EXHIBIT C

MEMORANDUM

May 23, 2003

TO: Mr. Jon Ozmint
Dr. J.L. Gowan
Mr. Richard Strocker
CC: Mr. George Gintoli
Ms. Shirley Furtick
FR: Diane Cavenaugh
RE: Initial Observations and Recommendations Regarding Department of Corrections Mental Health Services

As of this writing, I have visited Gilliam Psychiatric Hospital, Camille Graham Women's Center, Leath Correctional Facility, McCormick Correctional Facility, Lee Correctional Facility, and Kirkland Reception/Evaluation, Intermediate Care Services and Maximum Security Unit. I have observed services and treatment team meetings; have interviewed mental health, medical, security and administrative staff; and have read treatment plans. I will soon visit the other facilities and programs. Based on my experiences to date, I offer the following observations and recommendations.

NOTE: A table containing the following information is attached, for those who prefer a display to a narrative.

Observation 1:
The mental health services lack a shared mission, vision and purpose. They are grossly understaffed. There is insufficient structure throughout most programs, most particularly those that serve persons with acute mental illness or serious and persistent mental illness. There is a general sense of lack of direction throughout the programs/services/facilities, and chaos in some programs. Mental health services overlap with other behavioral health services, with minimal coordination or communication. Communication between some programs is very poor, adding to the many barriers to mentally ill inmates getting the services they need. Systems need to be established that ensure that security measures and mental health service delivery are coordinated.

Recommendation 1.1:
Hire a Mental Health Director with a strong background in administration, program development and clinical practice to oversee services for people with mental illness/retardation; develop and implement consistent services and programs throughout all facilities; and ensure compliance with SCDC policies and sound clinical practice.

Recommendation 1.2:
Evaluate the possibility of consolidating Mental Health, Substance Abuse, Sexual Offender, Youthful Offender and HIV programs under a Behavioral Healthcare Program.

Observation 2:
Psychiatric and psychiatric nursing services are in disarray due to the shortage of psychiatrists and lack of psychiatric oversight of prescription, administration and monitoring of psychotropic medications. The shortage of psychiatrists, with only approximately 1.5 FTE psychiatrists at this time, has resulted in inmates with serious mental illness being without medication. There is often a significant delay in inmates being

seen for an initial assessment and in being rescheduled prior to their prescriptions lapsing or when the inmates are suffering side effects of medication. It is very difficult to find a physician able/willing to refill existing prescriptions. Many physicians providing medical services are reluctant to prescribe psychotropic medications, more and more so as the lack of psychiatric backup has reached critical proportions.

Numerous inmates with psychotic disorders are on 23-hour lock-up because of behaviors attributable to untreated mental illness. Rehabilitative mental health services cannot be provided to these inmates because of the shortage of clinical and security staff.

Inmates who need to be involuntarily committed are frequently discharged to the general population because there is no physician to evaluate and attend Probate Court hearings.

The lack of psychiatric coverage has resulted in a critical situation, with extremes of poor care, inhumane treatment and dangerousness for staff and inmates. The situation at Gilliam Psychiatric Hospital is particularly bad, with a psychiatrist available only one day every two to three weeks, despite the fact that these inmates are acutely mentally ill and many of them are involuntarily committed. Inexplicably, Gilliam appears to have the least psychiatric coverage of all mental health services.

Recommendation 2.1:
Employ a minimum of four (4) full-time equivalent psychiatrists (or physicians dedicated to psychiatry), with 1.5 FTEs dedicated specifically to Kirkland Correctional Facility/Gilliam Psychiatric Hospital. This entails adding 2.5 FTE psychiatrists to the current staff. I recommend that three (3) additional full-time psychiatrists be employed in lieu of contract, part-time psychiatrists, if at all possible.

Recommendation 2.2:
Establish the position of Chief Psychiatrist to provide oversight of all psychiatric services, train and supervise psychiatric medical staff, provide consultation and training to non-mental health physicians and nurses, and participate in the development/implementation/review of programs, policies and procedures. This position could be part-time, though it is preferable that the position is full-time and be one of the four psychiatrists providing direct care.

Recommendation 2.3:
A psychiatrist should supervise the nurse practitioners and allow practice within the extent of their licenses, to extend psychiatric medical coverage.

Recommendation 2.4:
All physicians and nurses receive training and consultation, in general and on a case-by-case basis, about psychotropic medications. Dr. John Cusack is willing to provide this training. Training can also be provided by psychiatrists with the Department of Mental Health.

Recommendation 2.5:
Evaluate the possibility of siting psychiatrists at fewer institutions and have Outpatient clients brought from their institutions for their appointments, to decrease time spent on travel for this very limited resource.

Recommendation 2.6:
The Director of SCDC and the Director of SCDMH, approach the Budget and Control Board with evidence of inability to fill vacant psychiatric positions and seek higher salaries for psychiatrists.

Recommendation 2.7:
Develop a contractual relationship with USC and/or MUSC to establish a resident program in SCDC facilities, under the supervision of the Chief Psychiatrist.

Observation 3:
A high expectation of medication compliance (80% or no more than 2 days missed in "Pill Line") exists that is not appropriate for persons with mental illness, even those held in a controlled environment. While this is not policy, it is a common practice for some physicians, with encouragement from nursing staff. Medication has been abruptly discontinued by medical staff without involvement of clinical staff, a breach of SCDC policy. This practice is clinically counterproductive and medically contraindicated.

Recommendation: 3.1:
Medication will be discontinued only after a review and recommendation by a psychiatrist and the clinical treatment team.

Recommendation 3.2:
Physicians and nurses will be provided training about psychotropic medication, compliance, and the effects of discontinuing medication.

Observation 4:
While the Formulary for medications is necessary from a financial standpoint, it is not always conducive to good mental health care. Medications that best treat some intractable illnesses are not available or must be approved by a committee; staff's perceptions are that physician requests for medication, even with considerable justification, are more often denied than approved (I do not as of this writing have information to support or contest this perception). When medications are removed from the Formulary, inmates cannot be seen by a physician prior to elimination of the unapproved medication, resulting in inmates' medications being discontinued altogether. Some of the older medications, while effective, also have more side effects than newer medications. The shortage of psychiatrists prevents the follow-up care that is necessary with these medications, resulting in inmates having serious side effects with no treatment.

Recommendation 4.1:
Inmates with intractable illnesses with a proven history of unsuccessful treatment with other medications and successful treatment with a non-Formulary medication will be approved for non-Formulary medication when justified by the prescribing physician.

Recommendation 4.2:
Inmates who are prescribed a medication at the time that the medication is removed from the Formulary will continue the medication until s/he can be prescribed a medication from the Formulary.

Recommendation 4.3:
Inmates who have the means may purchase non-Formulary medications prescribed by his/her physician.

Recommendation 4.4:
Inmates with side effects will be considered in need of urgent care and will be given an appointment with a physician on an emergent basis if a regular appointment is not available.

Recommendation 4.5:
Evaluate the "Pill Line" to determine if there are more efficacious methods of administering medication. Leath Correctional Facility's system, wherein the nursing staff delivers medications to the inmates in their residences, should be reviewed as a potential model for other sites.

Observation 5:
Almost all mental health programs are understaffed, resulting in inadequate care for inmates and very poor morale among staff. Approximately 50% of the mental health positions on the organizational charts are vacant. Staffing is inconsistent from facility to facility, with some programs with inmates with less intensive needs having more staff than programs serving high-need inmates. Several mental health staff have been

"bumped" by staff from other services who do not have a background in mental health service delivery, making the staffing situation more difficult as experienced mental health staff are replaced by staff who have a behavioral science degree but not a mental health background.

It should be noted that in addition to the approximately 2200 inmates with mental illness that are under the care of the mental health staff, non-mental health inmates in lock-up must be evaluated by mental health staff on a regular basis. In addition, the staff provides crisis services to all inmates in the system.

Clinical staff spends a great deal of their time in scheduling inmates' appointments with the psychiatrist, reducing the time they have available for treatment delivery.

The number of Security staff in some programs is also of concern, as clinical and security staff report that they are not staffed at a level that enables them to perform all their duties, especially when a client is on Crisis status.

Recommendation 5.1:
Gilliam Psychiatric Hospital needs to be staffed at a level that ensures adequate coverage of persons who are acutely mentally ill. At this time, the level of staff at Gilliam Psychiatric Hospital needs to increase by the 1.0 FTE psychiatrist noted earlier and four (4) Human Services Specialist II positions. These positions are critical in order to provide sufficient coverage on the bays. Further staffing needs may emerge as a more appropriate treatment regime is established.

Recommendation 5.2:
The Intermediate Care Services programs for men and women need to be staffed at a level that supports a rehabilitative approach/programming. The addition of mental health aides, non-professionals skilled in the care of persons with serious mental illness in a secure setting, would enable enhanced programming. I recommend that two aides for each ICS program (four total) be employed and that an additional mental health professional be hired for Graham. Weekend and evening programming need to be added; if not now, when the financial situation improves. This might be accomplished with part-time staff, possibly dually employed with the Department of Mental Health.

The recommended caseload size range for ICS level of care is 20 - 35 per Case Manager.

Recommendation 5.3:
The recommended caseload size range for AMH is 35 - 50, with a range of 50 to 150 for Outpatient Services. Each facility that houses a significant number of mentally ill inmates needs to have a minimum of two mental health staff, for continuity of care, security and best practice reasons.

Recommendation 5.4:
Counseling staff in the male Outpatient and Area Mental Health programs be increased by five mental health professionals.

Recommendation 5.5:
An additional mental health position be established at Leath. One of the counseling staff at McCormick, which has three counselors, could be moved to Leath in lieu of one of these positions. I recommend that it be a master's level position.

Recommendation 5.6:
Master and bachelor's level mental health staff should be qualified mental health professionals or paraprofessionals. Mental health positions should require a background in mental health training and experience, not to be replaced with other behavioral or social service training and experience.

Recommendation 5.7:
Evaluate the possibility of further consolidation of Outpatient and Area Mental Health programs into fewer institutions, to increase availability of treatment, decrease travel time for staff and ensure mental health staff are not working alone in an institution.

Recommendation 5.8:
Employ an Appointment Clerk to coordinate the psychiatrists' schedules; this position will be much less expensive than mental health professionals' time spent in this activity, and will free up treatment staff to provide clinical care.

Observation 6:
Persons with serious mental illness require a great deal of structure, support and consistency, and the lack or opposite of these exacerbates symptoms and behaviors associated with the illness. In particular, the inmates at Gilliam Psychiatric Hospital and the men and women's Intermediate Care Services are in need of consistency and structure. The current programming at the hospital and at the ICS sites do not meet the needs of seriously mentally ill inmates, due to inadequate clinical and security staffing levels, scheduling conflicts with security measures and general operations, and insufficient programming. These programs should offer a full day of education, groups, activities, and individual time with staff. Evening and weekend activities are important in helping persons with mental illness attain stability. The current programs at the Kirkland ICS and Gilliam are scheduled 2 -4 hours a day, Monday - Friday, but even this rather minimal programming is often disrupted. The programming at the Graham ICS is non-existent.

Restructure special needs Lieber/Perry

Numerous inmates with severe behavioral problems have been expelled from the ICS program at Kirkland, resulting in them being placed in lock-up and receiving little or no treatment. These individuals are violent, impulsive, chronically if not continuously suicidal, self-mutilate and often treatment-resistant. They need special treatment approaches that are not currently available in any program, so they are frequently hospitalized or live in lock-up. The psychiatrist shortage contributes significantly in the lack of treatment for these individuals.

A special problem at Graham is that the acoustics in the day room of Intermediate Care Services are extremely bad, making it very difficult to hear and impossible to provide treatment. The noise contributes to inmates' considerable stress level and exacerbation of symptoms because of the difficulty people with serious mental illness have in blocking stimuli.

Similarly, the ICS inmates in lock-up at Lee are in an extremely noisy, disruptive environment where no treatment can be delivered. The counselors must shout to be heard and get very close to the door to hear the inmates, which is not only clinically unsound, it is not safe. As with Graham, these inmates are essentially receiving no services.

Many, if not most, of the inmates at Gilliam and the ICS programs are not in a work detail and have little support from families, thus have no access to funds to purchase materials and equipment that would help them structure their time and support stability. The materials and equipment of the programs is very limited and very dated.

Recommendation 6.1:
A consistent, clinically appropriate program day be developed for inmates at Gilliam and ICS. The addition of evening and weekend activities is preferred but not critical at this time. Programming needs to focus on management of symptoms and behaviors, practical living skills, behavior management, and normal life role functions. Discrete programming needs to be established to address the special needs of inmates with long sentences and those with short sentences.

Recommendation 6.2:
Address the acoustics problem in the Graham ICS, and ensure that the unit has adequate treatment space.

Recommendation 6.3:
Establish a Behavioral Management Unit for men that is sufficiently staffed to enable programming specific to the needs of individuals with severe acting-out behaviors and mental illness. These persons need to be distinguished from inmates whose acting-out behaviors are due to antisocial and criminal intent. The latter individuals need to be managed through Security and not Mental Health, as they are very disruptive to treatment and prey on vulnerable mentally ill inmates.

Recommendation 6.4:
I recommend television headphones be standard equipment for the inmates at Gilliam and the ICS programs. The headphones would belong to the institution and not the individuals. Providing headphones will give the inmates something to do outside program time and will cut down considerably on the restlessness, boredom and frustration that lead to increased symptoms, acting out and fights. When financially possible, educational and activities materials and equipment need to be updated.

Observation 7:
The distinction between Area Mental Health and Outpatient services is very unclear at this time. There is little, if any, difference in the level of care if an inmate is in an Outpatient service or an Area Mental Health service. The level of care is more dependent upon the number of mental health staff at a given facility than on inmates' needs. There is a considerable range of functional level among the inmates using both these services, with little distinction in the services provided.

Some staff, particularly Dr. Cusack, suggest housing Area Mental Health clients in the same wing(s), as they believe mentally ill inmates are being victimized by other inmates when they are in the general population.

Recommendation 7.1:
Programming needs to be developed and provided in keeping with the varying treatment needs of inmates served in these two sets of services, and the programs staffed accordingly.

Recommendation 7.2:
Evaluate the suggestion of Dr. Cusack and other staff regarding the need to house Area Mental Health clients in the same areas, away from the general population.

Observation 8:
Outpatient and Area Mental Health programs are designed around the Count, Pill Lines and Chow, which means minimal formal treatment and large blocks of time for inmates with nothing to do or to wait in a line. The decision to suspend services during the Count varies from facility to facility and officer to officer, so day-to-day programming is constantly disrupted. The Count time varies from day to day, so planning around the Count is almost impossible.

Staff report that dinner is as early as 3:00 p.m. for some inmates in mental health programs, making it very difficult to provide an effective treatment "program day" and resulting in an exceedingly long, boring afternoon and evening for the inmates. Many of the inmates have no funds and are unable to purchase snacks; they are hungry at night, adding to their frustration levels and contributing to an exacerbation of symptoms and behavioral problems.

Recommendation 8.1:
Develop systems that accommodate treatment and the Count and ensure consistency throughout the system.

Recommendation 8.2:
Administration of medication, i.e. "Pill Line," should be set up in a manner that is the most clinically appropriate for inmates with serious mental illness: for GPH and ICS, administration of medication is within the facility where the inmate resides or is in program, and/or medication administration is incorporated into the program day, with assistance from counseling staff.

Recommendation 8.3:
For Area Mental Health facilities, the counseling and medical staff should develop a plan for each facility that ensures that mentally ill inmates receive their medication in a consistent and clinically appropriate manner, in collaboration with mental health services. Mental health and medical staff should review practices for Outpatient mental health clients to determine if serious issues exist in the areas of medication administration, and to develop a plan to address any problems. This plan should be presented to Dr. Gowan in writing.

Recommendation 8.4:
Meal times for inmates in mental health programs need to be established in keeping with mental health programming. In particular, the evening meal needs to be at a time that is not disruptive to necessary treatment services and that does not contribute to the mentally ill inmate's symptomatology. If possible, snacks should be provided for inmates with mental illness who are hungry at night (due to mealtime or medication) or who need snacks as a part of mental health treatment. Supervisory mental health and operations staff need to develop a plan for each facility that addresses the needs of mentally ill inmates, programs and operations. These plans need to be presented to the Medical Director and the Operations Director, or their designees.

Note: After exploring these issues with Operations staff, I believe part of the problem is that mental health staff do not always advocate on behalf of their clients, largely because they do not feel empowered to do so. The issue of advocacy as a part of mental health treatment and how to meet the needs of inmates with mental illness while also meeting operations and security demands needs to be addressed within Medical Services, via training, discussion and collaboration with other divisions.

Observation 9:
The descriptions and protocols for mental health services vary by program, supervisor and front-line staff. The descriptions I have been provided to date are inadequate to demonstrate program content, inclusion and exclusion criteria, goals and outcomes. Descriptions of some services consist only of a written statement that the service is going to occur. Some staff conduct groups with no written descriptions. While some very good educational material has been purchased and is in use, it is important that the groups be more than presentation of "canned" material for them to be effective.

There is a general sense of "catch as catch can" to the provision of services: groups are often delayed or cancelled; one-to-one contacts are very brief and focus on inmates' day-to-day living requests; the caseloads are too high for most staff, so there is inadequate contacts with all inmates; and structured programming is minimal.

In some facilities, "Attitudinal Approaches" are used in lieu of best practice therapeutic approaches. While the "Attitudinal Approaches" have clinical underpinnings, standard treatment goals and strategies need to be employed. In addition, the "Attitudinal Approaches" are intended to be used by mental health and security staff alike, but security staff have not been trained in these approaches in many years.

Clinical documentation varies greatly, with some treatment plans used more as reports than an outline of goals to be achieved and strategies to be used. In general, the documentation system is adequate and not too burdensome for staff.

Recommendation 9.1:
A system-wide Mental Health Program needs to be developed that is inclusive of all services, has a common mission/vision, and has written program descriptions, treatment goals, protocols for treatment delivery and documentation, outcome measures, and evaluation. Mental health staff, led by supervisory staff, need to be involved in the development of these descriptions, protocols, etc.

Recommendation 9.2:
Evaluate mental health staff's activities to ensure that their time is being dedicated to mental health service delivery, including case management. Following that, establish a standard of direct service time for formal treatment delivery, including the provision of groups and individual sessions. I recommend a range of 45 – 65%, based upon the review of activities and the particular job assignment.

Observation 10:
There is no formal Quality Assurance/Improvement Program that evaluates the effectiveness of clinical care. There is an auditing system, but this system focuses more on documentation protocols being following than on evaluating the effectiveness of treatment programs.

Recommendation 10.1:
A Quality Assurance/Improvement Program be developed that focuses on effectiveness of clinical care as well as adherence to policies and procedures.

Observation 11:
While there are generally very good working relationships between mental health and security staff, there are areas of concern and confusion that should be addressed. Security is clearly the uppermost concern of everyone. However, mental health staff and clients are frustrated and the effectiveness of treatment is compromised because of not being able to adhere to program schedules. This varies from warden to warden, captain to captain, shift to shift.

Mental health staff and clients report that some security staff exacerbate mentally ill inmates' symptoms and behaviors by taunting them, yelling at them and in general having a disparaging attitude toward them. Some staff openly say to the inmates and staff that they believe the inmates are making up symptoms. During one of my visits, security staff reported that a client was placed on Crisis status but was not provided clothing or cover of any kind so was left naked all night; additionally, the staff on duty did not log the Crisis status so there was no mental health follow-up.

Another area of confusion is in the supervision of mental health staff. There appears to be a dual system, with wardens having a role in supervision, particularly in institutions where there is not a supervisor on site. Staff report that they are assigned duties and responsibilities by the wardens that are outside their job descriptions.

Recommendation 11.1:
Develop mechanisms that reinforce the concept that security is the primary objective of all SCDC staff, including mental health staff, and that mental health treatment for seriously mentally ill inmates plays a vital role in keeping potentially troublesome inmates stable.

Recommendation 11.2:
Establish system-wide policies and protocols for the delivery of mental health treatment and its coordination with security measures and other operations.

Recommendation 11.3:
Require all security staff who work with mentally ill inmates, including wardens, majors and captains, to participate in training about mental illness and the benefits of treatment.

Recommendation 11.4:
Clarify supervisory roles, with mental health staff supervised by mental health supervisors and mechanisms for mental health supervisors and wardens or their designees to collaborate on the mental health staff's assignments.

Recommendation 11.5:
Develop (or reiterate) clear policies for staff regarding treatment of inmates, and establish mechanisms to ensure that staff who interact inappropriately with inmates will receive supervision and training.

Recommendation 11.6
Assign security staff to Gilliam, Graham, and ICS programs on a permanent basis. Explore the possibility of doing the same with Area Mental Health programs.

Observation 12:
I have been very impressed with the caliber of mental health staff as a whole. I am particularly impressed by their positive regard for their consumers and their positive energy in the face of tremendous disadvantages. The large majority of them are very skilled, with excellent backgrounds. Morale, however, is a severe problem. The primary reason is the shortage of staff. A secondary reason is that of poor communication, program to program and with the Central Office/Headquarters. They feel cut off from information and uninvolved in decision-making about their programs. They are very worried that the mental health services will be privatized and they will lose their jobs and/or benefits. I would like to note that staff presented their concerns in a very professional manner, without blaming and negativism.

Recommendation 12.1:
Develop mechanisms, such as weekly or bi-weekly supervisors meetings, to enhance communication and care coordination, and to keep staff informed. In the absence of a Mental Health Director, the Medical Director should attend these meetings at least once per month. I recommend that the first meeting occur in the near future, to hear concerns and answer questions.

Recommendation 12.2:
Involve at least first-tier supervisors (Mitchell, Powell, Johnson and Page) in decision-making and problem-solving activities that affect mental health programs.

Recommendation 12.3:
Consider maintaining mental health services as a part of SCDC operations in lieu of privatizing these services. The reasons I recommend this are: a) privatization will likely result in SCDC losing some excellent staff, further disrupting services, b) there is a very real need for the mental health and security staffs to work together as one system; it will very likely be more problematic to have an outside organization accepted as part of the system; c) privatization has been tried in the past and is viewed by most staff as having failed and d) there is an excellent foundation upon which to build a good mental health program.

Summary of Minimal Additional Positions to Significantly Improve Services:
Director of Mental Health Services
2.5 psychiatrists
7 mental health professionals
10 mental health aides
1 clerk
Rough estimate of cost: $1.8 million

Summary of Immediate, Critical Positions Needed:
1.5 psychiatrists

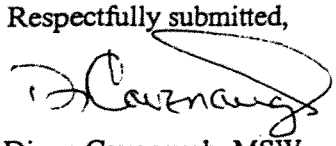
3 mental health professionals
4 mental health aides
Rough estimate of cost: $500,000

Further refinement of services should occur as the department's financial situation improves.

I am continuing to visit facilities and review programs and services, and may have other observations and recommendations. I will also provide sample programming and staffing models and, if desired, will work with staff on developing a system-wide Mental Health Program per Observation 9.

In our first meeting, we discussed periodic meetings to review the progress of this project. I am requesting a meeting in June so that we can review the work to date and further clarify future expectations.

Respectfully submitted,



Diane Cavenaugh, MSW
Program Manager I, South Carolina Department of Mental Health

MEMORANDUM

July 11, 2003

TO: Mr. Jon Ozmint
Mr. John Davis
Mr. Richard Strocker
CC: Mr. George Gintoli
Ms. Shirley Furtick
FR: Diane Cavenaugh
RE: SCDC Mental Health Program Description

Please find attached the Mental Health Program Description that I recommend for the Department of Corrections. I have given a copy of this description to the top-tier Mental Health Services supervisors for review/comment. I discussed the content with them as I was working on the document. This is not a definitive description of services and protocols, but should provide a good start for the supervisory staff and Health Services and Mental Health Services leadership to build a stronger mental health program for the Department.

While there are many enhancements that I would recommend were there resources to support them, I am recommending improvements and programming that are realistic to the Department's fiscal situation. I believe services can be improved a great deal with a few additional staff. As the budget situation improves I hope that the mental health services can be significantly enhanced.

For your convenience, I am summarizing below what I think are the key steps to making improvements in mental health services at the South Carolina Department of Corrections.

- Employ an Administrator to manage the state-wide mental health services; it might be possible to have one of the Department's seasoned mental health supervisors take on this role in addition to his/her current responsibilities, at least until the financial situation improves.
- Establish a Chief Psychiatrist position, to report to the Mental Health Services Administrator; I recommend Dr. Cusack for this role.
- Employ an additional 1.0 FTE psychiatrist, bringing the total to 3 full-time psychiatrists; if necessary, part-time psychiatrist positions could be eliminated in favor of full-time psychiatrists. If this is not possible, consider increasing the number of part-time psychiatrists throughout the state, perhaps by offering dual employment to psychiatrists employed by the Department of Mental Health.
- Employ a minimum of one and preferably two mental health professionals at Lee Correctional Institution.
- Employ a mental health professional for Graham.
- Employ four nonprofessional level mental health staff for Gilliam and two each for the men's and women's Intermediate Care Services programs (total of eight).
- Consider establishing a Behavior Management Unit which can serve inmates with severe acting-out problems, most of whom are currently on 23-hour lock-up; these inmates are seriously underserved and need more services as soon as possible.
- Implement stronger treatment programs at Gilliam and the two ICS programs by increasing the number and variety of services; sample schedules for these services are attached to the Mental Health Program Description narrative.

- Address the coordination of security measures and mental health service delivery so that mental health services are provided on a more consistent basis. I recommend a committee made up of security and mental health supervisors be given the responsibility for developing a plan to ensure that mental health services and security measures are coordinated throughout the system.
- If possible, assign permanent security staff to the hospital and ICS programs.
- Provide more training to all levels of security and operations staff working with inmates with mental illness.

In addition to the information noted above and contained in the memorandum of May 23 and the attached document, I would like to add an observation regarding the working relationship between the Department of Corrections and Department of Mental Health:

1. SCDC mental health staff throughout the system reported little difficulty in getting initial appointments at community mental health centers for inmates being discharged; there were a couple of exceptions and I have brought this to the attention of the directors of those centers, Columbia Area Mental Health Center (staff in all programs reported difficulty) and Charleston/Dorchester Mental Health Center (one staff person reported difficulty with this center). However, they said that when discharged inmates do not keep their appointments, there is little follow-up/pursuit by community mental health centers, so that former inmates with mental illness frequently do not receive mental health services after being discharged.

2. The directors and other staff at Bryan Psychiatric Hospital and Patrick Harris Hospital expressed considerable concern that inmates with mental illness who are maxing out are committed to the hospitals in very serious conditions, having not been given appropriate levels of mental health care for some time. The psychiatrist shortage at the Department of Corrections and the difficulty of getting people the medication they need appears to be the primary reason for this.

I will wait to hear from you about future directions.

Respectfully submitted,

Diane Cavenaugh, MSW, Program Manager I

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH PROGRAM

MISSION STATEMENT

Best-practice correctional mental health services are provided to inmates diagnosed with a mental illness, in a manner that ensures the health and safety of the community, the staff and the inmates.

VISION STATEMENT

The South Carolina Department of Corrections' Mental Health Program will be at the national forefront of correctional mental health service delivery.

GOALS

1. All incoming inmates are evaluated to determine if mental health services are needed.
2. All inmates who exhibit symptoms and behaviors of a mental illness receive a thorough evaluation by a mental health professional.
3. All inmates diagnosed with a mental illness receive an appropriate level of mental health to effectively treat their mental illness.
4. Best-practice correctional mental health care is provided.
5. Highly qualified staff are recruited and retained.
6. The quality assurance/improvement process ensures that service delivery is effective and efficient.
7. All staff (clinical, operations, administrative and security) who routinely work with inmates with a mental illness receive training about the symptoms and behaviors associated with the most common mental illnesses, and on effective approaches to persons with a mental illness.
8. All incoming staff receive training regarding mental illness during their orientation.
9. Discharge activities ensure inmates with a mental illness are prepared to leave the correctional system, with adequate follow-up in the community.

ORGANIZATION

The South Carolina Department of Corrections (SCDC) Mental Health Program is a function of the SCDC Health Services, and is responsible for serving all inmates who have been diagnosed with a mental illness and classified as mentally ill. The Mental Health Program also provides mental health services to special populations, crisis services to the general population and regular evaluations of persons in lock-up.

The Mental Health Program is managed by an Administrator with a strong background in mental health service delivery, program planning and administration. The Mental Health Administrator reports to the Director of Health Services. The Director of Health Services reports to the Director of SCDC.

The Mental Health Program Administrator is responsible for all functions and operations of the Mental Health Program, including program design, personnel management, fiscal management, quality assurance/improvement, contract monitoring, evaluation, coordination with SCDC Operations, policy development and implementation, and community relations as directed by the

Director of Health Services. The Mental Health Program Administrator directly supervises the top-level clinical supervisory staff within the Mental Health Program, and indirectly supervises all permanent clinical staff.

A Chief Psychiatrist provides medical oversight of all clinical services, supervises medical staff, provides training to all clinical staff; participates in development of mental health policies, provides direct care to inmates with mental illness, participates in quality assurance activities, and provides consultation and training to Health Services physicians and nurses. The Chief Psychiatrist reports to the Mental Health Program Administrator.

SCDC mental health services are administered in keeping with HR-19.02 of the Health Services Manual, the policies and procedures covering mental health service delivery within SCDC.

PROGRAM DESCRIPTIONS

Service
RECEPTION AND EVALUATION (R & E)

Purpose
Conduct mental health assessments of all incoming inmates who are identified during the screening process as exhibiting symptoms or behaviors associated with a mental illness. Make recommendations for placement and treatment of those inmates diagnosed with a mental illness. Re-evaluate inmates who have been referred for reclassification due to a diagnosed or suspected mental illness, and make recommendations for placement and treatment. Provide crisis services to incoming inmates experiencing an emotional crisis.

Goals
1. A thorough mental health evaluation of all new inmates and all current, referred inmates is completed within two weeks of entry into R & E.
2. A mental health diagnostic impression and recommendations for placement and treatment are completed within two weeks of the inmate's entry into R & E.
3. Best-practice crisis services are provided to all inmates who experience an emotional crisis during their stay in R & E.

Inclusion Criteria
An inmate of the South Carolina Department of Corrections (SCDC) who:
1. Is undergoing his/her initial screening, whose symptoms and behaviors indicate the possibility of a mental illness.
2. Has been referred to R & E for further evaluation and consideration for reclassification and alternate placement due to the possibility of a mental illness.
3. Is classified as mentally ill and whose current symptoms and behaviors indicate the need for alternate placement and treatment.
4. Is undergoing general screening and experiencing an emotional crisis that requires the intervention of a mental health professional.

Exclusion Criteria

An inmate of SCDC who:

1. Has been found Guilty But Mentally Ill and is referred directly to Gilliam Psychiatric Hospital at SCDC (males) or the Just Care (forensics) program of the Department of Mental Health (females) for his/her evaluation period.
2. Exhibits symptoms and behaviors of mental illness that necessitate immediate referral to Gilliam Psychiatric Hospital or Just Care, where R & E activities will be conducted.
3. Has completed the evaluations and activities of R & E, is no longer in need of these services and is ready for movement to another level of care.

Programming

1. Individualized evaluations conducted by mental health professionals, to include psychosocial history, mental status examination and psychological testing as indicated.
2. Psychiatric examination and review of medical history by a physician, psychiatric nurse or nurse practitioner.
3. Interviews with inmates' significant others as indicated, in keeping with confidentiality policies.
4. Interviews with community mental health treatment staff as indicated, in keeping with confidentiality policies.
5. Review of medical and mental health records from the community, hospitals and other correctional facilities, as indicated and in keeping with confidentiality policies.
6. Brief therapy groups, to provide support and education to incoming inmates.
7. Crisis stabilization services, available 24 hours a day/7 days a week.

Staffing

1. Supervisor with master's degree in one of the behavioral sciences and significant direct service, supervisory and management experience in the area of correctional mental health.
2. Mental Health Professionals with master's degree in one of the behavioral sciences and demonstrated knowledge and skills in evaluation, diagnosis, treatment planning and crisis stabilization. MHP staff to client ratio: 1:20
3. Psychiatrist and/or psychiatric nursing staff, at a level to enable one psychiatric/medication evaluation per client during the two-week R& E process. The level of medical staff will be determined by the Mental Health Program Administrator, the Chief Psychiatrist, the R & E supervisor, the SCDC Director of Nursing, and the Director of Health Services.

Outcome Measures

1. Eighty percent (80%) of inmates will be evaluated and referred to their ongoing placements within two weeks of entry into R & E.
2. Sixty-five percent (65%) of inmates will be successfully placed -- defined as not requiring re-evaluation and referral to a more intensive level of care within three months of initial placement.
3. Ninety-five percent (95%) of persons in crisis are evaluated and provided effective crisis stabilization services.

4. Ninety-five percent (95%) of persons are provided effective discharge/transfer services.

Service
PSYCHIATRIC HOSPITALIZATION
Gilliam Psychiatric Hospital (males)
Just Care/Department of Mental Health, via contract (females)

Purpose
Evaluate inmates of SCDC who are acutely mentally ill to determine if inpatient care is needed in order to manage their symptoms. Evaluate inmates who may need involuntary treatment, and conduct medical and legal proceedings accordingly. For males, hospitalize at Gilliam Psychiatric Hospital and provide intensive supportive therapy and psychiatric services that are conducive to a rapid amelioration of symptoms. Stabilize patients' mental health conditions and refer to a less restrictive treatment level, and conduct discharge planning activities for inmates being discharged from SCDC while hospitalized. For females, refer for to Just Care/Department of Mental Health for inpatient services; ensure a smooth transition to and from Just Care and coordination of referral, treatment and discharge activities with Just Care staff.

Goals
1. Inmates referred for evaluation to determine need for inpatient care are evaluated by a mental health professional within one business day of referral.
2. Inmates treated at Gilliam Psychiatric Hospital receive best-practice inpatient care.
3. Patients' conditions are stabilized rapidly and they are referred to a less restrictive level of care in keeping with their immediate and ongoing needs.
4. Female inmates referred to Just Care are provided the highest quality referral, transfer, and treatment/discharge coordination services by SCDC mental health staff.
5. Inmates discharged from SCDC while hospitalized are assured their environmental, emotional, familial and occupational needs are thoroughly and effectively addressed via SCDC discharge activities.

Inclusion Criteria
An inmate of SCDC who:
1. Exhibits symptoms and behaviors associated with acute mental illness and is referred by SCDC medical, mental health or security staff for an evaluation to determine if hospitalization is needed.
2. Is acutely mentally ill and needs hospital-level care to stabilize/ameliorate symptoms.
3. Is a danger to self or others due to a mental illness and who needs hospital-level care, voluntary or involuntary, to stabilize/ameliorate symptoms.
4. Exhibits ongoing symptoms and behaviors associated with a mental illness that cannot be effectively managed in a less restrictive/intensive level of care.
5. Has been found Guilty But Mentally Ill and is referred directly to Gilliam Psychiatric Hospital (GPH) at SCDC (males) or the Just Care (forensics) program of the Department of Mental Health (females) for his/her evaluation period.

Exclusion Criteria
An inmate of SCDC who:

1. Has been evaluated and determined not to have a mental illness.
2. Has been evaluated and determined to have a mental illness that can be effectively treated at a less restrictive/intensive level of mental health care.
3. Has been evaluated and determined to have a mental illness, but exhibits behaviors that are beyond the capacity of the security level at Gilliam Psychiatric Hospital.
4. Is stabilized and can be effectively treated at a less restrictive/intensive level of mental health care.
5. Is discharged from SCDC.

Programming

1. Individualized evaluations conducted by mental health professionals within one business day of admission, to include psychosocial history, mental status examination and psychological testing as indicated.
2. Psychiatric examination and review of medical history by a physician, psychiatric nurse or nurse practitioner, within one business day of admission.
3. When a psychiatrist is not available, consultation with a psychiatrist by other medical and clinical staff will occur within one business day of admission.
4. Employment of a variety of therapeutic approaches and strategies that are clinically proven to address the needs of persons with acute mental illness, including but not limited to reality orientation, psychoeducation, supportive therapy, cognitive behavior therapy, goal-setting, problem-solving, role modeling/playing, positive reinforcement, formal behavior change programs, ventilation, processing of thoughts and feelings, mild confrontation, and gentle pressure.
5. Interviews with inmates' significant others as indicated, in keeping with confidentiality policies.
6. Interviews with community mental health treatment staff as indicated, in keeping with confidentiality policies.
7. Review of medical and mental health records from other SCDC mental health service providers, the community, other hospitals and other correctional facilities, as indicated and in keeping with confidentiality policies.
8. Seven-day-a-week programming that emphasizes support, structure, therapy and education designed to stabilize the symptoms of acute mental illness and help persons with a serious mental illness learn to manage the illness in a less restrictive/intensive environment.
9. Case management activities designed to assist hospitalized inmates with environmental, familial, occupational and discharge issues.

Staffing/GPH

1. Administrator with an appropriate combination of administrative education and experience, and demonstrated knowledge and skills in the management of a psychiatric hospital. The GPH Administrator reports to the Mental Health Program Administrator.
2. Clinical Director with a master's degree in one of the behavioral sciences and significant direct service, supervisory and management experience in the area of correctional mental health/treatment of acute mental illness. The Clinical Director reports to the GPH Administrator.

3. Mental Health Professionals with master's degrees in one of the behavioral sciences and demonstrated knowledge and skills in evaluation, diagnosis, treatment planning and crisis stabilization with persons with an acute mental illness. Staff to patient ratio: 1:10
4. Psychiatrist and/or psychiatric nursing staff, at a level to enable each patient to be seen by a psychiatrist or psychiatric nurse within one business day of admission, immediately upon referral for medication problems, three times a week for briefly hospitalized inmates and every two weeks to once a month for long-term hospitalized inmates. The level of medical staff will be determined by the Mental Health Program Administrator, the Chief Psychiatrist, the GPH Administrator, the GPH Clinical Director, the SCDC Director of Nursing, and the Director of Health Services.
5. Paraprofessional staff with bachelor's, associate or high school degrees, to assist professional staff with treatment and case management activities and to provide support to inmates in their residential areas. Level of staff to be determined by the Mental Health Program Administrator, GPH Administrator and GPH Clinical Director.

Outcome Measures

1. Eighty-five percent (85%) of inmates admitted to GPH are evaluated by a mental health professional within one business day of referral.
2. Eighty-five percent (85%) of inmates admitted to GPH are evaluated by medical staff within one business day of admission, by or under the supervision of a physician.
3. Sixty percent (60%) of inmates admitted to GPH are discharged to a less restrictive/intensive level of care within two weeks of admission.
4. Ninety-five percent (95%) of inmates transferred from GPH are provided transfer and discharge planning that enables a successful transition to another level of care/placement within SCDC, to the Department of Mental Health or to the community.

Service

Behavior Management Unit (BMU)

Purpose

Provide intensive therapy services to inmates who are diagnosed with a mental illness and who exhibit severe acting out behaviors, toward others and toward themselves. Ensure the health and safety of the inmates and the staff by coordinating treatment activities and security measures in a therapeutic manner.

Goals

1. Inmates with behavior management problems due to a mental illness are quickly identified and evaluated by a mental health professional with expertise in working with behavioral management issues
2. Best-practice correctional mental health services are provided to inmates with behavioral management problems related to a mental illness.
3. Inmates are helped to manage their mental illnesses and behavioral problems in a healthier manner.
4. Inmates meet their individual treatment goals and are discharged to an appropriate level of care/placement.

Inclusion Criteria

An inmate of SCDC who:

1. Is diagnosed with a mental illness.
2. Exhibits chronic/frequent/continual dangerous or potentially dangerous behaviors toward self or others, including verbal and/or physical threats/abuse, self-injurious behaviors, suicidal thoughts/gestures/attempts, and destruction of property.
3. Has treatment needs that cannot be met in a less intensive treatment environment due to clinical and/or safety reasons, or less intensive treatment has been unsuccessful.
4. Is confined in a Maximum Security Unit or on Death Row and is diagnosed with a serious mental illness.

Exclusion Criteria

An inmate of SCDC who:

1. Has been evaluated by a mental health professional and is determined not to be suffering from a diagnosable mental illness.
2. Has been evaluated and determined to have a mental illness, but exhibits behaviors that are beyond the capacity of the treatment/security level at BMU.
3. Has successfully completed treatment and is ready for referral to a less intensive treatment/placement environment.
4. Is discharged from SCDC.

Programming

1. Psychiatric evaluation and medication management.
2. Intensive (daily to multiple times weekly) individual and group therapy with an emphasis on behavior management techniques, trauma-related treatment, and emotion regulation.
3. Family therapy, in keeping with confidentiality guidelines.
4. Employment of a variety of therapeutic approaches and strategies that are clinically proven to address the needs of persons with mental illness characterized by behavioral problems, including but not limited to supportive therapy, limit-setting, psychoeducation, experiential learning, cognitive behavior therapy, logical consequences, goal-setting, problem-solving, role modeling/playing, positive reinforcement, formal behavior change programs, ventilation, processing of thoughts and feelings, mild confrontation, gentle pressure and graduated task mastery.
5. Interviews with inmates' significant others as indicated, in keeping with confidentiality policies.
6. Interviews with community mental health treatment staff as indicated, in keeping with confidentiality policies.
7. Review of medical and mental health records from other SCDC mental health service providers, the community, other hospitals and other correctional facilities, as indicated and in keeping with confidentiality policies.
8. Case management activities designed to assist inmates with environmental, familial, occupational and discharge issues, including coordination of treatment with community care givers.
9. Crisis stabilization services, available 24 hours/day, 7 days/week.

Staffing

1. Supervisor with a master's degree in a behavioral science and demonstrated knowledge and skills in treatment of persons with mental illness/ behavioral problems; supervision of staff, and program management.
2. Psychiatrist and psychiatric nursing staff at a level that ensures a psychiatric evaluation within one week of admission to program, consultation to mental health professional and nursing staff within one business day of admission, immediate response to medication emergencies/problems and medication follow-up appointments one time a month. The level of medical staff will be determined by the Mental Health Program Administrator, the Chief Psychiatrist, the BMU supervisor, the Director of Nursing, and the Director of Health Services.
3. Mental Health Professional staff with a master's degree in one of the behavioral sciences and demonstrated knowledge and skills in evaluation, diagnosis, treatment planning/delivery and crisis stabilization with persons with serious behavioral problems associated with a mental illness. MHP staff to patient ratio: 1:15
4. Paraprofessional staff with bachelor's, associate or high school degrees, to assist professional staff with treatment and case management activities. Level of staff to be determined by Mental Health Administrator and BMU Supervisor.

Outcome Measures

1. Eighty percent (80%) of inmates are evaluated by a mental health professional within one business day of referral.
2. Eighty percent (80%) of inmates admitted to BMU are evaluated by medical staff within one business day of admission, by or under the supervision of a physician.
3. Fifty percent (50%) of inmates admitted to BMU demonstrate a decrease in acting-out behaviors within six months of admission to BMU.
4. Thirty-five percent (35%) of inmates admitted to BMU are discharged to a less intensive level of treatment/placement within one year of admission.
5. Ninety-five percent (95%) of inmates transferred from BMU are provided transfer and discharge planning that enables a successful transition to another level of care/placement within SCDC, to the Department of Mental Health, or to the community.

Service

Intermediate Care Services (ICS)

Purpose

Provide intensive therapy services to inmates who are diagnosed with a serious and persistent mental illness and who need intensive (daily) structure and support in order to manage the illness. Provide therapeutic and education activities that enable inmates to learn to manage their illnesses and gain social, communication, vocational, life management and practical living skills. Provide services that meet the special needs of inmates with serious and persistent mental illness, including those who are
serving short sentences and those who are serving long sentences.

Intermediate Care Services are sited in specific SCDC facilities with discrete programs/services.

Goals

1. Inmates participating in ICS programs are provided best-practice mental health care.
2. ICS participants attain and maintain stability of their mental illnesses.
3. ICS participants gain practical living, independent living and symptom management skills that enable them to function well in their environment, achieve higher levels of independence in SCDC, and transfer successfully to the community upon discharge.
4. ICS participants realize their treatment goals and are discharged to an appropriate level of care/placement.

Inclusion Criteria

An inmate of SCDC who:

1. Is diagnosed with a serious and persistent mental illness.
2. Is referred following an inpatient stay.
3. Requires intensive (daily) services, support and structure to manage symptoms of mental illness and prevent hospitalization.
4. Has treatment needs that cannot be met in a less intensive treatment environment due to clinical and/or safety reasons, or less intensive treatment has been unsuccessful.

Exclusion Criteria

An inmate of SCDC who:

1. Has been evaluated by a mental health professional and is determined not to have a diagnosable mental illness.
2. Has been evaluated and determined to have a mental illness, but exhibits behaviors that are beyond the capacity of the treatment/security level at ICS.
3. Has successfully completed treatment and is ready for referral to a less intensive treatment/placement environment.
4. Is discharged from SCDC.

Programming

1. Psychiatric evaluation and medication management.
2. Intensive (daily) psychosocial rehabilitation services, including individual, group and activities therapy emphasizing acquisition of a full continuum of practical living, psychosocial, occupational, symptom management, social and leisure skills that foster independence.
3. Employment of a variety of therapeutic approaches and strategies that are clinically proven to address the needs of persons with serious and persistent mental illness, including but not limited to supportive therapy, psychoeducation, experiential learning, goal-setting, problem-solving, role modeling/playing, positive reinforcement, formal behavior change programs, ventilation, processing of thoughts and feelings, mild confrontation, gentle pressure and graduated task mastery.
4. Activities therapy to provide structure and teach time management skills.
5. Work therapy to increase vocational skills and improve self esteem.
6. Family therapy, in keeping with individual's needs and confidentiality guidelines.
7. Interviews with inmates' significant others as indicated, in keeping with confidentiality policies.

8. Interviews with community mental health treatment staff as indicated, in keeping with confidentiality policies.
9. Review of medical and mental health records from other SCDC mental health service providers, the community, other hospitals and other correctional facilities, as indicated and in keeping with confidentiality policies.
10. Case management activities designed to assist inmates with environmental, familial, occupational and discharge issues, including coordination of treatment with community care givers.
11. Crisis stabilization services 24 hours/day, 7 days/week.

Staffing

1. Supervisor with a master's degree in a behavioral science and demonstrated knowledge and skills in treatment of persons with serious and persistent mental illness, supervision of staff and program management.
2. Psychiatrist and psychiatric nursing staff at a level that ensures a psychiatric evaluation within one month of admission to program, consultation to mental health professional and nursing staff within one week of admission, immediate response to medication emergencies/problems and medication follow-up appointments as indicated by individual need of the ICS participants. Level of staff to be determined by Mental Health Program Administrator, ICS Supervisor, Chief Psychiatrist, Director of Nursing, and Director of Health Services.
3. Mental Health Professional staff with a master's degree in one of the behavioral sciences and demonstrated knowledge and skills in evaluation, diagnosis, treatment planning and crisis stabilization with persons with serious and persistent mental illness. MHP staff to client ratio: 1:35
4. Paraprofessional staff with bachelor's, associate or high school degrees, to assist professional staff with treatment and case management activities, and provide activities therapy. Level of staff to be determined by Mental Health Administrator and ICS Supervisor.

Outcome Measures

1. Eighty percent (80%) of inmates are evaluated by a mental health professional within one business day of referral.
2. Eighty percent (80%) of inmates admitted to ICS are evaluated by medical staff within one week of admission, by or under the supervision of a physician.
3. Fifty percent (50%) of inmates admitted to ICS demonstrate an increase in symptom management and independent living skills within three months of admission to ICS.
4. Sixty-five percent (65%) of inmates participating in ICS are not hospitalized while in ICS.
5. Thirty-five percent (35%) of inmates admitted to ICS are discharged to a less intensive level of treatment/placement within one year of admission.
6. Ninety-five percent (95%) of inmates are provided transfer and discharge planning that enables a successful transition to another level of care/placement within SCDC, to the Department of Mental Health, or to the community.

Service
Area Mental Health Services (AMH)

Purpose
Provide therapy services to inmates who are diagnosed with a mental illness, are clinically stable, and need a moderate level of therapeutic contact to maintain stability. Provide therapeutic and education activities that help program participants gain increased independent living, social, communication, vocational, and mental illness management skills. Provide services that meet the special needs of inmates with serious and persistent mental illness, including those who are serving short sentences and those who are serving long sentences.

Area Mental Health Services are sited in specific SCDC facilities with discrete programs/services.

Goals
1. Inmates participating in AMH programs are provided best-practice mental health care.
2. AMH participants maintain stability of their mental illnesses.
3. AMH participants gain practical living, independent living and symptom management skills that enable them to function well in their environment, achieve higher levels of independence in SCDC, and transfer successfully to the community upon discharge.
4. AMH participants realize their treatment goals and are discharged to an appropriate level of care/placement.

Inclusion Criteria
An inmate of SCDC who:
1. Is diagnosed with a mental illness.
2. Is referred by an ICS program.
3. Requires moderate level of therapeutic contacts to manage symptoms of mental illness and gain skills to enable more independent functioning.
4. Has treatment needs that cannot be met in a less intensive treatment environment due to clinical and/or safety reasons, or less intensive treatment has been unsuccessful.

Exclusion Criteria
An inmate of SCDC who:
1. Has been evaluated by a mental health professional and is determined not to be suffering from a diagnosable mental illness.
2. Has been evaluated and determined to have a mental illness, but exhibits behaviors that are beyond the capacity of the treatment/security level at AMH.
3. Has successfully completed treatment and is ready for referral to a less intensive treatment/placement environment.
4. Is discharged from SCDC.

Programming
1. Psychiatric evaluation and medication management.
2. Individual and group therapy services and educational activities that help participants maintain stability and gain skills that enable a higher level of independence.

3. Employment of a variety of therapeutic approaches and strategies that are clinically proven to address the needs of persons with serious mental illness, including but not limited to supportive therapy, insight-oriented therapy, psychoeducation, cognitive behavior therapy, experiential learning, goal-setting, problem-solving, role modeling/playing, positive reinforcement, ventilation, processing of thoughts and feelings, graduated task mastery and mild confrontation.
4. Work therapy to increase vocational skills and improve self esteem.
5. Family therapy, in keeping with individual's needs and confidentiality guidelines.
6. Interviews with inmates' significant others as indicated, in keeping with confidentiality policies.
7. Interviews with community mental health treatment staff as indicated, in keeping with confidentiality policies.
8. Review of medical and mental health records from other SCDC mental health service providers, the community, other hospitals and other correctional facilities, as indicated and in keeping with confidentiality policies.
9. Case management activities designed to assist inmates with environmental, familial, occupational and discharge issues, including coordination of treatment with community care givers.
10. Crisis stabilization services, available 24 hours/day, 7 days/week.

Staffing

1. Supervisor with a master's degree in a behavioral science and demonstrated knowledge and skills in treatment of persons with serious mental illness, supervision of staff, and program management.
2. Psychiatrist and psychiatric nursing staff at a level that ensures a psychiatric evaluation within one month of admission to program, consultation to mental health professional and nursing staff within one week of admission, immediate response to medication emergencies/problems and medication follow-up appointments as indicated by individual need of the ICS participants. Level of staff to be determined by Mental Health Program Administrator, AMH Supervisor, Chief Psychiatrist, Director of Nursing and Director of Health Services.
3. Mental Health Professional staff with a master's degree in one of the behavioral sciences and demonstrated knowledge and skills in evaluation, diagnosis, treatment planning and crisis stabilization with persons with serious mental illness. MHP staff to patient ratio: 1:50

Outcome Measures

1. Eighty percent (80%) of inmates are evaluated by a mental health professional within one week of referral.
2. Eighty percent (80%) of inmates admitted to AMH are evaluated by medical staff within one week of admission, by or under the supervision of a physician.
3. Seventy-five percent (75%) of inmates participating in AMH are not hospitalized while enrolled in AMH.
4. Fifty percent (50%) of inmates admitted to AMH are discharged to a less intensive level of treatment/placement within one year of admission.

5. Ninety-five percent (95%) of inmates transferred from AMH are provided transfer and discharge planning that enables a successful transition to another level of care/placement within SCDC, to the Department of Mental Health, or to the community.

Service
Outpatient Mental Health (OMH)

Purpose
Provide therapy services to inmates who are diagnosed with a mental illness, are clinically stable, and need a minimal level of therapeutic contact to maintain stability. Provide therapeutic and education activities that help program participants gain increased independent living, social, communication, vocational, and mental illness management skills.

Outpatient Mental Health services are provided throughout the SCDC system.

Goals
1. Inmates participating in OMH programs are provided best-practice mental health care.
2. OMH participants maintain stability of their mental illnesses.
3. OMH participants gain symptom management skills that enable them to function well in their environment, achieve higher levels of independence in SCDC, and transfer successfully to the community upon discharge.
4. OMH participants realize their treatment goals and are discharged to an appropriate level of care/placement.

Inclusion Criteria
An inmate of SCDC who:
1. Is diagnosed with a mental illness.
2. Referred from an AMH or ICS program or GPH.
3. Requires infrequent therapeutic contacts to manage symptoms of mental illness and gain skills to enable more independent functioning.

Exclusion Criteria
An inmate of SCDC who:
1. Has been evaluated by a mental health professional and is determined not to be suffering from a diagnosable mental illness.
2. Has been evaluated and determined to have a mental illness, but exhibits behaviors that are beyond the capacity of the treatment/security level at OMH.
3. Has successfully completed treatment and is ready for referral to a less intensive treatment/placement environment.
4. Is discharged from SCDC.

Programming
1. Psychiatric evaluation and medication management.
2. Individual and group therapy services and educational activities that help participants maintain stability and gain skills that enable a higher level of independence.

3. Employment of a variety of therapeutic approaches and strategies that are clinically proven to address the needs of persons with mental illness, including but not limited to supportive therapy, insight-oriented therapy, psychoeducation, cognitive behavior therapy, goal-setting, problem-solving, role modeling/playing, positive reinforcement, ventilation, processing of thoughts and feelings, and mild confrontation.
4. Work therapy to increase vocational skills and improve self esteem.
5. Family therapy, in keeping with individual's needs and confidentiality guidelines.
6. Interviews with inmates' significant others as indicated, in keeping with confidentiality policies.
7. Interviews with community mental health treatment staff as indicated, in keeping with confidentiality policies.
8. Review of medical and mental health records from other SCDC mental health service providers, the community, other hospitals and other correctional facilities, as indicated and in keeping with confidentiality policies.
9. Case management activities designed to assist inmates with environmental, familial, occupational and discharge issues, including coordination of treatment with community care givers.
10. Crisis stabilization services, available 24 hours/day, 7 days/week.

Staffing

1. Supervisor with a master's degree in a behavioral science and demonstrated knowledge and skills in treatment of persons with mental illness, supervision of staff, and program management.
2. Psychiatrist and psychiatric nursing staff at a level that ensures a psychiatric evaluation within three months of admission to program, consultation to mental health professional and nursing staff within one month of admission, immediate response to medication emergencies/problems and medication follow-up appointments as indicated by individual need of the ICS participants. Level of staff to be determined by Mental Health Program Administrator, OMH Supervisor, Chief Psychiatrist, Director of Nursing and Director of Health Services.
3. Mental Health Professional staff with a master's degree in one of the behavioral sciences and demonstrated knowledge and skills in evaluation, diagnosis, treatment planning and crisis stabilization with persons with mental illness. MHP staff to patient ratio: 1:75 for inmates who need weekly or twice-monthly contacts; 1:100 for inmates who need contacts every 2-3 months; 1:150 for inmates who need less than quarterly contacts.

Outcome Measures

1. Eighty percent (80%) of inmates are evaluated by a mental health professional within one week of referral.
2. Seventy percent (70%) of inmates participating in OMH maintain emotional stability and do not require a higher level of mental health care.
3. Eighty-five percent (85%) of inmates participating in OMH are not hospitalized while enrolled in OMH.
4. Ninety-five percent (95%) of inmates transferred from OMH are provided transfer and discharge planning that enables a successful transition to another level of care/placement within SCDC, to the Department of Mental Health, or to the community.

QUALITY ASSURANCE/IMPROVEMENT PROCESS (QA/I)

The goals of QA/I are to ensure that best-practice mental health services are delivered to SCDC inmates diagnosed with a mental illness, and that services are delivered in keeping with the policies and procedures outlined in SCDC HR-19.02. The Quality Assurance/Improvement process (QA/I) is conducted under the supervision of the Mental Health Program Administrator. QA/I is staffed by mental health professionals with extensive experience in correctional mental health service planning, delivery and evaluation.

The QA/I process includes:

1. An annual written plan for each fiscal year that outlines the QA/I goals and objectives;
2. Recruitment and selection of well qualified staff to provide direct services and supervision of staff and programs;
3. Orientation and training of all clinical and security staff to ensure basic knowledge of mental illness;
4. Training of clinical staff to ensure knowledge of best-practice mental health service delivery, policies and procedures, and clinical documentation guidelines;
5. Supervision of staff to ensure that they receive appropriate clinical and administrative guidance;
6. Quarterly audits of a significant random sample of clinical records of all services;
7. An evaluation of outcome measures quarterly, using measurement instruments to gauge individual and program progress toward goals; and
8. An annual management report describing the evaluation process and outcomes.

SAMPLE SCHEDULE FOR INTERMEDIATE CARE SERVICES PROGRAMS

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
7:00 am	Medication	Medication	Medication	Medication	Medication		
8:00 am	Personal Care	Personal Care	Personal Care	Personal Care	Personal Care		
9:00 am	Housekeeping	Housekeeping	Housekeeping	Housekeeping	Housekeeping		
10:00 am	Morning Chat	Morning Chat	Morning Chat	Morning Chat	Morning Chat		
11:00 am	Community Meeting	One-to-One Work Detail Activities/ Free Time	One-to-One Work Detail Activities/ Free Time	One-to-One Work Detail Activities/ Free Time	One-to-One Work Detail Activities/ Free Time		
12:00 pm	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication		
1:00 pm	One-to-One/ Activities/ Free Time	One-to-One/ Activities/ Free Time	One-to-One/ Activities/ Free Time	Free Time	One-to-One/ Activities/ Free Time	Check-in	Check-in
3:00 pm	Goal Setting/ Work Detail/ Activities/ Free Time	Psychosocial Group/ Work Detail Activities/ Free Time	Practical Living Skills Group/ Work Detail/ Activities/ Free Time	Symptom Management/ Work Detail/ Activities/ Free Time	Group Therapy/ Work Detail/ Activities/ Free Time	Activities	Activities
5:00 pm	Dinner/ Medication/ Activities/ Free Time	Dinner/ Medication/ Activities/ Free Time	Dinner/ Medication/ Activities/ Free Time	Dinner/ Medication/ Activities/ Free Time	Dinner/ Medication/ Activities/ Free Time		
7:00 pm	Evening Chat	Evening Chat	Evening Chat	Evening Chat	Evening Chat		

NOTE:

1. The schedule describes ICS-staffed activities; medication, personal care and housekeeping occur every day, within or outside the ICS schedule.
2. The program offers a balance of therapy, education, and leisure/recreation activities, with a variety of teaching/learning methods, including didactic presentation, experiential learning, and graduated task mastery.
3. All clients have a scheduled day/week which is determined by the client and staff, even if made up primarily of Free Time.
4. Clients are referred to the groups and activities that are best suited to their needs during each program segment.
5. Clients have a choice of groups and activities during most program segments.
6. Each program component is planned in writing, with goals/objectives and an outline of specific activities for each meeting.
7. Education groups are generally 4 – 6 sessions in length per identified segment/class, with a continuum of classes for identified skill areas.

INTERMEDIATE CARE SERVICES SAMPLE PROGRAMMING DESCRIPTIONS

MEDICATION — Monday - Friday, 7:00 am - 8:00 am; 12:00 pm; 5:00pm - 6:00 pm
Clients are assisted in getting and taking their medications; staff accompany clients to Pill Line as needed, check to ensure medication was taken, encourage reluctant clients to take medication, answer questions, coordinate with medical staff

PERSONAL CARE — Monday - Friday, 8:00 am - 9:00 am
Clients complete personal care/grooming chores. If needed staff will provide one-to-one assistance to individual clients, or may lead a small group of clients in an experiential exercise to help with grooming and hygiene.

HOUSEKEEPING — Monday - Friday, 9:00 am - 10:00 am
Clients complete basic cleaning chores within their private areas. As needed on an individual basis, they are assisted by staff, who may work with individual clients or with small groups of clients on cleaning skills, upkeep of their private space, decorating.

MORNING CHAT — Monday - Friday, 10:00 am - 11:00 am
Group held each program day, to catch up on the prior evening's activities and issues, conduct reality orientation activities, review current events, and check in with each client about how s/he is doing. Morning Chat occurs in a relaxed atmosphere. It serves as a time for the counselor to identify any immediate concerns of the clients and to get to know the clients and their issues.

COMMUNITY MEETING — Monday, 11:00 am - Noon
All clients and all available, designated staff meet together for the purpose of making announcements, airing concerns, reviewing schedules, planning, and identifying problems and solutions.

GOAL SETTING — Monday, 1:00 pm and 2:00 pm
Clients are assisted in setting goals, outlining all the steps needed to have the goals realized, and identifying and eliminating any barriers to meeting goals. Progress toward meeting goals will be reviewed each week.

WORK DETAIL
Each client is assigned a job/task within or outside the program/facility; staff assist clients individually as needed to complete their job assignment.

PSYCHOSOCIAL SKILLS — Monday, Wednesday and Thursday, 3:30 pm - 4:30 pm
Skill training segments in a variety of personal and interpersonal skill areas, including decision making, problem solving, anger management, communication, assertiveness, self esteem, social skills, success relationships, time management, and stress management. Special groups are offered during this segment that address the special concerns of clients according to the length of imprisonment, particularly those with short sentences who will be moving to the community within a relatively short period of time and those with long sentences who face many year to a lifetime in prison.

ACTIVITIES — Various Times, Monday through Friday
A variety of leisure and recreational activities are available, to provide structure and diversion, and to teach time management skills.

FREE TIME Various Times, Monday through Friday

Clients are offered a full day of structured activities; at the same time, they may opt for "Free Time" where they can relax, take a "time out" or participate in their own activities. Free Time is negotiated between the client and the staff and is scheduled into each client's day. How the time will be spent is discussed between the client and the staff.

EVENING CHAT Monday – Friday, 7:00 pm – 8:00 pm

Clients and staff meet to review the day, identify/process any concerns, and talk about plans for the night and the following day.

ONE TO ONE Various Times Throughout the Week

Clients meet individually with their therapist/case manager, and with other staff as indicated by their treatment plans, to develop and review their treatment plans, set goals and review progress of goals, discuss issues of concern, work on specific problems and develop solutions, and gain support and guidance.

PRACTICAL LIVING SKILLS Wednesday, 3:00 pm - 5:00 pm (1 - 2 sessions)

Clients are assisted in learning how to take care of the practical side of life: self care (grooming, health, diet, exercise), home care (cleaning, decorating, repairs), money management, using community resources, and other skills necessary to living independently.

SYMPTOM MANAGEMENT Thursday, 3:00 - 5:00 pm (1 - 2 sessions)

Clients learn about their illnesses and how to manage the symptoms and behaviors that are a part of the illness.

GROUP THERAPY Friday, 3:00 pm - 5:00 pm (1 - 2 sessions)

Led by a mental health professional, group therapy offers clients the opportunity to share thoughts and feelings with others, discuss problems, receive feedback, learn new ways of dealing with situations and gain support. The mental health professional will refer clients to Group Therapy.

SAMPLE SCHEDULE FOR GILLIAM PSYCHIATRIC HOSPITAL

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
7:00 am	Medication	Medication	Medication	Medication	Medication	Medication	Medication
8:00 am	Personal Care	Personal Care	Personal Care	Personal Care	Personal Care	Personal Care	Personal Care
9:00 am	Housekeeping	Housekeeping	Housekeeping	Housekeeping	Housekeeping	Housekeeping	Housekeeping
10:00 am	Check-in	Check-in	Check-in	Check-in	Check-in	Check-in	Check-in
11:00 am	One-to-One/ Activities	One-to-One/ Activities	One-to-On/ Activities	One-to-One/ Activities	One-to-One/ Activities	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities
12:00 pm	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication	Lunch/ Medication
1:00 pm	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities	Check-in	Check-in
2:00 pm	Goal Setting/ Activities	Symptom Management/ Activities	Group Therapy/ Activities	Symptom Management/ Activities	Group Therapy/ Activities	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities
3:30 pm	One-to-One/ Family/ Activities	Psychosocial Group/ Activities	One-to-One/ Family/ Activities	Practical Living Skills/ Activities	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities	One-to-One/ Family/ Activities
5:00 pm	Dinner/ Medication/ Activities	Dinner/ Medication/ Activities	Dinner/ Medication/ Activities	Dinner/ Medication/ Activities	Dinner/ Medication/ Activities	Dinner/ Medication/ Activities	Dinner/ Medication/ Activities
6:30 pm	Check-in	Check-in	Check-in	Check-in	Check-in	Check-in	Check-in

NOTE:

1. The schedule describes formal GPH-staffed activities.
2. The program offers a balance of intensive therapy and education services, and leisure/recreation activities.
3. All patients have a scheduled day/week which is determined by the client and staff.
4. Patients are referred to the groups and activities that are best suited to their needs during each program segment.
5. Patients have a choice of groups and activities during most program segments.
6. Each program component is planned in writing, with goals/objectives and an outline of specific activities for each meeting.
7. Education groups are generally 4 – 6 sessions in length per identified segment/class and focus on the skills needed by persons with an acute mental illness or an acute exacerbation of an ongoing mental illness.

GILLIAM PSYCHIATRIC HOSPITAL SAMPLE PROGRAMMING DESCRIPTIONS

MEDICATION — Daily, 7:00 am - 8:00 am, Noon - 1:00 pm, 5:00 pm - 6:00 pm.
Patients are assisted in getting and taking their medications; staff accompany Patients to Pill Line as needed, check to ensure medication was taken, encourage reluctant Patients to take medication, answer questions, coordinate with medical staff

PERSONAL CARE — Daily, 8:00 am - 9:00 am
Patients complete personal care/grooming chores. If needed staff will provide one-to-one assistance to individual Patients, or may lead a small group of Patients in an experiential exercise to help with grooming and hygiene.

HOUSEKEEPING — Daily, 9:00 am - 10:00 am
Patients complete basic cleaning chores within their private areas. As needed on an individual basis, they are assisted by staff, who may work with individual Patients or with small groups of Patients on cleaning skills, upkeep of their private space, decorating.

CHECK-IN — Daily, 10:00 am - 11:00 am and 6:30 pm - 7:30 pm
Saturday and Sunday, 1:00 - 2:00 pm
Staff meet with patients individually and in groups to provide support to the patients, catch up on the prior evening's, morning's and day's activities and issues, conduct reality orientation activities, and formally and informally evaluate mental status.

ONE TO ONE — Multiple Times Daily
Patients meet individually with their therapist/case manager, the medical staff and other staff as indicated by their treatment plans, to develop and review their treatment regimes, review medications, set goals and review progress of goals, discuss issues of concern, work on specific problems and develop solutions, and gain support and guidance.

FAMILY THERAPY — Multiple Times Available Throughout the Week
Patients and their families are provided family therapy, with the goals to give support to the patients and their families, identify and resolve problems and conflicts, and plan for discharge to the community.

ACTIVITIES — Multiple Times Daily
A variety of leisure and recreational activities are available, to provide structure and diversion, and to teach time management skills.

GOAL SETTING — Monday, 1:00 pm - 2:00 pm
Patients are assisted in setting goals, outlining all the steps needed to have the goals realized, and identifying and eliminating any barriers to meeting goals. Progress toward meeting goals will be reviewed each week.

SYMPTOM MANAGEMENT — Tuesday and Thursday, 2:00 pm – 3:00 pm
Patients learn about their illnesses and how to manage the symptoms and behaviors that are a part of the illness, with an emphasis on acute symptoms that contributed to the hospitalization.

PSYCHOSOCIAL SKILLS Tuesday, 3:30 pm – 5:00 pm

Skill training segments in a variety of personal and interpersonal skill areas, including decision making, problem solving, anger management, communication, assertiveness, self esteem, social skills, success relationships, time management, and stress management.

GROUP THERAPY Wednesday and Friday, 2:00 pm – 3:30 pm

Led by a mental health professional, group therapy offers patients the opportunity to share thoughts and feelings with others, discuss problems, receive feedback, learn new ways of dealing with situations and gain support.

PRACTICAL LIVING SKILLS Thursday, 3:30 pm - 5:00 pm

Patients are assisted in learning how to take care of the practical side of life: self care (grooming, health, diet, exercise), home care (cleaning, decorating, repairs), money management, using community resources, and other skills necessary to living independently.