South Carolina Department of Corrections
Implementation Panel Report of Compliance
June 2022

Executive Summary

Mental Health Staffing

Appendix I summarizes systemwide mental health staffing, which indicated a 34% vacancy rate for qualified mental health professionals (QMHP) and a 20% vacancy rate for psychologists. Notably, the psychiatrist positions were all full and the mental health officer (MHO)/mental health technician positions only had a 5% vacancy rate.

Custody Staffing

The South Carolina Department of Corrections (SCDC) continues to have a very serious funded frontline custody vacancy rate. Appendix VI summarizes custody allocations/vacancies for SCDC systemwide, which documents a vacancy rate of funded frontline correctional officers to be 61.3%. The supervisor funded staffing vacancy rate was 15.8%. The overall (frontline and supervisory) funded vacancy rate for the agency stands at 43.9%. On an almost daily basis supervisors, Sergeants and Lieutenants in particular, fill the posts for these vacant correctional officer positions.

Due to these vacancies many essential and basic correctional practices are compromised, which includes negatively impacting inmates' timely access to needed mental health services. We are aware of the many efforts initiated by SCDC to this remedy this problem, which include important legislative efforts (e.g., request for increased salaries and benefits for correctional officers) as well as aggressive recruitment efforts. We also acknowledge the stress and commitment of the correctional officers who are working within SCDC under such circumstances. Unfortunately, until the vacancy rate is significantly reduced, many of the Settlement Agreement provisions will remain out of compliance.

A major concern of the Implementation Panel is that the various compromised correctional and mental health practices related to the staffing shortages will become normalized and/or institutionalized by the staff. For example, non-confidential clinical contacts are clearly better than no clinical contacts but should not be viewed as an acceptable practice as compared to confidential clinical contacts.

The Settlement Agreement (SA)

Appendix II provides our findings regarding specific provisions of the Settlement Agreement. The following sections will provide a summary of many of the SA provisions.

Reception and Evaluation Process

Significant improvement has occurred in meeting timeframes in the context of the R&E mental health screening process which is, in part, due to significantly decreased R&E staffing vacancies as summarized in Appendix II. The R&E healthcare screening process has also significantly improved related to the joint efforts of Dayne Haile, Daniel Mullins and Dennis Patterson (Institutional Medical Services Administration (IMSA) Team). A new process to receive and test R&E intake inmates for COVID-19 was introduced in late September/early October 2021, which has resulted in removing backlogs and allowing inmates faster access to mental health services. This, in turn, has allowed the R&E Mental Health team to begin to shift their focus to quality of services in contrast to the simple quantity and timeliness of services in partnership with The Division of Behavior Health CQA team.

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

Approximately 31% of the total inmate population is on the mental health caseload at this time, which is consistent with a mental health screening process being an effective process for identifying inmates in need of mental health services during some time in their incarceration.

Although it appears inmates in need of mental health treatment are being appropriately identified, it is less clear whether such inmates are being placed in the appropriate level of mental health care. An example of this is that currently about 5.11% of caseload inmates are classified as needing an L2 level of mental health care (LOC). In general, it would be expected that about 10-15% of the mental health caseload in a correctional system would be classified as needing an L2 LOC.

Related primarily to custody and mental health staffing deficiencies, significant problems remain regarding inmates having timely access to mental health evaluation and treatment services.

Gilliam Psychiatric Hospital (GPH)

Plans are being developed to provide additional much needed group therapy programming space and office space at GPH.

Due to multiple issues, patients at GPH, since January 2022, have predominantly been on a lockdown status. Programming has just recently begun to start at a very slow pace. During the past months, psychiatrists have reported having poor access to meeting with their patients in GPH.

Phlebotomy services have been absent in GPH for the past three months, which is very dangerous and unacceptable. The lack of phlebotomy services needs to be immediately corrected.

The current overly restrictive conditions of confinement at GPH need to be corrected and closely monitored. The problematic institutional culture at GPH that has facilitated lack of attention to providing a therapeutic milieu need to be addressed.

Restricted Housing Units/ SMHU / HLBMU/ CHOICES

RHU Policy

SCDC has completed extensive revisions of the 22.38 RHU Policy in consultation with the IP. The revised policy titled: RESTRICTIVE HOUSING AND THE LEVEL SYSTEM has increased screening and review of inmates placed in RHU with clearly delineated steps for how inmates can achieve removal from RHUs. The policy has been approved and is being processed for dissemination. Critical to the successful implementation of the Restricted Housing and the Level System Policy will be staff training and inmate education on the policy.

Providing adequate out of cell time remains problematic systemwide in the RHUs and higher security programs related to custody staffing and Covid-19 issues. Access for inmates to tablets is a significant mitigating factor but remains limited due to re-charging limitations. Other mitigating efforts need to be identified and initiated.

The renovation project in the RHU at the BRCI is a very significant positive step in improving the future conditions of confinement at that RHU.

Despite significant custody and mental health staffing vacancies, programming in the SMHU at the BRCI which included access to group therapies, daily recreational yard time and reasonable access to individual counseling and meeting with the psychiatrist via telepsychiatry, was very encouraging.

Programming within the HLBMU at the KCI was very problematic related to the nature of the physical plant and significant custody vacancies. In addition, phase 1 HLBMU inmates had less privileges than are provided to RHU inmates. It was our understanding that consideration for moving the HLBMU to the housing unit adjacent to the CSU is again being considered. We strongly recommend such a move occur because the current HLBMU physical plant is inadequate for implementation of that program as intended.

CHOICES continues to provide helpful programming, but significant limitations remain related to the custody and mental health officer vacancies.

The Treatment Planning Process

A comprehensive review of the treatment planning process was completed by QIRM. The frequent absence of psychiatrist involvement and inmate/patient attendance and involvement in the treatment planning meeting were particularly problematic. Lack of timely treatment plan development also remained a significant problem. The average quality assessment compliance score across programs in the context of treatment planning was only 49%.

We understand that the treatment planning process is greatly influenced by the significant mental health staff and custody staff vacancies, which along with Covid-19 related issues, have significantly negatively impacted the treatment planning process.

Maintenance of Accurate, Complete, and Confidential Mental Health Treatment Records

Substantial compliance has been maintained for the following provisions:

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

4.a.iii. Segregation and crisis intervention logs

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

4.a.ix. Quality management documents

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.

QIRM continues to develop and implement a comprehensive mental health quality improvement process and is launching the development and implementation of a dashboard for QI reporting purposes.

Medical, Medication Administration

Although still problematic, related to significant nursing staff vacancies and documentation issues, significant progress has been made in improving the medication administration process. This process will be further enhanced as the QI processes in the areas of patient medication compliance, medication management, nurse staffing and nurse training are further developed and implemented. Major improvement should be facilitated after problems implementing the bar scanning issues for the electronic medication administration record system have been resolved.

Crisis Intervention Cells

Significant issues remain in the context of providing continuous observation of suicidal inmates as well as providing confidential and timely sessions with mental health counselors, psychiatrists and psychiatric nurse practitioners for CI inmates. Security staffing shortages system wide prevent SCDC from providing continuous observation when required for inmates on crisis status in RHU cells. An IP member and SCDC officials inspected SSR cells and found none of the cells allow continuous staff observation and cells cannot be modified to allow crisis continuous staff observation. SCDC officials agreed to develop a plan for movement of SSR inmates to another location when their crisis status requires continuous observation. This is a high priority concern.

Crisis Stabilization Unit (CSU)

A new CSU program manager was hired during early April 2022 resolving the existing vacancy. The SCDC also created a Director of Crisis Intervention and Suicide Prevention position (which has been filled by a current psychologist), which will allow for a centralized contact for crisis concerns, better oversight regarding compliance with relevant policies and procedures, and

additional development of and implementation of pertinent suicide prevention training and programming.

SCOR

The Special Concerns Offender Reintegration (SCOR) program is designed to help motivate offenders in making a successful reintegration, stepping down from Restrictive Housing and returning to general population, while simultaneously providing opportunities for successful reentry into their communities upon release from incarceration. It is a general population program and restraints are not required for participants. The SCOR Program was implemented at the Evans CI Waxhaw Unit in March 2021. There are four phases and it takes a minimum of six months to complete the program.

SCDC has not developed and implemented a tracking system for inmates that have successfully completed the SCOR Program to evaluate if they have remained in the general population or have returned to an RHU because of safety concerns.

IP SCOR Recommendations:

- Enhance Inmate Awareness of the Evans CI SCOR Program throughout SCDC;
- Enhance the Orientation Program for Inmates arriving at SCOR;
- Revise the SCOR Program to include options for inmates that cannot return to the general population after completing the program successfully;
- Develop and implement a tracking system for inmates successfully completing the SCOR Program to measure the rate at which inmates remain in the general population over time.

Currently, SCDC has over 120 inmates confined in RHUs for safety concerns. The Evans CI SCOR Program has the potential to significantly reduce the RHU Safety Concern population.

Site Visits

From June 13-17, 2022, a focused site assessment was completed at Broad River Correctional Institution (BRCI), Kirkland Correctional Institution (KCI), Camille Graham Correctional Institution (CGCI), Evans Correctional Institution (ECI) and Perry Correctional Institution (PCI). Summaries of more site-specific observations and findings are presented in the Additional Information section of Appendix II.

Implementation Panel Changes

Significant personnel changes continue to occur in the IP. The retirement of the behavioral health monitor, Raymond Patterson, M.D. was a significant loss but the addition of subject matter expert Sally Johnson, M.D. is a significant gain. The impending retirement of IP coordinator, Tammie Pope, is already being mourned by all that have worked with her, but we are very happy for a new phase in her life. The IP members are pleased that Kelli Eargle will be the new IP coordinator and we look forward to working with her.

Findings

The findings of the Implementation Panel with regard to compliance on the provisions of the Settlement Agreement based on the review and site visit concluded on June 17, 2022 are as follows:

1. Substantial Compliance (active)----8
2. Substantial Compliance (sunset/greater than 18 months)---26
3. Partial Compliance---21
4. Non-Compliance---5

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

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 June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: Significant improvement has occurred in meeting timeframes in the context of the R&E mental health screening process, which is, in part, due to significantly decreased staffing vacancies as summarized in the current status section. The R&E healthcare screening process has also significantly improved related to the joint efforts of Dayne Haile, Daniel Mullins and Dennis Patterson (Institutional Medical Services Administration (IMSA) Team). A new process to receive and test new inmates for COVID-19 was introduced in late September/early October 202, which has resulted in inmates having faster access to mental health assessment and services.

Implementation Panel June 2022 Recommendations: Establish mental health rounds in the R&E in order to facilitate providing needed treatment services for mental health caseload inmates with length of stays (LOS) in the R&E greater than 30 days.

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 June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: An adequate QI process has been developed to monitor this provision. The R&E Mental Health team has begun to shift focus to continued quality improvement outside of the quantity of services and timeliness in partnership with The Division of Behavior Health CQA team.

Implementation Panel June 2022 Recommendations: Implement the shift in focus in the QI process as above while maintaining improvement in quantity and timeliness of services in order to achieve compliance.

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 June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: As per status update section and provision 1a. Significant improvement is noted in meeting timeline requirements for the R&E assessment process.

Implementation Panel June 2022 Recommendations: Continue with the IMSA efforts.

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 June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: Approximately 31% of the total inmate population is on the mental health caseload at this time, which is consistent with a mental health screening process being an effective process for identifying inmates in need of mental health services during some time in their incarceration. It would be useful to also determine via a QI study how many inmates during a monitoring period are placed on (added to) the mental health caseload who were not identified during the R&E process as well as tracking the number of inmates on the mental health caseload whose level of care has changed during the monitoring period.

Although it appears clear inmates in need of mental health treatment are being appropriately identified, it is less clear whether such inmates are being placed in the appropriate level of mental health care. An example of this is the percentage (about 5.11%) of caseload inmates being classified within SCDC as needing an L2 level of mental health care (LOC). In general, in a correctional system it would be expected that about 10-15% of the mental health caseload would be classified as needing an L2 LOC.

Implementation Panel June 2022 Recommendations: As above. We again discussed issues with leadership staff specific to the current outpatient LOCs (3,4 and 5) with a recommendation to consider reassessing actual care level needs within the current L3 group, moving those with higher needs into the L2 population and consolidating the remainder of L3 inmates with the other outpatient levels, creating one outpatient group. Frequency of outpatient services could then be standardized while still allowing for increased frequency based on individual clinical needs.

2.a. Access to Higher Levels of Care
2.a.i. Significantly increase the number of Intensive Outpatient inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;

Implementation Panel June 2022 Assessment: Compliance with increasing the number of Intensive Outpatient inmates vis-a-vis outpatient mental health inmates but partial compliance with providing sufficient facilities**.**

Implementation Panel June 2022 Findings: In the context of the correctional institutions site visited during this monitoring period, the QIRM reviews reported significant deficiencies in the delivery of mental health services to inmates at Evans, BRCI, CGCI, KCI, GPH and Perry CI. Many of these deficiencies are very basic processes such as timeliness of clinical contacts and treatment plans. Refer to the "additional information" section for more information re: these issues.

The number of Intensive Outpatient inmates vis-a-vis outpatient mental health inmates has significantly increased since 2014 and appears to have stabilized at ~11%. A closer look at this may well identify inmates in need of L2 services. Level changes would likely bring the L2 numbers within the population closer to that expected in most correctional systems.

Implementation Panel June 2022 Recommendations: See prior recommendation regarding reconceptualizing the outpatient level of mental health care.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: SCDC has significantly increased the number of male and female inmates receiving intermediate care services since 2014. However, it is likely that there are a significant number of additional inmates on the mental health caseload in need of L2 level of care services who have not been appropriately identified/classified. As already noted, based on our national experience, it would be expected that about 10-15% of the mental health caseload within a correctional system would be classified as needing an L2 LOC.

Implementation Panel June 2022 Recommendations: Address the above issue via LOC reviews at treatment team meetings and/or a quality improvement study that reviews accuracy of LOC assignments.

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 June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: Construction limitations prohibit expansion of the number beds at GPH, and the efforts to establish a larger capacity facility (contracted space) for female inmates has stalled. Overall, the number of male and female inmates receiving inpatient psychiatric services has not significantly increased since onset of the settlement agreement. At present there is not a waiting list to admit men into inpatient care at GPH and overall the census on that unit runs under capacity. There is a significant delay in accessing inpatient beds for females, resulting in those women being managed for extended periods in a setting that is limited in its abilities to meet their treatment needs.

Plans are currently being developed to provide more group therapy programming space and shared office space at GPH, by repurposing existing space adjacent to the living units that previously was, or currently is, being used by nursing and individual clinicians.

In addition, related to ongoing Covid 19 issues and a major temporary, or in some cases permanent, removal and/or reassignment of mental health and correctional staff at GPH related to an investigation, patients at GPH since January 2022 have predominantly been on lockdown status and have not been receiving required programming or out of cell time. Some programming has just recently been restarted, but at a very slow pace.

It is unacceptable for GPH, which houses the most seriously mentally ill inmates in SCDC, to be functioning similar to a RHU.

During the past months, psychiatrists have had poor access to meeting with their patients in GPH, due to correctional staff shortages, Covid lockdowns and a major sewer replacement project.

Phlebotomy services have been absent in GPH for the past three months, which is very dangerous and unacceptable.

Implementation Panel June 2022 Recommendations: The lack of phlebotomy services needs to be immediately corrected. The conditions of confinement at GPH need to be corrected and closely monitored as does the problematic institutional culture at GPH that has facilitated lack of a therapeutic milieu. Clinical staff need to take a more active role in creating a plan to assure basic services are accomplished at GPH regardless of factors such as those already identified.

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

Implementation Panel June 2022 Assessment: Partial Compliance

Implementation Panel June 2022 Findings: As per status update section. See 2.b.ii. findings.

Implementation Panel June 2022 Recommendations: See 2.b.ii. findings.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: As per status update section. Providing adequate out of cell time remains problematic related to custody staffing and COVID 19 issues. Access for inmates to tablets is a significant mitigating factor but remains limited due to re-charging limitations.

Implementation Panel June 2022 Recommendations: Consider other mitigation efforts to partially compensate for the limited out of cell time. Establish goals to track incremental improvements in amount of recreation and other out of cell time being offered and report on compliance with these goals (i.e. how many had 2 days or 3 days).

2b.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 June 2022 Assessment: Noncompliance

Implementation Panel June 2022 Findings: As per status update section. Barriers to compliance continue to be predominantly Covid related movement restrictions, quarantine issues, and staffing vacancies.

Programming in the SMHU at the BRCI was very encouraging (which included access to group therapies, daily recreational yard time and reasonable access to individual counseling and meeting with the psychiatrist via tele-psychiatry).

Programming within the HLBMU was very problematic related to the nature of the physical plant and significant custody vacancies. In addition, phase 1 HLBMU inmates had less privileges than are provided to RHU inmates. It was our understanding that consideration for moving the HLBMU to the housing unit adjacent to the CSU is again being considered. We strongly recommend such a move occur because the current HLBMU physical plant is inadequate for such a program.
CHOICES continues to provide very helpful programming but significant limitations are in place related to the custody vacancies, which include mental health officers.

Implementation Panel June 2022 Recommendations: Continue to monitor and mitigate.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: As per status update section. The partial compliance is related to not providing adequate and timely treatment following transfer to a higher level of care.

Implementation Panel June 2022 Recommendations: Remedy the above.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: SCDC Operations continues improvement in conducting required correctional facilities RHU and Crisis temperature checks and cell inspections; however, the overall compliance rate of 90 percent was not achieved for all institutions from October 2021 through March 2021. The aggregate percentage of cells recording temperature checks and conducting cleanliness inspections for all institutions for each month and overall for the six month period was 89 percent and is depicted below:

SEGREGATION UNITS- TEMPERATURE AND SANITATION CHECKS COMPLIANCE PERCENTAGES									
Institution	**Unit Type**	**Shift**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**	**Oct 21 to Mar 2022 Overall**
ALL INSTITUTIONS	MAX	ALL SHIFTS	**97%**	**94%**	**87%**	**80%**	**88%**	**86%**	**89%**

A scorecard that displays Operations' performance indicators was developed by the QIRM and the Agency Biostatistician during this reporting period. As described in the SCDC Update, for each measure, an accompanying definition was developed explaining: the data components, data source, established goals, policy requirements, reporting frequency, and calculation. This development allows QIRM's QI staff to prepare charts and graphs for use in quality and facility staff meetings, facility staff meetings, and other QI processes to promote improvement opportunities. Operations staff, including Operations leadership, institutional wardens, associate wardens, majors, and institutional

staff, have access to the temperature, sanitation, and showers data to monitor progress for each performance indicator.

The scorecard compliance color indicators are based on goals established by Operations as follows: **Green- 90-100%** **Yellow- 60-89%%** **Red-<60%.**

The Office of Operations and IT has implemented the previously reported plan to include a selection menu on the Zebra device for staff to electronically select specific options when temperatures and cleanliness are out of compliance. Documenting appropriate comments when RHU and Crisis cell temperatures are out of range and/or cells do not meet the required sanitation level remains deficient based on the SCDC Update:

- For temperatures- 54% of the time, comments were noted when temperature was out of range, and 11% of the time, the comments noted appropriate action was taken to rectify the deficiency.
- For cell sanitation-93% of the time, comments were noted when the cell was unclean, and 24% of the time, the comment noted appropriate action was taken to rectify the deficiency. Questionably, there were no unclean cells reported in November 2021.

Implementation Panel June 2022 Recommendations:

1. Continue efforts to achieve substantial compliance with conducting the required RHU cell temperature and cell cleanliness checks.
2. The Operations Division continue quality improvement efforts to ensure correctional staff document appropriate comments when cell temperatures are out of range and/or a cell is not in an acceptable condition.
3. Headquarters and Correctional Facility Management conduct timely follow up and take corrective action when compliance issues are identified.
4. Continue to conduct temperature and cleanliness checks for each institution's CI cells and 4 random RHU cells.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: The implementation of a formal quality management program under which segregation practices and conditions are reviewed continues. The Division of Operations has a quality management process that reviews and monitors segregation practices and conditions. QIRM completes regular audits of several categories within the RHU at each institution. These areas include timeliness and location of QMHP and Psychiatry sessions, timeliness of treatment plans, participation in treatment team, mental health reviews of Mental Health and Non-Mental Health inmates, segregation rounds, security checks, showers, temperature and sanitation, recreation, laundry services, cell cleaning supplies, RHU staff visitation, and RHU inmates on crisis. The Offender Automated Tracking System (OATS) allows Operations to track services and programs provided in RHUs.

Staffing shortages prevent compliance with the majority of the segregation practices and conditions reviewed i.e., security checks, temperature and cell cleanliness checks, recreation, showers, staff

visits, classification reviews, medical and mental health contacts/assessment, etc. Compliance for this provision will be achieved when the QI process demonstrates improvement in the context of the various indicators.

The following is a summary of the RHU findings for these sections:

- Inmates in RHU over 365 days;
  - The average number of inmates in RHU over 365 days for each month was:

October 2021	44
November 2021	46
December 2021	52
January 2022	55
February 2022	57
March 2022	57
Average for **October 2021 through March 2022:**	**52**

- RHU Seven (7) Day Short Term Inmate Reviews from January 2021 to March 2022;
  - 60 percent of the inmates in RHU received their required 7-day review.
- RHU Inmates in Short Term Status for less than the maximum 60 days or less from October 2021 to March 2022;
  - 83 percent of the inmates remained in RHU for less than the maximum 60 days or less.
- RHU Inmates in Security Detention Status that received required 90-day reviews;
  - 72 percent of the Inmates in Security Detention Status received their required 90-day reviews.
- RHU Inmates in Disciplinary Detention Status from January 2021 to March 2022 for more than the maximum 60 days;
  - 4 percent of the inmates in RHU for Disciplinary Detention exceeded the maximum 60 days.

The monthly RIM *Inappropriate Sanctions for Informal Disciplinaries Report* is used by Operations to monitor inappropriate phone or visitation sanctions. The report identified three mentally ill inmates who received informal disciplinaries resulting in telephone sanctions in October 2021; two were determined to be appropriate according to policy.

The Offices of Operations, Behavioral Health, and the Division of Inmate Records & Classification are reviewing inmates who remain in RHU for 365 days or more. From October 2021 to April 25, 2022, fifty-one (51) inmates in the RHU 365 days or more were reviewed and six were released to the general population or alternative housing..

Implementation Panel June 2022 Recommendations:

1. Continue the QIRM and Office of Operations formal quality management program reviewing SCDC segregation practices and conditions.

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 June 2022 Assessment: Substantial compliance

Implementation Panel June 2022 Findings: The provision was found in substantial compliance in July 2021 and remains. The SCDC Plan to eliminate the disproportionate use of force against inmates with mental illness continues. The plan includes coordinating efforts across multiple disciplines including Operations, Behavioral Health, and QIRM, as oversight bodies for monitoring, reporting, and providing recommendations based on data and audit outcomes. The Mental Health inmate population use of force incidents remained stable during the reporting period. The average percentage of UOF incidents involving Mental Health inmates was 0.80 percent and the average in the Non-Mental Health inmate population decreased from 0.19 percent to .12 percent.

The Offices of Operations, Behavioral Health Services, Medical, Programs, and Reentry and Rehabilitative Services, continue to hold meetings to discuss findings of collaborative work of Division of Mental Health's UOF Coordinator and QIRM Use of Force Reviewers, and address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates. The Behavioral Health Coordinator hired in October 2021 to replace the individual that resigned is a Licensed Professional Counselor and has over 20 years of behavioral health experience. SCDC Representatives from QIRM, Operations, and Behavioral Health meet with the designated IP member to discuss the UOF MINs comments provided by the IP Member for the previous month.

Implementation Panel June 2022 Recommendations:

1. SCDC QIRM, Operations, and Behavioral Health monitor all UOF incidents to identify and address the reasons for disproportionate Use of Force involving inmates with mental illness;
2. The Division of Operations, Behavioral Health Services UOF Coordinator and QIRM Use of Force Reviewers collaboratively work together to address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates;
3. QIRM continue QI studies regarding the Division of Behavioral Health reviewing UOF incidents involving inmates with a mental health designation; and
4. The Behavioral Health Coordinator ensure follow up is documented regarding any Division of Behavioral Health deficiencies identified in the review of Use of Force incidents involving inmates with a mental health designation.

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

Implementation Panel June 2022 Assessment: Substantial Compliance (December 2021)

Implementation Panel June 2022 Findings: This provision moved to substantial compliance in December 2021. SCDC assigned a qualified Use of Force Reviewer to the Office of Operations to assist in reducing inappropriate uses of force. The Operations Use of Force Reviewer regularly communicates with Behavioral Health and/or QIRM Use of Force Reviewers, on Behavioral Health notification and other use of force issues. He participates in monthly meetings with the IP Use of Force Reviewer and Behavioral Health, Legal, Operations, and QIRM leadership and reviewers to jointly review use of force Management Information Notes (MINs) and discuss issues. The Reviewer also meets monthly with Behavioral Health, Operations, and QIRM staff to discuss strategies for

reducing disproportionate uses of force involving inmates on Behavioral Health's caseload, and compiled/ reported monthly data to include (1) the percentage of all use of force incidents precipitated by a legitimate penological need, (2) the percentage of all immediate use of force incidents precipitated by an immediate threat reasonably perceived, and (3) the percentage of threat reasonably perceived/ penological need violations resulting in corrective action. Operations leadership has incorporated threat reasonably perceived verbiage and QMHP notification requirement verbiage into all Security Post Orders to emphasize the importance leadership places on both requirements and leadership's determination to improve agency performance in these areas. Operations leadership meets with institutional/divisional leadership when a reasonably perceived threat violation is identified and initiates appropriate follow up to address violations.

The use of force incidents from October 2021 to March 2022 averaged 50 per month, a reduction from 56 per month from April 2021 through September 2021.

An average of 99.7% of all use of force incidents between October 1, 2021, and March 31, 2022, involved an immediate threat reasonably perceived by a Correctional Officer or (in planned uses of force) a legitimate penological need for force, or corrective action with an Officer in error. Excluding corrected incidents, the period average was 90.0%. A low compliance rate of 97.1% occurred during March 2022.

The Office of Investigation and Intelligence (OII) data related to Use of Force for October 2021 through March 2022 is provided in the below table.

OII	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
UOF Referrals Reviewed	8	10	11	6	11	15
UOF Investigations Opened	7	10	11	6	10	14
UOF Investigations Pending	19	24	29	29	35	34
UOF Investigations Closed	5	5	6	6	5	16

For the October 2021 to March 2022 Reporting Period, there were 23 inmate grievances alleging excessive force, an increase from 14 inmates alleging excessive force from April 2021 to September 2021.

SCDC continues to utilize a Use of Force Review Team consisting of a QIRM Use of Force Reviewer, the Behavioral Health UOF Coordinator, and the Operations' Administrative Director for a decision on whether a Use of Force matter should be referred to DDOII as excessive UOF. The UOF Team reviews the documentation provided and collects other information necessary for a referral decision and either recommends referral to DDOII for investigation or declines to recommend

referral using the same email string. If referral to DDOII is recommended, the inmate is notified by the IGC that the grievance will be held in abeyance during the DDOII investigation.

The SCDC Use of Force Review Team refers issues raised in the grievance that should be addressed by the warden or other staff at the institution. Recommendations reflected in the UOF Review Team's determination are forwarded to the Chief, Inmate Grievance Branch.

The following review of use of force incidents continue:

- IP continues to monitor SCDC Use of Force MINS Narratives monthly to identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force.
- Headquarters Operations Leadership continues meetings with Institution Management staff where high numbers of problematic UOF incidents are identified to develop strategies to address inappropriate UOF.
- QIRM, Operations Leadership and the Behavioral Health UOF Coordinator regularly meet to discuss Agency UOF issues.
- The IP Use of Force Reviewer, QIRM UOF Reviewers, the Behavioral Health UOF Reviewer and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force.
- The Division of Behavioral Health continues to provide a written report for all incidents involving UOF to prevent inmate self-injury. The written report of all UOF incidents to prevent inmate self-injury are discussed at all monthly UOF MINs meetings.

SCDC continues to take corrective action for Use of Force policy violations employees.

Implementation Panel June 2022 Recommendations:

1. Operations, the Behavior Health UOF Coordinator and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM, the Behavior Health UOF Coordinator and Operations leadership continue frequent meetings to discuss UOF and other relevant issues;
3. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer, QIRM, the Behavior Health UOF Coordinator and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. QIRM QI Inmate Grievances submitted alleging staff excessive force and physical abuse;
6. QIRM QI incidents and grievances referred to the Office of Investigations and Intelligence related to UOF and Physical Abuse;
7. Continue referrals to the Office of Investigations and Intelligence, Inmate Grievance Program, and Use of Force Review Team for excessive force and physical abuse and document the reasons an investigation is not opened;
8. QIRM to include the UOF violations QIRM identified in their review of use of force incidents in each reporting period UOF Reports; and

9. Require meaningful corrective action for employees found to have committed use of force violations.

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 June 2022 Assessment: Substantial Compliance (June 2022)

Implementation Panel June 2022 Findings: Per the SCDC Status Update, this provision has moved from partial compliance to substantial compliance in documenting attempts to contact clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates. The QIRM QI Study demonstrates the mean compliance rate for SCDC attempts to contact clinical counselors (QMHPs) prior to planned use of force from October 2021 to March 2022 was 95 percent. This is an improvement from the April 2021 through September 2021 mean compliance rate of 86.0 percent. The Office of Operations continues to take corrective action when staff fail to contact a QMHP prior to a planned UOF. Behavior Health has plans to conduct qualitative reviews of the QMHPs attempts to avert planned UOF involving mentally inmates.

Implementation Panel June 2022 Recommendations:
1. Continue Substantial Compliance with attempts to contact clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates.
2. QIRM continue QI studies regarding SCDC attempts to contact clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates.
3. Behavioral Health conduct qualitative reviews to evaluate QMHP attempts to avert planned UOF involving mentally ill inmates.

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

Implementation Panel June 2022 Assessment: Substantial Compliance (December 2021)

Implementation Panel June 2022 Findings: The SCDC achieved substantial compliance for this provision in December 2021 as 90.5 percent of the security staff received the required training regarding the appropriate methods of managing mentally ill inmates in the Calendar Year 2021.

The CY 2022 SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates requires newly hired correctional officers receive 11 hours of initial training. Permanent correctional officers' annual training concerning the appropriate methods of managing mentally ill inmates is 5 hours.

CY 2022 Managing Mentally Ill Offenders Curriculum

Program	Course/Class Code	Hours	Total
Agency Orientation - 1.00 & 1.20	Intro to Mental Health	2.0	4.0
	Suicide	2.0	
Basic Training - 3.00, 3.00A, 3.60, 3.97 & 3.99	Pre-Crisis Intervention (Communication)	3.0	7.0
	Mental Health	2.0	
	Suicide	2.0	
Annual In-Service	Inmate Suicide Prevention - 1015.20V	4.0	5.0
	Mental Health in the Correctional System - 1096.12V	1.0	

The IP continues to encourage SCDC Management and responsible training staff to consult with Behavior Health staff to assess if correctional staff are receiving sufficient training to manage and appropriately respond to mentally ill inmates, particularly staff performing duties in housing units that are designated as residential mental health programs.

Number of Security Staff by Course(s) Not Completed but Required as Part of the Managing Mentally Ill Offenders Training in CY 2022 (January 1 - March 31)

# Required to take Training	NONE Completed		Partial Completion		Fully Completed		Have NOT Completed Training
	#	%	#	%	#	%	
1853	**3**	**.02**	**1850**	**99.8**	**0**	**0.00**	**1853**

The above table indicates 99.8 percent of the required SCDC employees have partially completed the Managing Mentally Ill Offenders training in CY 2022. None of the required employees have fully completed the required training. For the provision to remain in substantial compliance, 90 percent of the required employees must complete the training in CY 2022.

Implementation Panel June 2022 Recommendations:

1. Training, Operations and Behavior Health staff conduct periodic evaluations to determine if correctional staff are receiving sufficient training to manage and appropriately respond to mentally ill inmates;
2. Continue to document and track the number of required employees completing the mandatory training for appropriate methods of managing mentally ill inmates in the 2022 Calendar Year;
3. Continue to ensure correctional officers receive the required SCDC mandatory training concerning the appropriate methods of managing mentally ill inmates and suicide prevention for Calendar Year 2022.

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 June 2022 Assessment: Substantial compliance (December 2020)

Implementation Panel June 2022 Findings: No information has surfaced in the reporting period to prevent the provision from progressing to sustained compliance. Per the SCDC Update, OBH has

created a plan with a goal to reduce the disproportionate use of force involving mentally ill inmates during 2022-2023. The plan addresses:

- Training for security staff from all institutions in Crisis Intervention Team Training and Mental Health First Aid (MHFA) for Public Safety training to current and new security staff (except those CIT certified);
- Consultation by CQM manager to institutional QMHPs and Administrators on QMHP intervention prior to a planned UOF and averting the UOF using de-escalation techniques
- Engagement of the interdisciplinary treatment team;
- Appropriate tracking and follow-up.

Implementation Panel June 2022 Recommendations:

1. OBH implement the plan to reduce the disproportionate use of force involving mentally ill inmates.
2. QIRM to continue QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation;
3. The Behavioral Health UOF Reviewer to monitor inmates with a mental health designation identified as high risk for use of force;
4. The Behavioral Health UOF Reviewer to monitor inmates involved in UOF incidents with a mental health designation, recommend placement in a mental health residential program when appropriate, and track their status while awaiting placement;
5. QIRM to ensure Use of Force compliance reviews and reports are completed on a consistent and timely basis.

3. Employment of enough trained mental health professionals:

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: As per status update section, which provides a comprehensive review of the treatment planning process. The frequent absences of psychiatrists and the inmate/patient in the treatment planning meeting are particularly problematic. OBH determined interdisciplinary representation was noted, with at least five disciplines present 36% of the time. The facilitating QMHP documented concerns/decisions 57% of the time. Lack of timely treatment plans remained a significant problem.

The average quality score for all programs in the context of treatment planning was 49%.

We understand that the treatment planning process is greatly influenced by the significant mental health staff and custody staff vacancies, which along with Covid 19 related issues, have significantly negatively impacted the treatment planning process.

Implementation Panel June 2022 Recommendations: It is unlikely that the treatment planning process will improve significantly until the staffing vacancies have been remedied. Given this, staff are encouraged to focus on integrating mitigating interventions into treatment planning where applicable and available.

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 June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: Receiving relevant training in a timely manner remains a problem, which appeared to be at least partially related to Covid 19 outbreaks.

Implementation Panel June 2022 Recommendations: Continue to monitor.

4. 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.iii. Segregation and crisis intervention logs;

Implementation Panel June 2022 Assessment: Substantial Compliance (December 2021)

Implementation Panel June 2022 Findings: No significant changes. Substantial compliance continues.

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

Implementation Panel June 2022 Assessment: Substantial compliance (December 2020)

Implementation Panel December 2021 Findings: Substantial compliance continues.

Implementation Panel June 2022 Findings: Substantial compliance continues.

4.a.ix. Quality management documents; and

Implementation Panel June 2022 Assessment: Substantial compliance (December 2020).

Implementation Panel July 2021 Findings: Substantial compliance continues.

Implementation Panel June 2022 Findings: Substantial compliance continues.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings:

Disciplinary Records

The SCDC implemented a tracking system to ensure each SCDC correctional facility's Mental Health Disciplinary Treatment Team (MHDTT) reviews disciplinary sanctions imposed for inmates with a Mental Health Designation Level 1, 2, and 3 remains. (*Disciplinary Sanctions Modified by MHDTT Report*). SCDC has revised procedures to ensure when an inmate on the mental health caseload has a disciplinary hearing, a mental health statement is obtained from Behavioral Health. The reviewed procedures requires the Disciplinary Hearing Officer (DHO) to document if a Behavioral Health statement was received and the statement was uploaded in SCDC Inmate Disciplinary System software. SCDC has also developed a RIM Report that can be generated from the entered data to indicate the DHO level of compliance in obtaining a statement from Behavioral Health for inmates on the mental health caseload having a disciplinary hearing.

Medication Administration Records

See provision 5b. status update section.

Implementation Panel June 2022 Recommendations:

1. SCDC continue to track and ensure each correctional facility's MHDTT reviews disciplinary sanctions imposed for inmates with a Mental Health Designation Level 1, 2, and 3 utilizing the *Disciplinary Sanctions Modified by MHDTT Report*.
2. SCDC implement the revised procedures to ensure Behavioral Health provides a statement for inmates on the mental health caseload scheduled for disciplinary hearing; document the Behavioral Statement was received and upload it in the SCDC Inmate Disciplinary Hearing software.
3. SCDC generate periodic RIM Reports measuring the DHOs' level of compliance receiving and uploading mental health statements from Behavioral Health for inmates on the mental health caseload having a disciplinary hearing.

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 June 2022 Assessment: Substantial Compliance (July 2021)

Implementation Panel June 2022 Findings: Substantial compliance continues.

5.a. Improve the quality of MAR documentation;

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: Our July 2021 findings included the following:

> Numerous medication administration deficiencies have been identified by SCDC via their QI system. Compliance will be achieved when the QI process demonstrates significant improvement re: these deficiencies. See 5.b. and 5.c. above.

Our opinion remains the same.

Implementation Panel June 2022 Recommendations: As per status update section.

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

Implementation Panel June 2022 Assessment: Noncompliance

Implementation Panel June 2022 Findings: As per status update section.

Implementation Panel June 2022 Recommendations: As per status update section.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Assessment: As per status section.

Implementation Panel June 2022 Findings: As per status section.

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

Implementation Panel June 2022 Assessment: Partial compliance

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

Implementation Panel June 2022 Assessment: Noncompliance

Implementation Panel June 2022 Findings: As per status update section. Staff reported that many of the transfer timeline delays were due to Covid testing issues. We continue to discuss with staff issues related to not transferring inmates due to perceptions of them not needing a CSU level of care but threatening self-harm for reasons other than being related to a mental illness.

Implementation Panel June 2022 Recommendations: Continue to address the issues related to not transferring inmates due to perceptions of them not needing a CSU level of care but threatening self-harm for reasons other than being related to a mental illness. Retain awareness that risk of self-harm can persist regardless of issue motivating the crisis presentation by an inmate. Review actual self-harms attempts in this subcategory.

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

Implementation Panel June 2022 Assessment: Noncompliance

Implementation Panel June 2022 Findings: Our July 2021 findings included the following:

> See status update section. The lack of compliance with suicide prevention, management watch procedures is very alarming and potentially dangerous.

Our assessment remains the same.

Implementation Panel June 2022 Recommendations: Remedy the above ASAP. This must be considered high priority.

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

Implementation Panel June 2022 Assessment: Substantial Compliance (December 2020)

Implementation Panel June 2022 Findings: Per SCDC provided Crisis Cell Suicide Supply Inventories. Substantial Compliance continues and was achieved in December 2020. A required inventory of female hygiene is maintained and available for issue to female inmates on crisis status.

Implementation Panel June 2022 Recommendations:

1. Continue to monitor and verify compliance with the provision and correct any identified deficiencies;
2. Continue the use of a tracking system to ensure compliance; and
3. SCDC to report each monitoring period if female inmates in CI have access to necessary hygiene supplies.

6.e Increase access to showers for CI inmates;

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: Per the SCDC Status Update and review of provided documents, this provision remains in partial compliance. Inmates on CI status are not receiving increased showers necessary to meet compliance with the provision. The inability for SCDC correctional facilities to provide inmates on CI status increased showers appears to be due to significant security staffing shortages.

To assess compliance and ensure that inmates on CI are provided increased shower access the following is utilized:

- Showers conducted on Saturday, Sunday, or Monday count towards the first shower (Monday) of the week.
- Showers conducted on Tuesday or Wednesday count towards the second shower of the week.
- Showers conducted on Thursday or Friday count towards the third shower of the week.
- For inmates arriving or departing an RHU, a shower is not required to be provided that day.
- All inmates in RHU, to include those in a safe cell, are required to be provided a shower three times per week during the periods indicated above.
- All inmates in CSU are required to be provided a shower every weekday M-F and on weekends if staffing permits.

The compliance levels for the October 2021 to March 2022 Reporting Period were:

- All Institutions Safe Cells 67 percent
- Broad River CI CSU 64 percent
- Camille Graham CI CSU 82 percent

Implementation Panel June 2022 Recommendations:
1, Remedy the above and ensure inmates in safe cells and CSU receive the increased showers necessary to meet compliance with the provision.

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

Implementation Panel June 2022 Assessment: Noncompliance

Implementation Panel June 2022 Findings: As per status update section.

Implementation Panel June 2022 Recommendations: Remedy the above. When unable to remove an inmate from the cell, facilitate normal volume conversations by improving ability to hear and converse by opening exterior doors or cell flaps, while adequately attending to safety precautions. Assure individual safety concerns are available on the OATS system.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: Per the SCDC Update and 2.b.vi. Findings. SCDC Operations continues to conduct required correctional facilities CI temperature checks and cell inspections. There was an 89% average compliance with the checks for all institutions. Staff failure to document appropriate comments when a CI cell temperature is out of range and/or the inspected cell is unclean remains problematic. The data indicated by the end of the reporting period, comments were noted when a RHU cell temperature was out of range 61% of the time, and 13% of the time, the comments noted appropriate action was taken to rectify the deficiency. The data indicated that 97% of the time, comments were noted when a RHU cell was unclean, and 1% of the time, the comment noted appropriate action was taken to rectify the deficiency. For CSU Safe Cells, 44% of the time, comments were noted, when temperature was out of range, and 21% of the time, the comments noted appropriate action was taken to rectify the deficiency. The data indicated 100% of the time, comments were noted when a CSU cell was unclean, and 3% of the time, the comment noted appropriate action was taken to rectify the deficiency.

Implementation Panel June 2022 Recommendations:
1. Continue the Operations Division's temperature and cleanliness check quality management process for each institution's CI cells and 4 random RHU cells and address the identified deficiencies with comments;
2. All prisons to continue performing required daily inspections for cleanliness and taking temperatures of random cells;
3. SCDC QIRM to continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperature and cleanliness inspections;
4. Security Staff utilize the Zebra selection menu to record when temperatures and/or cell inspections are not within establish ranges; and utilize the drop down menu to record comments for deficiencies.

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

Implementation Panel June 2022 Assessment: Partial compliance

Implementation Panel June 2022 Findings: As per status update section.

Implementation Panel June 2022 Recommendations: Compliance will be found when the QI process results in significant positive changes toward compliance with crisis intervention practices.

Additional Information

Site Assessments

From June 13-17, 2022, we did focused site assessments at Broad River Correctional Institution (BRCI), Kirkland Correctional Institution (KCI), Camille Graham Correctional Institution (CGCI), Evans Correctional Institution (ECI) and Perry Correctional Institution (PCI).

Appendix I summarizes systemwide mental health staffing, which indicated a 34% vacancy rate for qualified mental health professionals (QMHP) and a 20% vacancy rate for psychologists. Notably, the psychiatrist positions were all filled, and the mental health officer (MHO)/mental health technician positions only had a 5% vacancy rate.

Appendices III, IV & V provide relevant mental health statistics for the above institutions.
Appendix VI summarizes custody allocations/vacancies for SCDC systemwide, which documented a vacancy rate of funded frontline correctional officers to be 61.3%. Several of the visited institutions had even higher vacancy rates.

QIRM reports relevant to the above institutions, which were consistent with our site visits, included the following results:

Kirkland Correctional Institution (KCI)

The count at KCI was 1453 with a capacity 2329 inmates.

The frontline correctional officer vacancy rate was 60.8%.

Review of the Kirkland Correctional Institution Compliance report indicated significant compliance issues, which included but were not limited to the following:

1. Lack of compliance with timely clinical contacts with clinicians with HLBMU inmates.
2. Lack of compliance with clinical contact being held in a confidential setting for QMHPs with HLBMU inmates.
3. Lack of compliance with treatment plan updates for HLBMU inmates.
4. Lack of compliance re: mental health rounds in the segregation housing units.
5. Lack of compliance with clinical contacts occurring in a confidential setting.
6. Lack of compliance with access to showers for segregation inmates.

7. Lack of compliance with suicide risk assessments for inmates while on suicide precautions in the ICS, HLBMU, R&E and at GPH.
8. Lack of compliance with security checks in RHU.
9. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
10. Lack of compliance with inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.

Intermediate Care Services

The count was 148 with a capacity of 180. Inmates, on average, were offered 3-4.5 hours per week of structured therapeutic activities.

We interviewed two groups of inmates receiving an intermediate level of mental health care services (ICS) in a community-like setting. Inmates on B-side verbalized very positive perceptions of the ICS program, which included good access to their clinicians and relatively good access to programming in the context of significant custody staff shortages. Community meetings were no longer occurring related to Covid-19 issues. ICS inmates did not have access to the large outdoor yard. Most inmates were aware of their treatment plan. Medication times frequently varied related to nursing vacancies.

ICS inmates on B-side were less positive regarding their experiences with the ICS program but confirmed reasonable access to their clinicians and programming in the context of staffing vacancies.

Gilliam Psychiatric Hospital

Related to Covid-19 issues and reassignment of mental health and correctional staff at GPH related to an investigation during March 2022, patients at GPH since January 2022 have predominantly been on a lockdown status. Programming has just recently begun to start at a very slow pace.

During the past months, psychiatrists have had poor access to meeting with their patients in GPH. Phlebotomy services have been absent in GPH for the past three months, which is very dangerous and not acceptable.

There appears to be long-standing institutional cultural issues that have facilitated staff acceptance of lack of a therapeutic environment at GPH.

HLBMU & CHOICES

The HLBMU count was 15 with a capacity of 24 inmates. 1.0 FTE of the 2.0 FTE QMHPs was vacant and 2.0 FTE of the 3.0 FTE MHOs were vacant. Significant correctional officer vacancies issues were present, which has very negatively impacted access to programming.

Programming within the HLBMU was very problematic related to the nature of the physical plant and significant custody vacancies. A number of usual in unit items and access had been discontinued (TVs, unit microwaves, unit seating) after individual incidents of misconduct, with no clear plan as to how or when to restore access. In addition, phase 1 HLBMU inmates had less privileges than are provided to RHU inmates. It was our understanding that consideration for moving the HLBMU to the housing unit adjacent to the CSU is again being considered. We strongly recommend such a move occur because the current HLBMU physical plant is inadequate for such a program. We also

recommend a more individualized, creative, and time limited approach to responding to misconduct involving basic unit accommodations.

The CHOICES count was 33 with a capacity of 64 inmates. CHOICES continues to provide very helpful programming but significant limitations are in place related to the custody vacancies, which include mental health officers.

SSR

The SSR count was 31 with a capacity of 50. The SSR Unit was toured and the IP made recommendations for the room SCDC had designated to conduct groups with 4 or less SSR inmates. The determination was that inmates participating in the group room would sit on a stool in full hand restraints and in leg irons attached to the floor. Prior to the site visit, a SSR inmate submitted correspondence making complaints regarding SSR conditions of confinement. IP SSR tours and interviews with Kirkland staff resulted in findings the inmate had legitimate complaints. SCDC does not have a safe cell where staff can continuously observe an inmate placed on crisis status with that observation level. An IP member and SCDC officials inspected SSR cells and found none of the cells allow continuous staff observation and cells cannot be modified to allow continuous staff observation. SCDC officials agreed to develop a plan for movement of SSR inmates to another location when their crisis status requires continuous observation. This is a high priority concern. SCDC policy requires the delivery of legal mail within 48 hours. The inmate complained SSR inmate legal mail is routinely not delivered within 48 hours. Kirkland staff interviews confirmed due to staffing shortages legal mail is not always delivered within 48 hours. SSR visitation remains suspended, although in other Kirkland housing areas visitation has resumed. SSR staff are not following SSR behavior level D status recreation time frames. Inmates in SSR are not provided access to education programs. SSR has inmates on the mental health caseload and there are no Mental Health Officers assigned to the housing unit. It is recommended SCDC conduct an assessment of SSR operations to include but not limited to the following areas;

- SSR Placement and Retention
- RHU SSR Behavior Levels
- Classification Review
- Crisis Placement and Supervision
- Legal Mail
- Visitation
- Education Programs
- MHO Staffing.

Broad River Correctional Institution

The count was 1280 with a capacity of 1598 inmates. The total mental health caseload was 555 inmates with 172 inmates with a L3 level of mental health care and 345 inmates with a L4 level of mental health care.

The funded frontline correctional officer vacancy rate was 53% at the time of the site visit. Of the 194 FTE frontline correctional officers only 91 FTE positions were filled. Only 2.0 FTE of the 8.0 FTE

allocated QMHP positions were filled. 12.0 FTE nursing positions of the allocated 28 FTE positions were filled.

Review of the BRCI Compliance report indicated significant compliance issues, which included but were not limited to the following:

1. Lack of compliance with timely clinical contacts with QMHP and Psychiatric sessions for SMHU inmates
2. Lack of compliance with clinical contact being held in a confidential setting for QMHP and Psychiatric sessions for SMHU inmates.
3. Treatment plan updates were not timely for SMHU inmates.
4. Lack of compliance re: mental health rounds in the segregation housing units being regularly performed on a timely basis.
5. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
6. Lack of compliance with confidentiality of sessions with QMHP for Inmates on CISP.
7. Lack of compliance with inmates who had a 24-hour and 7-day follow-up after being removed from crisis in the RHU.
8. Lack of compliance with inmates in ST custody status that received a 7-day and 30-day review or with inmates in SD custody status with a 90- day review.
9. Lack of compliance with access to yard time and showers for segregation inmates.
10. Lack of compliance with security checks in RHU.

Secure Mental Health Unit (SMHU)

Programming in the SMHU at the BRCI was very encouraging (which included access to group therapies, daily recreational yard time and reasonable access to individual counseling and meeting with the psychiatrist via tele-psychiatry).

Crisis Stabilization Unit (CSU)

A new CSU program manager was hired during early April 2022 after this position had been vacant. The SCDC also established a Director of Crisis Intervention and Suicide Prevention, which will allow for a centralized contact for crisis concerns, better oversight regarding compliance with relevant policies and procedures, and development of and implementation of pertinent suicide prevention programming and training.

Camille Graham Correctional Institution

Three units, including Blue Ridge, where the higher need mental health inmates (L2 and crisis) are housed, were on quarantine at the time of our site visit. The funded frontline correctional officer vacancy rate was 66.7%. In contrast, the mental health staffing in terms of vacancies was good (i.e., a very low vacancy rate). Nursing staff vacancies remained very problematic.

Approximately 80% of the total inmate population were on the mental health caseload.

Review of the Camille Graham Compliance report indicated significant compliance issues, which included but were not limited to the following:

1. Lack of compliance for inmates who had a treatment plan completed while in the CSU.
2. Lack of compliance with follow-up sessions post CSU discharge.
3. Continued lack of compliance with clinical contact being held in a confidential setting, with QMHPs in the RHU and in the CSU.
4. Lack of compliance with access to yard time and showers for segregation inmates and patients in the RHU.
5. Lack of compliance with suicide risk assessments for inmates in the CSU on suicide precautions.
6. Lack of compliance with security checks in RHU.
7. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
8. Lack of compliance with inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.

Blue Ridge HU

The Blue Ridge HU was used only for inmates in need of a L2 level of mental health care. A-side has a capacity of 75 inmates and B-side has a capacity of 17 inmates. The census has ranged from 49-68 women during the monitoring period.

A community meeting reportedly takes place on a weekly basis. Inmates were reported to be offered, on average, 2-3 hours per week of therapeutic activities. Seventeen ICS inmates had off unit jobs.

Due to quarantine issues, we did not interview ICS patients or observe a treatment team meeting.

RHU

24 of the 28 RHU inmates were on the mental health caseload. Mental health rounds were reported to occur on a daily basis, which was not consistent with QI findings. Inmates had limited access to the concrete recreational yard. No groups were taking place due to staffing shortages. There was some mixing between the R&E function and the RHU functions. There appeared to be considerable delay in processing inmates through R&E and getting them assigned to population. Some inmates reported being locked down for more than 3 months awaiting unit assignment. Inmates on R&E status are not allowed commissary or tablet privileges for unknown reasons. SCDC should consider allowing inmates in R&E access to the commissary and tablet to mitigate reduced out of cell time.

RHU was toured and a sample of inmates were interviewed. SCDC inmates placed in RHU pending disciplinary status can remain for up to 30 days: SCDC policy allows 9 days to process a disciplinary report and 21 days to conduct a disciplinary hearing. An inmate complained her night medications for sleeping were delivered in the late afternoon and when she did not stand for the evening count her RHU recreation was taken for the next day. Recreation is not offered daily to RHU inmates due to staffing shortages. Interviewed inmates voiced they were offered recreation on the average 2-3 days a week. There was an inmate that had been on RHU Short Term Investigation status for over 100

days. The investigation was recently closed and now the inmate is awaiting a disciplinary hearing for an assault charge received as the result of the investigation. Camille Graham staff acknowledged most likely the inmate would receive disciplinary detention for the rule violation and would be released from RHU after the disciplinary hearing with credit for time served. The inmate is on the mental health caseload and remaining in RHU pending the disciplinary hearing did not appear warranted. An inmate that is L3 was interviewed on the recreation yard. The inmate was crying and voiced needing to talk to someone about her RHU status. Camille Graham Behavioral Health staff was contacted with IP requesting the inmate to be seen by the QMHP as soon as possible.

CSU

The daily CSU census generally ranged from 3-5 patients. Compliance issues with constant observation was present related to custody staff vacancies.

Access issues to psychiatric inpatient beds continues to be problematic due to limited bed availability. Final drawings have been completed for security hardening of a 12-bed women's inpatient unit at Lancaster Hospital although the construction date is on hold pending finalization of a specific scope of work agreement between SCDC and MUSC. Projected date of completion is now spring 2023.

Evans Correctional Institution

The funded frontline correctional officer vacancy rate was 69% at the time of the site visit. One of the 2.0 FTE QMHP positions was vacant. Both of the 2.0 MHO positions were filled.

Review of the Evans Correctional Institution Compliance report indicated significant compliance issues, which included but were not limited to the following:

1. Lack of compliance with clinical contact being held in a confidential setting for QMHP for inmates in crisis cells.
2. Lack of compliance with 60-hour timeframes being met to ensure inmates are transferred to the CSU or removed from CI/SP status in a timely manner.
3. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
4. Lack of compliance with inmates who had a 24-hour and 7-day follow-up after being removed from crisis in the RHU.
5. Lack of compliance with inmates in ST custody status that received a 7-day and 30-day review or with inmates in SD custody status with a 90- day review.
6. Lack of compliance with access to yard time for segregation inmates.
7. Lack of compliance with security checks in RHU.

SCOR

The Program has a capacity for 64 single celled inmates and currently has 10 inmates assigned. A total of 93 inmates have completed the program since its inception in March 2021.

The IP held a community meeting with SCOR inmates during the Evans CI site visit on June 15, 2022. Inmates advised the IP the program made them feel safe; however, they were concerned what

their options would be when the program was completed after six months. The majority expressed they would never be able to return to the general population due to their circumstances and/or safety concerns. Many of the inmates participating in the community meeting revealed crisis placements prior to their transfer to SCOR.

The interviewed inmates indicated they were only out of cell 2 hours per day Monday and through Friday due to staffing shortages. The majority reported they were sent to the SCOR Program without any prior notice and only received the program information after arrival at Evans CI. Two inmates reported they were removed from the statewide protective custody housing unit at Broad River CI for unknown reasons and sent to SCOR.

A positive finding was discovered by IP members participating in the Treatment Team Meeting during the Perry CI site visit on June 16, 2022. An inmate was encountered who had successfully completed the Evans CI SCOR Program and was in the general population along with three other SCOR graduates in his dorm. The inmate reported neither he nor the other SCOR inmates in his dorm were experiencing any serious adjustment problems in the general population.

Perry Correctional Institution

The total mental health population was 277 inmates with an institutional count of 662 inmates. The frontline correctional officer vacancy rate was 58% at the time of the site visit.

2.0 FTEs of the 4.0 FTE QMHP positions were vacant. All 7.0 FTE MHO positions were filled as were 15 of the 19 FTE nursing positions. The 0.6 FTE psychiatrist position was filled by a psychiatrist and a psychiatric nurse practitioner via telehealth with coverage being provided on Mondays and Tuesdays.

Review of the Perry Correctional Institution Compliance report indicated significant compliance issues, which included but were not limited to the following:

1. Lack of compliance with clinical contact being held in a confidential setting for QMHPs with inmates in the RHU on crisis status.
2. Lack of compliance with inmates who had a 24-hour and 7-day follow-up after being removed from crisis in the RHU.
3. Lack of compliance re: mental health rounds in the segregation housing units.
4. Lack of compliance with access to yard and showers for segregation inmates.
5. Lack of compliance with suicide risk assessments for inmates while on suicide precautions in the RHU.
6. Lack of compliance with security checks in RHU.
7. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
8. Lack of compliance with inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.

RHU

Depending on correctional coverage, RHU inmates have access to the recreational cages up to 2-3 days per week. The required protocol to be eligible for recreation may be precluding some inmates

from having access to recreation. This was reviewed with administrative staff. The RHU had six safe cells. Showers were offered but many inmates stated they did not go out for showers due to concerns about the way the required searches were conducted.

We talked with RHU inmates in multiple tiers and in all three RHUs. Information obtained from them was consistent with the QIRM findings (i.e., #s 1, 3, 4, 7). The 70+ TV flat screens placed in the RHU did not provide audio via the inmates' individual headphones/ radios and inmates reported the channels were rarely changed. Closed captions on the TVs were not easily visible through the double doors. We strongly recommended to leadership staff that central office remedy this issue.

Staff do not conduct inmate groups in RHU; however, since the last IP visit to Perry, stools have been installed in designated RHU common areas where RHU groups could be held for up to 4 inmates. Inmates would be placed in leg irons attached to the stool and floor while attending a group.

Stepdown Unit

We interviewed inmates on this unit in a community meeting-like setting. Mental health caseload inmates reported limited access to mental health services. Other inmates complained about limited implementation of relevant policies and procedures. Medications scheduled to be administered at nighttime (i.e., HS medication) were generally administered at around 5 p.m. Information provided by staff identified a very structured schedule of activities consisting of 5 to 8 hours of structured activities each week. Statistics kept for more than 5 years showed an impressive success rate in regard to completion of the programs and positive impact in functioning once released back to the compound or to the community.

Outpatient LOC

We attended an outpatient treatment team meeting (all inmates from the yard). One of the inmates interviewed had completed the SCOR program at ECI about 6 months ago. He reported that he and three other SCOR graduates were transferred to PCI and have made good adjustment in the general population at PCI. He attributed this to staff not allowing problems impacting safety to happen as frequently at PCI as other places. Overall the inmates attending team were familiar with their treatment plans and felt that they were receiving an adequate level of care.

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Office of the Ombudsman and the Medical Concerns Team

Dayne Haile (Office of the Director) provided the following information:

> At the recommendation of the Director, the Office of the Ombudsman and the Medical Concerns Team were piloted in November of 2021. Director Stirling wanted to pilot an official Office of the Ombudsman to see how it would function within SCDC. He has now made this Office permanent. The Office of the Ombudsman consists of a director and two part-time administrative staff members. Another FTE for this office, which will be an Administrative Coordinator, has just been approved.
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> The Medical (Mental Health) Concerns Team has one FTE Registered Nurse and two part-time Registered Nurses. The Office fields phone calls, e-mails and text messages

7 days a week, 365 days a year to include evenings and weekends. When the team was first created the response time was lengthy but has since been reduced to an average of 2.12 days to resolve concerns. This process has allowed the Agency to be more proactive in meeting the medical needs of the inmate population.

Additionally, SCDC developed an Institutional Medical Concerns Team which will visit each institution to determine their needs so that we can improve the medical care provided to our inmate population. This team has been effective and will continue to assist institutions.