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

Executive Summary

This fourth 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 fourth 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 May 2 thru May 5, 2016, the second site visit was October 31 thru November 4, 2016, the third site visit was February 27 thru March 3, 2017, and this site visit was July 10 thru July 14, 2017. As has been the process before each site visit, the Implementation Panel 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 fourth site visit. We requested that documents be provided to the IP at least two weeks prior to the site visits and SCDC has not provided the requested documents on time. 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 July 14, 2017, which was attended by Director Bryan Stirling and members of the administrative, operations, and clinical staff of SCDC; plaintiffs' counsel Daniel Westbrook; defendant's counsel Roy Laney; and the mediator, Judge William Howard. During the Exit Conference we provided our preliminary findings based on the current site visits and addressed questions and concerns offered by any of the participants.

Consistent with our past reports, 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 fully accomplished and will be monitored closely. We commend SCDC on their efforts to fully implement the required training and have made recommendations for revisions in the training process and curricula. As Exhibit B reflects, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance – 11 components
2. Partial Compliance – 44 components
3. Noncompliance – 4 components

As discussed during this site visit and during our Opening and Exit Conferences with the parties, the Implementation Panel's primary concerns regarding SCDC's failure to demonstrate substantial compliance with the Settlement Agreement have been reported in detail in previous reports and, regrettably, will be repeated in this report, albeit with some notations of individual staff components or facilities that are positive and significant areas with minimal improvement and/or regression. The specific areas impacting the failures to achieve substantial compliance 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. Since the last site visits and report, the IP members have had conference calls with the parties to provide technical assistance and consultation regarding the need for a Master Plan for mental health services to include all levels of care based on a realistic needs assessment to meet the requirements of the inmate population and the Settlement Agreement. However an adequate plan with integrated components for a comprehensive system has not been provided.

A great deal of time and effort by the parties and their experts was dedicated to the development of policies and procedures prior to implementation of the Settlement Agreement, and most of the policies and procedures have been completed while others continue to be revised and/or developed. 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.

In our last report we recognized the major achievement of the development of the Quality Assurance Risk Management (QARM). Since the last visit, this vital and essential component of the SCDC management structure has changed their name to Quality Improvement Risk Management (QIRM). The Implementation Panel continues to be very positively impressed by the efforts of the QIRM component, which in addition to conducting audits of facility mental health services and operations, presented very informative booklets describing important data and analysis for several facilities during this site visit. We strongly recommend this process should be expanded to include all facilities scheduled for inspections for each upcoming visit. We have also reported our positive impressions of the staff providing IT and web based information data collection and analysis components, and strongly encourage the continuation and expansion of their efforts at the central levels. The pilot program for implementation of the Electronic Health Record (EHR) NextGen, including the planned implementation of eZmar, the electronic medication administration records, was reviewed on site and a number of concerns were discussed, including the breakdown of communication between systems resulting in medication errors at Camille Graham C.I. and Leath C.I. These breakdowns have resulted in reports by inmates and staff of inmates missing medications as prescribed, which represents a crisis in the provision of health care. While on site, plans to address these issues were being developed.

During our past site visits the IP emphasized 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. Since the last site visit SCDC Division of Behavioral Health has hired Health Services Office Assistants (HSOA's) to facilitate the data collection and analysis component at the facility level, which is an important improvement; however the training of the HSOA's has not been coordinated with QIRM and the actual reporting during this site visit was inconsistent and inadequate. As previously reported, the dire need for staffing 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.

The Low Intensity Behavioral Management Unit at Allendale C.I. became operational in 2016, and was visited during the last site visit and by the Implementation Panel coordinator in July after the full IP visit. The Low Intensity BMU continues to develop and has demonstrated some progress. During the last site visit the IP was informed the High Intensity Behavioral Management Unit had begun although not scheduled to open until March 2017. We were informed during this visit the High Intensity BMU did not open in April 2017, and is not scheduled to open until January, 2018. Further, the former Self Injurious Behavior Program was closed, and a temporary High Level BMU was opened in the building (D Dorm) with 24 available beds. The IP had conference calls with SCDC to discuss development of a realistic, needs assessment-based Master Plan to include all levels of mental health care, including BMU's, as the previous draft plan presented by SCDC was not comprehensive and included a target number of beds for the High Level BMU of 112 beds that did not appear to be based on a needs assessment. The Crisis Stabilization Unit at Camille Graham C.I. was completed and opened since the last visit, as were four suicide resistant cells at Leath C.I.

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 reemphasized 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). The information gleaned from the pilot program at Camille Graham C.I. and Leath C.I. for implementation of the EHR is compelling and SCDC has committed to review and refinement of the EHR, eZmar and pharmacy systems (CIPS) to assure continuation and improvement of mental health services.

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, Leath Correctional Institution, Kirkland Correctional Institution, Broad River

Correctional Institution, McCormick Correctional Institution, and Perry Correctional Institution. As reported during our Exit Conference, the Implementation Panel considers the conditions at Camille Graham Correctional Institution and Perry Correctional Institution to be at a severe crisis level that requires immediate correction. Not only are the staffing levels for clinicians, as well as operations staff, unacceptably low, preventing the implementation of effective treatment measures, but also based on the operations staffing Perry C.I. has experienced frequent and continuing lockdowns since at least February 2016 and has been unable to provide adequate recreation or showers. Similar problems with providing services at male facilities have been reported and during this site visit McCormick C. I. was on lockdown and inmates were not receiving adequate services. The Implementation Panel monitors use of force across all facilities and during this site visit observed a use of force incident in the RHU that was subsequently referred for investigation. The IP will review that investigation when completed. The problems reported at Camille Graham C.I. regarding medication management constitute serious medication errors resulting in inmates not receiving medications as prescribed. These conditions must be corrected immediately, and plans to address the multiple factors contributing to the crises at Perry, Leiber and Graham must be developed and implemented. . The operations and mental health vacancies continue to adversely contribute to inadequate treatment and unsafe conditions of confinement at other institutions (as reported based on previous site visits) and must be corrected.

The Implementation panel also noted and reported on several positive achievements demonstrated at several facilities including:

1) Excellent efforts at Camille Graham by management and staff to address deficiencies reported by the IP from prior visits, as well as establishment of the CSU for women;
2) Excellent efforts by management and mental health staff at Broad River C.I. to identify and assess inmates on the mental health caseload that had not been assessed or seen within required timeframes;
3) Efforts by management and mental health and operations staff to develop the High Intensity BMU at Kirkland; this program is not yet functioning as a BMU;
4) Efforts by management staff at Perry to implement inmate mentors to assist with monitoring inmates in RHU or lockdown status and other innovative measures to mitigate the dire conditions in the RHU; this facility remains in crisis;
5) Efforts by management and central offices to complete suicide resistant cells at Leath C.I.;
6) Excellent efforts by management operations and the program director for the development and implementation of the Step Down Program at McCormick.

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 remain in Partial Compliance and are likely to be impacted by the eventual development of a Master Plan for the Mental Health Services Delivery System.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC status update section. Based on discussion with staff, it appeared that the partial compliance was related to inadequate mental health and custodial staffing allocations, which are exacerbated by lockdowns and staff being pulled elsewhere.

The average length of stay in the Camille Graham R&E remained >40 days. Staff reported that R&E inmates are now receiving about 3 hours per day of of out of cell recreational time. However, inmates reported receiving only about one hour per day of out of cell recreational time.

July 2017 Recommendations: As per our March 2017 recommendations, which stated the following:

1. Continue to QI the relevant timeframes.
2. Adequately address the mental health and correctional staffing vacancies.
3. Accurately track the out of cell time offered to R&R inmates on a weekly basis.

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

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

July 2017 Implementation Panel findings: We expressed our concern regarding the number of inmates who have not been screened for reasons that were not clear based on the study. We also are concerned about the lack of a protocol for inmates refusing to be screened that should include a record review and discussion with custody staff concerning these inmates.

We were told that at CGCI the inmates listed as not screened are inmates who have refused screening. We were not clear whether this was the case at the other institutions.

July 2017 Recommendations:

1. Need to address and correct the large number of inmates who have not been screened.
2. Need to develop a written protocol for assessing inmates who have refused screening.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC update.

July 2017 Recommendations: The above QI study is a good start in implementing this provision. As we have stated during prior site visits, quality improvement reports including this one, 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.

Please use the above format for QI studies and other audits.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC status update.

July 2017 Recommendations:

1. Implement the processes summarized in the SCDC status update section.
2. Continue to monitor the relevant timeframes.
3. QI the reasons for the small number of urgent/emergent referrals.
4. Address staffing needs for prompt psychiatric and medical assessments.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per 1A.

July 2017 Recommendations: As per 1A.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: Although the above study is not specific to provision 2.a.1., it is a useful study relevant to provision 2.a. (Access to Higher Levels of Care). It appears that the delay in discharging inmates from GPH, who are ready for discharge from a clinical perspective, is related to a shortage of ICS beds that are adequately staffed from custody and mental health perspectives.

July 2017 Recommendations: A staffing needs analysis for all aspects of the mental health system throughout the SCDC, which should include both mental health and custodial staff, is needed. This analysis should be completed in a timeframe that would permit the Director to request additional FTE positions, if needed, for the next fiscal year.

In addition, a salary analysis should be completed specific to mental health staff positions to determine the level of salary that is needed to be competitive for hiring purposes.

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

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

July 2017 Implementation Panel findings: From a literal perspective, the SCDC status update did not adequately address this provision, which states the following: "Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore." GPH beds should not be counted as residential beds because they are hospital beds. However, it is likely that SCDC will have enough ICS beds if the current bed capacity is adequately staffed with correctional and mental health staff. The staffing needs analysis previously referenced should help determine whether the current understaffing is related to allocations, vacancies or both issues.

KCI ICS

The data relevant to the number of hours of out of cell structured therapeutic activities actually received by individual ICS inmates, on average on a weekly basis was very low, and reportedly inaccurate.

Data was presented relevant to ICS Inmates seen for individual sessions with the QMHP. However, the methodology relevant to this data and the assessment of results were very unclear.

The lack of medication administration at KCI not being available on a HS basis (i.e., at night) is very problematic. In addition liquid oral medications and long acting injectable medications are not available or limited because nursing staff have been removed from ICS, which is also very problematic.

During the morning of July 11, 2017 we observed a treatment team meeting in the male ICS at KCI. The appropriate staff were present, inmates were interviewed by the team and a reasonable multidisciplinary discussion occurred during the meeting.

We also discussed with staff issues related to the trauma experienced by the team and other inmates related to the four homicides within the ICS during this year.

CGCI

We assessed the female ICS services at Camille Graham CI during July 13, 2017

Significant improvement was noted regarding inmate access to out of cell structured therapeutic activities since the March 2017 site assessment. Staff reported offering ICS inmates 15 hours per week of out of cell therapeutic activities with about 5-7 hours actually being used by the inmates.

We interviewed inmates in Section C in a community-like setting. These inmates were either L-2, L-3 or L-4. Most inmates reported receiving one to two groups per week with some inmates indicating participation in three groups per week. The main reason for not participating in groups was reported to be related to scheduling conflicts with school, work, etc. Inmates uniformly describesd the groups as being very helpful. They also described most mental health staff as being very helpful to them.

In general, there were not many complaints verbalized by inmates regarding correctional staff although one CO was clearly identified by many inmates as being very problematic due to being inappropriately provocative toward inmates. Inmates described continuity of medication issues related to both untimely medication renewals and other medications not being available. These issues appeared to be due to eZmar software issues and psychiatrists' vacancies.

Community meetings have been held on a weekly basis and were described by staff and inmates as being very helpful.

We observed a treatment team meeting during the afternoon of July 13, 2017. We were again encouraged by the multidisciplinary discussion and the presence of a psychiatrist, Dr. Wang.

July 2017 Recommendations:

1. Complete the staffing needs analysis.
2. Provide accurate information regarding the number of hours of out of cell structured therapeutic activities both offered and received by individual ICS inmates, on average, on a weekly basis.

3. Provide accurate and meaningful data relevant to the frequency that ICS inmates were being seen for individual sessions with a QMHP.
4. The lack of medication administration for HS, liquid, and long acting injectable medications needs to be remedied.
5. We met with Samuel Soltis, Ph.D., Deputy Director of Health Services, Tina Blakely-Huggins, Assistant Deputy Director of Health Services and Abby Daniels, Project Manager RIM re: the medication issues with a focus on developing an interim solution until the software issue has been resolved. We suggested that a pharmacist and nurse visit high-risk housing units on a regular basis until the software issue has been resolved and establish a similar process in a clinic setting for general population inmates.

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 July 2017 Assessment: **partial compliance**

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

As per SCDC status update.

The amount of out of cell time, both structured and unstructured, actually used by GPH inmates is alarmingly small. Based on information obtained from staff, it appears that this issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) since the correctional staff vacancy rate has generally been less than 12%.

July 2017 Recommendations:

1. Complete the previously referenced staffing needs analysis for GPH that should include both custody and mental health staffing positions.
2. Focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH.
3. Continue to monitor implementation of the scheduled GPH renovations, which continue to be on schedule..
4. Fix the "treatment chairs" as well as their configuration in GPH.
5. Further explore the reasons for the low admission rate of female inmates to an inpatient psychiatric unit.
6. Finalize options for inpatient psychiatric beds for females.
7. 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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: The 40% mental health staffing vacancy rate noted during the November 2016 site assessment is little changed from the current 37% vacancy rate or the 38% vacancy rate during March 2017. The department implemented an aggressive recruiting campaign as reported in our March 2017 report and the current SCDC status update section relevant to hiring of both correctional and mental health staff. We previously opined that the salary for psychiatrists is likely not competitive to psychiatrists' salaries in the community in contrast to other state institutions, which continues to be our opinion. The SCDC overall correctional officer staffing vacancy rate for institutions was 29.5 % as of July 2017. The vacancy rate for Level III institutions (highest security) at Lee Correctional Institution, Lieber Correctional Institution McCormick Correctional Institution, Perry Correctional Institution and the female Camille Graham Correctional Institution exceeded 40 %.

Key administrative staff thought that it was too early to assess the effectiveness of the recruitment campaign. We emphasizedthat it was important to have an assessment regarding the salary structure by December 2017 since psychiatrists completing their residency training during July 2018 will be making job decisions often by January 2018.

As referenced in the prior section, a staffing needs analysis for all aspects of the mental health system throughout the SCDC, which should include both mental health and custodial staff, is needed. This analysis should be completed in a timeframe that would permit the Director to request additional FTE positions, if needed, for the next fiscal year.

July 2017 Recommendations: As above.

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 July 2017 Assessment: **compliance (07/17)**

July 2017 Implementation Panel findings: As per SCDC status update section. There appear to be issues, at times, between the Warden and mental health staff relevant to continued placement of a small number of inmates in the HLBMU.

July 2017 Recommendations:

1. Continue with this process.
2. Resolve the placement issue for relevant inmates in the HLBMU referenced above.
3. Re-educate mental health staff on the criteria for referral to the BMUs as including inmates with personality disorders rather than exclusively SMI.

2.b. Segregation:

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

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

July 2017 Implementation Panel findings: During the morning of July 11, 2017, we interviewed HLBMU inmates in the HLBMU at the KCI. The inmate census in this unit was 21 with a current capacity of 24. This unit, which was initially started within the SSR building was moved to D-dorm on June 5, 2017. The previous program at D- dorm, which was the self-injurious behavioral unit, was closed with some of the inmates remaining in the HLBMU and other inmates being transferred to the intermediate care unit (ICS).The HLBMU at KCI will eventually be expanded (112 beds) and moved to the Broad River CI around December 2017.

Related to a disturbance at another prison, many inmates were subsequently transferred to the SSR at the KCI, which resulted in correctional officers assigned to the HLBMU being pulled to provide coverage at the SSR. As a result, the HLBMU program has essentially never been appropriately implemented due to the custody staffing shortages (average about two officers per day with only one officer assigned at times) and inadequate mental health staffing (1.0 FTE QMHP and 1.0 FTE mental health technician, both of whom provide coverage to the SSR) within the unit. Related to the fiscal year cycle, supplies have been extremely limited for this program which means that they have not had access to group therapy materials and do not have enough tables or chairs. In addition, at least one of the televisions was not working in addition to a microwave in need of repair.

Related to the custody staffing pattern, inmates had extremely limited access to the outdoor recreation yard. Inmates were also very upset that their visitations did not include weekend visits Inmates had numerous complaints regarding the program which included the following:

1. Several inmates claimed that they had no idea why they had been transferred to this program.
2. Lack of structured programming within the program.
3. Lack of access to outdoor recreation.
4. Lack of access to medications being administered at night.
5. Lack of access to weekend visitation.
6. Concerns about being shackled while being escorted out of the unit.
7. Lack of access to mental health treatment.

The HLBMU is currently not a treatment program although the physical plant is certainly better than what was available within the SSR and, at least, some RHUs. It is clear that many of the problems are related to inadequate mental health and custody staffing. Unfortunately, inmates are not being provided with many privileges that could at least mitigate the lack of programming such as reasonable access to the yard, increased out of cell time within the dayroom's, at least intermittent visitation during weekends, and/or permission to have pictures of their families within their cells.

Based on short interviews with these inmates, it appears likely that at least several of them would be capable of transitioning to a general population yard without going through the HLBMU program.

The LLBMU appears to be very successful based on data presented by SCDC staff.

During the morning of July 12, 2017, we site visited the McCormick CI, where we gathered information re: the Step-Down program ("SDP"). Fifty-three inmates have successfully graduated from this program during the past three years with five inmates having been returned to an RHU with three of the five RHU returnees eventually returning to the SDP.

Eligibility for the SDP includes having a security detention (SD) custody classification and being disciplinary free for at least six months.

SDPs are also located at Lee CI and Leiber CI. The Lee SDP had a total of forty-seven graduates and the Leiber SDP had thirty-three graduates. Other statistics relevant to these programs were consistent with these programs being very successful. These programs have been successful related to a very competent and conscientious program director and numerous community volunteers who provide classes to the SDP inmates.

Issues for the SDP continue to involve custody institutional cultural issues that need to be addressed.

The RHU Behavior Level System for inmates on Security Detention Status has not been implemented. The stand alone Step Down Program Policy for inmates that are released from Security Detention and require heightened supervision remains in the development phase.

July 2017 Recommendations:

1. Provide privileges to inmates in the HLBMU that would at least partially mitigate the lack of programming within this unit.
2. Reassess which inmates, if any, in the HLBMU are not in need of a BMU but could transition to a general population yard.
3. The program director of the Step Down Program ("SDP") should be actively involved in the hiring of the correctional staff for this unit and should have significant input in removing COs who turn out to not be a good fit for the program.
4. Implement the RHU Behavior Level System for inmates on Security Detention status prior to the next IP Site visit;
5. Finalize the SDP Policy for inmates that are released from Security Detention and require heightened supervision and move forward with implementation prior to the next IP Site Visit.
6. There are many lessons to be learned for the implementation of the BMUs from the experience of the SDP, which include the optimal size of the program, number of admissions in a specific period of time and selction of correctional officers working in such programs.

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

Implementation Panel July 2017 Assessment: **noncompliance**

July 2017 Implementation Panel findings: Mr. Dubose reported that mental health staff have received training relevant to the mental health rounding process. When possible from a staffing perspective, the same mental health clinicians are performing rounds on the same inmates for at least six months at a time. The rounding process reportedly no longer includes, on a routine basis, a mini-mental status examination unless clinically indicated.

During the afternoon of July 11, 2017 we observed the mental health rounding process in the RHU at Broad River CI, which was done in a competent manner. However, the RHU environment was chaotic and very noisy, which appeared to be related to the presence of the implementation panel members and a large contingent of correctional officers and upper management staff coming onto the unit. Due to the extreme noise level, it was very difficult to interview inmates during the rounding process.

During the morning of July 12, 2017, we observed the mental health rounding process in the RHU at the McCormick CI. There were 36 inmates in the RHU with 10 of these inmates being on the mental health caseload. The institution was on lockdown status during the site visit.

The RHU was filthy at the time of the site visit related, in part, to inmates flooding the unit the evening before in response to a cell search process having been completed. The unit had not been cleaned following the flood due to a statewide lockdown. Inmates reported access to showers on a three times per week basis. They indicated very little access to the outdoor recreational areas.

During the rounding process, we observed a use of force incident that was very problematic from a variety of perspectives including inadequate de-escalation techniques being implemented.

During the afternoon of July 12, 2017, we observed the mental health rounding process at the Leath CI RHU, which was done in a competent manner. The covering for the outer door window was opened during the rounds process, at our request, which required the presence of two correctional officers. This allowed the clinician to hear the inmate much more clearly and resulted in a much more humane interaction.

The unit was very clean and quiet. Inmates generally described reasonable access to the outdoor recreational yard although it was not uncommon for an inmate to lose yard privileges due to not standing during count. This latter issue is a systemwide practice.

During the morning of July 13, 2017 we observed the mental health rounding process in the RHU at the Camille Graham Correctional Institution, which was done in a competent manner. The RHU was clean and the housing unit was reasonably quiet. Staff reported that inmates have access to up to three hours per day of outdoor recreational time. However, similar to other SCDC institutions, inmates can lose access to the recreational time for disciplinary reasons that include not standing for counts. Issues related to such a process are described later in this report by Mr. Sparkman.

Significant issues relevant to medication management were present in the RHU that are similar to those described in a a prior section that summarized the ICS program at CGCI.

We observed the mental health rounding process in one of the tiers during the morning of July 14, 2017 at the Perry CI. Although the tier was reasonably clean, the conditions of confinement were terrible. Inmtes do not get any out of cell time for recreational purposes, very limited access to showers and very limited laundry exchange. Mattresses were frequently dirty and torn. Inmates also complained of very limited access to cleaning materials for purposes of cleaning their cells.

The Perry Correctional Institution correctional officer staffing for the RHU is at a crisis stage. A review of cell check logs revealed due to staffing shortages correctional officers are unable to make thirty-minute checks and frequently the time between the checks exceeded one hour. There are occasions when the time between cell checks was three to four hours. At times, RHU Correctional Officer Staffing is one correctional officer in each control room of the three RHU buildings and one correctional officer to float between the three buildings. Clearly, this is unsafe for staff and inmates and makes it impossible for essential services to be provided for RHU inmates. The lack of correctional supervision has provided inmates the opportunity to cause significant damage to the physical plant. Two recent incidents occurred where inmates knocked holes in their cell walls. In one of the incidents, the inmates were able to exit their cell and cause significant damage to the RHU physical plant. In the other incident, an inmate alleges the inmate in an adjacent cell knocked a hole in the cell wall and was able to assault him with bodily fluids. The Perry Correctional Institution RHU Supervisor reported an attempt is made to provide inmate showers two times a week (scheduling calls for three showers per week). A review of inmate cell activity cards revealed inmates received no more than one shower per week and some inmate cards indicated no showers. A review of May 2017 shower records for one of the RHU buildings was conducted. Based on the documentation, none of the inmates assigned to the building received a shower during the month.

An incentive program has been initiated that included crank radios and special visits as rewards. Siginficant problems at PCI existed re: access to a psychiatrist and medication management issues.

Inmates on the mental health caseload in the segregation units at the Broad River CI, McCormick CI, Leath CI, CGCI and Perry CI were overrepresented, which was consistent with systemwide statisitics.

July 2017 Recommendations:

1. We remain very concerned about the conditions of confinement within the RHU at the Broad River Correctional Institution and at the McCormick CI. We were unable to adequately assess inmate access to yards at both prisons and showers at the McCormick CI. Such data should be gathered and reported prior to our next site assessment.
2. Consider revising the practice of losing yard privileges due to not standing for counts and other minor violations. SCDC should at a minimum provide an inmate due process before arbritarily restricting out of cell recreation.
3. Consider establishing a privilege level that would allow for the window covering in the outer door at the Leath CI RHUto remain open.
4. Consider eliminating the Perry CI RHUs from housing SD inmates due to crisis correctional officer staffing.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: The above data is very difficult to interpret because the methodology is not explained and an assessment relevant to the results is absent. However, staff were in agreement that mental health caseload inmates in segregation housing units were frequently not being seen in a timely manner as required by policies and procedures.

July 2017 Recommendations: Provide relevant data in the format previously referenced relevant to QI reports.

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

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

July 2017 Implementation Panel findings: See 2.b.i. (Provide access for segregated inmates to group and individual therapy services).

July 2017 Recommendations: As per our March 2017 recommendations, which included the following:

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 July 2017 Assessment: **compliance (11/2016)**

July 2017 Implementation Panel findings: As per SCDC status update. Our March 2017 findings included the following:

> 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.

July 2017 Recommendations: Our March 2017 recommendation that SCDC attempt to understand the reasons for the significant differences in the context of the length of stays in the RHU as previously referenced remains.

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

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

July 2017 Implementation Panel findings: SCDC provided Cell Temperature and Cleanliness Logs for all institutions except Ridgeland and Turbeville. A review of the documents revealed when temperatures and cleaniness logs had deficiencies there were no comments to identify the corrective action taken to address the issue(s). The provided logs had missing dates as well as incomplete and blank forms. Most troubling were facility logs that identified cell temperatures below 60 degrees and no information measures were taken to address the unacceptable low temperatures.

July 2017 Recommendations:

1. Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2. Provide additional training to correctional officers on the proper procedure to perform daily cell inspections for cleanliness and temperature checks including documenting forms accuratedly and completely;
3. Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness Logs;
4. SCDC QIRM continue to perform QI Studies regarding Correctional Staff taking daily, random cell temperatures and cleanliness inspections.

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

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

July 2017 Implementation Panel findings: As per SCDC status update section.

July 2017 Recommendations: We discussed with staff having the IP members review a draft of the proposed training for comment purposes and to pilot the training before rolling it out systemwide.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: SCDC continues disproportionate use of force against inmates with mental illness. Approximately 17 percent of the SCDC inmate population is on the

mental health caseload; however, use of force against inmates with a mental illness accounts for 40 percent of total incidents for the time period of June 3, 2016 through March 2017. SCDC has revised the OP 22.01 Use of Force Policy in March 2017 and the Use of Force Training Curriculum in June 2017. Use of Force Train for Trainer has been provided to 162 SCDC Officers and 62 Non-Uniform Staff. As of June 23, 2017, 1,266 SCDC employees have completed the Use of Force training. This includes 1,000 certified staff and 266 noncertified staff.

SCDC plans to have all staff trained on the revised Use of Force Policy by December 31, 2017. QIRM generates Use of Force Reports to monitor the Use of Force against mentally ill and non-mentally ill inmates. The revised Use of Force Policy has an identified accountability component with Use of Force violations being tracked and requiring Police Services to investigate major incidents. Implementation has not been fully accomplished.

July 2017 Recommendations:

1. SCDC continue to monitor all Use of Force to identify and address the reasons for disproporinate Use of Force against inmates with mental illness;
2. Develop strategies to reduce use of force against inmates with mental illness and non-mentally ill inmates;
3. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC status update and SCDC has revised the OP 22.01 Use of Force Policy requiring instruments of force are employed in a manner consistent with manufacturer's instructions. The policy includes a grid identifying the amount of chemical agents that can be deployed for each application in accordance with manufacturer recommendations. The Use of Force Training Curriculum for all Staff was revised in March 2017. Use of Force Train for Trainer was provided to 162 SCDC Officers and 62 Non-Uniform Staff. SCDC plans to have all staff trained on the revised Use of Force Policy by December 31, 2017. Implementation remains in progress as SCDC has post orders that conflict with using MK 9 in a manner consistent with manufacturers's instructions.

July 2017 Recommendations:

1. SCDC review applicable policies and post orders to ensure all that references to instruments of force require their use is fully consistent with the manufacturer's instructions;
2. Operations and QIRM continue to review use of force incidents through the automated system;
3. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;

4. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.

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 July 2017 Assessment: **compliance (3/2017)**

July 2017 Implementation Panel findings: SCDC remains in compliance.

July 2017 Recommendations: Operations and QIRM 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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC status update and Appendix 7.

An issue remains that SCDC Physicians are ordering inmates to remain in the restraint chair for two hours as opposed to up to two hours. Restraint Chair use continues to occur infrequently. SCDC reported Restraint Chair use as follows: February 17-1, March 17-3, April 17-0, and May 17-0. A total of 4 incidents. There are continued issues with accurately documenting restraint chair use and strictly adhering to the required time frames.

July 2017 Recommendations:

1. SCDC Training Staff conduct additional training to applicable Operations and Medical Staff ensuring an understanding of restraint chair requirements and documentation. The training should emphasize that placement of an inmate in the restraint chair is "up to two hours".
2. QIRM 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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: Collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs is provided in the June 2017 SCDC Status Update and Appendix 7.

July 2017 Recommendations:

1. QIRM continue to prepare a Restraint Chair Report for each monitoring period.
2. The IP review SCDC Electronic Use of Force Reports involving the Restaint Chair during the next site visit.

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

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

July 2017 Implementation Panel findings: As per SCDC Update.

The IP monitors SCDC Use of Force MINS Narratives monthly and continues to identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force. A use of force incident witnessed by the IP, the Assistant Deputy Director for Operations and the SCDC consulting psychiatrist during the site visit to the McCormick CI on July 12, 2017, clearly fell in this category. The IP has requested and received confirmation from SCDC officials the incident will be investigated by the SCDC Police Services Division with findings and conclusions provided to the IP. The revised OP 22.01 Use of Force has an accountability component. QIRM reviews Use of Force Reports and makes appropriate referrals to Operations and Police Services when violations are identified during their review. Police Services has the responsibility to investigate serious incidents. Appendix 6 the SCDC Use of Flow Chart identifies the process for addressing use of force violations.

July 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
3. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. SCDC implement the accountability component of OP 22.01 Use of Force and ensure meaningful corrective action is taken for employees found to have committed use of force violations.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy requiring instruments of force are employed in a manner consistent with manufacturer's instructions. The policy includes a grid identifying the amount of chemical agents that can be deployed for each application in accordance with manufactuer recommendations. The Use of Force Training Curriculum for all Staff was revised in March 2017. Use of Force Train for Trainer

was provided to 162 SCDC Officers and 62 Non-Uniform Staff. SCDC plans to have all staff trained on the revised Use of Force Policy by December 31, 2017. Since March 2017, SCDC Operations has revised procedures limiting the locations and staff that have access to MK 9. The revision has resulted in a reduction in the inappropriate use of MK 9. Implementation remains in progress as SCDC has post orders that conflict with using MK 9 in a manner consistent with manufacturers's instructions. Inappropriate MK 9 use continues to be identified by QIRM and the IP during their review of Use of Force incidents involving chemical agents.

July 2017 Recommendations:

1. SCDC review applicable policies and post orders to ensure all that reference MK 9 require that use is fully consistent with the manufacturer's instructions;
2. Operations and QIRM 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.
3. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
4. IP continue to monitor monthly Use of Force MINs to identify any inappropriate MK 9 use;
5. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force. In February 2017, QMHPs were only contacted in 13 percent of the planned use of force incidents. There was an improvement in April 2017 with QMHPs contacted in 42 percent of planned use of force incidents. Although SCDC has demonstrated improvement in having QMHPs involved in planned use of force incidents, the percentage of their involvement remains at an unacceptable level.

July 2017 Recommendations: Provide additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force.

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

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

July 2017 Implementation Panel findings: SCDC remains in partial compliance. The mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates is as follows:

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

SCDC has not provided documentation that all correctional officers have received the training.

July 2017 Recommendations: QIRM provide documentation verifying all employees have completed the mandatory training for appropriate methods of managing mentally ill inmates developed by SCDC.

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;

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

July 2017 Implementation Panel findings: As identified in the SCDC Status Update 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.

July 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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per the June 2017 SCDC Status Update and The Use of Force electronic monitoring and tracking system remains in place 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 by the Mental Health Department.

July 2017 Recommendations: As recommended in March 2017, formalize in writing the procedures for how the Mental Health Department staff will review use of force incidents involving mentally ill inmates;

1. Employment of enough trained mental health professionals:

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 July 2017 Assessment: **partial compliance**

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

July 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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per our March 2017 findings, which stated the following:

> 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).

July 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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings:

73.54% of SCDC mental health employees have taken either the basic training for the mental health provision course.

We had significant concerns, which we discussed with staff, regarding the two-hour training module that is completed online.

July 2017 Recommendations:

1. Consider using the IP members as consultants relevant to reviewing future draft training modules relevant to mental health services.

2. Continue monitoring completion of the training course for the remaining SCDC mental health employees.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC status update section.

July 2017 Recommendations: As per SCDC status update section.

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

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

July 2017 Implementation Panel findings: Compliance continues.

July 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 July 2017 Assessment: **partial compliance**

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

July 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 July 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.

*July 2017 Implementation Panel findings:*As per our March 2017 findings.

July 2017 Recommendations: See 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 July 2017 Assessment: **compliance (3/2017)**

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

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

Implementation Panel July 2017 Assessment: **compliance (7/2017)**

July 2017 Implementation Panel findings: As per SCDC status.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

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

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

July 2017 Implementation Panel findings: On-site review by QIRM found various prisons that did not maintain any constant observation log sheets. In addition, as per the SCDC status update section, problems existed with compliance with the 15 minute checks.

July 2017 Recommendations: Remedy the above and perform a QI relevant to this issue.

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

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

July 2017 Implementation Panel findings: As per the SCDC status update section.

July 2017 Recommendations: As per the rollout schedule for the EMR.

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

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

July 2017 Implementation Panel findings: Remains in compliance.

July 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 July 2017 Assessment: **compliance (3/2017)**

July 2017 Implementation Panel findings: As per SCDC update.

July 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 July 2017 Assessment: **compliance (3/2017)**

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

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 July 2017 Assessment: **compliance (3/2017)**

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.ix. Quality management documents; and

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

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

July 2017 Recommendations: Continue to develop the QI process.

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

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

July 2017 Implementation Panel findings: As per SCDC status update section.

Significant software issues and user errors have resulted in medication distribution and administration problems. We discussed with key administrative staff temporary work arounds, as previously sumarrized in this report, to implement until these issues have been resolved.

July 2017 Recommendations:

1. As above.
2. We strongly recommended that the eZmar needs to be used at the the time of medication administration regardless of location.

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC status update.

July 2017 Recommendations: Implement the EHR as planned.

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

5.a. Improve the quality of MAR documentation;

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

July 2017 Implementation Panel findings: As per the SCDC status update section. See sections 4.a.x. and 5.b.

July 2017 Recommendations: Resolve communications problems with eZmar and pharmacy electronic systems, and continue internal monitoring via RIM and QIRM.

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

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

July 2017 Implementation Panel findings: The QIRM audits have not included data specific to completion of documentation relevant to medication on a dose by dose basis. This data is being monitored by the Director of Nursing.

July 2017 Recommendations: The above referenced audits need to be included in the reports by QIRM relevant to this issue

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

Implementation Panel July 2017 Assessment: **noncompliance**

July 2017 Implementation Panel findings: As per SCDC status update section.

July 2017 Recommendations: Implement the appropriate steps to resume HS, liquid, and long acting injectable medication administration as clinically indicated.

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

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

July 2017 Implementation Panel findings: The QIRM audits have not included data specific to completion of documentation relevant to medication on a dose by dose basis. This data is being monitored by the Director of Nursing.

July 2017 Recommendations: The above referenced audits need to be included in the reports by QIRM relevant to this issue

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 July 2017 Assessment: **partial compliance**

July 2017 Implementation Panel findings: As per SCDC status update section. The inspection process is not yet been completed. Crisis intervention cells in F1 at the KCI and in the RHU at the McCormimcik CI were identified, which were still not suicide resistant. The four CI cells at the Leath CI, which were located in the Phoenix Housing unit, were sucide resistant.

The CGCI CSU is now open. The physical renovations were nicely done. Staffing remains an issue.

July 2017 Recommendations: Complete the process of inspecting all cells with the plan of having them approved prior to the IP's December visit.

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

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

July 2017 Implementation Panel findings: Overflow "CI" cells are being usd in the RHU at PCI, which were not suicide resistant.

July 2017 Recommendations: Remedy the above.

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

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

July 2017 Implementation Panel findings: QIRM subsequently learned that the practice of continuous observation has not been fully implemented in all the institutions.

July 2017 Recommendations: Remedy the above.

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

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

July 2017 Implementation Panel findings: As per SCDC status update section. However, not all CI safe cells currently have suicide resistant mattresses.

July 2017 Recommendations: Obtain and distribute the ordered suicide resistant mattresses upon their arrival. QIRM perform QI studies to ensure institution staff are tracking and documenting the cleaning of smocks and blankets.

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

Implementation Panel July 2017 Assessment: **noncompliance**

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.

July 2017 Implementation Panel findings: No change since the March 2017 site visit.

July 2017 Recommendations: As per the March 2017 recommendation.

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

Implementation Panel July 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.

July 2017 Implementation Panel findings: The above audit does not meet criteria for an adequate QI study for reasons previously discussed regarding the format of the order that should include following subsections:

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

In addition, the sample size is too small.

July 2017 Recommendations: Perform an adequate audit relevant to this issue.

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

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

July 2017 Implementation Panel findings: As per SCDC status update.

July 2017 Recommendations: Remedy the identified issues.

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

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

July 2017 Implementation Panel findings: The SCDC status update section is only referring to the training relevant to a QI process. This provision requires actual QI studies relevant to crisis intervention practices.

July 2017 Recommendations: Begin performing QI studies as referenced above.

Conclusions and Recommendations:

The Implementation Panel has provided its assessments of compliance with the elements of the Settlement Agreement as well as recommendations in this and past reports and while on-site. As of the end of this site visit, July 14, 2017, 11 of the 58 elements (18.9%) were found to be in Substantial Compliance. The site visits began in May, 2016 and over the past two years SCDC has made progress in some areas in pursuit of the development and implementation of an adequate mental health services delivery system and internal processes to support the system, including QIRM and the EHR. We appreciate the particular efforts and activities by Director Stirling, central administrative staff, and staff at specific facilities to support the efforts to develop and provide adequate inmate healthcare. These efforts demonstrate attempts to improve services utilizing current resources. However, as stated in this and past reports major impediments to substantial compliance remain largely related to inadequate staffing, ineffective training and supervision, variable adherence to policies and procedures, and ingrained correctional cultural practices. The IP has provided technical assistance, suggestions, and recommendations and are hopeful our efforts and reports have been informative and helpful. The concerns identified as crises, both systemically and at specific facilities, are very problematic and require immediate and sustained corrective actions. We are deeply concerned about the continuing inadequate mental health care and harmful conditions of confinement. We look forward to further development of the mental health services delivery system in the South Carolina Department of Corrections and appreciate the cooperation of all parties in the pursuit of adequate mental health care for inmate residents living in SCDC.

Consistent with the Settlement Agreement and past reports, we are providing this report initially as a draft report to the parties for any comments and we will consider those comments when finalizing this report. The IP requests all comments regarding this report be provided within fifteen days of the date of this Draft Report.

Respectfully submitted,

Raymond F. Patterson, MD, Implementation Panel Member
On Behalf of Himself and
Emmitt Sparkman, Implementation Panel Member;
Jeffrey Metzner, MD, Subject Matter Expert; and
Tammie M. Pope, Implementation Panel Coordinator