South Carolina Department of Corrections
Implementation Panel Report of Compliance
March 2017

Executive Summary

This third 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 third site visit 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 Implementation Panel was from May 2 thru May 5, 2016, the second site visit was October 31 thru November 4, 2016, and this third site visit was from February 27 thru March 3, 2017. We have requested and received a plethora of documents, including policies and procedures and additional reports as noted in this report, however several documents were received during the week prior to the third site visit. We requested that documents be provided to the IP at least two weeks prior to the site visits. 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 March 3, 2017, which was attended by Deputy Director Michael McCall and members of the administrative, operations, and clinical staff of SCDC; plaintiffs' counsel Stuart Andrews; defendant's counsel Bart Vincent; 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 Implementation Panel'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 Implementation Panel are also included. Appended to this report is Exhibit B to the settlement agreement, which is a summary of the Implementation Panel'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 Implementation Panel wants to acknowledge the work that has gone into development of the policies while acknowledging that training and implementation have yet to be accomplished and will be monitored closely. As Exhibit B reflects, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance – 9 components
2. Partial Compliance – 44 components
3. Noncompliance – 5 components

As discussed during the site visits and during our Exit Conference with the parties, the Implementation Panel'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 and appropriateness of evaluation, referral and treatment components; (4) lack of timely assessments and adequate treatment at the mental health programmatic levels; (5) operations practices and adherence to policies and procedures; (6) access to all higher levels of care, particularly timely hospital level care for male and female inmates; and (7) future planning for adequate numbers of beds and staffing for mental health higher levels of care as the hospital and male CSU and ICS programs will be in need of additional resources.

We recognize that the policies and procedures have been substantially completed. 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 and should be of primary focus going forward.

A major achievement has been development of the Quality Assurance Risk Management (QARM). The Implementation Panel continues to be very positively impressed by the efforts of the QARM component, as well as IT and web based information data collection and analysis components, and strongly encourages the continuation and expansion of their efforts at the central levels. The IP reemphasized during our discussions and on-site reviews, the data collection and analysis 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 fully accomplished but has continued to improve, 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 fully achieved. However significant progress is noted in this report.

The Low Intensity Behavioral Management Unit became operational in 2016, and the High Intensity Behavioral Management Unit has begun although not scheduled to open until March 2017. The Crisis Stabilization Unit at Camille Graham is scheduled to open in April 2017.

As noted in our previous reports, the Implementation Panel has continued to provide technical assistance and suggestions regarding how obtaining compliance with the Settlement Agreement criteria and its requirements could be accomplished, and reemphasizes 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, Lieber

Correctional Institution, and Allendale Correctional Institution. As reported during our Exit Conference, the Implementation Panel considers the conditions at Lieber 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. Plaintiffs' counsel have expressed their very serious concerns for the inadequate numbers of operations staffing for SCDC facilities and the resultant harm to their clients, including prolonged lockdowns, extremely limited access to out of cell activities including mental health and medical services, showers, and recreation. The IP is very gravely concerned that the deficiencies in operations staffing, at crisis levels based on our onsite reviews at Lieber and Perry, and reportedly at other facilities, are in need of immediate corrective actions. These severe shortages of operations staff directly impact access to mental health care and services. Without adequate operations staff at all SCDC facilities, it will be extremely difficult if not impossible to meet the requirements of the Settlement Agreement and these conditions of confinement clearly and directly contribute to the harm and dangerous conditions for inmates and staff. These conditions must be corrected immediately, and plans to address the multiple factors contributing to the crisis at Lieber and Perry must be developed and implemented. By contrast, the Low Intensity BMU at Allendale has begun with the support of adequate operations/custody staffing, however the mental health staffing is inadequate. The IP interviewed Character Program Coordinator inmates at Allendale and were very positively impressed by their efforts to assist other inmates and themselves in developing and continuing appropriate behaviors, activities and incentives.

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. <u>The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:</u>

1.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Implementation of the relevant policy and procedure continues to be problematic, especially in meeting the required timeframes. Identified obstacles to achieving compliance with the required timeframes continue to include current custody and mental health staffing shortages.

The over-referrals issue described during the previous site assessment should be significantly improved with the new referral criteria.

Improvement is noted in the context of monitoring the required timeframes and revising the mental health referral criteria.

March 2017 Recommendations:

1. Continue to QI the relevant timeframes.
2. Adequately address the mental health and correctional staffing vacancies.

1.a. Accurately determine and track the percentage of the SCDC population that is mentally ill.

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: It is very likely that the percentage of inmates within SCDC that are on the mental health caseload is underrepresented based on national statistics.

March 2017 Recommendations: As per recommendations summarized in other sections of this report relevant to R&E process and the planned annual mental health screening assessment.

1.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Issues remain regarding the need for a more accurate and efficient database as described in the prior site assessment to produce 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.

March 2017 Recommendations: Produce QI reports addressing relevant elements of this provision.

1.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: We made specific recommendations regarding revision of Appendix 1 regarding the timeframes for urgent psychiatric evaluations and clarification regarding the timeframes for routine secondary evaluations. Appendix 2 provides data relevant to the QI specific to mental health timeframes regarding R & E screening and subsequent mental health evaluations.

March 2017 Recommendations: Continue to monitor the relevant timeframes and revise the flow chart.

1.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Improvement is noted from the perspective of identifying inmates who have reached the anniversary of their last assessment, which will provide a list of inmates to be assessed for their annual screening as previously summarized.

March 2017 Recommendations: Begin the mental health screening process for inmates identified as needing their annual assessment.

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.

2.a. Access to Higher Levels of Care

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

Implementation Panel March 2017 Assessment: **noncompliance**

March 2017 Implementation Panel findings: The above referenced audits were reviewed. Missing from the studies were narratives of the assessment of the results and planned actions, if any, based on such an assessment. These studies appeared to indicate that at least some of these inmates with multiple admissions to either the CSU or GPH needed a higher level of mental health care.

March 2017 Recommendations: Future QI studies should include the recommended standalone report as described in an earlier section of this report.

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

Implementation Panel March 2017 Assessment: **noncompliance**

March 2017 Implementation Panel findings: No change from November 2016 site assessment, in part, related to staffing vacancies. During the site visit we did not assess the male ICS services at Kirkland CI.

We did assess the female ICS services at Camille Graham CI during March 2, 2017. Inmates in Section D were interviewed in the community-like setting during the morning of March 2. These inmates reported that they were essentially restricted to their rooms from about 8 AM-3:30 PM on a daily basis except during lunch. They also indicated that they did not have access to their personal TVs during the same period of time. These inmates also indicated that they were not receiving any programming such as structured therapeutic groups. Poor access to outdoor recreation time was also described by these inmates.

There were no chairs available in the dayroom although benches were present. These ICS inmates indicated that other ICS inmates from Section C had recently been allowed to remove the dayroom chairs from Section D and also periodically would take their cleaning supplies. Many of these inmates appeared to be of a geriatric age group. These ICS inmates also voiced their fears regarding the return of a specific ICS inmate, who was currently in the RHU, who had on two different occasions thrown scalding water on several peers.

Mental health staff confirmed that these inmates recently were not receiving structured therapeutic groups due to the loss of an activity therapist, who was recently promoted to a different position. Correctional officer leadership reported that the information obtained from these inmates regarding essentially being restricted to the rooms for long periods of time was inaccurate.

Key custody staff stated that chairs in the dayroom, which were not bolted to the floor, posed a security risk because several inmates were prone to throw chairs at others. They also indicated that these inmates all had chairs in their rooms, which could be brought to the dayroom space as needed.

We also interviewed about 14 ICS inmates in Section C, which had a count of 27 inmates during the site visit, in a community -like setting. Most of these inmates were either L-3 or L-4, with the minority having an ICS level of care. These inmates also described lack of structured therapeutic programming and poor access to outdoor recreation. They also voiced concerns about being isolated from other general population inmates due to being housed in

the "mental health unit." Many of these inmates described access to their mental health counselor ranging from monthly to once every three months.

Inmates in Section C described continuity of medication issues related to both untimely medication renewals and other medications not being available in the pharmacy because of apparent stock supply issues. Staff confirmed the accuracy of these continuity of medication issues.

We observed a treatment team meeting during the afternoon of March 2. We were encouraged by the multidisciplinary discussion and the presence of a psychiatrist, Dr. Wang.

March 2017 Recommendations:

3. Restart the ICS admission process for male inmates as planned.

4. Begin the planning process for more ICS beds.

5. Structured therapeutic programming for the female inmates needs to be restarted. The amount of structured therapeutic programming on a weekly basis offered to the average ICS inmate needs to be tracked as well as the actual number of hours per week actually used by the average inmate.

   Structured therapeutic programming should be treatment plan driven in contrast to "Round Robin" selected groups.

   We discussed in detail with both leadership and line mental health staff issues related to the reported refusal rate demonstrated by ICS inmates. If the refusal rate exceeds 30%, a QI process needs to be initiated to address this issue.

6. Access to outdoor recreation also needs to be tracked and monitored.

7. We also discussed with staff issues related to housing ICS inmates with non-ICS inmates in the same unit. Staff need to identify the involved issues closely and develop solutions.

8. Community meetings on a weekly basis should occur in both ICS housing units, which should be attended by both custody and mental health staff.

2.a.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Renovations at GPH, with specific reference to the nursing station, are not expected to be completed until December 2017.

Since the November 2016 site assessment, there has been a net gain of 2.0 FTE mental health counselors working at GPH in addition to a recreational therapist supervisor and a 1.0 FTE recreational activities therapist. Other gains in staffing included 2.0 FTE sergeants and a unit manager. The inmate count during February 27, 2017 was 87 inmates. A waitlist for admissions was started during January 24, 2017 and had 12 inmates on the waitlist during the first day of our site visit.

At the time of our site visit five structured therapeutic groups per week (12 inmates per group) were scheduled in addition to three activity therapy groups per day (12 inmates per group). Inmates received two hours per day of out of cell unstructured time on a daily basis with higher functioning inmates receiving additional hours of unstructured time out of cell during weekend days.

Additional security measures have occurred and/are being planned in response to an inmate assault upon a psychiatrist during late December 2016.

During the morning of February 28, 2017, we observed a GPH treatment team meeting, which was attended by the appropriate staff and conducted in a competent manner. Inmates being staffed during this meeting were interviewed by the treatment team as part of the process.

We also observed two of the renovated group treatment rooms, which included in one room "treatment chairs" and in the other group room "therapy tables." The room with the treatment chairs was organized in a classroom style in contrast to a semicircular configuration that would facilitate the group process. There were significant problems with the "treatment chairs" due to their excessive height, which resulted in the legs of inmates sitting in these chairs becoming numb after about 15-20 minutes.

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 (one of whom had not been transferred for 2-3 weeks) and occasional waiting lists (including currently) for male inmates. SCDC must track all referrals for inpatient/hospital level care as well as waiting lists and rejections of referrals.

The reasons for the low number of female inmates admitted to an inpatient psychiatric unit via GEO were unclear but appeared to be related to limited beds and contractual issues. During our site visit we interviewed an inmate who was currently housed in the RHU due to the lack of timely access to an inpatient psychiatric bed. This inmate was grossly psychotic and had been in need of inpatient psychiatric care for 2-3 weeks. Staff had apparently misinterpreted a

court order relevant to the use of involuntary medications, which had contributed to her decompensated state due to medication noncompliance.

March 2017 Recommendations:

1. Continue to focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH.
2. Continue to monitor implementation of the scheduled GPH renovations.
3. Fix the “treatment chairs” as well as their configuration.
4. Further explore the reasons for the low admission rate of female inmates to an inpatient psychiatric unit.
5. Explore other options for inpatient psychiatric beds such as the female forensic division of the State Hospital and/or renegotiate the current contract with the vendor that is providing inpatient psychiatric care for women. Timely access to female hospital beds must be available or this requirement will be found in noncompliance.
6. Provide training/supervision to mental health staff regarding court orders relevant to involuntary medications.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: The 40% vacancy rate noted during the November 2016 site assessment is little changed from the current 38% vacancy rate. The department has implemented an aggressive recruiting campaign as previously summarized relevant to hiring of both correctional and mental health staff. The salary for psychiatrists is likely not competitive to psychiatrists’ salary in the community in contrast to other state institutions.

Appendix 3 provides a summary of current mental staffing allocations and vacancies.

The expedited hiring process is very encouraging.

March 2017 Recommendations: It is very likely that the salary structure for psychiatrists and psychologists will need to be reconsidered depending on the outcome of the current recruiting/hiring efforts.

2.a.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 March 2017 Assessment: **partial compliance**

March 2017 Recommendations: Begin the formal QI process as planned.

2.b. Segregation:

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: It is encouraging that the LLBMU has been initiated on a small scale and the HLBMU is scheduled to be implemented during April 2017. These programs are beginning with low numbers of inmates. As the census grows, there will be a need for additional staff and additional programmatic interventions including Cognitive Behavioral and other therapies by trained and credentialed professionals.

We met with five HLBMU designated inmates in a group setting to discuss the beginning of the HLBMU. These inmates expressed concerns about this program but were generally optimistic about their participation. They also described physical discomfort re: the therapy chairs for reasons previously summarized. They also described their dissatisfaction with the current recreational yards.

We also observed the area that will be used for the new recreational yards to be constructed for the HLBMU. We strongly recommended that these yards include a toilet, mister and pull up bars.

March 2017 Recommendations:

1. Continue with the current implementation schedule relevant to BMU's. Consider changing the names of the two programs to delete reference to the terms "low level" or "high level."
2. Construct the new recreational yards.
3. Fix the "therapy chairs."

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

Implementation Panel March 2017 Assessment: **noncompliance**

March 2017 Implementation Panel findings:

Implementation of the activity schedule for the Camille Graham R&E has been delayed for about one week.

Crank radios had been provided to inmates in the LLBMU and at GPH. They have not been provided to inmates in the RHU due to potential issues related to providing crank radios to inmates on the mental health caseload but not to other inmates in the RHU.

Since the November 2016 site assessment, 22 mental health caseload inmates from PCI have been transferred to other prisons with 27 mental health caseload inmates remaining at PCI. Sixteen (16) of the 27 inmates are in the RHU with 12 of these inmates refusing to transfer.

The adjustment unit at PCI, which is designed for vulnerable inmates, remains at this location.

During the morning of February 28, 2017, we observed the mental health rounding process in the RHU at the Kirkland CI. The process essentially involved the mental health worker performing a mini-mental status examination that focused on the presence or absence of suicidal or homicidal ideation and the presence or absence of auditory or visual hallucinations. Related to how the mental health workers are assigned to the mental health rounding process in this RHU, the mental health worker appeared to not be very familiar with these inmates.

During the afternoon of February 28, 2017 we observed the mental health rounding process in the RHU at Broad River CI, which was done in a competent manner. The mental health worker performing the rounds appeared to be very familiar with these inmates. Inmates reported very limited access to the outdoor recreational cages. Broad River CI officials acknowledged that inmates are not being provided access to the outdoor recreation cages due to security staffing shortages.

During the afternoon of March 1, 2017, we observed the mental health rounding process in the RHU at the Leiber CI. The mental health clinician followed a written protocol that included an abbreviated mental health review of systems. For reasons previously summarized, it is our recommendation that the rounds process be modified as previously referenced. Significant issues specific to the RHU conditions of confinement were present that included limited access to yard and showers as well as poor access to clinical interventions being conducted in a confidential setting.

Many, if not all, of the above conditions of confinement issues at the Leiber RHU were directly related to the severe custody and mental health staffing vacancies.

Review of a limited number of randomly selected records of mental healthcare caseload inmates (see Appendix 5) surprisingly demonstrated better than expected frequency of clinical contacts although there were frequent delays due to custody staffing issues. A significant issue was the frequent lack of access to providing clinical interventions/ assessments in a setting that allows for adequate confidentiality.

During the morning of March 2, 2017 we observed the mental health rounding process at Camille Graham CI, which also used a mini-mental status examination approach as previously referenced.

The reported inmate access to showers and outdoor recreation was not consistent with documentation of such activities, which appeared to be a documentation problem. During the morning of March 3, 2017 we observed the rounding process at Allendale CI which also used a mini-mental health status examination approach as previously referenced.

March 2017 Recommendations:

1. Mental health staff need to evaluate the inmates at the PCI refusing to transfer in order to determine whether transfer to a higher level of mental health care is indicated.
2. Standardize the mental health rounding process to have the same mental health clinicians performing rounds on the same inmates for at least six months at a time. The rounding process should not include on a routine basis a mini-mental status examination unless clinically indicated. It would also be useful for these clinicians to be able to provide inmates during the rounds process with written materials such as puzzles or psychoeducational information.
3. The staffing vacancies at the Leiber CI have resulted in very significant problems in the context of the mental health system. A remedy needs to be developed and implemented as soon as possible.
4. Documentation issues specific to access to showers and yard time for RHU inmates at the Camille Graham CI need to be remedied.

2.b.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Improvement is noted in the context of having developed caseload monitoring sheets. We made specific references to recommended revisions of the data collected with specific reference to including the dates of the last five psychiatric clinic appointments as well as the last five appointments with the inmate's mental health counselor. In addition, we recommended that the weekly structured therapeutic activity offered and used by an individual inmate be included on the caseload monitoring sheet.

March 2017 Recommendations: as above.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Information relevant to the HLBMU has been provided in a previous section of this report. The LLBMU is operational with 10 inmates (5 in Phase 1, 3 in Phase 2, and 2 in segregation). The programming schedule appears to be adequate, however out of cell time for unstructured activities does not occur after 4pm on weekdays and not at all on weekends. Visitation is also an issue discussed on site and is to be modified.

Based on discussions with custody and mental health staff at Camille Graham CI, it was clear that there is a need for a female Behavioral Management Unit although the size of such a unit would be relatively small. We discussed with key staff potential options for such a unit.

March 2017 Recommendations:

1. Implement the LLBMU and HLBMU as planned.
2. Consider options for developing a female BMU.

2.b.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 March 2017 Assessment: **compliance (11/2016)**

March 2017 Implementation Panel findings: There has been a 9% overall decrease in the number of inmates on the mental health caseload who are housed in RHU from December 7, 2016 until January 18, 2017. Inmates with L4 MH classification have an average length of stay in segregation of about 507 days compared to 94 days for non-mental health caseload inmates.

March 2017 Recommendations: Attempt to understand the reasons for the significant differences in the context of the length of stays in the RHU as previously referenced.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: It was clarified that a similar procedure needs to be implemented for the Crisis Stabilization Unit cells.

March 2017 Recommendations: As above and QARM continue to perform studies to evaluate the results of cell temperature and cleanliness checks. Operations currently is only conducting

temperature and cleanliness checks for random cells. Temperature checks for random cells is acceptable; however, inspections for cleanliness should be conducted daily for all RHU cells.

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

Implementation Panel March 2017 Assessment: **noncompliance**

March 2017 Implementation Panel findings: Partial compliance will be achieved when the draft policy has been finalized and approved.

March 2017 Recommendations: Finalize and obtain approval regarding the above draft policy. Then begin implementation that initiates with training of staff.

2.c. Use of Force:

2.c.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy and formalized procedures for addressing administrative violations and excessive force. QARM has increased the number of UOF Reviewers from one to three since the November 16 site assessment and increased reviewing and tracking responsibilities for the positions. An automated Employee Corrective Action Tracking System has been developed for employees receiving corrective action for use of force violations. Since the November 16 site assessment, QARM referred 65 potential UOF violations to the Operations Division for review. Information was provided that six (6) of the referrals resulted in employee corrective action. The outcome for the other 59 referrals is pending. The UOF review process has been enhanced to assist eliminate the disproportionate use of force against all inmates including mentally ill inmates. A proposed policy revision is in progress that the Inspector General will no longer routinely conduct administrative investigations. It is anticipated that the use of force incidents will require routine administrative investigation and the policy revision will potentially impact administrative investigations being conducted and completed in a timely manner.

March 2017 Recommendations: Operations and QARM continue to conduct reviews and studies to identify disproportionate use of force against inmates and take the appropriate corrective action when incidents occur to eliminate the practice. Ensure that Operations determines final action on all referrals for potential use of force violations and that required administrative investigations are conducted critical to the elimination of disproportionate use of force against inmates.

2.c.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy requiring that chemical munitions be employed in a manner consistent with manufacturer's instructions during use of force incidents. Operations and QARM continue to monitor use of force incidents to ensure all instruments of force are employed in a manner fully consistent with manufacturer's instructions. SCDC has established specific guidelines on the amount of chemical agents that should be deployed for each application. These guidelines have been incorporated in the OP 22.01 Use of Force Policy. Progress has been made in instruments of force being employed in a manner consistent with the manufacturer's instructions. Although there has been progress, primarily with chemical agents, there continue to be too many incidents where excessive amounts and types of munitions are utilized without necessary justification. SCDC is addressing these issues with improved procedures, employee corrective action and limiting of issue of certain types of chemical agents (i.e. MK 9) for certain areas.

March 2017 Recommendations:

1. Finalize Training Lesson Plans on the Use of Force requiring instruments of force are employed in a manner consistent with the manufacturer's instructions;

2. Train Employees on the revised OP 22.01 Use of Force Policy;

3. Operations and QARM continue to review use of force incidents utilizing through the automated system and take appropriate action when violations and/or issues are identified.

2.c.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 March 2017 Assessment: **compliance (3/2017)**

March 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy. There are formalized procedures for addressing administrative violations and excessive force. Policy now strictly prohibits the use of restraints in the crucifix or other positions that do not conform to generally-accepted correctional standards.

March 2017 Recommendations: Operations and QARM staff continue to review and monitor use of force incidents through the automated system to ensure restraints are not used to place inmates in the crucifix or other positions that do not conform to generally accepted correctional standards. Pursue corrective action when violations and/or issues are identified.

2.c.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: SCDC has made significant progress limiting the amount of time inmates remain in the restraint chair. QARM identified that Operations and Medical Staff have documented different times inmates are removed from restraint chairs. This was analyzed by QARM and perceived to be a procedure flaw that is being addressed. There were no incidents identified for failure to report use of the restraint chair. Reviewed information reveals inmates only remain in the restraint chair as long as necessary to gain control. Medical staff is being informed their orders cannot be that an inmate remain in the restraint chair for a predetermined amount of time.

March 2017 Recommendations: Provide clarification to Medical/Mental Health staff their orders cannot be that an inmate remain in the restraints for a predetermined amount of time. Operations and Medical/Mental Health staff continue to prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control. QARM continue to track and monitor compliance with use of the restraints.

2.c.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: It is encouraging that only seven inmates were placed in restraint chair during this monitoring period and the duration of being placed in restraints was almost always significantly less than four hours. Six of these inmates were placed in restraint chair for mental health reasons.

We discussed the need to concurrently QI the relevant policy and procedure for inmates placed in restraints for mental health purposes.

March 2017 Recommendations: as above.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: OP 22.01 has been revised prohibiting the use of force in the absence of a reasonably perceived immediate threat. The revised Use of Force

Training Lesson Plan is in the development stage.

March 2017 Recommendations:

1. Complete the revision of the Use of Force Training Lesson Plan;
2. Schedule SCDC Staff for training on the revised Use of Force Policy;
3. All Staff complete the training for the revised Use of Force Policy;
4. Operation and QARM continue to monitor use of force incidents to ensure use of force is only when there is a reasonably perceived immediate threat.

2.c.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: OP 22.01 has been revised prohibiting 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. The revised Use of Force Training Lesson Plan is in the development stage.

March 2017 Recommendations:

1. Complete the revision of the Use of Force Training Lesson Plan;
2. Schedule SCDC Staff for training on the revised Use of Force Policy;
3. All Staff complete the training for the revised Use of Force Policy;
4. Operation and QARM continue to monitor use of force incidents to ensure crowd control canisters, such as MK-9, are not utilized in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions.

2.c.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 March 2017 Assessment: **partial compliance**

March 2017 Recommendations: Provide training/supervision relevant to documentation specific to notification of the clinical counselors prior to a planned use of force to request assistance and the actual intervention and outcome of the intervention (e.g., was planned use of force required?).

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings:
SCDC provides the following training to correctional officer concerning the appropriate methods of managing mentally ill inmates;

Introduction to Mental Health	1.5 hours	Orientation (all new employees)
Mental Health	2.0 hours	Basic Training
Pre-Crisis and Suicide Prevention	3.0 hours	Basic Training
Interpersonal Communications	10.0 hours	Basic Training
Communication Skills/Counseling	1.5 hours	Annual In-Service
Mental Health Lawsuit	4.2 hours	Annual In-Service
Suicide Prevention	4.0 hours	Annual In-Service
Crisis Intervention Training (CIT)	40.0 hours	Annual In-Service (Specialized Employees)

Since the November Site Assessment 1357 of the total 5403 correctional officers have received all or portions of the above training. The identity and number of correctional officers that had not received the required training on methods of managing mentally ill inmates was not provided.

March 2017 Recommendations:

QI studies are needed to identify the correctional officers that have not received the required SCDC training as it pertains to the appropriate managing of mental health offenders. Training Lesson Plans need to be developed and training provided to all correctional officers that will be assigned to the LLBMU and HLBMU Programs.

2.c.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 March 2017 Assessment: **compliance (3/2017)**

March 2017 Implementation Panel findings: A monthly UOF Report Mentally Ill vs Non-Mentally ill is generated. No issues were identified with the use of force data utilized to produce the report.

March 2017 Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: The Use of Force electronic monitoring and tracking system remains in use to monitor use of force incidents involving inmates including mentally ill inmates. Mental Health staff is electronically forwarded use of force incidents involving mentally ill inmates for review. Formalized procedures on how the use of force incidents involving mentally ill inmates are reviewed have not been completely developed. SCDC has revised the OP 22.01 Use of Force Policy and formalized procedures for addressing administrative violations and excessive force. The UOF review process has been enhanced to assist eliminate the disproportionate use of force against all inmates including mentally ill inmates. A proposed policy revision is in progress that the Inspector General will no longer routinely conduct administrative investigations. It is anticipated that the use of force incidents will require routine administrative investigation and the policy revision will potentially impact administrative investigations being conducted and completed in a timely manner.

March 2017 Recommendations:

1. Formalize the procedures for how Mental Health staff will review use of force incidents involving mentally ill inmates;

2. Ensure procedures addressing how routine administrative use of force investigations will be assigned and conducted are in place.

3. <u>Employment of a sufficient number of trained mental health professionals:</u>

3.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: See 2.a.iv.

March 2017 Recommendations: See 2.a.iv.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Significant improvement has occurred relative to the participation of psychiatrists in the treatment team process for the higher levels of mental

healthcare. Issues clearly remain due to the significant psychiatrists vacancies (e.g., psychiatrists attending treatment team meetings and/or signing treatment team plans for inmates who are not under their direct care although such a practice is better than having no psychiatric involvement).

March 2017 Recommendations: Remedy the significant mental health staffing vacancies.

3.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: The newly completed training module is online training that takes about two hours to complete. The percentage of mental health staff that have completed the four week module was reported to be 51%
March 2017 Recommendations: Provide the required training for mental health staff that have not completed the training.

3.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 March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: See 2.a.iv.

March 2017 Recommendations: See 2.a.iv.

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

Implementation Panel March 2017 Assessment: **compliance (3/2017)**

March 2017 Recommendations: Continue to monitor.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: See 3.g. Partial compliance is present due to the plan specific to 3.g. and the use of supervision and/or counseling as part of a remedial program specific to this provision.

March 2017 Recommendations: Implement 3.g and the counseling/supervision component of this provision.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: We discussed with staff the use of a QI process other than peer review that needs to be established in order to meet the elements of this provision. Peer review likely (depending on South Carolina state law) would not allow the results to be used for supervision/managerial purposes in contrast to a QI process that was not a peer review process.

March 2017 Recommendations: As above.

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

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

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

Implementation Panel March 2017 Assessment: **compliance (3/2017)**

March 2017 Recommendations: Provide detailed RIM reports prior to each site visit.

4.a.ii. Inmates transferred for ICS and inpatient services;

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: SCDC was able to produce reports consistent with this provision relevant to male ICS inmates but not to inmates transferred to GPH or contractual provider.

March 2017 Recommendations: develop and demonstrate the capacity to track the number and timeliness of inmates being transferred to GPH, contractual providers and ICS programs.

4.a.iii. Segregation and crisis intervention logs;

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Recommendations: continue to monitor.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: The EHR and the planned web based management information system should facilitate compliance with this provision. During the afternoon of March 2, 2017 we were provided with a demonstration of the web based management information system. We were extremely impressed with the improvements made in the system and type of data that can be mined from it.

March 2017 Recommendations: Continue to improve the web based management information system and implement the EMR as planned.

4.a.v. Use of force documentation and videotapes;

Implementation Panel March 2017 Assessment: **compliance (3/2017)**

March 2017 Implementation Panel findings: No issues were identified with the use of force data since the November 16 site assessment. SCDC Policy OP 22.01 addresses the retention of recordings.

March 2017 Recommendations: Operations and QARM continue to monitor use of force documentation and videotapes through the SCDC automated use of force system.

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

Implementation Panel March 2017 Assessment: **compliance (3/2017)**

March 2017 Implementation Panel findings: A monthly UOF Report Mentally Ill vs Non-Mentally ill is generated. No issues were identified with the use of force data utilized to produce the report.

March 2017 Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

4.a.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 March 2017 Assessment: **compliance (3/2017)**

March 2017 Implementation Panel findings: SCDC was able to produce reports consistent with this provision.

March 2017 Recommendations: none

4.a.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 March 2017 Assessment: **compliance (3/2017)**

March 2017 Recommendations: none

4.a.ix. Quality management documents; and

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Improvement continues relevant to the implementation of this provision.

March 2017 Recommendations: Continue to develop the QI process.

4.a.x. Medical, medication administration, and disciplinary records

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: The EHR and the planned web based management information system should facilitate compliance with this provision.

March 2017 Recommendations: Implement EHR and continue to improve the web based management information system.

4.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 March 2017 Assessment: **partial compliance**

March 2017 Recommendations: Implement the EMR as planned.

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

5.a. Improve the quality of MAR documentation;

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Recommendations: Provide QI reports for the next site assessment.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: See 5.a.

March 2017 Recommendations: See 5.a.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: The timing of the pill call lines have been reviewed by institution.

March 2017 Recommendations: We discussed with staff issues specific to the timing of HS medications, which needs to be administered after 8 PM. Implement this recommendation.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: See 5.a.

March 2017 Recommendations: See 5.a.

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

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

Implementation Panel March 2017 Assessment: partial compliance

March 2017 Implementation Panel findings: CI cells in several institutions had not been approved by mental health and/or were not suicide resistant as discussed on site. All CSU CI cells are now located in a healthcare setting. However the CGCI CSU will not open until April 2017.

March 2017 Recommendations: Complete the above referenced renovations.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: Partial compliance was found due to the combination of the use of two holding cells for suicide watch purposes at CGCI and Lieber CI and noncompliance with the documentation that the inmates were being checked on as required by policy and procedure.

March 2017 Recommendations: Continue to monitor and train staff.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Recommendations: Continue to monitor, supervise and train staff relevant to the specific suicide prevention policy.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: We discussed with staff various ways of auditing this provision that included obtaining information directly from inmates as well as inspecting the storage rooms that contain suicide resistant clothing, blankets and mattresses for inmates in CI.

March 2017 Recommendations: As above.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: A QI was performed that indicated significant compliance issues in both documenting showers offered daily as well as showers being offered in certain facilities during unreasonable times (e.g., 1:30 am).

March 2017 Recommendations: Correct the above.

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

Implementation Panel March 2017 Assessment: **noncompliance**

March 2017 Implementation Panel findings: Based on the email from Dr. Ridgeway, at CSU high security inmates are generally not seen in a confidential setting related to reported correctional officer shortages as well as mental health staff shortages.

March 2017 Recommendations: Remedy the above.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: The above process specific to RHU will be implemented in the CSU.

March 2017 Recommendations: As above.

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

Implementation Panel March 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: During the afternoon of February 28, 2017, we observed a treatment team meeting at the Broad River CSU, which was attended by the treatment team except for a psychiatrist. Most of the psychiatric time is provided by several tele-psychiatrists with onsite psychiatry being provided by a psychiatrist on weekends. Female psychiatrists at Broad River have not provided onsite coverage to the CSU due to their safety concerns about walking through the yards to the CSU. Staff confirmed difficulties in seeing inmates in a confidential setting primarily related to custody staffing issues.

Some of the inmates reviewed during the treatment team meeting were interviewed as part of the treatment planning process.

March 2017 Recommendations:

1. Psychiatric coverage predominantly by telepsychiatry is better than no psychiatric coverage, but is very problematic. It can be, in part, remedied by working with custody staff to make it safe for female psychiatrists to walk or ride to the CSU.
2. Clinical interventions/assessments conducted in a non-confidential setting is not adequate. This issue needs to be remedied.
3. A QI needs to be performed regarding relevant elements of the suicide prevention program.

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 continue in their pursuit of development of their own internal processes and support systems for an adequate mental health services delivery system and quality management system. This report reflects the IP's findings and recommendations as of March 3, 2017. 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.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member

Jeffrey Metzner, MD
Subject Matter Expert

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