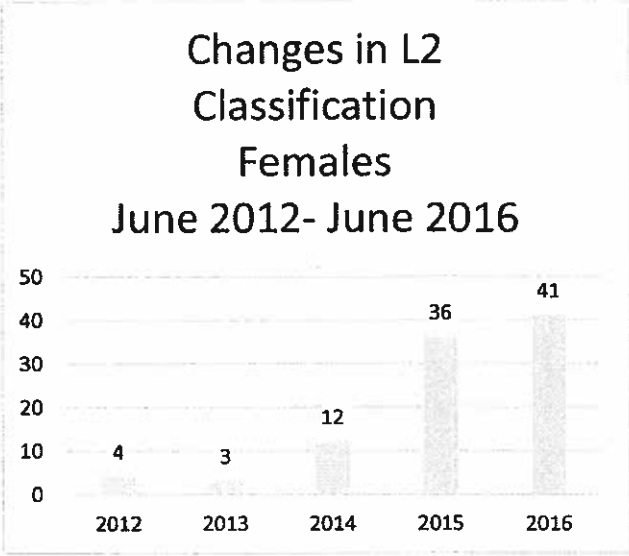
**ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* During the 90-day psychiatric appointments, MEDCLASS should be reviewed to determine if an inmate needs a higher level of care. QARM has not been able to evaluate this practice effectively as this is not recorded as discreet data and inconsistences in how this information is documented. It has been recommended that Mental Health staff receive training on how to document this information. Post training, QARM staff will begin to track these reviews.

Although a specific plan has not been articulated, QARM staff are currently tracking the number of males and females identified as requiring intermediate care services. No documentation is available to support this MEDCLASS review; however, from June 2012-June 2016 review, male inmates receiving intermediate care services has decreased 12.2%. From June 2012-June 2016, female inmates receiving intermediate care services has increased 925%.




*November 2016 Implementation Panel findings:* It has been our experience that inmates receiving an ICS level of care generally comprise 10% to 15% of the total mental health caseload population.

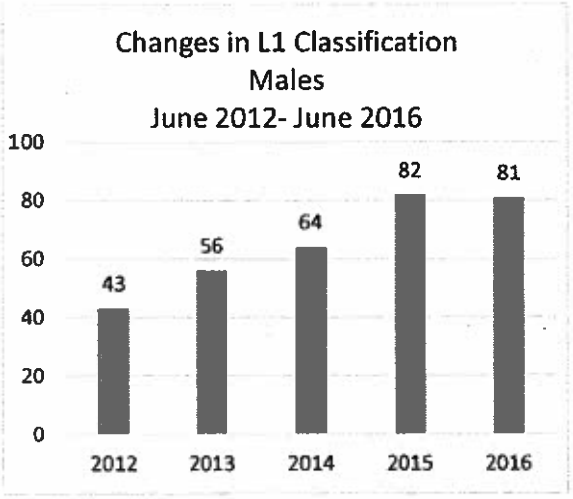
*Recommendations:* See 2(a)(i) recommendations. We also recommend that a QI be performed relevant to referrals made to ICS that are not accepted for program participation.

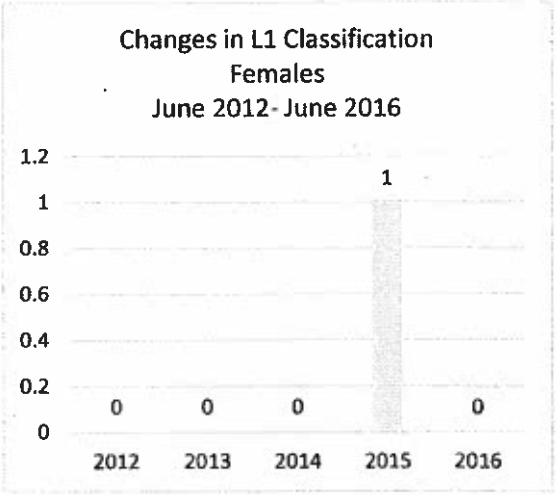
**iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* GPH maintains a consistent, full census, averaging approximately 80 inmates. Plans to improve/renovate the GPH facility are on-going. Because GPH's capacity is 80% consistently, without a documented waiting list or list of denials due to bed space, QARM is unable to determine increases. During the 90-day psychiatric appointments, MEDCLASS should be reviewed to determine if an inmate needs a higher level of care. QARM has not been able to evaluate this practice effectively as this is not recorded as discreet data and inconsistences in how this information is documented. It has been recommend that Mental Health staff receive training on how to document this information. Post training, QARM staff will begin to track these reviews.

Although a specific plan has not been articulated, QARM staff are currently tracking the number of males and females identified as requiring inpatient psychiatric services.



## GPH Renovations

The chart below outlines planned and completed renovations to GPH Division Maintenance & Engineering plans for GPH:

| | |
|---|---|
| **1) Kirkland Correctional Institution -- Gilliam Psychiatric Hospital (GPH)** | |
| a) Administration Area: | |
| i) Four (4) group counseling rooms: | |
| • Renovate two (2) offices for group counseling rooms and two (2) conference rooms. | [redacted] |
| • Add cameras (2 ea. per room). Add cameras to view corridor. | Larger Glazing view panels. Complete. Cameras received awaiting IP address for programing. Furniture/chairs to be determined |
| • Add larger security glazing view panels in doors. | |
| • Furniture / chairs. | |
| b) Existing Nurse's Station in Admin Area – scope of work has not been determined at this time. | |
| c) Hospital Housing Unit: *(Note: Must be mindful not to violate the current 87 bed SCDHEC hospital license)* | |
| i) The cells and door view panels are adequate at this time. | |
| ii) Install 5 benches and 2 restraint group tables with stools per wing of the housing unit.. | [redacted] |
| iii) Provide an enclosed nurse's station to include hand sink ("no restroom facilities") to both A & B wings. Preliminary plans are being developed for submission and review by SCDHEC – Health Services. | Projected Completion December 1, 2017 *(If construction documents have SCDHEC & OSE approvals by January 1, 2017)* |
| iv) Install security cameras in hospital cells -- 1st floor one wing. | |
| v) Renovate showers on both wings to include push button valves and an ADA shower with ADA with ligature resistant ADA fixtures | |
| vi) Install four (4) silent TV's in security cages in the dayroom for both wings. | B- Wing Complete<br>A-Wing TV's are on order |
| d) All areas to be painted to accommodate a more therapeutic setting. | Color(s) selected |
| **2) Kirkland Correctional Institution -- Modular Unit at GPH** | |
| a) Additional office space: | |
| i) Renovate the open area for additional office spaces and add a wall in the existing ICS pill room to make two offices. | ICS Pill room must be relocated before the renovations can begin. The new area in the Admin. Area is ready for the ICS pill room. Awaiting notification of the move |

*November 2016 Implementation Panel findings:* Some of the planned renovations have been completed as per the SCDC status update section.

We met with GPH line staff during the afternoon of November 1, 2016. Inmates continued to receive a minimal amount of out-of-cell structured therapeutic time per week. Related, in part, to psychiatric staffing vacancies, the treatment team process does not include a psychiatrist.

Inmates do not have access to dayroom time within the housing unit. A therapeutic milieu did not appear to exist within the housing unit. The renovations have not yet resulted in increased inpatient services for any inmates.

Data provided prior to the site visit indicated no waiting lists for male or female inmates for access to hospital level care; however, during the site visit, the IP was apprised there had been three referrals for female inmates and occasional waiting lists for male inmates. SCDC must track all referrals for inpatient/hospital level care as well as waiting lists and rejections of referrals.

*Recommendations:* As per the SCDC status update section relevant to renovations. Implement a QI process relevant to a needs assessment specific to an inpatient level of care. See 2(a)(i) recommendations.

**iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* The Division of Mental Health has demonstrated an increase in the number of positions allotted to provide more mental health services at all levels of care since October 2014. From October 2014 to October 2016, the Division saw an increase in total positions (filled + vacant) of 49.0%.

The following chart demonstrates clinical staffing totals from October 2014-October 2016:

| 10/2014 | Full-Time | | Pink Slip | | Dual | | Contract | |
|---|---|---|---|---|---|---|---|---|
| | Filled | Vacant | Filled | Vacant | Filled | Vacant | Filled | Vacant |
| Administration Totals | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **REGIONAL MENTAL HEALTH** | | | | | | | | |
| **Totals** | **69** | **8** | **0** | **0** | **0** | **0** | **1** | **0** |
| **CENTRAL SERVICES** | | | | | | | | |
| **Central Services Totals** | **26** | **1** | **7.26** | | | | | |
| **Division Totals** | **97** | **9** | **7.26** | | | | | |

| 10/2016 | Full-Time | | Pink Slip | | Dual | | Contract | |
|---|---|---|---|---|---|---|---|---|
| | Filled | Vacant | Filled | Vacant | Filled | Vacant | Filled | Vacant |
| Administration Totals | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **REGIONAL MENTAL HEALTH** | | | | | | | | |
| Totals | **71** | **45** | **0** | **0** | **0** | **0** | **0** | **0** |

| CENTRAL SERVICES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Central Services Totals | 24 | 18 | 3.3 | 0 | 1.67 | 0 | 1.7 | 0 |
| **Division Totals** | **95** | **63** | **3.3** | **0** | **1.67** | **0** | **1.7** | **0** |

*November 2016 Implementation Panel findings:* The 40% vacancy rate is very concerning and is most likely due to noncompetitive salaries. It will be extremely difficult, if not impossible, to achieve compliance with most clinical elements of the settlement agreement unless the staffing vacancies issue is remedied.

*Recommendations:* Effectively address the salary issues.

**v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* The treatment team at each program reviews each patient that is presented for admission. The treatment team submits to the Division Director of MH a report including those who are denied admission. These reports will be forwarded to Division QARM to identify trends for denials. These reports will also be reviewed by the CQI committee which is being developed. This is a new process, and very little documentation is available.

Monthly Admission Recommendation Record, in month of September, ICS had 14 referrals. 3 were accepted, and 11 were denied. Reasons were provided in 91% of the denials. During intake, staff participated as follows for those denied admission to ICS:

- Psychiatrist 90%
- Psychologist 0%
- QMHP 90%
- Medical 0%
- Operations 90%

*November 2016 Implementation Panel findings:* A preliminary plan for the required QI process has been formulated.

*Recommendations:* More comprehensively develop a QI process and implement it. See 1(a).

**b. Segregation:**

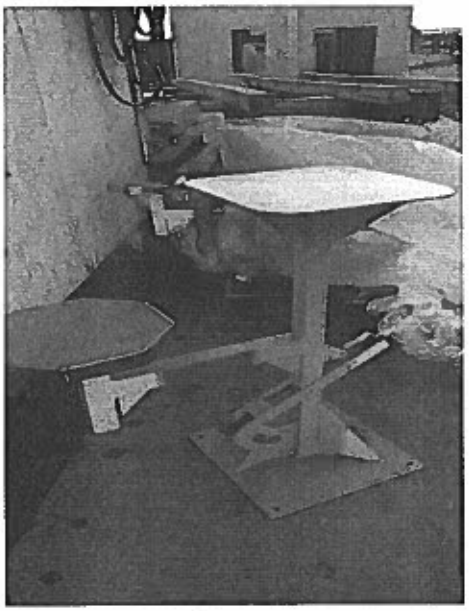
**i. Provide access for segregated inmates to group and individual therapy services;**

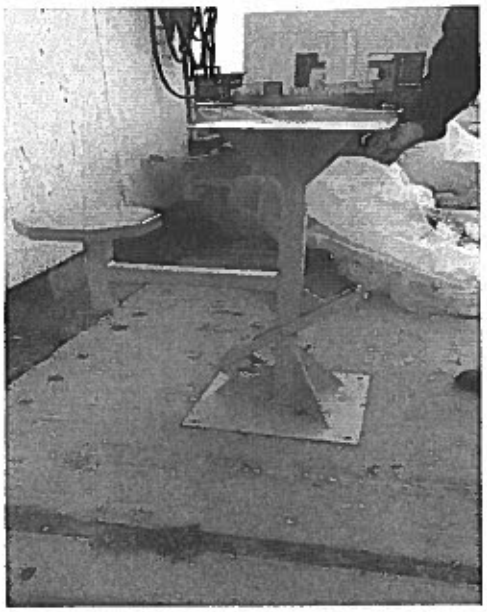
*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* Provisions are underway to accommodate for therapy for inmates in segregation. SCDC has built "group therapy chairs" that will allow for group sessions while providing security, in that each inmate will be secured to his/her own chair, which is bolted to the floor, and will remain in restraints during the groups, as determined by mental health and security staff. Provisions will be made to accommodate up to six inmates per groups.

Currently there is no documentation available to track the number of RHU inmates participating in groups. In the CSU group therapy rosters have been provided, but they failed to indicate those inmates participating in groups with a designated segregation status. Although groups are reported as ongoing, this documentation is insufficient to support this requirement.

Therapeutic chairs have been constructed:





*November 2016 Implementation Panel findings:* as per SCDC status update section.

*Recommendations:* complete the required renovations and implement the treatment program.

**ii. Provide more out-of-cell time for segregated mentally ill inmates;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* An electronic tool for calculating and tracking structured versus unstructured out-of-cell time was created and shared for consideration with Operations to be used at CSU, GPH, CGCI, and RHUs.

CSU has pilot-tested the data collection tool, which tracks inmate name, SCDC number, structured versus unstructured activity type, specific activity (groups, activity therapy, recreation indoors, recreation outdoors, individual counseling), whether or not the inmate participated, name/time of groups, and time out and time returned to cell. The database automatically calculates the out of cell time. Although the database in and of itself does not increase out of cell time, it allows staff to see if an inmate is not being provided out of cell time per policy and may act as a catalyst in establishing opportunities for more time out of cell.

## Audit of Total Out-of-Cell time for 10% of inmates in CSU (Crisis Stabilization Unit)

| Month | # of Inmates in CSU | Structured | Unstructured | Total |
|---|---|---|---|---|
| May 2016 | 24 | 28 hours: 20 minutes | 63 hours: 18 minutes | 91 hours: 38 minutes |
| Inmate A | | 17 hours: 34 minutes | 41 hours: 34 minutes | 59 hours: 8 minutes |
| Inmate B | | 10 hours: 46 minutes; refused structured groups | 21 hours: 44 minutes | 32 hours: 30 minutes |
| | | | | |
| June 2016 | 36 | 17 hours: 28 minutes | 85 hours: 34 minutes | 103 hours: 2 minutes |
| Inmate C | | 1 hour: 15 minutes | 1 hour: 46 minutes | 3 hours: 1 minute |
| Inmate D | | 1 hour: 21 minutes | 14 hours: 48 minutes; refused activities | 16 hours: 9 minutes |
| Inmate E | | 1 hour: 1 minute | 12 hours: 40 minutes | 13 hours: 41 minutes |
| Inmate F | | 13 hours: 51 minutes | 56 hours: 20 minutes | 70 hours: 11 minutes |
| | | | | |
| July 2016 | 52 | 4 hours: 34 minutes | 22 hours: 53 minutes | 27 hours: 27minutes |
| Inmate G | | 40 minutes | 5 hours: 1 minute | 5 hours: 41 minutes |
| Inmate H | | 58 minutes | 10 hours: 41 minutes | 11 hours: 39 minutes |
| Inmate I | | 28 minutes | 1 hour: 42 minutes; refusal of activities | 2 hours: 10 minutes |
| Inmate J | | 4 hours: 41 minutes | 6 hours: 10 minutes | 10 hours: 51 minutes |
| Inmate K | | 2 hours: 56 minutes | 5 hours: 10 minutes | 8 hours: 6 minutes |
| | | | | |
| August 2016 | 43 | 3 hours: 39 minutes | 52 hours: 41 minutes | 56 hours: 20 minutes |
| Inmate L | | 1 hour: 1 minute | 6 hours: 56 minutes | 7 hours: 57 minutes |
| Inmate M | | 1 hour: 8 minutes | 14 hours: 59 minutes | 16 hours: 1 minute |
| Inmate N | | 1 hour: 30 minutes | 26 hours: 44 minutes | 28 hours: 14 minutes |
| Inmate O | | 0 hours: 0 minutes | 30 minutes | 30 minutes |

Results based on a 10% sample of inmates in the CSU in May 2016 –August 2016

Based on the sample of 15 inmates, 3 received the minimum 10 hours structured/10 hours unstructured out-of-cell time.

*November 2016 Implementation Panel findings:* This particular provision is applicable specifically to inmates in segregation in contrast to those in CSU.

During the afternoon of November 2, 2016, we briefly toured the RHU at the Broad River CI. In addition to not having access to group therapies, inmates in this unit had access to outdoor yard on only three occasions during the month of October 2016. The lack of adequate numbers of custody staff was reported to be the cause of this problem.

During November 3, 2016, we site-visited the Perry Correctional Institution (PCI). This correctional institution had an average daily census of about 900 inmates with 380 inmates during November 3, 2016, on the mental health caseload. Seventy (70) of the 127 RHU inmates were also on the mental health caseload, with 22 of these inmates in security detention housing, 43 inmates

in short term housing and three inmates in disciplinary detention housing. About 40 inmates remained in the RHU for at least weeks at a time due to lack of general population housing beds systemwide being available to them.

The PCI workforce included 289 FTE positions, with 218 of these positions being security positions. At the time of the site visit, there were 96 FTE vacancies, which included 14 non-uniform vacant positions. It was our understanding that this significant vacancy rate was due to salary issues specific to the correctional officers and the surrounding availability of much higher paying jobs in the local community. As a result of these correctional officer vacancies, RHU inmates have not had access to out of cell recreational time since at least February 2016. Access to showers was reported limited to 1-2 times per week.

Three (3) of the seven FTE mental health staff positions at PCI were vacant. Coverage by a psychiatrist was limited to 10 clinics per month that included four clinics being held via telepsychiatry.

We were also informed that all mental health caseload inmates, as well as inmates requiring an outpatient or higher level of medical care, can only be housed in level III facilities related to the healthcare staffing of facilities systemwide within SCDC.

We site-visited Lee CI during the morning of November 4, 2016. Of the 1357 inmates, 252 (19.3%) were on the mental health caseload. About 200 inmates were receiving an outpatient level of care, 37 inmates an area services level of care and 24 inmates were receiving an L5 service level of care. Mental health staff reported providing up to 24 group therapies per week.

The capacity of the RHU was 200 beds with 92 beds occupied. There were 65 inmates in the RHU on an RHU status with 24 of these inmates being mental health caseload inmates. The RHU also housed inmates who did not want to leave the RHU due to their safety concerns as well as pretrial "safe keepers" from county jails. Staff reported that inmates received access to recreational time on a three times per week basis although this was not consistent with information provided by inmates and review of activity log documentation. Showers reportedly were provided on a three times per week basis. Inmates reported that there were significant issues with intermittent lack of cold water in the showers, which appeared to be accurate based on our observation of two showers.

The "Super Max" housing unit has been shut down for close to two years.

The mental health dormitory housed 136 inmates with the vast majority of these inmates receiving an outpatient mental health level of care. Lee Correctional Institution also had an Addiction Treatment Unit.

There were 4.0 FTE mental health staff vacancies of the 7.0 FTE allocations. Two psychiatrists provided on-site clinics twice per month and two telepsychiatrists provided clinics on a twice per week basis. About 11 hours per week of psychiatrist time was provided.

96 of the 268 operational staff positions were vacant.

*Recommendations:* See 2(b)(i) recommendations.

The lack of access to out-of-cell group therapies is exacerbated by the inadequate access to outdoor recreation. We discussed with staff at Perry Correctional Institution specific steps that, if taken, would help mitigate the extremely harsh conditions of confinement in the RHU. They included providing increased privileges to RHU inmates, who were only in the RHU due to lack of access to general population beds, providing crank radios to all RHU inmates and consideration of providing break-resistant iPads to RHU inmates on a privilege-level basis.

Related to the factors contributing to the significant correctional and healthcare staff vacancies, it is our recommendation that PCI not house inmates requiring an area mental health services level of care because such services are essentially not available to most inmates requiring an area mental health services level of care.

We also recommend that strong consideration be given to staffing facilities classified as either level I or II in order to be able to house levels I & II inmates requiring healthcare services for reasons that include costs and fairness.

**iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* An electronic tool for tracking caseload and clinical services was created, shared, and demonstrated for Mental Health staff. This electronic tool had the capacity to track the following:

- Number of New Admissions
- Number Transferred to Caseload
- Number Admitted to GPH/ICS/Geo
- Number Admitted to SIB
- Number Released from Caseload
- Number Crisis added to caseload
- Percent Crisis NOT seen with 24 hours (1 day) OUT OF Compliance
- Percent Crisis NOT seen with 7 days hours OUT OF Compliance
- Number GPH added to caseload
- Percent GPH Admissions NOT seen within 48 hours (2 days) hours OUT OF Compliance
- Percent seen by counselor within 14 days of arrival
- Number recommended for Group Therapy
- % recommended for Group Therapy
- % QMHP visits OUT OF compliance with 30 day standard
- % Tx plans OUT OF compliance with 90 day standard
- % Psych appointments OUT OF compliance with 90 day standard
- Number released from SCDC
- % released with MH appointment
- % released with 30 day script
- AVERAGE Total days in caseload

Mental Health Staff are utilizing a variation of the tool but on a more limited scale and scope. The current system does not allow for flagging when services are out of compliance and is limited in reporting capabilities.

In a review of four randomly selected institutions—Perry, Lee, Allendale and Broad River—timeliness of sessions for seeing the QMHP and Psychiatrist were reviewed for inmates in RHU. 100% of inmates had a MEDCLASS of L-4. Results are below:

| Institution | Average days to QMHP Review | Range of days to see QMPH | Average days to QMHP Review |
|---|---|---|---|
| **Perry** | 32 | 7-142 | Unable to determine |
| **Lee** | 56 | 27-149 | Unable to determine |
| **Broad River** | NO DATA RECORDED | NO DATA RECORDED | NO DATA RECORDED |
| **Allendale** | 92 | 36-129 | Unable to determine |

*November 2016 Implementation Panel findings:* Consultation needs to be obtained with central office IT staff as per recommendation 1.a. in order to develop an adequate management information system relevant to this provision.

*Recommendations:* as above.

**iv. Provide access for segregated inmates to higher levels of mental health services when needed;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* Policy # HS-19.10 Mental Health Services - Behavioral Management Unit (BMU) has been written and signed.

The BMU and LLBMU are designed with the intent of better providing mental health services to inmates who frequently find themselves in segregation, those with a mental health diagnosis and personality disorder. Projected opening date for the LLBMU at Allendale is December 2016.

QMHPs report conducting weekly rounds with inmates in RHUs. Counselors currently document contact in the AMR but a tracking and reporting system to quantify visits has not been established. Effective next month, this information must be submitted to Mr. [redacted] on a monthly basis.

Fourteen institutions have submitted reports to the Division of Mental Health. There is not a standardized method for reporting and information provided is limited in indicating compliance. In cases where staff report that they are out of compliance, in many cases the reason is not provided. Staff do not report the number or percentages of rounds completed.

QARM has not conducted an audit to validate reported information.

*November 2016 Implementation Panel findings:* Partial compliance is found related to the policy developed relevant to the concept of a behavioral management unit.

The "60-hours holding crisis" cells in the Broad River CI RHU, the R&E (Unit F-1), the Perry CI RHU, and the Lee CI RHU were not suicide resistant. The crisis cells at the Broad River RHU did

not have beds. It was our understanding that the CSU at the Broad River CI will no longer be a pilot project beginning November 7, 2016.

*Recommendations:* Implement Policy # HS-19.10 and the suicide prevention policy.

Track the occupancy rate of the Broad River CSU and the waiting list, if any, that develops.

**v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;**

*Implementation Panel Assessment:* compliance

*November 2016 SCDC Status Update:* QARM has recently started compiling data to track the number of inmates in security detention, disciplinary detention, maximum security, and short term lock up by inmates with and without a mental health classification. Data currently reflects that inmates without a mental health classification spend more days in all areas of lock-up as compared to those with a mental health classification. Resource Information Management (RIM) distributes spreadsheets weekly outlining the following:

- Institution
- "Days in lock-up".
  - o
- SCDC #
- Name
- Current Custody
  - DD
  - SD
  - MX
  - ST
- "Begin Date in DD
- SD
- MX
- ST Custody"
- Dorm

This information is analyzed and reports sent to the wardens and headquarters leadership.

*Comparison of the Average Number of Days Spent in Segregation by Mental Health or Non Mental Health Classification between September 22 & October 6, 2016*

| September 22, 2016 | | October 6, 2016 | |
|---|---|---|---|

| Mental Health Class | Avg Days in/Custody | | Avg Days in/Custody | Percent change |
|---|---|---|---|---|
| L1 | 254 | | 187 | -26% |
| L2 | 29 | | 45 | 55% |
| L3 | 143 | | 135 | -6% |
| L4 | 483 | | 450 | -7% |
| L5 | 90 | | 93 | 3% |
| MH/OK | 137 | | 227 | 66% |
| MR | 34 | | | |
| SA | 48 | | 44 | -8% |
| UNCLAS | 18 | | 19 | 6% |

*November 2016 Implementation Panel findings:* See SCDC status update.

*Recommendations:* Continue to monitor.

**vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* BRCI CSU was audited in August. Observation showed that the cells were being cleaned when inmates were taken to their showers, but this was not documented anywhere. Temperatures were not being checked in the cells.

This data has not been provided to the Division QARM from any other institutions.

A cell-side log is being developed that will allow for tracking of cell cleaning and temperatures. Equipment (for checking temperature) has been purchased for GPH, and additional units have been ordered to cover the other segregation areas.

*November 2016 Implementation Panel findings:* See SCDC status update.

*Recommendations:* Implement a cell-side log.

**vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* QARM will established a Continuous Quality Improvement Review Committee (CQIRC) to review data concerning inmate safety and

security, analyze operational performance, identify deficiencies, recommend corrective actions, and ensure compliance on an ongoing basis.

This committee has not been formally established. A policy is currently being drafted for consideration for its operation.

*November 2016 Implementation Panel findings:* As per SCDC status update section.

*Recommendations:* Establish and implement the CQIRC.

**c. Use of Force:**

**i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* The automated Use of Force (UoF) System was developed to provide a means of review and tracking use of force within the SCDC. In this system, when a use of force occurs, a MIN is created and uploaded into the automated UoF System, where it is reviewed at multiple levels for compliance with policy and training. The QARM UoF review staff track these incidents to look for trends, disparities in the use of force between inmates with and without SMI. The following outlines the types of reports that will be generated and their content.

**Use of Force Reviews and Reports**

1. Review All MINS daily **(Weekly Report)**
    a. Track Use-of-Force (UoF) allegations
        i. Track UoF allegations total
            1. Track and report by institutions
        ii. Track and compare UoF allegations by MI vs NMH
            1. Track and report UoF MI vs NMH by institutions
2. Review UoF Videos daily **(Weekly Report)**
    a. Report of videos with excessive use of force
    b. Review all documentation uploaded to UOF system
3. Monthly Use of Force MINS review **(Monthly Report)**
    a. Compare the number of UoF MINS with the number of UoF uploads to the automated UoF system
        i. Report total number not uploaded
        ii. Review by institution any discrepancies
4. Grievances **(Monthly)**
    a. Track by institution total and number of grievances related to excessive UOF
5. Use of Force from MINS and Automated UoF **(Weekly with Monthly Summary)**
    a. Total # UoF by institutions
        i. Where UoF occurring
        ii. # UoF against MI vs NMH
        iii. By categories

iv. Planned vs unplanned
1. UoF against MI vs NMH

6. Use of Force involving chemical munitions **(Weekly with Monthly Summary)**
   a. By institutions
   b. By type
      i. Chemicals
      ii. Type
         1. Amount used
            a. Within reason or excessive
               i. If excessive, justification to support
   c. MI vs NMH
7. Report UoF returned to institutions **(Weekly with Monthly Summary)**
   a. By institution
   b. Reasons for kickbacks
   c. Patterns of UoF with staff and inmates

In a review of UoF incidents between June 1-August 29, 2016:

- 93% of were unplanned uses of force.
- 67% involved inmates without a mental health classification.
- 69% involved chemical munitions;
- 30% involved defensive tactics;
- 0% involved the use of a restraint chair;
- 2% involved the use of hard restraints, and
- less than 1% involved the Forced Cell Movement Team.
- Perry and Tuberville had the most uses of force.

*November 2016 Implementation Panel findings:* The SCDC has developed an electronic use of force reporting and reviewing process. Monthly use of force statistics identified in the SCDC Status Update are provided to the designated IP member in a monthly report. Use of Force statistics include inmates and employees involved in use of force incidents. There is a serious concern SCDC management does not have formalized procedures to address administrative violations and excessive force identified during the electronic use of force reviews. The designated IP Member is reviewing SCDC Management Information Notes (MINS) narratives and provides feedback to SCDC Compliance and Operations officials on a monthly basis. SCDC reported there were no employees disciplined for use of force violations for the time frame June 1 to October 31, 2016. SCDC has not developed or implemented a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness. SCDC does not currently have an acceptable system of accountability for when employees commit use of force violations and/or are found to have used excessive use of force.

*Recommendations:* SCDC must develop and implement a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness. A policy and monitoring of use of force on mentally ill and non-mentally ill inmates has been developed; however, the monitoring does not have an accountability component. All staff need training on the new Use of Force Policy. An SCDC department independent of the

SCDC Compliance and Operations Departments will need to be designated to investigate and take action when use of force violations and/or excessive use of force is substantiated.

**ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* UoF Review staff track these incidents and provide reports to Operations, to include types of force and compliance with policy, and compares the UoF incidents against inmates with and without SMI. QARM has been unable to determine manufacturer's guidelines that specifically dictate exact quantities appropriate for use of chemical munitions. Therefore, a quantifiable amount of agent has not yet been defined to be excessive in the use of force involving various chemical munitions.

*November 2016 Implementation Panel findings:* SCDC has revised the OP 22.01 Use of Force Policy and requires all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions. An electronics use of force reporting system has been developed and implemented by SCDC to track instruments of force; however, the monitoring/tracking system does not have an enforcement component for compliance. In a November 11, 2016, meeting with the SCDC Director of Training it was determined the Use of Force Policy and Training Lesson Plans contained language that contradicted manufacturer guidelines for instruments of force in some cases.

*Recommendations:* The SCDC Use of Force Policy and Lesson Plans will require review to ensure the policy and lesson plan language that is contradictory to instruments of force manufacturer guidelines is removed. The Use of Force Master Plan will need to designate a SCDC Department independent of the SCDC Compliance and Operations Departments to investigate, take action, and enforce compliance when instruments of force are used in a manner not consistent with manufacturer guidelines.

**iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* SCDC does not use the crucifix position or others that do not conform to generally-accepted correctional standards. A recommendation to formally ban this practice by stating such in policy has been submitted by Division QARM.

*November 2016 Implementation Panel findings:* As identified by SCDC QARM, Use of Force OP 22.01 does not prohibit the use of the crucifix position or others that do not conform to generally accepted correctional standards. The SCDC Electronic Use of Force Monitoring and Tracking System does not assess incidents to determine if the use of the crucifix position or others that do not conform to generally accepted correctional standards have been utilized in use of force

incidents. The Use of Force Monitoring and Tracking System does not have an enforcement component for compliance.

*Recommendations:* SCDC will need to adopt the recommendation formally submitted by the Division of QARM to revise Use of Force OP 22.01 to prohibit the use of the crucifix position or others that do not conform to generally accepted correctional standards. The SCDC Electronic Use of Force Monitoring and Tracking System will need to include verifying the use of the crucifix position or others that do not conform to generally accepted correctional standards are not utilized in use of force incidents. An enforcement component for compliance independent of the Operations and Compliance Departments needs to be developed.

**iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* No documentation has been provided to indicate that staff are removing restraints before a predetermined period of time if the inmate complies. QARM has discussed the need internally and will make the recommendation for further training and policy revision to specifically include in HS 19.08, Mental Health Services - Clinical Use of Restraints for Mental Health Purposes, language that distinctly states that a predetermined period of time is prohibited.

*November 2016 Implementation Panel findings:* SCDC OP 22.01 Use of Force Policy establishes restraints can only be utilized for the period of time necessary to gain control. The SCDC Electronic Use of Force Monitoring and Tracking System tracks use of force incidents involving the use of restraints. During a meeting with SCDC officials at the Broad River CI CSU on November 2, 2016, it was discovered there had been inaccurate data on the use of restraint chairs. SCDC reported one use of force incident involving restraint chair use from June 1, to September 30, 2016. In the meeting, it was discovered there had actually been three use of force incidents involving the restraint chair.

*Recommendations:* SCDC needs to review use of force reporting procedures and ensure responsible staff are re-trained on electronic use of force reporting and tracking.

SCDC needs to ensure the Electronic Use of Force Monitoring and Tracking System has a requirement that any use of force involving use of restraints includes a review to determine if restraints were only used for the time necessary to gain control.

**v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* At this point, Division QARM has not tracked or trended this information.

*November 2016 Implementation Panel findings:* SCDC OP 22.01 Use of Force establishes protocols for use of the restraint chair including length of time an offender can remain in a restraint chair. The SCDC Electronic Use of Force Monitoring and Tracking identifies the mental health status of inmates involved in a use of force incident. As identified in the November 2016 SCDC Status Update, the Division QARM has not tracked or trended the length of time or mental health status of inmates placed in restraints. Also, as indicated in the previous section, SCDC has not submitted accurate data regarding use of force incidents involving the restraint chair.

*Recommendations:* SCDC needs to utilize the Electronic Use of Force Monitoring and Tracking System to identify the length of time and mental health status of offenders placed in the restraint chair.

SCDC QARM should immediately begin monitoring and tracking use of the restraint chair including the length of time in the restraint chair and the mental health status of the offender.

**vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* Policy OP-22.01 and training for use of force describe circumstances where a use of force is acceptable because of a particular threat. However, the policy does not prohibit use of force in the absence of a reasonably perceived immediate threat, although it is implied. QARM has discussed the need internally and will make the recommendation for further training and policy revision as follows: "The use of force in the absence of a reasonably perceived immediate threat is prohibited."

QARM has not reviewed the training curriculum to determine the extent to which this is covered.

*November 2016 Implementation Panel findings:* SCDC OP 22.01 Use of Force Policy and Training Use of Force Lesson Plans do not prohibit the use of force in the absence of a reasonably perceived immediate threat. Staff conducting SCDC Electronic Use of Force Monitoring and Tracking are not reviewing use of force incidents to identify if use of force was due to a reasonably perceived immediate threat.

*Recommendations:* Revise SCDC OP 22.01 Use of Force Policy and Training Use of Force Lesson Plans to prohibit the use of force without a reasonably perceived immediate threat.

Require all SCDC employees to receive training that use of force is prohibited without a reasonably perceived immediate threat. Staff should utilize the SCDC Electronic Use of Force Monitoring and Tracking System to review use of force incidents to identify if use of force was due to a reasonably perceived immediate threat.

**vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* Policy OP-22.01 and training for use of force describe circumstances crowd-control canisters can be used. However, the policy does not explicitly state that their use is prohibited in individual cells in the absence of objectively identifiable circumstances set forth in writing and only in volumes consistent with manufacturer's instruction, although it is implied. QARM has discussed the need internally and will make the recommendation for further training and policy revision as indicated below.

"The use of crowd-control canisters such as MK-9 is prohibited in individual cells in the absence of the following circumstances, and only in volumes consistent with manufacturer's instruction." (The list of objectively identifiable circumstances will need to be determined by Operations managers and included in the policy.)

QARM has not reviewed the training curriculum to determine the extent to which this is covered.

*November 2016 Implementation Panel findings:* In the SCDC November 2016 Status Update, QARM has identified the OP 22.01 Use of Force Policy does not explicitly prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only in volumes consistent with manufacturer's instructions. A meeting between the responsible IP Member and the SCDC Director of Training on October 31, 2016, confirmed employees have not been trained on the revised Use of Force Policy that includes circumstances in which crowd control canisters can be used in use of force incidents. Review of SCDC July, August, and September 2016 Use of Force MINS narratives by the responsible IP Member identified a significant number of use of force incidents in which MK-9 munitions were not utilized in a manner consistent with manufacturer guidelines, including excessive amounts of munitions.

*Recommendations:* Revise the OP 22.01 Use of Force Policy as recommended by QARM and ensure the Use of Force Lesson Plans include the requirements to prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only in volumes consistent with manufacturer's instructions.

Retrain all employees certified to utilize chemical munitions on proper use in accordance with manufacturer guidelines. The SCDC Use of Force Master Plan will need to designate a SCDC department, independent of the SCDC Compliance and Operations Departments, to investigate, and take action when violations are identified on the use of crowd control canisters, such as MK-9, being utilized in individual cells in the absence of objectively identifiable circumstances set forth in writing and utilized volumes are not consistent with manufacturer guidelines.

**viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* In a review of MINS narratives, it has been observed that counselors are being notified prior to a planned use of force; however, this information has not been tracked specifically to date. Since the recent hiring of two additional Use of Force Reviewers, QARM will be able to more effectively capture and report this data.

*November 2016 Implementation Panel findings:* SCDC OP 22.01 Use of Force Policy Section 11.6 identifies when on duty a mental health practitioner shall conduct the intervention for mentally ill inmates prior to a planned use of force. In a meeting with the responsible IP Member on October 31, 2016, the SCDC Director of Training verified employees have not been trained on the reviewed SCDC Use of Force Policy. The November 2016 SCDC Status Update reports QARM has not been specifically monitoring and tracking this requirement in planned use of force incidents. A review of July, August, and September 2016 SCDC Use of Force MINS Narratives by the responsible IP Member has identified planned use of force incidents where the counselors were notified for intervention prior to the use of force.

*Recommendations:* Train all SCDC employees on the revised OP 22.01 Use of Force Policy including the requirement when on duty, a mental health practitioner shall conduct the intervention for mentally ill inmates prior to a planned use of force.

QARM should begin specifically monitoring and tracking the requirement when reviewing planned use of force incidents.

**ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* The Division of Mental Health and the Division of Staff Development and Training have developed a mandatory training schedule for staff related to managing mentally ill inmates.

QARM did not request the full training outline prior to completion of this report. Although QARM is aware that this is standard practice, this Division failed to acquire the appropriate documentation in time for reporting.

*November 2016 Implementation Panel findings:* In a meeting with the responsible IP Member on October 31, 2016, the SCDC Director of Training provided information that a training plan to provide correctional officers training on the appropriate methods of managing mentally ill inmates has been developed. The IP Mental Health Experts have not reviewed the training plan to assess

if the curriculum provides acceptable training to correctional officers on the appropriate methods of managing mentally ill inmates.

*Recommendations:* The IP Mental Health Experts review the SCDC Training Lesson Plans regarding Methods of Managing Mentally Ill Inmates for Correctional Officers and determine if it is appropriate.

After approval by the IP Mental Health Experts, SCDC needs to establish and finalize how the training will be delivered, develop a schedule for rollout of the training, and ensure all SCDC correctional officers receive the training.

**x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* The Use of Force Reviewer is collecting data based on information uploaded to the Automated Use of Force system and, to date, has shared findings with operations staff leadership at both the institutional and corporate levels.

*November 2016 Implementation Panel findings:* SCDC has developed use of force data reports and generates monthly reports. The responsible IP Member began receiving the monthly use of force reports in March 2016. The SCDC QARM generated an October 17, 2016, Use of Force Summary Report for the time frame June 1 through August 29, 2016, and distributed the report to SCDC officials and the IP. The quality and accuracy of the SCDC use of force incident data and reports is questionable. During the site visit at the Broad River CI CSU on November 2, 2016, SCDC staff revealed three (3) use of force-restraint chair incidents for the reporting period. SCDC collected data and provided use of force reports that identified only one (1) use of force-restraint chair incident during the reporting period. Further assessment is needed by QARM and the responsible IP Member to verify the collected use of force incident data accurately reflects the SCDC use of force incidents occurring.

*Recommendations:* QARM should continue to generate a quarterly use of force summary report for distribution to responsible SCDC officials and the IP and assess the quality and accuracy of the SCDC obtained data and issued quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates.

**xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* SCDC is operating under the UoF policy as it exists now. There is the automated UoF review system, but not all the MIN's are uploaded into the system, and therefore, the appropriate review is not always done as required. In order to capture those that are not uploaded, the QARM has begun monitoring all UoF MINs daily and reporting when inappropriate use of force is suspected.

Any discrepancy between UoF MINs and those uploaded in the automated UoF system are tracked and reported to the warden and Division of Operations.

The QARM has found deficiencies in the process outlined in the policy and has made recommendations for change.

QARM is developing a mechanism to track UoF allegations for compliance and has recommended that Operations put into policy that allegations will be documented in the MINs and automated UoF system.

QARM consulted with Use of Force expert Emmitt Sparkman to outline a system for more effectively tracking and reviewing Use of Force at all levels. This information has not been formally implemented as QARM awaits final approval from the Division of Operations.

*November 2016 Implementation Panel findings:* SCDC has developed an electronic monitoring and tracking system for use of force incidents. The November 2016 SCDC Status Update identifies the deficiencies with the formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed. As identified earlier in this document, the quality management system does not have an accountability component for when employees commit use of force violations and/or are found to have used excessive force. SCDC needs to designate a department, independent of the SCDC Compliance and Operations Departments, to investigate and take action when use of force violations and/or excessive use of force is substantiated. A formal quality management program without an accountability component is incomplete and unacceptable.

*Recommendations:* SCDC should accept the QARM recommendations to address the deficiencies identified in the Electronic Monitoring and Tracking System utilized as the formal quality management system to review use of force incidents involving mentally ill inmates. Develop an accountability component for the SCDC Electronic Use of Force Monitoring and Tracking system utilized as the formal quality management system. Designate a department, independent of the SCDC Compliance and Operations Departments, to investigate and take action when use of force violations and/or excessive use of force is substantiated.

**3. Employment of a sufficient number of trained mental health professionals:**

**a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* Division of Mental Health has demonstrated an increase in the number of positions allotted to provide more mental health services at all levels of care since October 2014. From October 2014 to October 2016, the Division saw an increase in total positions (filled + vacant) of 49.0%. Full-time Staffing numbers have not increased significantly.

The following chart demonstrates clinical staffing totals from October 2014-October 2016; however, QARM has not compared these figures to those recommended by APA and ACA.

| 10/2014 | Full-Time | | Pink Slip | | Dual | | Contract | |
|---|---|---|---|---|---|---|---|---|
| | Filled | Vacant | Filled | Vacant | Filled | Vacant | Filled | Vacant |
| Administration Totals | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| REGIONAL MENTAL HEALTH | | | | | | | | |
| Totals | 69 | 8 | 0 | 0 | 0 | 0 | 1 | 0 |
| CENTRAL SERVICES | | | | | | | | |
| Central Services Totals | 26 | 1 | 7.26 | | | | | |
| **Division Totals** | **97** | **9** | **7.26** | | | | | |

| 10/2016 | Full-Time | | Pink Slip | | Dual | | Contract | |
|---|---|---|---|---|---|---|---|---|
| | Filled | Vacant | Filled | Vacant | Filled | Vacant | Filled | Vacant |
| Administration Totals | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| REGIONAL MENTAL HEALTH | | | | | | | | |
| Totals | 71 | 45 | 0 | 0 | 0 | 0 | 0 | 0 |
| CENTRAL SERVICES | | | | | | | | |
| Central Services Totals | 24 | 18 | 3.3 | 0 | 1.67 | 0 | 1.7 | 0 |
| **Division Totals** | **95** | **63** | **3.3** | **0** | **1.67** | **0** | **1.7** | **0** |

*November 2016 Implementation Panel findings:* See 2(a)(iv).

*Recommendations:* See 2(a)(iv).

**b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* QARM initially collected, entered, and analyzed data and created reports for GPH treatment team participation. Since August 2016, Division Mental Health has begun internal tracking of this information. Staff pilot tested data collection tools at GPH so data are limited.

**Data collected and tracked by QARM**

*Week of July 27*

| GPH Treatment Team Participation | |
|---|---|
| PSYCHIATRIST | 100.00% |
| PSYCHOLOGIST | 59.52% |
| OMHP | 4.76% |
| MEDICAL | 0.00% |
| OPERATIONS | 0.00% |
| INMATE | 0.00% |

*Week of July 4*

| GPH Treatment Team Participation | |
|---|---|
| PSYCHIATRIST | 0.00% |
| PSYCHOLOGIST | 111.54% |
| OMHP | 111.54% |
| MEDICAL | 107.69% |
| OPERATIONS | 0.00% |
| INMATE | 73.08% |

*Week of July 11*

| GPH Treatment Team Participation | |
|---|---|
| PSYCHIATRIST | 0.00% |
| PSYCHOLOGIST | 100.00% |
| OMHP | 100.00% |
| MEDICAL | 100.00% |
| OPERATIONS | 0.00% |
| INMATE | 70.00% |
| INMATE REFUSALS | |

**Data Reported form Division of MH**

*Week of August 1*

| GPH Treatment Team Participation | |
|---|---|
| PSYCHIATRIST | 0.00% |
| PSYCHOLOGIST | 0.00% |
| OMHP | 0.00% |
| MEDICAL | 0.00% |
| OPERATIONS | 0.00% |
| INMATE | 0.00% |

*November 2016 Implementation Panel findings:* Problems relevant to the treatment planning process included the lack of a psychiatrist on a regular basis at the treatment team meetings at all levels of care except for ICS and the self-injurious behavioral unit. Psychiatrists were not present at any other Treatment Team meetings observed or reported. An additional problem was identified at Camille Graham based on a limited records review in which staff inserted "See treatment team note," referring to the sign-in sheet of the meeting; however, several listed disciplines, including

psychiatrists, were not present. This practice must stop. Further, SCDC only recently began regular inmate participation at treatment plans with the exception of ICS and CSU.

It was encouraging that inmates were just recently included in the treatment planning meetings at the Perry Correctional Institution and the Lee CI.

*Recommendations:* See recommendations relevant to mental health staffing. Training regarding treatment plan meetings is recommended.

**c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* The Division of Mental Health has made it mandatory for all newly hired full-time MH clinicians to attend the 4-week Basic Training, which teaches them an overview of the correctional system, including the above. To date, 125 mental health clinicians have completed the training. Furthermore, our training plan includes a review of all the newly developed policies that were drafted to bring us into compliance with the mental health lawsuit. All SCDC employees and contract staff are being required to complete a training module on each policy. These training modules are still being developed.

The chart below reports the number of staff completing the Mandatory/Inmate Suicide Prevention Training Requirements 2016.

| **2016 AGENCY INMATE SUICIDE TRAINING MANDATES** | **Hours** | **Information** | **# complete** | **# not complete** |
|---|---|---|---|---|
| Suicide Prevention Training (Instructor-Led) Training Available 04/27/16-present | 2.0 | Custody Staff Total: 3035 | 1692 | 1343 |
| Inmate Suicide Prevention Training, Video Part 1 Training Available 9/02/16-present | 1.0 | Mandates as Indicated Below Total: 693 | 300 | 393 |
| Inmate Suicide Prevention Training, Video Part 2 Training Available 09/22/16-present | 1.0 | Mandated as Indicated Below Total: 693 | 258 | 435 |

*November 2016 Implementation Panel findings:* as above.

*Recommendations:* Complete training for all mental health clinicians.

**d. Develop a plan to decrease vacancy rates of clinical staff positions, which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* SCDC Health Services hired a recruiter in November 2015. The position was later vacated, and a replacement was hired in the fall of 2016. QARM has not determined increases in pay grades and decreases in workloads. Efforts have been made by SCDC's Recruiting and Employment to streamline the process, decreasing the time frame from interview to on-boarding.

*November 2016 Implementation Panel findings:* See 2(a)(iv).

*Recommendations:* See 2(a)(iv).

**e. Require appropriate credentialing of mental health counselors;**

*Implementation Panel Assessment:* partial compliance

SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4 stipulates that QMHPs will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure.

*November 2016 SCDC Status Update:* As of 10-10-16, the following report indicates a licensure rate of 37%:

# DIVISION OF BEHAVIORAL/MENTAL HEALTH and SUBSTANCE ABUSE SERVICES
# MENTAL HEALTH LICENSED STAFF

| Name | Job Title | Hire Date | Licensure Type (LPC, LMSW, LISW, LPC-I, LPC, LPC-S, PH.D.) | Location |
|---|---|---|---|---|
| **CURRENT STAFF WITH LICENSURE HIRED PRIOR TO 2013** | | | | |
| Hollifield, Deborah | HSC I/CCC IV | 6/7/1999 | LPC | GPH |
| ~~Caldwell, Donald~~ | ~~HSC I/CCC IV~~ | ~~10/1/2007~~ | ~~LBSW~~ | ~~ICS~~ |
| Bradley, Antionette | HSC II/CCC V | 1/28/2008 | LMSW | ICS |
| Goodson, Charles | HSC I/CCC III | 10/6/2008 | LMFT | R&E |
| Gordon, J. Blake | HSC II/Clinical Supervisor | 3/9/2009 | LPC | BMHSAS |
| Foulks, Fawn | HSC II/Clinical Supervisor | 5/2/2012 | LPC | BMHSAS |
| Oberman, Bruce | HSC II | 2/17/2009 | LMSW | R&E |
| DuBose, Kennard | Division Director | 5/2/2012 | LMSW, CAC II | BMHSAS |
| **TOTAL = 7** | | | | |
| **NEW STAFF WITH LICENSURE HIRED AS OF 2013** | | | | |
| Jones, Kim | HSC II/Regional Manager | 7/17/2013 | LMSW | BMHSAS |
| Russell, Crystal | Assistant Director - BMHSAS | 11/4/2013 | LPC-S | Watkins |
| ~~Burgess, Bradley~~ | ~~HSC I/CCC IV - Lead Counselor~~ | ~~11/18/2013~~ | ~~LPC-I~~ | ~~Kershaw~~ |
| ~~Gales, Dana~~ | ~~HSC I/CCC IV~~ | ~~12/2/2013~~ | ~~LPC~~ | ~~GPH~~ |
| ~~Reeser, Nel~~ | ~~HSC I/CCC IV~~ | ~~4/2/2014~~ | ~~LMSW~~ | ~~GPH~~ |
| Richardson, Cindy | HSC III/Clinical Supervisor | 5/2/2014 | LPC | BMHSAS |
| ~~Delgado, Yolanda~~ | ~~HSC III/Program Manager~~ | ~~5/2/2014~~ | ~~LPC-I~~ | ~~BMHSAS~~ |
| ~~Tucker, Bernice~~ | ~~HSC I/CCC IV~~ | ~~8/17/2014~~ | ~~LPC~~ | ~~C. Graham~~ |
| Privette, Rosa | HSC I/CCC IV | 11/17/2014 | LPC-S | Lee |
| Ridgeway, Reuben | Chief Psychologist | 12/2/2014 | Ph.D. | BMHSAS |
| S. Watson/T.Anderson | Psychologists (sharing 1 position) | | Ph.D. | GPH |
| Thomas, Helena | HSC I/CCC IV | 12/17/2014 | LPC-I | Evans |
| Porter, Shawana | HSC I/CCC IV | 1/2/2015 | LPC-I | Turbeville |
| Holzmann, Diane | HSC I/CCC IV | 2/17/2015 | LPC-I | Broad River |
| Watson, Lottie | HSC I/CCC IV | 3/17/2016 | LMSW | GPH |
| Cunningham, Nastassjiah | HSC I/CCC IV | 4/2/2015 | LMSW | ICS |
| Singleton, Shirley | HSC I/CCC IV | 6/2/2015 | LMSW | Lieber |
| ~~Taylor, Kenneth~~ | ~~HSC I/CCC IV~~ | ~~10/2/2015~~ | ~~LPC-I~~ | ~~GPH~~ |
| Jones, Joseph "Frank" | HSC I/CCC IV | 10/2/2015 | LMSW | McCormick |
| ~~Morgan, Margaret~~ | ~~HSC I/CCC IV~~ | ~~10/19/2015~~ | ~~LMSW~~ | ~~Broad River~~ |
| ~~Kennedy, Kelli~~ | ~~HSC I/CCC IV~~ | ~~11/2/2015~~ | ~~LPC-I~~ | ~~Lieber~~ |
| Gibson, Charlette | HSC I/CCC IV | 12/2/2015 | LMSW | KR&E |
| ~~Johnson, Sandra~~ | ~~HSC I/CCC IV~~ | ~~12/2/2015~~ | ~~LMSW~~ | ~~KR&E/ICS~~ |
| Bisson, Martie | HSC I/CCC IV | 1/4/2016 | LPC-I | Perry |
| Means, Cassandra | HSC II/CCC V - Regional Manager | 2/17/2016 | Ph.D.; LPC, LPC-S | Lieber |
| Amick, Toni | HSC I/CCC IV | 3/2/2016 | LPC | BRCI/CS Unit |
| ~~Clark, Lisa~~ | ~~HSC I/CCC IV~~ | ~~3/2/2016~~ | ~~LPC-I~~ | ~~BRCI/CS Unit~~ |
| Holloman, Kathy | HSC I/CCC IV | 3/17/2016 | LPC-I | BRCI/CS Unit |
| Valverde, Paola | HSC I/CCC IV | 5/2/2016 | LPC-I | C. Graham |
| Feemster, Ryan | HSC I/CCC IV | 7/5/2016 | LPC | Tyger River |
| Houck, Susan | HSC I/CCC IV | 7/5/2016 | LMSW | Allendale |
| Hunt, Alisha | HSC I/CCC IV | 7/5/2016 | LMSW | C. Graham |
| Otano, Naomi | HSC I/CCC IV | 7/5/2016 | LMSW | Kershaw |
| ~~Shirley, Kimberly~~ | ~~HSC I/CCC IV~~ | ~~7/5/2016~~ | ~~LMSW~~ | ~~McCormick~~ |

Current Licensure as of 10-10-2016 (Updated: 10/10/2016)

*November 2016 Implementation Panel findings:* See SCDC status update.

*Recommendations:* Perform a QI study relevant to the pertinent provisions of SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4.

**f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* This remedial program was developed in Policy HS-19.07.

3.3.10 Improvement Action Plans:

- When problems or opportunities for improvement are identified from any of the above sources, a CQM action plan will be created and documented for each area for improvement identified.
- An identified finding can be determined to be either an individual or system finding (or both). The following actions are then initiated:

  1) Individual: The clinician and the Regional Manager/Program Supervisor complete the development and implementation of an improvement action plan; and

  2) System: The Division Director, the CQM Director, and the ARC Team complete the development and implementation of an investigatory review and corrective action process plan.

- The improvement action plan will specify tasks, suggest completion dates, and parties responsible.
- The improvement action plan should focus on specific findings so as to help prevent the occurrence of similar problems in the same or other areas or individuals. The plan may include, but is not limited to:
  1) policy, procedure, and/or system changes;
  2) designating ways to handle compliance issues;
  3) additional training;
  4) restricting work responsibilities of individual employees for whom there are compliance or competence concerns;
  5) disclosure of the matter to external parties providing assistance; and
  6) recommendation for sanctions or discipline.

- The CQM Director approves the plan prior to implementation and monitors implementation to ensure successful and sustained resolution. If the problem is systemic, the Division Director and/or Deputy Director will also approve the plan prior to any substantial change.

- Improvement actions that involve personnel-specific intervention will require the establishment and monitoring of an individual performance improvement plan.

No documentation is currently available to substantiate full compliance.

*November 2016 Implementation Panel findings:* The SCDC status update provided a plan that was too generic.

*Recommendations:* Refer to g (below).

**g. Implement a formal quality management program under which clinical staff is reviewed.**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* H.S Policy 19.07, Section 3.3.1 stipulates that the "Mental Health Services Quality Management Director or designee will conduct on-site audits of mental health services at each facility on a twice annual basis. Additional audits may be conducted as recommended by administrative or clinical staff or the ARC Team. Each audit is designed to systematically evaluate mental health service delivery at each institution by:

- Assessing service components for compliance with current practices, policies and procedures including, but not limited to: a review of service delivery logs, treatment plans, individual and group counseling records, timely and effective case management, crisis intervention follow-up, medication monitoring, and discharge planning.
- Reviewing treatment team staffing logs;
- Reviewing quarterly administrative staff training and meetings;
- interviewing inmates and staff."

The role of the Mental Health Services Quality Management Director has been absorbed into the QARM; however, it has been recommended to the Division Director for Mental Health this role should be reestablished within the Division of Mental Health to provide more direct MH internal audits and feedback as the current position under compliance is responsible for tracking all policies associated with the Mental Health Lawsuit.

*November 2016 Implementation Panel findings:* The above plan is too generic. It is our understanding that peer reviews and performance audits performed by the regional mental health staff will help satisfy the requirements of this provision.

*Recommendations:* As above.

**4. Maintenance of accurate, complete, and confidential mental health treatment records:**

**a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:**

**i. Names and numbers of FTE clinicians who provide mental health services;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage confidential medical records and ensure accuracy in medication identifying the number of FTE clinicians who provide MH services.

*November 2016 Implementation Panel findings:* The EHR and the planned web based management information system should facilitate compliance with this provision.

*Recommendations:* See above.

**ii. Inmates transferred for ICS and inpatient services;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* Once implemented, the EHR will more adequately manage confidential medical records and ensure accuracy in tracking inmates who transferred for ICS and inpatient services.

*November 2016 Implementation Panel findings:* See 4(a).

**iii. Segregation and crisis intervention logs;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* QARM has not obtained documentation outlining a system that dramatically improves SCDC's ability to store and retrieve on a reasonably expedited basis. Logs are currently documented on paper. An electronic system would be more feasible in meeting this requirement.

*November 2016 Implementation Panel findings:* See 4(a).

**iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage confidential medical records and ensure the ability to store and retrieve Records related to mental health program or unit (including behavior management or self-injurious behavior programs).

*November 2016 Implementation Panel findings:* See 4(a).

**v. Use of force documentation and videotapes;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* An automated Use of Force System has been established to document use of force and provide an electronic storage and accessibility to video recordings of uses of force.

*November 2016 Implementation Panel findings:* The accuracy of use of force reporting, documentation, and videotaping has not been determined. SCDC does not have a preservation policy for video and audio recordings.

*Recommendations:* A QI needs to be performed to determine use of force data is accurate and use of force video tapes are maintained. SCDC needs to develop a preservation policy for video and audio recordings.

**vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* An automated Use of Force System has been established to document use of force and provide an electronic storage and accessibility to video recordings of uses of force. Use of Force Reviewers collect and track data to produce reports that will be shared on a quarterly basis. To date, one report has been created and shared with Operations leadership.

*November 2016 Implementation Panel findings:* SCDC has developed quarterly reports reflecting total use of force incidents against mentally ill and non-mentally ill inmates by institution. The quality of obtained use of force data is questionable due to findings not all use of force incidents are being reported.

*Recommendations:* A QI needs to be performed to determine the accuracy of use of force reports involving mentally ill and non-mentally ill inmates by institution.

**vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* An automated system has been created to document information on inmates in CI. Because this is an electronic system, the ability to store large amounts of data and to retrieve information on an expedited basis has been greatly enhanced. To date, one report has been partially generated but has not been shared with leadership.

*November 2016 Implementation Panel findings:* See 4(a)(i).

**viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* These reports are generated from RIM and provided on a weekly basis. Because they are electronic and created from existing systems, QARM staff are able to analyze the information and save results on a shared folder on SCDC's network. Because of the electronic nature of this information, barriers to storage and accessibility are minimized. Limited reports have been distributed.

*November 2016 Implementation Panel findings:* See 4(a)(i).

**ix. Quality management documents; and**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* These reports are created by QARM staff and are saved on a shared folder on SCDC's network. Because of the electronic nature of this information, barriers to storage and accessibility are minimized. Limited reports have been distributed.

*November 2016 Implementation Panel findings:* See 4(a)(i).

**x. Medical, medication administration, and disciplinary records**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage confidential medical records and ensure accuracy in medication administration, while allowing for better retrieval of statistical data.

*November 2016 Implementation Panel findings:* See 4(a)(i).

**b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage

confidential medical records and ensure annual review and upgrades in mental health management information system.

*November 2016 Implementation Panel findings:* See 4(a)(i).

**5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**

**a. Improve the quality of MAR documentation;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* The EHR will more adequately manage confidential medical records and track administration of psychotropic medication. Because of accessibility of information and data, this should allow for immediate feedback to staff regarding MAR documentation. Built-in features should remind staff when information is incomplete, which should further improve documentation.

In a QARM audit of CGCI MARs in September 2016, it was found at least once that a psychotropic medication was reordered without the required periodic review. The report from this audit has not been finalized or shared with the medical and mental health directors at this time.

*November 2016 Implementation Panel findings:* See SCDC status update.

*Recommendations:* Work with nursing staff regarding development and implementation of relevant QI studies.

**b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* Because of accessibility of information and data in the EHR, this should allow for immediate feedback to supervisors regarding MAR documentation. Built-in features should remind staff when information is incomplete or orders have not yet been carried out, which should further improve MARs documentation.

*November 2016 Implementation Panel findings:* See 5(a).

**c. Review the reasonableness of times scheduled for pill lines; and**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* A pill line schedule has been provided for each institution. Implementation of an electronic health management systems will verity these times for reasonableness as automated time stamps are a part of the EHR system.

*November 2016 Implementation Panel findings:* See 5(a).

**d. Develop a formal quality management program under which medication administration records are reviewed.**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* Institutional nurse supervisors are required to review MARs and report to Central Office administrators, but QARM has not assessed the efficacy of this QM program, internal to Health Services, under which medication administration records are reviewed.

*November 2016 Implementation Panel findings:* See 5(a).

**6. A basic program to identify. treat, and supervise inmates at risk for suicide:**

**a. Locate all CI cells in a healthcare setting;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* CI cells at Broad River CSU are located in a healthcare setting. QARM staff are working with operations to identify the location of each CI cell in each institution and determine if it is in a healthcare setting. In cases where this is not the case, staff will determine the proximity of CI cells to the healthcare setting.

*November 2016 Implementation Panel findings:* The CI cells at the Broad River CI RHU, the R&E (Unit F-1), the PCI RHU, and the Lee CI RHU were not suicide resistant. The Broad River RHU CI cells did not have beds. A QI needs to be performed regarding relevant elements of the suicide prevention program.

*Recommendations:* See above.

**b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* QARM has drafted a memo suggesting that specific language be included in policy and information relayed in training explicitly prohibiting any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths.

*November 2016 Implementation Panel findings:* A QI needs to be performed re: relevant elements of the suicide prevention program.

*Recommendations:* See above.

**c. Implement the practice of continuous observation of suicidal inmates;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* SCDC Policy HS-19.03 section 6.1 establishes that "when an inmate is referred to CI on an urgent or emergent basis, he or she is to be placed in a safe cell under constant observation until he/she is evaluated by a QMHP. Only inmates already in a segregation cell may be placed in a safe cell within a segregation unit. Whoever makes the urgent or emergent referral will ensure the initiation of constant observation."
QARM has discussed internally and made the recommendation for the development of a CSU policy that should outline who and how often inmate records should be audited for compliance. QARM has also discussed the need to outline and develop a system to alert if an inmate observer is closely approaching or exceeding the five-hour limitation.

In an August 2016 audit of the BRCI CSU Inmate Observers program, it was noted that in 1426 hours of suicide watch of 16 different suicidal inmates, the observers documented 98.88% of the required 15-minute documentations during their watches. There were 15/1426 hours of suicide watches (or 1.12%) during which they failed to document at least one 15-minute note. Of the 16 inmates evaluated, there were 42 times that the inmate observers documented that an employee, usually an MHT, relieved them for a portion of their shift (typically 30 min – 1 hr.). Thirteen of those 42 times (31%) did not have an accompanying "Employee Watch Log" provided to document continuous SP watch by that employee.

In a September 2016 audit of Camille Graham, the QARM auditor was told that the CI cells in the RHU were checked every 15 minutes, and documentation was provided to support that statement. However, no documentation could be provided to show continuous watch of suicidal inmates.

QARM staff have not collected documentation about continuous suicide watches from other institutions at this point.

*November 2016 Implementation Panel findings:* A QI needs to be performed regarding relevant elements of the suicide prevention program.

*Recommendations:* See above.

**d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* While it is observed at BRCI CSU that inmates are provided clean, suicide-resistant clothing, blankets, and mattresses, specific documentation has not been requested. The assessment of documentation will be included in all standard CI reviews and audits.

*November 2016 Implementation Panel findings:* A QI needs to be performed regarding relevant elements of the suicide prevention program.

*Recommendations:* See above.

**e. Increase access to showers for CI inmates;**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* Refer to SCDC Policy HS-19.03

- RHU inmates in CSU will be allowed daily showers if security staffing presence permits. Otherwise, RHU inmates will be allowed to shower a minimum of 3 times per week.
- Non-RHU inmates in CSU will be allowed to shower daily, unless restricted by a psychiatrist or licensed psychologist.
- All non-RHU CSU inmates, unless clinically contradicted, shall have access to out of cell time for 10 hours structured and 10 hours unstructured in a 7 day period.

**CSU Inmate Showers from May 12 – July 31, 2016**

| | |
|---|---|
| Total Inmates in the Sample | 21 |
| Total # RHU Inmates | 14 |
| Total # Non-RHU Inmates | 7 |
| Average # days in CSU | 11 |
| Total days in CSU for all inmates | 227 |
| Averages Showers given/offered | 96% |
| Total showers given/offered | 217 |
| Average showers refused | 7% |
| Total showers refused | 156 |
| Average showers not offered | 28% |

QARM staff has not been given quantifiable data from other institutions regarding showers in their RHU's.

*November 2016 Implementation Panel findings:* A QI needs to be performed regarding relevant elements of the suicide prevention program.

*Recommendations:* See above.

**f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* No data to verify or substantiate that meetings between CI inmates and mental health counselors, psychiatrists, and psychiatric nurse practitioners were confidential. However, in an August 2016 audit at BRCI CSU, it was observed that individual sessions were held in a confidential setting.

*November 2016 Implementation Panel findings:* A QI needs to be performed regarding relevant elements of the suicide prevention program.

*Recommendations:* See above.

**g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and**

*Implementation Panel Assessment:* noncompliance

*November 2016 SCDC Status Update:* BRCI CSU was audited in August. Observation showed that the CI cells were being cleaned when inmates were taken to their showers, but this was not documented anywhere. Temperatures were not being checked in the cells.

This data has not been provided to the Division QARM from any other institutions.
A cell-side log is being developed that will allow for tracking of cell cleaning and temperatures. Equipment (for checking temperature) has been purchased for GPH, and additional units have been ordered to cover the other segregation areas.

*November 2016 Implementation Panel findings:* A QI needs to be performed regarding relevant elements of the suicide prevention program.

*Recommendations:* See above.

**h. Implement a formal quality management program under which crisis intervention practices are reviewed.**

*Implementation Panel Assessment:* partial compliance

*November 2016 SCDC Status Update:* A formal QM program has not been established; however, QARM is drafting a policy to establish an agency CQI policy under which CI practices will be reviewed.

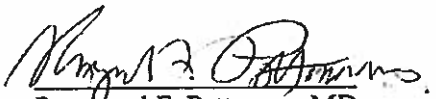
*November 2016 Implementation Panel findings:* A QI needs to be performed regarding relevant elements of the suicide prevention program.

*Recommendations:* See above.

**Conclusions and Recommendations:**

The IP has provided its recommendations on specific items in the Settlement Agreement in this report and while on-site. We have also provided suggestions to SCDC to pursue development of their own internal processes and support systems for an adequate mental health services delivery system and quality management system. We are providing this report initially as a draft report to the parties for any comments they want to make, and we will consider those comments when finalizing this report; however, the report will reflect the IP's findings and recommendations as of November 4, 2016. The IP is hopeful that this report has been informative. We look forward to further development of the mental health services delivery system within the South Carolina Department of Corrections and appreciate the cooperation of all parties in the pursuit of adequate mental health care for inmates living in SCDC. The IP requests any comments regarding this report be provided within fifteen days of the date of this Draft Report.
Sincerely,

**Respectfully Submitted,,**



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