South Carolina Department of Corrections
Implementation Panel Report of Compliance
November 2018

Executive Summary

The South Carolina Department of Corrections (SCDC) has demonstrated efforts to improve care and meet the requirements of the Settlement Agreement. However, it continues to have great difficulty in achieving those goals for multiple reasons which will be described in this report. This eighth report of the Implementation Panel (IP) will provide our review and analysis of the status of compliance based on information presented in documents reviewed prior to and during the onsite visits to SCDC facilities from November 12-16, 2018, as well as on site discussions and technical assistance to the SCDC since our last IP visit from July 12-16, 2018. The Settlement Agreement is now in its third year of implementation, which began in May 2016. The Settlement Agreement requires three visits per twelve month period for the first three years with reductions to two visits per twelve month period for the successive years. The Settlement Agreement "year" is from May-April, and therefore the third "year" will end at the end of April 2019.

Beginning with the first visit and report by the IP based on the visit in May 2016, we have reported our very serious concerns regarding SCDC's inability or failures to attain substantial compliance largely because of: 1) Staffing deficiencies, including clinical, operations/custody, administrative and support staff; 2) Conditions of confinement, including specifically the Restrictive Housing Units (RHU), and segregation of any type; 3) Prolonged stays in Reception and Evaluation (R&E) 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 higher levels of care, particularly timely hospital and residential (Intermediate Care, Behavioral Management Units, Area Mental Health/Enhanced Outpatient) levels of care; and 7) Future planning for adequate numbers of beds, programmatic space and staffing for mental health higher levels of care, including Crisis Stabilization Units (CSU).

In our reports we have reviewed and commented on all of these areas, noting some improvements in clinical staffing, and R&E reductions in length of stays and services at Camille Graham, as well as successes with the BMUs. However the other areas above, despite efforts at specific facilities by administrative and operations staff, remain problematic. The conditions of confinement have not substantially improved, in fact, have worsened to include general population inmates with the system-wide lockdown beginning in April, 2018 following the riot at Lee C.I. The staffing deficiencies for Operations staffing continues to retard or prevent compliance with many of the basic requirements of SCDC policies and the Settlement Agreement. Although there have been some improvements in clinical staffing for psychiatrists and psycholiogists which was sorely needed, the deficiencies in nursing and medical staffing, and excessively high caseload numbers for Qualified Mental Health Professionals (QMHP) remain problematic and do not have a positive impact on mental health care, treatment and management of inmates with mental health needs.

In the Implementation Panel Report of Compliance for the July 2018 site visit the IP reported on the positive impact on mental health services and the requirements of the Settlement Agreement demonstrated by staff at facilities where the lockdown had been modified or eliminated. The IP provided similar feedback during this site visit and at the Exit Conference held on November 16 at the end of the visit. The IP continues to acknowledge the very positive efforts and impact of the Quality Improvement Risk Management staff and healthcare leadership, and is encouraged by the progression of the development and implementation of the electronic health record (EHR). The IP remains deeply concerned with the continuation of segregation conditions, medication management, planning of services for inmates who require higher levels of care and movement/relocation of mentally ill inmates. The mass movement of caseload inmates at Level 3 (Area Mental Health/Enhanced Outpatient) to Broad River C.I., and mass movement of female inmates from Graham C.I. to Leath C.I. remain problematic. The planning for movement, creation, and/or expansion of existing programs was discussed during this visit and the IP expressed our concerns for adequate needs assessments, preparation of inmates and staff and provision of adequate human resources, space and supportive services to facilitate successful implementation or changes. These discussions included proposals and plans that may directly affect inmates, services and programs at Kirkland C.I., Broad River C.I., Graham C.I., Lee C.I. and Evans C.I. and may indirectly impact other facilities and services.

The IP has reported on the suicide rates by calendar year for inmates living in SCDC. As of November, 2018 there have been six inmate suicides reported at SCDC. For an average daily population of approximately 20,000 inmates the annual suicide rate for calendar year 2018 is 30 per 100,000 at SCDC. The national average suicide rate for prisons reported by the Department of Justice, Bureau of Justice Statistics for the most recently available years is 16-17 per 100,000. The Suicide Prevention and Management program at SCDC requires collaboration and coordination by administrative, clinical and operations staff. The IP has strongly and repeatedly recommended the internal review, analysis and restructuring of the processes to include policies and procedures, timely and effective involvement of central classification at the Broad River C.I. CSU, and the review process and documentation by the Suicide Prevention Committees and clinicians involved in the Psychological Autopsy analysis.
The IP has acknowledged the efforts and actions by SCDC to recruit and retain staff, and the positive impact regarding increased numbers of psychiatrists and psychologists is impressive and very helpful. However the continuing deficiencies in operations/correctional officer staff so adversely impacts inmates living with mental illness, as well as inmates not on the mental health caseload, and is exacerbated by the conditions of confinement, that basic services are compromised and may be over-utilized by inmates to attempt to obtain out of cell time and showers as well as to address safety concerns. More specifically, the IP notes the following progress and concerns:

Progress

- Developed RHU Training and began rolling the training out to designated employees in November 2018;
- Expanded the number of training hours offered correctional employees in Pre Service and In Service regarding appropriately managing mentally ill offenders;

- Inmates on RHU Security Detention status has been reduced to less than 300 as of November 14, 2018. SCDC data indicates approximately 100 inmates on Security Detention status have gone six months without a disciplinary report conviction;
- Lieber CI offering UOF Workshops to provide assistance and training to employees;
- Increasing availability of showers in RHU for inmates at Lieber CI and Broad River CI;
- Continued minimal use of the restraint chair;
- The MH UOF Coordinator conducting a study to identify inmates frequently involved in UOF and making recommendations for additional service to potentially reduce UOF;
- Overall improvement in operations at Kirkland CI and Lieber CI;
- The continued success of the BMU Programs.

Concerns

- Critical shortage of front line correctional officers particularly at Level 3 institutions preventing the providing of basic services to inmates in the general population and RHU;
- Deplorable conditions of confinement at Lee CI and Broad River CI Murray Unit;
- RHUs at male institutions not being provided cleaning supplies on a weekly basis to improve sanitation.
- The RHU Stepdown Policy has not been revised to mirror practice and inmates eligible for participation in the Stepdown Programs are not being placed (approximately 100 appear eligible for consideration and remain in RHU);
- Identified institutions are not following guidelines for placing inmates in Control Cells;
- Low number of UOF investigation based on the number of identified QIRM UOF violations and UOF/Physical Abuse Complaints;
- High number of grievances regarding UOF and Physical Abuse returned to inmates without being processed;
- High number of inmates in RHU without a crank radio;
- Access to Management Meetings are not being held with inmates in the housing units due to the lockdown hindering addressing inmate issues and concerns;
- SCDC data identifies Institution Upper Management presence in RHU is lacking and Duty Wardens are not making rounds in RHU on weekends as required by policy and procedure;
- Institution Lockdown tracking is insufficient. Institutions should provide the following information daily :

    - Areas/Locations of Institution on lockdown;
    - Number of hours each area/location was locked down for the 24 hour period;
    - Each service and/or program impacted by the lockdown;
    - Number of inmates impacted;
    - The reason for the lockdown for each institution area/location.

The IP has consistently reported grave concerns that SCDC is highly unlikely, if not completely unable, to meet the conditions and requirements of the Settlement Agreement and the provision of constitutionally adequate mental health care without major and consistent increases in staffing and resources and/or major reductions in the numbers of inmates housed in SCDC facilities. Consultants to SCDC have recommended security staffing levels necessary to provide adequate services consistent with correctional practices and SCDC policies. SCDC has engaged in

increased recruitment efforts, with some success, however retention of staff is also adversely affected by working conditions. Progress has been made in reducing the lockdown status at most facilities, however inmates in RHUs and in general population at some facilities continue to not receive out of cell time as required. The IP has also continued to provide technical assistance and suggestions on providing crank radios and other interventions to assist staff and inmates during these staff shortages and lockdown restrictions. The SCDC total population continues to decrease toward 19,000 inmates while the mental health caseload has increased from 3126 to 4163 at the time of this visit. The percentage of inmates on the mental health caseload is 21.8 %, with 52.2% of female and 19.1% of male inmates on the caseload. These increases are more consistent with national averages and represented the impressive improvements by SCDC to appropriately identify those inmates in need of mental health services. Unfortunately, even with the improvements in mental health staffing, the deficiencies in operations/security and nursing staffing compromise the delivery and consistency of mental health services. The wardens and their staff at several facilities, with the support of central administration and regional directors, are continuing to try to provide the services that they can and "think outside the box." However to implement and sustain necessary changes, including program development, requires the increased resources identified and discussed on site and in IP reports, including this report.

As Exhibit B illustrates, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance---21
2. Partial Compliance---32
3. Non-Compliance---6

The Implementation Panel clearly understands this is a complex and ongoing process. The difficulties in providing necessary and required services given the resource deficiencies and conditions of confinement is very challenging for all. The improvements in identification of inmates in need of mental health services, sincere and effective efforts at specific facilities to provide services, the essential role and participation by QIRM and the healthcare and operations leadership staff , and the development of the EHR are all very encouraging. We also appreciate the efforts to design or modify programs and have cautioned leadership to involve staff, consultants, and where appropriate inmates, in the discussions and planning process for expansion, relocation and inmate movement. The specific Settlement Agreement criteria, requirements, findings and recommendations are listed below.

1. 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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: The above results are encouraging. Lack of achieving compliance appears to be a staffing issue (i.e., vacancies). Future QI studies should

include in the sample inmates who were not placed on the mental health caseload as a result of the screening process.

November 2018 Implementation Panel Recommendations: As above.

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

Implementation Panel November 2018 Assessment: compliance (November 2018)

November 2018 Implementation Panel findings: The referenced QI results were consistent with the R&E mental health screening process adequately identifying inmates with a mental illness.

November 2018 Implementation Panel Recommendations: The referenced QI could be improved as follows:

1. Assess whether the initial mental health screening was accurate at the time of the screening.
2. Classify the reasons for inmates, who had not been placed on the mental health caseload in R&E, were later placed on the caseload. Such an assessment may have relevance in the context of revising the mental health screening instrument.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: The methodology re: the above study was problematic for the following reasons:

1. The sample was too small.
2. The sample was not randomly chosen.
3. The findings were not consistent with other studies reported re: compliance with relevant timeframes.

November 2018 Implementation Panel Recommendations: Repeat the study with the above referenced methodological issues being adequately addressed.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update.

Camille Graham CI

During the morning of November 16, 2018, the IP met with most of the R&E inmates in a group setting during their one hour of out of cell time. They confirmed that they were receiving one hour per day of out of cell time in either the dayroom or outdoor yard (weather permitting). Only two of the inmates reported being in the R&E for more than 30 days. Many of the inmates, who had been receiving psychotropic medications in jail prior to their transfer to R&E, had not yet been prescribed psychotropic medications because they had not yet been evaluated by the psychiatrist. All the inmates described the mental health screening process to have been timely and comprehensive.

November 2018 Implementation Panel Recommendations:

1. Implement and QI the planned actions, which included the following: "Implement measures of corrective action for R&E staff who fail to provide available and appropriate services to mentally ill inmates who remain at R&E for an extended period of time."
2. Accurately track the out of cell time offered to R&E inmates on a weekly basis.
3. Continue to provide the average and median LOS data in the future for inmates in the R&E upon transfer from the R&E.
4. QI the R&E process re: the verification of prescribed medications and the bridge ordering process.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: See 1.a.i.

November 2018 Implementation Panel Recommendations: As per 1.a.i.

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 2018 Assessment: noncompliance

November 2018 Implementation Panel findings: As per status update section. The number of Area Mental Health inmates has increased (although not significantly). Significant issues remain in providing sufficient facilities for treatment with specific reference to staff

resources as evidenced by partial compliance in meeting clinical timeframes.

During the afternoon of November 13, 2018, the Implementation Panel (IP) met with most of the Murray dormitory inmates in a community group setting. These inmates continued to complain about poor access to mental health and medical services since the system wide lockdown. Other complaints included the timing of the morning medication administration process, periodically missing medications, significant property and clothing issues, and conditions of confinement related to partial lockdown status. They also reported staff on inmate assaults and inmate on inmate assaults. Community meetings had just recently been restarted.

Most of the above information was not consistent with information obtained from staff.

November 2018 Implementation Panel Recommendations: We recommend that community meetings occur at least twice per week to address the above issues reported by inmates. These meetings should be attended by mental health, nursing and custody staff. The access to management meetings should resume on at least a monthly basis for similar reasons.

Lee Correctional Institution

The mental health dorm (Better Living in Community), which is not an area menta health level of care, is now on a modified lockdown status, meaning that some access to mental health groups on the unit is provided for these inmates. For somewhat unclear reasons, inmates over the age of 50 were not transferred to the East Yard dorm that is apparently not locked down or is on a more modified lockdown status.

The IP remains very concerned about the modified lockdown status of the mental health dorm due to the potential of the conditions of confinement exacerbating some of the inmates' mental disorders.

Lieber Correctional Institution

The inmate count was 1161 inmates. The mental health count during November 15, 2018 was 282 inmates with 36 of these inmates being in the RHU. The mental health staffing was as follows:

1.0+ FTE Psychiatrists
1. 0 FTE MHT
4.0 FTE QMHPs (1.0 FTE vacancy)

There were a total of 243 FTE correctional officer positions with 101 FTE vacancies.

Lieber CI remained on lock down status except for a character dorm and a faith based dorm. Refer to the relevant data in the status update section for information specific to meeting timeframes for clinical contacts. Cooper dorm was reported to house a large number of mental health caseload inmates.

Camille Graham CI

We site visited CGCI during the morning of November 16, 2018. During November 14, 2018 the total inmate count was 633, which included 39 RHU inmates. Twenty of the RHU inmates were on the mental health caseload. The mental health caseload included 265 inmates with the following level of care designations:

Classification	Total	RHU
L1 inpatient	2	0
L2 ICS	18	0
L3 Area MH	57	0
L4 outpatient	159	14
L5 stable, but being monitored	27	2
Non-mental health	368	19
Crisis level	0	0

Staffing was as follows:

Psychiatrists: 2 psychiatrists providing a total of 47.5 hours coverage per week
Psychologists: .05 FTE (vacant)
QMHPs: 7.0 FTEs
MHTs: 3.0 FTEs
On-site clinical supervisor: 1.0 FTE

The average QMHP: inmate patient ratio was 1:60

There were significant nursing staff vacancies, especially on the second shift. Most vacancies were covered by agency nursing staff.

We observed a treatment team meeting during the morning of November 16, 2018, which was also attended by the psychiatrist and other clinical staff. The nature of the clinical discussion was negatively impacted by the size of the non-clinical team members observing the treatment team process.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section, which summarizes SCDC's plans for significantly increasing the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore. Increased staffing allocations have been requested as part of SCDC's budget request that has been submitted to the governor.

Our previous two reports included the following:

> We discussed with staff issues related to the current number of inmates determined to be in need of an ICS level of care. For purposes of this provision, inmates in any type of mental health residential level care (e.g., a BMU) should be included in the statistics relevant to receiving an ICS level of care. It has been our experience that 10% to 15% of the total mental health caseload population is usually in need of an ICS level of care at any given time, which is significantly more than the current percentage of caseload inmates receiving an ICS level of care.

Our opinion re: the above remains unchanged.

Kirkland Correctional Institution

Pre-site data included the following information:

During the morning of November 13, 2018, we attended an ICS treatment team meeting/staffing and interviewed most of the F I ICS inmates in the community meeting setting. The process observed during the treatment team staffing meeting improved as compared to our previous site visit from the perspective of treatment planning.

The Fl ICS inmates were very complimentary of the treatment being provided although few inmates were being offered 10 hours of groups per week. They described the group treatment as being helpful as was individual treatment. In addition, good access to the psychiatrists and the QMHPs was reported by these inmates.
Clinical Staffing for the ICS was reported as follows:

1.58 FTE psychiatrists (# Hours/week on-site = 58.46)
0.37 Psychiatric Nurse Practitioner
8.0 FTE Mental Health Counselor (1.0 FTE vacancy)
3.0 FTE MHTs (1.0 F vacancy)
16.0 FTE RNs (14.0 FTE vacancies)
13.0 FTE LPNs (10.0 FTE vacancies)
4.0 FTE paramedics/tech (3.0 vacancies)

The above nursing staff cover for both GPH and Kirkland's ICS. Vacancies are covered, at least in part, by agency nursing staff.

Medication administration on an HS basis continues to occur around 4 :30 pm.

November 2018 Implementation Panel Recommendations:

1. Implement the proposed expansion of ICS.
2. Remedy the timing of hs medication administration

HLBMU

November 2018 Implementation Panel findings: During the morning of November 13, 2018, we

interviewed all of the HLBMU inmates in two group settings. These inmates predominantly had very positive statements re: the treatment program in the HLBMU**.** Issues described during our previous site visit have been successfully resolved via the HLBMU program director and Warden Davis (e.g., access to the dining hall, not being cuffed when off the housing unit, etc.). The many group therapies offered to these inmates were reported to be very helpful to them.
We were very impressed with the continuing evolution of this program.

We also toured the physical plant of the proposed BMU at the BRCI, which has much more programming space than the current program.

November 2018 Implementation Panel Recommendations: We recommend that the current HLBMU inmates complete their program at the current location unless they want to be transferred to the new program at BRCI for several different reasons. They include allowing the culture at the new program to be established independent of the Kirkland BMU to avoid the inevitable conflicts that will arise related to "we didn't do it that way…" at Kirkland and to facilitate the termination process for these inmates from the BMU.

Please note that the above recommendation is only a recommendation and not a mandate. The potential advantage of not following this recommendation is that the culture of the program developed at Kirkland can be carried over to BRCI if both the staff and the inmates are transferred to the new program. If the staff are not transferred, maintaining the same culture will likely not occur and the potential for conflicts related to different correctional practices will increase as referenced above.

Regardless of which choice is made, the admission of new inmates to the BRCI HLBMU should be gradual to allow a therapeutic culture to be developed.

Camille Griffin Graham Correctional Institution

We interviewed 16 ICS inmates in a community meeting setting. They reported during the past 1-2 months being offered one hour of structured therapeutic group activities per day, which was a decrease from previous months. The groups were described as being helpful. Good access to their psychiatrist and individual counselors was described by these inmates. Many of these inmates reported having various cleaning jobs on the unit, which was clean in appearance.

Medication continuity issues did not appear to be present re: psychotropic medication but were described re: other types of medications.

We also interviewed most of the women on the C side of the Blue Ridge dorm, which included only two ICS inmates. A significant number of these women reported participating in one or more mental health groups per week, which were generally described as being helpful. Some access problems to the psychiatrist and counselors were reported by a minority of inmates. Both staff and inmates described various issues on this unit related to an increasing number of inmates housed on this unit with personality disorders. Medication continuity issues did not appear to be present although several inmates were very vocal re: the medications that were either prescribed or not prescribed to them. Many inmates reported having a job that was either on the unit or off the unit.

We discussed with staff issues re: community meetings on this unit. We recommended that such meetings occur at least twice per week and that staff debrief among themselves in a meeting that immediately follows the community meeting.

November 2018 Implementation Panel Recommendations:

1. Continue to increase the number of hours of structured therapeutic activities being offered to ICS inmates.
2. Community meeting recommendations as above.

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 2018 Assessment. partial compliance

November 2018 Implementation Panel findings: As per current status section.

Our last report included the following:

> The amount of out of cell time, both structured and unstructured, actually used by GPH inmates remains alarmingly small. This issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) although institutional cultural issues likely contribute.

We interviewed most of the GPH patients, who were housed on the open unit (side A), in a community meeting setting. These inmates reported access to the recreational cages 1-2 hours per day and 1-2 groups per weekday (3 hours per group). Meeting with the psychiatrist on a weekly basis in a private setting was also reported by these inmates. They were very complimentary of the treatment program, which was described as being helpful. Medication management issues did not appear to be present. The major recommendation was having access to more group programming.

During the afternoon of November 12, 2018, we also interviewed six inmates housed on the closed unit in GPH (side B). These inmates described very limited access to out of cell unstructured time (1-2 hours per day) and very limited out of cell structured therapeutic treatment programming (1-2 groups per week).

The major barrier to providing adequate out cell structured therapeutic time for inmates housed on side B was described by staff to be lack of adequate correctional officer coverage, which is exacerbated by correctional officers on this unit commonly being pulled to cover areas other than GPH. Staffing analysis has previously identified the need for 37 additional CO's, and additional Sergeants and Lieutenants.

The nursing coverage provided at GPH is not being provided by psychiatric nurses, which has obvious ramifications in the context of establishing a therapeutic milieu. This appears to be directly related to the current job requirements for these GPH nursing positions. The nursing staff allocations and vacancies were as follows:

16.0 FTE RNs (14.0 FTE vacancies)
13.0 FTE LPNs (10.0 FTE vacancies)
4.0 FTE paramedics/tech (3.0 vacancies)

The above nursing staff cover for both GPH and Kirkland's ICS. Vacancies are covered, at least in part, by agency nursing staff.

As reported in the status update section the relevant policy states that the "Frequency of Session is determined by clinical symptom presentation and treatment needs"; therefore, best practice has been established as "every other week" for QMHP sessions and Psychiatry sessions in GPH." We do not agree that best practice is every other week clinical contact by a QMHP and a psychiatrist. Best practice would be minimally every week contact in an inpatient psychiatric setting.

The clinical staffing for GPH was reported as follows:

	Total FTE as of November 2018	Staffing Plan FTE
Psychiatrists:	1.68 (67.25 hrs/week)	4.0
Psychologists:	.56 (22.50 hrs/week)	.5
QMHP's:	7.00 (2.0 FTE vacancies)	8.00
MHT's:	7.00	16 .0

Recreational therapists 3.0 FTEs 3.0
Bay Counselors 9.0 FTEs (2.0 FTE vacancies)
Hospital Administrator 1.0 FTE

Renovations at GPH have been completed with specific reference to the nursing stations.

November 2018 Implementation Panel Recommendations: We stated the following in our July 2018 report:

> The significant custody staffing allocations should be a high priority to remedy. These officers should be regularly assigned to GPH and receive enhanced mental health training relevant to working in an inpatient setting.

We again recommend the above. We also recommend that the nursing staff gradually be transitioned to a nursing staff with significant inpatient psychiatric experience.

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

Implementation Panel November 2018 Assessment: compliance (November 2018)
November 2018 Implementation Panel findings: The significant decrease in mental health staffing vacancies, especially the psychiatrists, is very encouraging. Compliance is present in the context of meeting the goals of the Settlement Agreement staffing plan.

Despite this significant achievement, SCDC is aware of the need for increased mental health

staffing allocations based on the significantly increased numbers of inmates identified with mental health problems that require psychiatric intervention. This need is demonstrated by the budget request submitted to the governor's office for such increased allocations.

November 2018 Implementation Panel Recommendations: Continue to advocate for needed mental health staff allocations.

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 2018 Assessment: compliance (July 2017)

November 2018 Implementation Panel findings: Staff were unclear whether the findings/recommendations of the Denials Committee were followed by the relevant program. It was also our understanding that the Denials Committee was also unaware of the outcome of their findings.

November 2018 Implementation Panel Recommendations: Future data should include the actual outcome of the Denials Committee's recommendations. It is our recommendation that the Denials Committee's name be changed (e.g., clinical assessment team), which could be used for both higher level of care rejection appeals and for consultation purposes re: recommended level of care. The appeals decision made by this team should be binding on the two institutions involved in the case.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section. The data re: lack of compliance with timely mental health contacts remains extremely problematic and continue to be related to correctional staff vacancies and the prolonged institutional lockdown.

We previously recommended the following:

> SCDC should identify strategies that could potentially immediately remove all inmates in RHU on Security Detention status with the Mental Health Designation Levels 1, 2, 3.
> A QI Study should be conducted to assess why a high number of inmates that graduated from the LLBMU in March 2018 have been placed in RHU.

Since the above recommendation, 34 such inmates have been transferred to either a general population unit or to the BMU.

The QI re: LLBMU outcomes included the following:

About half of the inmates who graduated from the LLBMU in February returned to lock-up within 3 to 7 months of their graduation. However, none of the inmates were placed on Security Detention status, which was their original status before transferring to the LLBMU program. Three of the inmates who returned to lock-up had offenses that were serious – including attempted escape, striking an employee, and possession of a weapon. Other offenses that resulted in the inmates' return to lock-up were less serious issues that were pertaining to contraband, including possession of a cellphone or drug possession.

All the inmates who returned to RHU continued to receive appropriate and consistent Mental Health assessments, evaluations, follow-ups, and treatment as needed. Given the nature of the inmates' mental illness and behavioral issues, as evidenced by the above results, there is approximately a 50% chance that inmates who graduate from the LLBMU program will continue to exhibit behavioral problems once they leave the program. Those who transferred to a different institution altogether were more likely to present with serious offenses. The receipt of mental health services did not have an impact on the inmates returning to lock-up, as they all received consistent mental health care.

Planned Actions

QA will continue to review and assess the effectiveness of the LLBMU program and provide the appropriate mental health services to inmates while in the LLBMU to help prevent behaviors that result in a return to lock-up status. It is important to note, although 47% of inmates did return to RHU, none were placed on Security Detention status. This study will be shared with LLBMU staff to continue addressing the criminal thinking element of the program.

November 2018 Implementation Panel Recommendations:

1. Continue to QI outcomes re: graduates of the BMUs.
2. Remedy the above referenced issues.

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

Implementation Panel July 2018 Assessment: noncompliance

November 2018 Implementation Panel findings: As per status update section. It is very concerning that most institutions did not offer outside recreation during the reporting period of June 2018 – September 2018 and are now only offering very limited access to out of cell recreational time.

Broad River Correctional Institution

November 2018 Implementation Panel findings: Conditions of Confinement continue to be impacted by correctional staff shortages. The system-wide lockdown has further exacerbated BRCI being able to provide basic services. Staff reported that showers are now being offered to RHU inmates on a three times per week basis. Outdoor recreation was reported being offered on Tuesdays and Thursdays for

one hour each day.

A member of the Implementation Panel visited the BRCI on November 16, 2018. Inmates reported receiving showers three times weekly; however, disputed outside recreation was being provided. Sanitation levels had marginally improved. Inmates complained cell maintenance issues were not addressed in a timely manner.

RHU inmates reported they had not received crank radios.

November 2018 Implementation Panel Recommendations:

Remedy the identified deficiencies and begin providing basic RHU services. Continue QI studies monitoring BRCI efforts to improve RHU conditions of confinement.

Lee Correctional Institution

During the morning of November 14, 2018, the IP briefly toured the RHU and interviewed at the cell front about 10 inmates. At least four of these inmates reported psychotic symptoms and one stated he had 4 CSU admissions during past six months. They reported access to showers but much less than a three per week basis. Similar to information obtained from staff, these inmates have not had access to out of cell recreation since the April 2018 lockdown. The unit was very dirty. Maintenance issues in the unit are not being addressed. RHU Supervisory staff reported approximately 20 cell lights were non-operational. A brief sample of the daily activity sheet indicated that 30-minute checks were not being completed.

Staff reported that on the day of the site visit that the RHU was allocated 17 FTE correctional officer positions with only 3.0 FTE positions filled. Related to staff shortages and a small number of inmates "dashing" (i.e., throwing urines and feces) at staff, it was not uncommon for nursing staff to not administer medications in the RHU once or twice per week.

Lee CI was reported to be scheduled to begin "tiering" after all of the other prisons have begun the tiering process. The date for Lee CI to begin such a process appeared to not yet be known.

Crank radios have been distributed to many of the RHU inmates. TVs were present in the RHU hallway that immediately face the cells.

Our July 2018 report included the following:

> The prolonged lockdown for all inmates, especially those on the mental health caseload, is very stressful and is likely to exacerbate the symptoms of many inmates on the mental health caseload. More efforts need to be implemented to mitigate such negative effects that should include a plan to facilitate a transition to ending the lockdown soon (e.g., begin allowing inmates out of cell time on a daily basis, which will be the most effective approach). Providing inmates with reading materials, music, crank radios, etc. are examples of other interventions that can help to mitigate the harmful effects of the lockdown.

November 2018 Implementation Panel Recommendations: The conditions of confinement in the RHU are deplorable with little end in sight due to the chronic correctional officer shortages. These conditions put inmates with a mental illness at high risk of deterioration. Inmates without a mental illness are at significant risk of experiencing significant emotional distress that will likely exacerbate behavioral dysfunction that led to their initial placement in RHU.

Related to the difficulties re: medication administration in the RHU, inmates with insulin dependent diabetes have been transferred to other institutions where such problems do not exist to the same extent. A similar argument can be made with respect to inmates in the RHU with a mental disorder diagnosis (i.e., such inmates should not be in a RHU with such conditions of confinement). These factors are extemely problematic for meeting the mental health needs of the population and compliance with the Settlement Agreement.

Evans Correctional Institution RHU

During our November 14, 2018 site visit, the RHU census was 100 inmates, which included 31 inmates on the mental health caseload. Inmates were reported to be offered showers on a two times per week basis. RHU inmates have not had access to outdoor recreation since 2017 due to chronic correctional vacancies (currently 42% for frontline COs). The unit was reasonably clean.

Lieber Correctional Institution RHU

During the morning of November 15, 2018, we briefly visited the RHU at the Lieber CI. The unit was clean and relatively quiet. Inmates confirmed that they were receiving 1-2 showers per week and were generally offered one hour per week of outdoor recreational time. Out of cell clinical contacts were being provided via a designated two days per week "mental health day." Medication management problems did not appear to be present. Four safety cells were present in the RHU. The two safety cells inspected by the IP were suicide resistant.

We attended a mental health treatment team meeting and observed the staffing of five inmates. The meeting was attended by a psychiatrist, classification officer, deputy warden for treatment, QMHPs, correctional officer and nursing staff. Each inmate attended the staffing, where their treatment plan was reviewed with the team. The process was conducted in a very respectful manner.

We were impressed by differences in the RHU environment/milieu at the Lieber RHU as compared to the Lee CI RHU, which was due, at least in part, to the improved conditions of confinement despite the significant correctional officer vacancies.

Camille Griffin Graham RHU

Twenty of the 39 RHU inmates were on the mental health caseload.

Inmates reported that two RHU groups per day are provided to mental health caseload inmates. RHU inmates reported generally being offered one hour per weekday of outdoor recreation, showers three times per week. Access issues to the psychiatrist were not present. Medication

management issues did not appear to be present. Inmates complained requests to meet with their assigned QMHP were not being addressed.

Inmates consistently praised the staff for providing crank radios. The unit was clean and quiet.

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 November 2018 Assessment: noncompliance
November 2018 Implementation Panel findings: See 2.b.i.

November 2018 Implementation Panel recommendations: See 2.b.i.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section. We toured the housing unit at Evans CI that will become the Special Concerns Unit. The program is still under development. We expressed concerns that recruitment of both correctional officers and QMHPs for this program will be very difficult based on the history at Evans CI re: relevant staff vacancies, which has clear program implications.

November 2018 Implementation Panel Recommendations: Please send us the pertinent policy and procedure re: the Special Concerns Unit when it has been developed.

2b.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 November 2018 Assessment: compliance (November 2016)

November 2018 Implementation Panel findings: The above findings are very concerning. We agree with the planned actions, which are as follows:

> Follow-up with the Wardens and Mental Health Supervisors, reiterating the purpose of this process as it relates to identifying sanctions that align with the inmate's symptomology and reducing the amount of time an inmate is housed in restrictive housing. Coordinate with the Division of Operations recommending this metric is added to the Division of Operations dashboard to be additionally monitored by Regional Directors.

November 2018 Implementation Panel Recommendations: As above and QIRM should continue to perform CQI studies. The SCDC planned action is critical for the provision to remain in compliance.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: Based on the QIRM data several correctional institutions monitoring cells for sanitation and temperature are at an unacceptable level. When deficiencies are identified corrective action is not taken to address the deficiencies. RHU inmates complained supplies were not provided to clean their cells on a regular basis. The exception being CGCI where inmates are provided cell cleaning opportunities two times per week. CGCI also had the cleanest RHU of any visited by the IP Panel.

November 2018 Implementation Panel Recommendations:

1) Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2) 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 and uploaded in the shared file;
3) SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: SCDC continues to develop their formal quality management program under which segregation practices and conditions are reviewed. Per the Status Update audits and meetings are scheduled to address deficiencies.

November 2018 Implementation Panel Recommendations: Continue to develop the SCDC formal quality management program to review segregation practices and conditions. Ensure Operations has sufficient qualified staff at institutions before relevant continuous quality improvement responsibilities are transitioned from QIRM.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings:

The SCDC Division of Behavioral Health has developed formalized procedures to review UOF involving inmates with a mental health designation. The MH UOF Coordinator and Operations Administrative Regional Director are working closely together to address UOF issues. QIRM staff continues to meet weekly with Operations Leadership and the MH UOF Coordinator to discuss UOF and other relevant issues. During the meetings, QIRM UOF Reviewers report by institution: the number of uses of force, type of use of force, plan or unplanned, type of chemicals used, use of force discrepancies that violate policy and procedure. Disproportionate UOF involving inmates with mental health designation remains an issue. Restraint Chair use is the exception with SCDC having only having two uses of the restraint chair for the relevant months.

November 2018 Implementation Panel Recommendations:

1. SCDC continue to monitor all Use of Force incidents to identify and address the reasons for disproportionate Use of Force involving inmates with mental illness;
2. SCDC formalize the draft policy to review inmates with a mental health designation that are involved in use of force incidents.
3. The Division of Operations Administrative Regional Director and Division of Mental Health UOF Coordinator collaboratively work together to address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates;
4. IP Panel Mental Health Experts review the draft policy regarding review of UOF incidents involving inmates with a mental health designation.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings:
Per Status Update. SCDC has revised the applicable UOF Reports to include Canines. There were no UOF incidents identified involving canines for the relevant months. SCDC Operations Leadership and QIRM has made progress addressing Chemical Agent MK9 use through additional oversight and training. Although more progress is needed, the developed action plan appears to be making an impact. Revisions to the Housing Unit Post Orders requiring *Cover Teams* to use MK-9 consistent with manufacturer's instructions has not been provided the IP.

SCDC continues efforts to ensure all instruments of force, (e.g., chemical agents and restraint chairs) are employed in a manner fully consistent with manufacturer's instructions, and are tracked to enforce compliance. Reports are compiled and distributed weekly and monthly containing the summaries for types of force utilized as well as the MINs summaries.

SCDC had two incidents during the relevant period that required restraint chair use: June (1)

and August (1). A documented review for each restraint chair use was conducted. UOF Reports identified that hard restraints were utilized a total of two times. The IP was not provided data on the amount of time the inmates remained in hard restraints nor was information provided regarding whether an assessment was conducted to determine if SCDC guidelines for hard restraint use were followed.

SCDC reported no incidents where batons were used in a UOF.

SCDC has been unsuccessful providing UOF Training for In-Service for existing employees. As of September 30, 2018, 97.6 percent of the required SCDC employees have not completed the necessary UOF training for the Calendar Year 2018. The SCDC UOF Training for Calendar Year 2019 has been revised and it is critical required staff receive the UOF training.

November 2018 Implementation Panel Recommendations:

1. Operations, the MH UOF Coordinator and QIRM continue to review use of force incidents through the automated system to ensure instruments of force are fully consistent with the manufacturer's instructions;
2. Operations and QIRM begin tracking the amount of time inmates remained in hard restraints and perform assessments to determine if SCDC guidelines for hard restraint use were followed;
3. QIRM continue to meet weekly with Operations leadership and the MH UOF Coordinator to discuss UOF and other relevant issues;
4. Revise Housing Unit Post Orders requiring *Cover Teams* to use MK-9 consistent with manufacturer's instructions;
5. Revise the MINs Electronic Form to include the Mental Health Classification of inmates involved in UOF;
6. Revise the SCDC UOF policy and require an annual review of the Agency List of approved UOF instruments and munitions;
7. Required Staff complete Use of Force Training in Calendar Year 2019.

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 November 2018 Assessment: compliance (July 2017)

November 2018 Implementation Panel findings:
As per status update section. SCDC remains in compliance. Neither SCDC nor the IP identified any incident where an inmate was placed in the crucifix or other position that did not conform to generally accepted correctional standards.

November 2018 Implementation Panel 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 November 2018 Assessment: compliance (March 2018)

November 2018 Implementation Panel findings:
As per status update sections. There were two (2) reported uses of the restraint chair: June (1) and August (1). The June 18 Restraint Chair use was on the orders of Operations and the August 18 Restraint Chair use was by Mental Health order. The inmate placed in the restraint by Operations remained for 120 minutes and the inmate placed by Mental Health remained for 43 minutes. Both restraint chair uses were reviewed by SCDC officials with recommendations for improvement. The inmate placed in the restraint chair by Operations did not appear to meet SCDC guidelines for placement. Alternatives were not exhausted and written and video documentation indicate the restraint chair was initiated at a time when the inmate was not disruptive, nor a threat of physical harm to himself or others, nor actively damaging state property. SCDC has been very successful in limiting restraint chair use and remains in compliance. UOF Reports identified that hard restraints were utilized a total of two times during the relevant period. The IP needs data on the amount of time inmates remained in hard restraints and whether SCDC guidelines for hard restraint use were followed.

November 2018 Implementation Panel Recommendations:
QIRM continue to track and monitor compliance with use of the restraint chairs. Inmates placed in hard restraints should be monitored and tracked by QIRM in addition to restraint chairs to include: compliance with guidelines and the amount of time in hard 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 November 2018 Assessment: compliance (December 2017)

November 2018 Implementation Panel findings:
Per SCDC update. QIRM collects data and issues quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs. For the two restraint chair uses in the relevant period, the time inmates were in the restraint chair followed SCDC guidelines: 120 minutes and 43 minutes respectively (SCDC Update time of 42 minutes differs from the SCDC Restraint Chair Report of 43 minutes).

November 2018 Implementation Panel Recommendations:
QIRM continue to prepare a Restraint Chair Report for each monitoring period.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings:
The IP continues to monitor SCDC Use of Force MINS Narratives monthly and 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 MH UOF Coordinator regularly meet to discuss Agency UOF issues. The IP Use of Force Reviewer and SCDC Operations Leadership also continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force. Lieber CI in February 2018 and November 2018 held Workshops to provide additional training and assistance to their staff regarding UOF. Similar specialized training for staff should be considered by other institutions experiencing UOF issues. Especially since as of September 30, 2018, over 96 percent of the Agency staff has not received the required annual in-service UOF training.

SCDC Use of Force MINS for June 2018 through September 2018:

June 2018	115
July 2018	125
August 2018	129
September 2018	136

The number of UOF incidents has increased each month since June 2018 to a high of 136 UOF incidents in September 2018. The May 2018 high of 156 UOF incidents was not surpassed in any of the four months.

SCDC had 43 UOF and 27 Physical Abuse Inmate Grievances submitted by inmates during the relevant months. The QIRM update indicated the majority of the grievances were returned to the inmate and only five (5) inmate UOF and Physical Abuse grievances were referred to Police Services for investigation. This is problematic.

SCDC Police Services provided data identifying nine Use of Force investigations opened during the relevant months. The number of Police Services UOF investigations is alarmingly low with a system that averages 100 plus UOF incidents per month and had 70 UOF/Physical Abuse Grievances for the relevant months. QIRM UOF Reviewers identified a possible 160 UOF Policy violations during the relevant months. This provides additional evidence the number of Police Services UOF investigations is low.

SCDC provides monthly documentation on the number of employees receiving formal corrective action for UOF violations. The Agency clarified there is a system to track employee discipline (See Update), albeit it does not currently track informal employee action for UOF violations. Discussions are underway to revise the system to capture the informal measures used to address UOF violations, i.e. verbal counseling, additional training.

SCDC continues to pilot the Canine Policy and Training prior to full implementation. There have been no UOF incidents involving canines reported to the responsible IP Member during the relevant period to assess if there are any issues or concerns.

SCDC is implementing strategies to address inappropriate and excessive use of force by employees. The IP is encouraged by the Agency's recent efforts. The low number of Police Services UOF investigations based on the number of QIRM identified UOF violations and high number of UOF/Physical Abuse inmate grievances returned without processing is concerning to the IP.

November 2018 Implementation Panel Recommendations:

1. Operations, the MH UOF Coordinator and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM, the MH UOF Coordinator and Operations leadership continue weekly 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 MH 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 and the Agency Grievance Coordinator continue to QI Inmate Grievances related to UOF and Physical Abuse;
6. QIRM QI incidents and grievances referred to Police Services related to UOF and Physical Abuse;
7. Police Services begin tracking the number of referrals received for UOF and Physical Abuse and document the reasons an investigation is not opened;
8. Remedy the high percentage of employees not receiving annual Use of Force Training; and
9. Require meaningful corrective action 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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings:
SCDC has made a concerted effort to address the misuse of MK9. For the relevant period MK9 non-compliance was:

% of time MK9 identified as not being used within SCDC guidelines: June 18 (64%), July 18(75%) and August 18 (60%);
% of time MK9 volumes exceeded SCDC guidelines: June 18 (73%), July 18 (50%), and August 18 (80%).

Additional improvement is needed. The majority of correctional staff have not received UOF training for the calendar year. Lack of training most likely contributes to employee MK9 use issues.

November 2018 Implementation Panel Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM Use of Force Reviewers continue to generate reports involving crowd control canisters including MK-9;
3. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. The IP Use of Force Reviewer and SCDC Operations Leadership continue jointly reviewing Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of crowd control canisters including MK-9;
6. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to qualify that MK-9 use will be consistent with manufacturer's instructions; and
7. Provide correctional staff additional training on the proper use of MK9.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings:
Per the update Section. SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates. Except for September 18 (88%) clinical counselors (QMHPs) were contacted less than fifty percent of the time prior to a planned UOF. It is inexcusable that institutional staff have failed to address the continued failure to notify a clinical counselor prior to a planned UOF. The average for four months was 42 percent.

November 2018 Implementation Panel Recommendations:
Remedy the above. As identified in previous reports, additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force is needed. Employees must be held accountable when the required assistance from QMHPs is not requested prior to a planned UOF incident involving mentally ill inmates. When operations employees notify mental health staff of a planned UOF, the mental health staff must complete a face to face interaction to assist or document reasons the interaction was not completed.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings:
The current SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates is an 11 hour program for new correctional officers. Permanent correctional officers receive 4 hours annual training concerning the appropriate methods of managing mentally ill inmates. A revised training program was rolled out in October 2018 and will be fully implemented in the Calendar Year 2019. The revised program will expand the annual training 2-2.5 hours for a total of 6-6.5 hours annually for permanent correctional officers. Per the SCDC Update, only 34.5 percent of the required employees have received annual training concerning the appropriate methods of managing mentally ill inmates thus far for the Calendar Year 2018.

November 2018 Implementation Panel Recommendations:

- Continue to document and track the number of required employees completing the mandatory training for appropriate methods of managing mentally ill inmates in the Calendar Year; and
- For each relevant period, report the progress being made with required employees attending the training.

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 November 2018 Assessment: compliance (March 2017)

November 2018 Implementation Panel findings:
SCDC continues to generate a monthly UOF Report Mentally Ill vs. Non-Mentally Ill. No issues were identified with the use of force data utilized to produce the report.

November 2018 Implementation Panel 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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings:
The MH UOF Coordinator has implemented procedures and is monitoring UOF incidents involving inmates with a mental health designation. The draft policy has been submitted and is awaiting approval. The IP Mental Health Experts have not reviewed the policies and procedures. A QI study was conducted and examined current placement (lock up, institution, program,) for inmates involved in 3 or more uses of force in a six month period. (December 2017-May 2018) Twenty nine inmates were involved in three or more uses of force between December 2017 and May 2018. BMU placement was recommended for 34 percent of the identified inmates.

November 2018 Implementation Panel Recommendations:
Once the policies and procedures are approved, responsible Behavioral Health staff should receive training on the policy. QIRM should perform QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation. The IP Mental Health Experts will need to review the policy before final approval. SCDC should continue monitoring inmates with a mental health designation identified as high risk for use of force and repeat the High Risk UOF Case Study for each relevant period. Responsible officials should diligently strive to place recommended RHU inmates in a BMU Program and track their status while awaiting placement.

3. 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 2018 Assessment: compliance (November 2018)

November 2018 Implementation Panel findings: As per status update section. Compliance is achieved in the context of QMHPs' ratios for GPH, CSU and ICS. Psychiatrists' ratios are short by about 10 FTEs. Also see IP findings under 2(a)(iv).

November 2018 Implementation Panel Recommendations: Begin to remedy the above via the annual budgetary request process.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section. It was unclear the causes of the partial compliance—staffing vacancies, scheduling issues, etc.?

November 2018 Implementation Panel Recommendations: Assess the causes of the partial compliance and devise a corrective course of action.

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 2018 Assessment: compliance (March 2018)

November 2018 Implementation Panel findings: It was not clear the percentage of staff not yet trained who had been working for at least 45 days.

November 2018 Implementation Panel Recommendations: Determine the answer to the above issue and implement appropriate correction actions.

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 November 2018 Assessment: compliance (December 2017)

November 2018 Implementation Panel findings: See 2.a.iv.

November 2018 Implementation Panel Recommendations: See 2.a.iv.

3.e Require appropriate credentialing of mental health counselors;

Implementation Panel November 2018 Assessment: compliance (March 2017)

November 2018 Implementation Panel findings: As per status update section Compliance continues.

November 2018 Implementation Panel Recommendations: Continue to monitor.

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

Implementation Panel November 2018 Assessment: compliance (July 2018)

November 2018 Implementation Panel findings: As per status update section. We will re-assess compliance during the next site visit with the assumption that this position will no longer be vacant.

November 2018 Implementation Panel Recommendations: Continue efforts to fill the Quality Improvement Manager for Behavioral Health vacancy.

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

Implementation Panel November2018 Assessment: compliance (July 2018)

November 2018 Implementation Panel findings: See 3.f.

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

Implementation Panel November 2018 Assessment: compliance (March 2017)

November 2018 Implementation Panel findings: Compliance continues.

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

Implementation Panel November 2018 Assessment: substantial compliance (July 2017)

November 2018 Implementation Panel findings: Compliance continues from the perspective of tracking such referrals. We will continue to monitor the outcome of such referrals (rates for acceptance, rejection, waiting lists).

November 2018 Implementation Panel Recommendations: Continue to keep data re: the above.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section

November 2018 Implementation Panel Recommendations: Develop the above referenced reporting processes.

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

Implementation Panel November 2018 Assessment: compliance (March 2017)

November 2018 Implementation Panel findings: As per SCDC update.

November 2018 Implementation Panel Recommendations: Operations and QIRM 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 November 2018 Assessment: compliance (March 2017)

November 2018 Implementation Panel findings: As per SCDC update.

November 2018 Implementation Panel 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 November 2018 Assessment: compliance (March 2017)

November 2018 Implementation Panel findings: As per status update section.

November 2018 Implementation Panel Recommendations: Continue to produce and disseminate 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

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 2018 Assessment: compliance (March 2017)

November 2018 Implementation Panel findings: As per status update section.

November 2018 Implementation Panel Recommendations: Continue to produce and disseminate quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution.

4.a.ix. Quality management documents; and

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section.

November 2018 Implementation Panel Recommendations: Implement the above referenced reports.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section

November 2018 Implementation Panel Recommendations: Implement the planned EHR improvements.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: See 4.a.iv.

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

November 2018 Implementation Panel findings: Staff reported that three institutions continue to have medications delivered under the cell door. Our opinion remains unchanged that this practice is below the standard of care.

November 2018 Implementation Panel Recommendations: Remedy the above.

5.a. Improve the quality of MAR documentation;

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section. eZmars continues to be a work in progress.

November 2018 Implementation Panel Recommendations: As per status update.

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

Implementation Panel November 2018 Assessment: noncompliance

November 2018 Implementation Panel findings: As per status update section. Our March 2018 findings included the following:

> Due to the very significant nursing vacancies and systemic deficiencies previously summarized that are not due to individual nursing staff, it is not reasonable to hold clinicians responsible for completing and monitoring MAR's under these conditions. It is reasonable to expect nursing staff to continually advocate for necessary staff, supplies and equipment.

Our opinion remains the same.

November 2018 Implementation Panel Recommendations: Remedy the nursing shortage.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As summarized in a previous section,

administration of medication under the door is not acceptable. Many morning and hs medication pill call lines are scheduled at unreasonable hours related to nursing staff shortages.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: See prior findings relevant to medication administration.

November 2018 Implementation Panel Recommendations: It is anticipated that the eZmar system will eventually facilitate an adequate QI process for reviewing the medication administration process.

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 November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: Compliance is present re: all CSU cells being located in a healthcare setting. Due to custody staffing shortages, it was common for QMHP clinical contacts to not occur in a setting with adequate confidentiality.

During the afternoon of November 13th, we observed a staffing of three inmates in the BRCI CSU. Similar to our past observation of such staffings, two of the inmates' precipitating factor for the admission appeared to be primarily a safety concern.

Our March and July 2018 findings included the following:

> It was very common that CSU patients had been admitted following a self-harming event or suicide attempt which was later assessed to have been directly related to safety and security concerns or other custodial issues. Interventions within the CSU frequently involved a "therapeutic transfer" that was often only a temporary solution as evidenced by subsequent repeat CSU admissions within the next six months. Such interventions turned out to be temporary solutions due to resource issues at the receiving institution that resulted in recommended interventions not being implemented.
>
> The CSU at BRCI has essentially been functioning as a clearing house for the entire system in the context of admitting many inmates who have security issues that were either not being adequately addressed or perceived by the inmates as not being adequately addressed. The CSU is hampered in adequately intervening for the following reasons:

1. The lack of a central office classification officer, who could implement appropriate interventions specific to safety concerns; and
2. Lack of timely access to specific treatment programs such as the LLBMU and the HLBMU due to waiting list issues.

November 2018 Implementation Panel Recommendations: The above issues have not yet been resolved. Please refer to our recommendations, summarized in the provision re: the "Denials Committee," for additional recommendations.

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

Implementation Panel November 2018 Assessment: compliance (December 2017)

November 2018 Implementation Panel findings: As per status update section

November 2018 Implementation Panel Recommendations: Continue to self- monitor.

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

Implementation Panel November 2018 Assessment: noncompliance

November 2018 Implementation Panel findings: As per status update section. We strongly disagree with the use of inmate observers outside of the CSU due to both supervision issues and current data as reported in the status update section.

Lee CI

Information provided prior to the site visit indicated 23 inmates had been placed on crisis intervention (CI) status and none were referred and transferred to the CSU at Broad River within 60 hours as required by policy. Staff informed the IP that none of these inmates had been placed on constant observation as required by policy. The staff reported that all 23 inmates received a Columbia Suicide Risk Assessment (SRA) prior to release from suicide precautions as per policy and all 23 were "low risk". The IP requested 10 of the 23 SRA's be provided and the IP and Dr. Salley Johnson, SCDC consultant, received only 6 of the 10 requested. Of the 6 reviewed, only 2 document submissions had a suicide risk screening form which was a daily suicide screening document, not the SRA required. The staff could not demonstrate or provide the requested SRA's and acknowledged they had not been done. This is a very serious and unacceptable practice. The IP recommends a system wide QI to assess whether this practice is occurring in other facilities, with corrective action plans.

Evans CI

Staff reported that the decision whether or not to place inmates on constant observation prior to being seen by a QMHP is generally being made by a registered nurse. We discussed with staff that inmates waiting to be seen by a QMHP following a referral for suicide risk should always be placed on constant observation. R.N.s generally do not have the credentials to perform an adequate suicide risk assessment.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section. Review of a November 2018 QIRM report indicated that this directive was not implemented at all prisons. For example, inmates in Unit F1 at Kirkland were not provided with a mattress because "inmates destroy them and use them as weapons." Similar issues were present at the Broad River RHU.

November 2018 Implementation Panel Recommendations: The default exclusion of mattresses at the above institutions should be changed so that the decision to not provide a mattress is based on factors specific to the individual in question.

6.e Increase access to showers for CI inmates;

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: noncompliance

November 2018 Implementation Panel findings: As per status update section. Access to confidential spaces continues to be problematic.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: See 2 b.vi.

November 2018 Implementation Panel Recommendations: See 2 b.vi.

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

Implementation Panel November 2018 Assessment: partial compliance

November 2018 Implementation Panel findings: As per status update section. We discussed with leadership staff the importance of involving nursing, custody and mental health staff in the QIRM process from the very beginning of the QI process for a variety of different reasons. Consultation with Dr. Johnson would also be very beneficial to the process.

November 2018 Implementation Panel Recommendations: As above.

Conclusions and Recommendations:

The Implementation Panel has provided its analysis, findings and recommendations in this report and on-site for this eighth site visit, which took place from November 12-16, 2018. Our recommendations have been consistent with those in previous reports for the great majority of the Settlement Agreement criteria. We have continued discussions with staff and inmates regarding the impact and sequelae of the major riot that occurred at Lee C.I. on April 15, 2018 which has impacted the whole system. The majority of facilities have had modifications or elimination of the statewide lockdown, however others have not. The Implementation Panel understands and appreciates the difficulties and complexities to totally ending the lockdown, which again is even more complicated because of the pre-existing and continuing staff deficiencies. The Implementation Panel re-iterated during the visit and in this report re-emphasizes that the IP does not endorse nor recommend SCDC engage in any practices that are unsafe for staff or inmates. However, the ongoing impact of these factors has been extremely problematic for the adequate delivery of mental health care and achieving substantial compliance with the Settlement Agreement. During the course of this visit the IP was requested to change the dates for the next site visit from March, 2019 to later next year, and to modify the IP document request to lessen the volume of documents. As stated earlier in this report, and clarified for staff on site, the third year of implementation of the Settlement Agreement ends on April 30, 2019. The IP is not able to change the March 4-8, 2019 site visit dates; however, based on discussions with SCDC leadership staff the IP has agreed to modify the document request on a trial basis for the March visit. The discussions included the process for specific criteria to "sunset," i.e. to no longer require IP review once the specific criterion has been in substantial compliance for a continuous 18 month period, unless there are significant changes relative to that criterion. We hope this process will be helpful, however strongly encouraged SCDC to continue their own internal monitoring to be able to demonstrate continuing compliance. We also understand SCDC is reformulating its process for data collection between QIRM and Mental Health and hope the anticipated changes will support consistent, valid and reliable information and analysis. The work done to date by QIRM has been very helpful to the IP and we look forward to even more improvement as the EHR becomes more functional for data mining and analysis.

As always, we hope this report has been informative and the technical assistance provided has been helpful. We appreciate the cooperation and assistance of all parties in the pursuit of these goals. The IP wishes a safe and happy holiday season to all, and we look forward to the next site visit in March, 2019.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

Emmitt Sparkman
Implementation Panel Member