STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

T.R., P.R., and K.W., on behalf of themselves and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc.,

Plaintiff(s)

vs.

State of South Carolina, South Carolina General Assembly, and South Carolina Department of Corrections,

Defendant(s)

2005-CP-40-02925

FILED
2005 JUN 20 AM 9:47
BARBARA A. SCOTT
C.C.C.P. & G.S.

(Please Print)
Submitted By: Daniel J. Westbrook
Address: Post Office Box 11070
Columbia, SC 29211

SC Bar #: 012939
Telephone #: (803) 799-2000
Fax #: (803) 256-7500
Other:
E-mail: dan.westbrook@nelsonmullins.com

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION *(Check all that apply)*

If Action is Judgment/Settlement do not complete

- [ ] **JURY TRIAL** demanded in complaint.
- [X] **NON-JURY TRIAL** demanded in complaint.
- [ ] This case is subject to **ARBITRATION** pursuant to the Circuit Court Alternative Dispute Resolution Rules.
- [ ] This case is subject to **MEDIATION** pursuant to the Circuit Court Alternative Dispute Resolution Rules
- [X] This case is exempt from ADR (certificate attached).

NATURE OF ACTION *(Check One Box Below)*

Contracts
- [ ] Construction (100)
- [ ] Debt Collection (110)
- [ ] Employment (120)
- [ ] General (130)
- [ ] Breach of Contract (140)
- [ ] Other (199)

Torts - Professional Malpractice
- [ ] Dental Malpractice (200)
- [ ] Legal Malpractice (210)
- [ ] Medical Malpractice (220)
- [ ] Other (299)

Torts – Personal Injury
- [ ] Assault/Slander/Libel (300)
- [ ] Conversion (310)
- [ ] Motor Vehicle Accident (320)
- [ ] Premises Liability (330)
- [ ] Products Liability (340)
- [ ] Personal Injury (350)
- [ ] Other (399)

Real Property
- [ ] Claim & Delivery (400)
- [ ] Condemnation (410)
- [ ] Foreclosure (420)
- [ ] Mechanic's Lien (430)
- [ ] Partition (440)
- [ ] Possession (450)
- [ ] Building Code Violation (460)
- [ ] Other (499)

Inmate Petitions
- [ ] PCR (500)
- [ ] Sexual Predator (510)
- [ ] Mandamus (520)
- [ ] Habeas Corpus (530)
- [ ] Other (599)

Judgments/Settlements
- [ ] Death Settlement (700)
- [ ] Foreign Judgment (710)
- [ ] Magistrate's Judgment (720)
- [ ] Minor Settlement (730)
- [ ] Transcript Judgment (740)
- [ ] Lis Pendens (750)**
- [ ] Other (799)

Administrative Law/Relief
- [ ] Reinstate Driver's License (800)
- [ ] Judicial Review (810)
- [ ] Relief (820)
- [ ] Permanent Injunction (830)
- [ ] Forfeiture (840)
- [ ] Other (899)

Appeals
- [ ] Arbitration (900)
- [ ] Magistrate-Civil (910)
- [ ] Magistrate-Criminal (920)
- [ ] Municipal (930)
- [ ] Probate Court (940)
- [ ] SCDOT (950)
- [ ] Worker's Comp (960)
- [ ] Zoning Board (970)
- [ ] Administrative Law Judge (980)
- [ ] Public Service Commission (990)
- [ ] Employment Security Comm (991)
- [ ] Other (999)

Special/Complex /Other
- [ ] Environmental (600)
- [ ] Automobile Arb. (610)
- [ ] Medical (620)
- [ ] Pharmaceuticals (630)
- [ ] Unfair Trade Practices (640)
- [X] Other (699)

class action for declaratory and injunctive relief

Submitting Party Signature: _____ **Date:** June 20, 2005

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

*FOR MANDATED ADR COUNTIES ONLY

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

The parties shall select a neutral within 210 days of filing of this action, and the Plaintiff shall file a "Stipulation of Neutral Selection" on or before the 224th day after the filing of the action. If the parties cannot agree upon the selection of the neutral within 210 days, the Plaintiff shall notify the Court by filing a written "Request for the Appointment of a Neutral" on or before the 224th day after the filing of this action. The Court shall then appoint a neutral from the Court-approved mediator/arbitrator list.

The initial ADR conference must be held within 300 days after the filing of the action.

Case are exempt from ADR only upon the following grounds:

Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;

Cases which are appellate in nature such as appeals or writs of certiorari;

Post Conviction relief matters;

Contempt of Court proceedings;

Forfeiture proceedings brought by the State;

Cases involving mortgage foreclosures; and

Cases that have been submitted to mediation with a certified mediator prior to the filing of this action.

Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference had been concluded.

Please Note: **You must comply with the Supreme Court Rules regarding ADR. Failure to do so may affect your case or may result in sanctions.**

* Florence, Horry, Lexington, Richland, Greenville, and Anderson

STATE OF SOUTH CAROLINA	)	IN THE FIFTH JUDICIAL CIRCUIT
	)	
COUNTY OF RICHLAND	)	CIVIL ACTION NO. _____
T.R., P.R., and K.W., on behalf of themselves and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc.,	)	
Plaintiffs,	)	
v.	)	**SUMMONS**
STATE OF SOUTH CAROLINA, SOUTH CAROLINA GENERAL ASSEMBLY, and SOUTH CAROLINA DEPARTMENT OF CORRECTIONS,	)	
Defendants.	)	

TO: THE DEFENDANT SOUTH CAROLINA GENERAL ASSEMBLY:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is hereby served upon you, and to serve a copy of your Answer to the said Complaint upon the subscribers at 1320 Main Street, Post Office Box 11070, Columbia, South Carolina, 29211 within thirty (30) days after service hereof, exclusive of the day of such service, and if you fail to answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in said Complaint.

NELSON MULLINS RILEY & SCARBOROUGH, LLP

Stuart M. Andrews, Jr.
Jeffrey S. Patterson
Daniel J. Westbrook
1320 Main Street - 17th Floor (29201)
P.O. Box 11070
Columbia, SC 29211
(803) 799-2000

Attorneys for Plaintiffs

Columbia, South Carolina
June 20, 2005

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COUNTY OF RICHLAND	)	CIVIL ACTION NO. _____
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TO: THE DEFENDANT STATE OF SOUTH CAROLINA:

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Plaintiffs,	)	
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TO: THE DEFENDANT SOUTH CAROLINA DEPARTMENT OF CORRECTIONS:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is hereby served upon you, and to serve a copy of your Answer to the said Complaint upon the subscribers at 1320 Main Street, Post Office Box 11070, Columbia, South Carolina, 29211 within thirty (30) days after service hereof, exclusive of the day of such service, and if you fail to answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in said Complaint.

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T.R., P.R., and K.W., on behalf of themselves and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc.,	)	
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STATE OF SOUTH CAROLINA, SOUTH CAROLINA GENERAL ASSEMBLY, and SOUTH CAROLINA DEPARTMENT OF CORRECTIONS,	)	
Defendants.	)	

Plaintiffs allege as follows:

INTRODUCTION

1. Over the course of many years and through different administrations, the Defendants have failed to provide reasonably adequate medical treatment to inmates suffering from serious mental illness in the custody of the South Carolina Department of Corrections ("SCDC" or the "Department"). This class action seeks declaratory and injunctive relief on behalf of such inmates. For years the Defendants have known their system of providing medical treatment for mentally ill inmates was in a state of crisis, a state exacerbated in recent years by inadequate funding for the Department. Despite this knowledge, the Defendants have failed to take adequate steps to remedy the situation. Instead, the Defendants have knowingly maintained a system of medical care that fails to provide reasonably adequate medical treatment for mentally ill inmates, in violation of Article 12, § 2 of the South Carolina

Constitution. The Defendants' deliberate indifference to the mental health needs of inmates has resulted and continues to result in the infliction of cruel and unusual punishment and the needless infliction of pain and suffering, in violation of Article 1, § 15 of the South Carolina Constitution.

JURISDICTION

2. The adequacy of medical treatment of inmates under the custody of the State of South Carolina, including treatment for mental health care, is a condition subject to judicial scrutiny under the Constitution of South Carolina.

3. This Court has jurisdiction to grant declaratory and injunctive relief pursuant to the South Carolina Uniform Declaratory Judgment Act, S.C. Code Ann. § 15-53-10, *et seq.*, by ordering Defendants to provide reasonably adequate mental health care to persons incarcerated in the South Carolina Department of Corrections who suffer from mental illness.

VENUE

4. Venue is properly set before this Court because many of the acts and omissions giving rise to Plaintiffs' claims occurred in Richland County.

PARTIES

Representative Plaintiffs

5. The representative plaintiffs are inmates who suffer from serious mental illness and who are confined in facilities maintained and operated by the Defendants. Due to the highly private and personal nature of the facts surrounding their claims and in order to protect their dignity and privacy, the representative plaintiffs will be identified in this Complaint only by initials.

6. T.R. suffers from paranoid schizophrenia. He has a history of bizarre behavior, including drinking his own urine. His illogical thought processes make it difficult for him to converse in a meaningful way. Like most persons with schizophrenia, he suffers from hallucinations and delusions. For example, he believes that at night, while he is sleeping, doctors come into his cell and perform surgery on him. He complains of loud, banging noises from the adjacent cell, even when it is empty. In 1993, an SCDC mental health administrator concluded that the only SCDC facility capable of providing T.R. the level of care he needed was Gilliam Psychiatric Hospital. Instead of being placed in Gilliam, however, T.R. has lived for the last seven years – and for most of the seven years before that – in an SCDC lock-up unit, even though his last disciplinary conviction occurred over twelve years ago. During most of this fourteen-year period, T.R. has been isolated in a small cell 23-24 hours a day. His clothes, blanket, sheets, and mattress are often filthy. Although he is scheduled to receive injections of an antipsychotic medication every three-four weeks, these often are administered several weeks late and, on one occasion, nine weeks late. T.R. sees a mental health counselor approximately once a month, but takes part in no structured therapeutic activities.

7. P.R. suffers from schizophrenia, anxiety disorder, and is mentally retarded. Upon her incarceration at SCDC, she was scheduled to be transferred to an inpatient psychiatric facility, but was not seen by a psychiatrist for over a month and not admitted into such a facility until nearly seven months had passed, due to lack of beds. When she was discharged from the inpatient facility SCDC failed to forward her medication to her new facility. After being without her medication for two days, P.R. set herself on fire with a cigarette lighter, hallucinating that voices ordered her to do so. During one twelve-month period, P.R. was placed in "crisis intervention" on ten separate occasions, where she remained

in solitary confinement 23-24 hours a day in a small stripped-down cell, without a mattress, and with only a paper gown to wear. During the entire twelve-month period, it is uncertain how many days P.R. actually spent in crisis intervention, due to SCDC's inadequate record-keeping. It is clear, however, that she spent at least 37 days in crisis intervention during these twelve months and saw a psychiatrist only twice. Later, during a stretch of over eight months, P.R. was placed in crisis intervention on six separate occasions. During that entire eight-month period she was never seen by a psychiatrist.

8. K.W. is a small, twenty-six year old inmate with a diagnosis of psychosis NOS (not otherwise specified). His arms bear the scars of his persistent self-mutilation. He explains in a quiet voice that self mutilation "runs in the family," as his mother "cut her throat and slashed her wrists." K.W. has been in SCDC custody since 1997, most of that time in lock-up. One day in 2003 K.W. cut both of his arms with a razor. He was taken to the emergency room of a nearby hospital. Less than three hours after he cut himself, he was returned to his SCDC lock-up unit, stripped naked, and placed in a cell from which everything not fixed down had been removed - blanket, sheets, mattress, everything. Within an hour, he had re-opened his wounds. After receiving further treatment for his cuts, correctional officers immobilized him in a restraint chair, where he remained for nearly twelve hours. K.W. then was given a shower, before being returned to the restraint chair for approximately four more hours. Nearly sixteen hours after being originally placed in the restraint chair, K.W. was released, naked, to his cell, with nothing but a suicide blanket. The next day K.W. cut himself again, on two separate occasions. At no time during this period was K.W. referred to a psychiatrist. In fact, eight months passed before he saw a psychiatrist,

and then only because his behavior became so unstable he was transferred to Gilliam Psychiatric Hospital.

Plaintiff Protection and Advocacy for People with Disabilities, Inc.

9. Plaintiff Protection and Advocacy for People with Disabilities, Inc., ("P&A") is a private, not for profit South Carolina corporation established as the protection and advocacy system for the State of South Carolina and charged by state and federal law to protect and advocate for the rights of people with disabilities in South Carolina.

Defendants

10. The State of South Carolina has established and operates numerous penal institutions for persons convicted of crimes.

11. The South Carolina General Assembly is the legislative branch of the State government. The General Assembly controls funding for SCDC and is specifically charged with providing for the health and welfare of inmates in SCDC institutions.

12. SCDC is an agency of the State of South Carolina that is charged with administering State penal institutions.

CLASS ACTION ALLEGATIONS

13. The named plaintiffs bring this action on behalf of themselves and all others who are similarly situated, pursuant to Rule 23 of the South Carolina Rules of Civil Procedure.

14. The class consists of all individuals who currently are or who will in the future be confined in institutions or facilities maintained and operated by SCDC, and who suffer from serious mental illness, as defined below. The class is so numerous that joinder of all members is impracticable.

15. "Serious mental illness" means a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. It involves a serious, severe mental state or condition that (1) is manifested by substantial discomfort, pain, and/or disability that cannot be legitimately ignored by appropriate clinical staff; (2) requires a mental health assessment, diagnostic evaluation, treatment planning and disposition planning; and (3) is generally associated with (a) the inability to attend to and effectively perform the usual or necessary activities of daily living; (b) an extreme impairment of coping skills, rendering the patient exceptionally vulnerable to unintentional or intentional victimization and possible mismanagement; or (c) behaviors that are bizarre and/or dangerous to self or others. Serious mental illness includes psychiatric conditions and states that span the entire diagnostic spectrum and is not limited to specific diagnoses.

16. There are questions of law and fact that are common to the class. These questions include the nature and constitutionality of the conditions, practices, and policies affecting the mentally ill inmates in the custody of SCDC.

17. The conditions, practices, and policies challenged in this action apply in substantially the same manner to the named plaintiffs and all members of the class so that the claims of the named plaintiffs are typical of those of the class.

18. The named plaintiffs will fairly and adequately represent the interests of the class. They possess a personal interest in the subject matter of this suit. They are represented by counsel who are experienced in class action and prisoner rights litigation.

19. Defendants have acted and refused to act on grounds generally applicable to the class, thereby making appropriate final declaratory and injunctive relief with respect to the class as a whole.

BACKGROUND ALLEGATIONS

I. Overview of the SCDC Mental Health System

20. SCDC has become a repository for a significant number of South Carolina's mentally ill citizens. As of August 24, 2004, 2,146 SCDC inmates had been diagnosed by the Department as mentally ill. However, studies conducted to determine the prevalence of mental disorders among prison inmates in the United States have found that between eight and nineteen percent of a total prison population have significant psychiatric or functional disabilities. See Metzner, Guidelines for Psychiatric Services in Prisons, Criminal Behavior and Mental Health 3, 252-267 (Winter 1993). Thus, given SCDC's population of approximately 24,000 inmates, over 4,500 inmates in SCDC custody may suffer from serious mental illness.

21. In 2004, SCDC released over 9,500 inmates back into society. Given the studies referenced above, it is reasonable to conclude that between 750 - 1,800 of these inmates may suffer from significant psychiatric or functional disabilities.

22. From 2002-2003, SCDC's overall inmate population increased 5%, one of the highest percentage increases among sixteen Southern states surveyed in a Southern Legislative Conference (SLC) report.

23. SCDC's prison population is projected to increase 32% between 2003-2008. During that same period the projected percentage increase in the Southeast is only 19.6%.

24. From fiscal year 1998-1999 to fiscal year 2003-2004, South Carolina decreased its operating budgets by 4.71%, the only state among the sixteen surveyed by the SLC to decrease its budgets.

25. In 2004 South Carolina spent less money per inmate than any other state in the nation, and 23% less than South Carolina itself spent per inmate in 2001.

26. Studies show that the prevalence of schizophrenia and other psychotic disorders is 3-5 times greater in prison populations than in the general population of the United States.

27. Persons suffering from mental illness are vulnerable under the best of circumstances. In a prison setting, however, inmates with mental illness are particularly vulnerable to physical, sexual, mental, and emotional abuse.

II. The Three Reports

28. For years the Defendants have been aware that the SCDC mental health care system is in a state of crisis, necessitating immediate efforts to remedy a systemic failure to provide adequate medical services to inmates suffering from mental illness. In 1999, at SCDC's request, Raymond F. Patterson, M.D., a nationally prominent psychiatrist and expert on mental health services for prisoners, conducted an investigation of SCDC's mental health care system. Funded by the Prisons Division of the National Institute of Corrections, Dr. Patterson provided an on-site assessment of the SCDC mental health care system and, in 2000, issued to SCDC a technical assistance report. See National Institute of Corrections Technical Assistance Report, TA # 00P1052 ("Patterson Report"), attached as Exhibit A and incorporated by reference herein.

29. Dr. Patterson's technical assistance activities included reviewing policies and procedures in effect throughout the SCDC mental health system, as well as meeting with key participants and stakeholders in the system. Id. Following his observation, analysis, and assessment, Dr. Patterson concluded that **"the system is currently in crisis and immediate efforts to rectify the inadequate resource provision to the mental health system must be undertaken."** See Patterson Report at 2 (Exhibit A) (emphasis added).

30. The Patterson Report set forth five general considerations and actions required "to establish and maintain an adequate mental health system" at SCDC. Id. Included among the actions Dr. Patterson deemed necessary were the further development of policies and procedures, the provision of adequate staffing of mental health professionals, and the development and provision of programmatic activities. The Defendants have substantially failed to implement the recommendations set forth in the Patterson Report.

31. As a result of the findings set forth in the Patterson Report, the South Carolina General Assembly convened a Joint Legislative Proviso Committee ("Legislative Committee") for the purpose of investigating and reporting on the state of mental health care for prison inmates in South Carolina. The Legislative Committee published its report in October 2000. The Legislative Committee Report is attached as Exhibit B and incorporated by reference herein.

32. The Legislative Committee Report noted numerous and substantial deficiencies in the provision of mental health care services and resources provided to inmates in the SCDC system. To address and remedy these deficiencies, the Legislative Committee Report made a series of recommendations, divided into immediate, short-term, and long-term action items.

33. The Legislative Committee concluded in October 2000 that **"steps must be taken immediately to address the current crisis."** Legislative Committee Report at 6 (Exhibit B) (emphasis added). Among the Committee's observations and recommendations for immediate action were the following:

a) SCDC should "immediately" hire specialized staff to address shortages in all professional positions, "from social workers and nurses to psychologists and psychiatrists."

b) Special attention should be given to the needs of female inmates with mental illness, given that more than 40 percent of the female inmates at SCDC have some form of mental illness and are "particularly vulnerable to sexual and physical abuse." A more suitable facility is needed "to alleviate the current staff of overcrowding and lack of adequate services and security." The Report expressed serious concern that SCDC had only four acute female beds - not enough "to adequately treat this population."

c) Conditions at Gilliam Psychiatric Hospital, SCDC's inpatient mental health facility for male inmates, "are essentially deplorable." Gilliam's "critical staff shortages make it difficult to adequately observe and treat patients."

d) Newer and more effective medications should be added to existing formularies. Medications needed to treat potentially "life-threatening" side effects are unavailable due to lack of funds.

e) SCDC should develop a "unified mental health services delivery system that coordinates all behavioral health services," including the aggressive treatment of inmate addictions.

See Legislative Committee Report at 6-10 (Exhibit B).

34. Evidence of the continued deterioration of the Department's mental health system was provided in May 2003, when the South Carolina Department of Mental Health ("DMH"), at the request of SCDC, concluded a study of the mental health care system in place at SCDC. Diane Cavenaugh, the DMH program manager assigned to conduct the study, set forth her observations and conclusions in a memorandum report dated May 23,

2003. A copy of this report is attached as Exhibit C and incorporated by reference herein ("DMH Report").

35. The DMH Report, which was submitted to SCDC, confirmed that the crisis identified by Dr. Patterson and the Legislative Committee in 2000 had not abated. Included among the DMH findings were the following:

a. Psychiatric and psychiatric nursing services are in disarray due to the shortage of psychiatrists and lack of psychiatric oversight of prescription, administration and monitoring of psychotropic medications. The lack of psychiatric coverage has resulted in a critical situation, with extremes of poor care, inhumane treatment and dangerousness for staff and inmates. (Exhibit C at 1-2).

b. Medication has been abruptly discontinued by medical staff without approval of psychiatrists or other clinical staff, a breach of SCDC policy. This practice is clinically counterproductive and medically contraindicated. (Id. at 3).

c. Medications that best treat some intractable illnesses are not available or must be approved by a committee; staff's perceptions are that physician requests for medication, even with considerable justification, are more often denied than approved. The shortage of psychiatrists prevents the follow-up care that is necessary with these medications, resulting in inmates having serious side effects with no treatment. (Id. at 4).

d. Almost all mental health programs are understaffed, resulting in inadequate care for inmates. Approximately 50% of the mental health positions on the organizational charts are vacant. (Id. at 3).

e. The current programming at Gilliam Psychiatric Hospital and at the Intermediate Care Services sites do not meet the needs of mentally ill inmates. (Id. at 5).

f. Numerous mentally ill inmates with severe behavioral problems have been placed in lock-up and receive little or no mental health treatment. (Id. at 5).

g. The level of care is more dependent upon the number of mental health staff at a given facility than on inmates' needs. (Id. at 6).

h. There is a general sense of "catch as catch can" to the provision of mental health services: groups are often delayed or cancelled; one-to-one contacts are very brief and focus on inmates' day-to-day living requests; the caseloads are too high for most staff, so there is inadequate contact with all inmates; and structured programming is minimal. (Id. at 7).

i. There is no formal Quality Assurance/Improvement Program that evaluates the effectiveness of clinical care. (Id. at 8).

36. The DMH Report set forth a number of detailed recommendations for improving the SCDC mental health care system, which the Defendants have substantially failed to implement.

37. By virtue of the Patterson Report, the Legislative Committee Report, the DMH Report, and other sources of information, the Defendants are charged with both actual and constructive knowledge of the severe deficiencies existing in the SCDC's mental health services program that pose a daily threat to the health and well being of mentally ill persons in the custody of the Department. Despite this knowledge, the Defendants have failed to take any meaningful steps to rectify the crisis identified by Dr. Patterson five years ago.

III. Access to Mental Health Services

38. According to a November 2004 study by the University of South Carolina ("USC"), twenty of SCDC's twenty-nine facilities are currently accredited by the American Correctional Association ("ACA"). As the accreditations for these facilities expire, however, SCDC has not been seeking to re-accredit them. The USC study concludes that it is "unlikely" that any SCDC health services "currently meet ACA accreditation requirements." The USC study further concludes that, relative to other states, SCDC's health services are "significantly underfunded."

39. Under standards recommended by the American Psychiatric Association, SCDC should have a minimum of 14.3 FTE psychiatrists to treat its population of over 23,000 inmates. Instead, SCDC has fewer than 3 FTE psychiatrists. As a direct result of the shortage of psychiatrists, many inmates who are mentally ill see a psychiatrist infrequently, seldom receive needed psychiatric therapy, and are prescribed mental health medications by general physicians, rather than psychiatrists. The system-wide shortage of psychiatrists has resulted and continues to result in delays in diagnosis and treatment of mental illness. The shortage of psychiatrists also prevents SCDC from appropriately managing necessary medications for mentally ill inmates and from adequately monitoring the patient's response to the medications, including oftentimes serious side effects resulting from psychotropic medications.

40. SCDC also is grossly understaffed in psychologists, mental health counselors, nurses, and other clinical staff, as well as administrative support for clinical staff. As of 2003, approximately 50 percent of the mental health staff positions on the SCDC organizational chart were vacant. For over two years, the position of Division Director of Mental Health Services at SCDC has been vacant. As a result of staff shortages in other areas, clinical staff must spend time performing non-clinical duties, reducing the time available for the delivery of treatment. Moreover, mental health staff are required to evaluate and provide crisis services to all SCDC inmates, not just those diagnosed as mentally ill.

41. SCDC staff shortages have had and continue to have a significant adverse effect on SCDC's ability to provide and administer both treatment plans and treatment programs designed for mentally ill patients, including programs for suicide prevention, substance abuse, quality assurance, and discharge planning.

42. Staff shortages result in missed medication dosages and the failure to provide adequate rehabilitation and therapeutic services.

43. Staff shortages prevent SCDC from maintaining accurate and reliable records on mentally ill inmates.

44. SCDC is not only understaffed, its counselors are undertrained. In 2000 the South Carolina Legislative Audit Council concluded SCDC's counseling staff "did not meet minimum qualifications for their positions."

45. SCDC fails to provide adequate screening and evaluation of mentally ill inmates. When inmates are initially placed in SCDC custody, there is often a significant delay before they receive an initial mental health assessment.

46. As of July 2003, 20 percent of SCDC's correctional officer ("CO") positions were unfilled – the highest vacancy rate among sixteen Southern states surveyed by the Southern Legislative Conference. The American Correctional Association recommends that prison systems operate with no more than a ten percent vacancy rate for COs. The shortage of COs results in an inmate-to-CO ratio in South Carolina of 9.4, well above the 5.8 national average.

47. COs are not only underpaid and understaffed, they are also undertrained in the management of mentally ill inmates. SCDC provides grossly insufficient training to COs with respect to the nature, symptoms, manifestation, and treatment of mental illness. COs also receive grossly insufficient training with respect to addressing and managing aggressive or unusual behavior by inmates resulting from mental illness.

48. As a result of their lack of proper training, COs often misinterpret the behavior of mentally ill inmates as malingering or as willful misconduct and punish such

inmates with unnecessary and inappropriate physical force, sometimes in violation of SCDC policies and State regulations and often without adequate input or supervision by mental health professionals.

49. COs use tear gas and pepper spray disproportionately more often on mentally ill inmates than on other inmates.

50. Due to their lack of training, some COs exacerbate the condition of mentally ill inmates by taunting, disparaging, or taking advantage of them.

51. The actions by COs described in paragraphs 41-43 contribute to inmate aggression, exposing the mentally ill inmates, other inmates, and staff to unnecessary risks and increasing the degree of disruption within the facility.

52. Due to the lack of trained COs, clinical staff are often required to take on non-clinical duties, allowing them less time to provide clinical services for mentally ill inmates.

53. SCDC does not have sufficient physical facilities or services to provide for acute psychiatric illnesses.

54. As noted in the 2000 Legislative Committee Report, conditions at Gilliam Psychiatric Hospital, the acute facility for men, are "essentially deplorable." Exh. B at 8.

55. Even though over 350 of SCDC's women inmates are diagnosed as mentally ill, SCDC has no acute inpatient psychiatric hospital for women. Instead, SCDC contracts with a facility called Just Care for the use of four or fewer beds, which is insufficient to meet the needs of female inmates suffering from mental illness.

56. Because of the insufficient space and services, inmates in lock-up who are transferred to one of SCDC's acute facilities do not receive long-term psychiatric care. Instead, SCDC generally reassigns such patients to lock-up units after discharge from Gilliam or Just Care. Once returned to lock-up, these inmates are not provided reasonably adequate medial treatment.

IV. SCDC's Disciplinary Process and Lock-up Conditions

57. Although SCDC's Intermediate Care Services ("ICS") program is designed for inmates who suffer from chronic and serious mental illness, many such inmates are not eligible for ICS because of disciplinary infractions attributable to their illness.

58. Because the Defendants fail to provide adequate mental health treatment, many mentally ill inmates find it difficult to comply with institutional rules and regulations. Inmates charged with breaking prison rules typically receive a hearing before hearing officers employed by SCDC. Hearing officers sometimes fail to acknowledge the role that mental illness has played in the conduct at issue or take the mental health status of the inmate into account in determining either guilt or the appropriate sanctions.

59. As a result of SCDC's disciplinary practices and procedures, mentally ill inmates are often punished for displaying symptoms of their disorders. Such punishment includes being placed in administratively segregated, non-clinical "lock-up" units.

60. The conditions of SCDC's lock-up units exacerbate the mental illnesses of inmates sentenced to administrative segregation. As a result, such inmates find it even more difficult to comply with prison rules, leading to further disciplinary sanctions, including additional time in lock-up, and a resultant further deterioration of the inmates' mental condition.

61. The accrual of disciplinary sanctions often delays the parole eligibility dates of mentally ill inmates, causing them to spend proportionately more time in prison than inmates who do not suffer from mental illness.

62. Inmates in SCDC lock-up units are confined in solitary cells for 23-24 hours a day. Contact with other human beings is minimal. Lock-up inmates are not allowed to work at normal prison jobs, and are rarely allowed to attend rehabilitative or vocational programs or activities. Lock-up inmates have extremely limited library access and eat all meals alone in their cell. Lock-up units are noisy, foul-smelling, and unsanitary. Mentally ill inmates often remain in lock-up for weeks, months, and even years. They rarely engage in structured therapeutic activities and receive grossly inadequate psychiatric therapy

63. Cells on lock-up units are small, with solid walls and doors. A typical cell holds a concrete slab bed, a mattress, sink, and toilet. Inmates are allowed showers three times per week, though shower privileges are often revoked by COs. "Recreation" consists of being allowed to visit for one hour per day a "dog run" - an enclosed yard area approximately the same size as a cell. Dog runs contain no equipment, so that inmates can do little more for recreation other than pace. Due to their mental disorders, some inmates rarely or never leave their cells.

64. Sanitation and hygiene in some SCDC lock-up units are deplorable. At times the stench of urine and feces is pervasive. When sinks fail to work properly, some inmates drink from toilets. Often cells are not properly cleaned. Some inmates have reported to a lock-up cell to find it covered with the blood, urine, or feces of its previous inhabitant.

65. Inmates placed in lock-up often do not receive a mental health screening until 30 days after placement. Thereafter, mental health screenings are often conducted no

more than every 90 days. Counseling sessions for inmates in lock-up are infrequent, brief, impersonal, and non-therapeutic. Lock-up units at SCDC contain no enhanced clinical features for mentally ill inmates and such inmates rarely have access to any structured therapeutic activities.

66. Inmates in lock-up units who exhibit suicidal or self-destructive behavior are not always given immediate clinical attention, as required by SCDC policy, but instead may be beaten, gassed, and placed in restraint chairs for extended periods of time.

67. Inmates who decompensate mentally or who pose a risk of physical harm to themselves or others are sometimes placed by SCDC in a form of lock-up called "crisis intervention," often without any medical input into the decision.

68. Inmates in crisis intervention are placed in non-clinical lock-up units with a paper gown, a suicide blanket, or nothing, sometimes for a week or longer.

69. Inmates on crisis intervention often receive little or no consultation or therapy from psychiatrists during this time.

70. SCDC does not have adequate treatment space or staff to adequately monitor or evaluate mentally ill inmates on lock-up units.

71. Typically, the only treatment SCDC provides to mentally ill inmates in lock-up is medication, and medication is often delayed, not provided, or provided on an irregular basis.

72. When mental health staff do speak with prisoners in lock-up, it is frequently done within earshot of other prisoners and staff. Many prisoners refuse to speak with mental health staff under these conditions because they fear harassment and victimization. In many cases, these cell-door mental health consultations cause more harm than good; because

of the complete lack of confidentiality, a prisoner may minimize the description of his or her symptoms.

73. In some lock-up units the acoustics make it difficult to hear and impossible to communicate in any therapeutically effective manner. The noise of the unit contributes to inmates' considerable stress levels and exacerbates the condition of mentally ill inmates.

74. The restrictive settings, social isolation, sensory deprivation, and general conditions of the SCDC lock-up units are clinically inappropriate. Confinement in the lock-up units exacerbates the condition of inmates already suffering from mental illness and causes psychological harm to those who previously had not suffered from mental illness.

V. Inadequate Provision and Administration of Medications

75. Prescribed medications are an extremely important part of a clinically effective treatment program for many persons suffering from mental illness. Unfortunately, certain medications can cause serious, painful, and potentially fatal side effects. Great strides have been made in recent years, however, particularly in the development of new anti-psychotic medications more effective in treating psychosis, yet with less severe side effects.

76. Medications that SCDC ordinarily provides to inmates in its custody are listed in the SCDC formulary (the "Formulary"). Despite their proven effectiveness and reduced side effects, some of the newer, more effective mental illness medications are not listed in the Formulary and, therefore, are seldom available for SCDC inmates.

77. Inmates with mental illness who have a proven history of successful treatment with non-Formulary medications are often denied access to these medications, even

when access is requested by the inmate's physician and/or even when the inmate has private means to purchase the medication.

78. From time to time SCDC removes medications from the Formulary, usually for non-clinical reasons. Due to clinical staff shortages, inmates often are unable to see a psychiatrist before a prescribed medication is removed from the Formulary. Moreover, such inmates may not see a psychiatrist until weeks or months after the prescribed medication is removed from the Formulary. As a result, once an inmate's medication is removed from the Formulary, he or she may not receive any medications for a period of time or may receive one that either fails to treat his condition effectively or causes adverse side effects. Moreover, the decision to discontinue an inmate's medication is sometimes not conveyed to other clinical staff. The lack of continuity in medications is a serious impediment to the effective treatment of mentally ill inmates at SCDC.

79. At times, SCDC staff has discontinued prescribed medications for mentally ill inmates, without the consultation or approval of any psychiatrist, which is clinically inappropriate and violates SCDC policy.

80. Due to the adverse side effects caused by many antipsychotic medications, and due to the lack of insight and delusional thinking of many psychotic persons, mentally ill patients often are non-compliant in taking prescribed medications. The Defendants have failed to adequately monitor the administration of medications to ensure that mentally ill inmates are correctly taking their prescribed medications and that the medications are having their intended effect. Because of the lack of an adequate quality assurance program, as well as insufficient staffing, the problems that mentally ill inmates experience in taking medications frequently go undetected and uncorrected.

81. The failure to adequately supervise the administration of medications for mentally ill inmates has led to numerous instances of "pill hoarding", whereby inmates do not ingest a prescribed medication but secretly retain it, increasing the potential for abuse and suicide.

COUNT I

Violation of South Carolina Constitution Article 12, § 2

82. Article 12, Section 2 of the South Carolina Constitution requires the Defendants to provide for the health and welfare of all inmates confined in SCDC penal institutions created by the General Assembly. As set forth above, the Defendants have knowingly maintained a system of medical care that fails to provide reasonably adequate medical treatment for mentally ill inmates, entitling the Plaintiffs to declaratory and injunctive relief.

COUNT II

Violation of South Carolina Constitution Article 1, § 15

83. Article 1, Section 15 of the South Carolina Constitution prohibits the State from inflicting cruel and unusual punishment upon inmates. The Defendants' failure to provide reasonably adequate medical treatment to mentally ill inmates under the circumstances set forth above evidences a deliberate indifference to the mental health needs of inmates and a needless infliction of pain and suffering, constituting cruel and unusual punishment for which the Plaintiffs are entitled to declaratory and injunctive relief.

WHEREFORE, Plaintiffs pray that this Court enter an order declaring the Defendants to be in violation of the representative Plaintiffs' rights under the South Carolina Constitution, requiring the Defendants to design, maintain, fund, and provide resources for a

reasonable and adequate system for the mental health care of inmates suffering from mental illness, and entering all other relief the Court deems appropriate.

Respectfully submitted,

NELSON MULLINS RILEY & SCARBOROUGH, LLP

Stuart M. Andrews, Jr.
Jeffrey S. Patterson
Daniel J. Westbrook
1320 Main Street – 17th Floor (29201)
P.O. Box 11070
Columbia, SC 29211
(803) 799-2000

Attorneys for Plaintiffs

Columbia, South Carolina

June 20, 2005

Richland Common Pleas

Clerk : Barbara A. Scott
Richland County Judicial Center
Columbia, SC 29201
(803) 576-1999

DUPLICATE

Received From: Nelson,

Date : 6/20/2005
RECEIPT # 4560
Clerk: COCMETTS

Paying for: T R,

Transaction Type: Clerk Civil Pmt
Payment Type: Check $150.00

Reference # 483029
Comment:

Total Paid $150.00

Case #	Caption	Previous Balance	Amount Paid	Balance Due	S/T
2005CP4002925	T R vs State Of South Carolina	**$150.00**	**$150.00**	**$0.00**	699
Total Cases:	**1**	**$150.00**	**$150.00**	**$0.00**	

EXHIBIT A

Joint Legislative Proviso Committee Report On Mental Health Care For Prison Inmates In South Carolina

October 2000

Executive Summary

The South Carolina Department of Corrections (SCDC) is dedicated to long-term public safety and in that capacity incarcerates persons sentenced to prison by South Carolina judges. While its primary duty is to protect the public, which includes innocent victims of crime, the SCDC must simultaneously provide basic care for the inmates in its institutions, including mental health services for those inmates with mental illnesses.

A recent review of the mental health services system at SCDC found the system to be in a state of "crisis," according to a consultant retained by the department to review its mental health services. It is apparent that immediate funding is needed to provide staff and services to the more than 2,200 inmates with mental illnesses in the SCDC prison system. Providing the necessary funding for basic services not only will allow the department to comply with state and federal regulations, it may have the additional benefit of protecting the state of South Carolina from a class action lawsuit filed on behalf of these inmates.

SCDC is requesting **$4,187,657** in new funding for **FY-2001-02** to address immediate needs and **$4,336,130** in **FY-2002-03** to provide services needed to ensure compliance with state and federal laws regarding the humane treatment of persons with mental illnesses. Immediate new funding needs include **$2,796,193** for **140 FTEs** and **$1,052,566** for **medication and contract services.** An additional **$5,803,500** is needed to move inmates with mental illness to a more suitable treatment facility.

The following report addresses a proviso passed by the South Carolina Legislature in June, 2000 directing that **"a joint committee shall be established by the South Carolina Department of Mental Health and the Department of Corrections to study the ongoing needs of mentally ill inmates, including sexual predators, and develop an in-depth plan to address programmatic, budgetary, and capital building needs...."(*see Appendix K* for complete text of proviso and proviso membership).**

The proviso was prompted in part by concern about the growing number of inmates with mental illnesses entering the prison system and the dwindling number of resources available to care for them. This combination has resulted in inadequate treatment programs for inmates with serious mental illnesses, a dilemma which has had multiple effects. First and foremost, inmates with mental illnesses are not receiving adequate treatment for their illnesses and oftentimes leave prison worse off than when they entered. Second, the public is being short-changed because these inmates are eventually released, only to return to their local communities and commit more crimes secondary to inadequately treated mental illnesses. Third, the state of South Carolina loses because needless lawsuits are filed, either on behalf of the inmates or their victims, which result in more negative publicity for the state and a greater expenditure of tax dollars than would otherwise have been spent to initially address the problem.

The Department of Corrections is aware of the deficiencies that exist in its treatment programs for inmates with mental illnesses. In an attempt to clarify the deficiencies the department requested technical assistance in March 2000 from a consultant with the Prisons Division of the National Institute of Corrections. The consultant's report described the SCDC's mental health services system as "currently in crisis," adding that "immediate efforts to rectify the inadequate resource provision to the mental health system must be undertaken at all clinical levels and in all facilities."

This report would be disheartening were it not for the fact that the current director of SCDC is not only aware of the crisis but is willing to take the necessary steps to correct the documented deficiencies. Furthermore, all parties involved in treatment services for the mentally ill in South Carolina are talking (see proviso committee membership) and believe a solution is possible if necessary funding is approved by the S.C. Legislature.

The following report outlines the Proviso Committee's recommendations for addressing the immediate, short-term and long-term treatment needs of inmates with mental illnesses. Recommendations include:

Immediate Action

- Hire additional specialized staff. **FY-2001-02 Cost $2,796,193**
  Annualized from FY 2001-02 **FY-2002-03 Cost $4,062,887**
- Move female inmates with acute mental illnesses to a more suitable facility. **Cost $1,095,000**
- Move male inmates with acute mental illnesses to a more suitable facility. **Cost $4,708,500**
- Move inmates with developmental disabilities to a more suitable facility. **Cost $**(no additional)
- Add new medications to existing formularies. **Cost $1,030,000**
- Develop a unified mental health services delivery system. **Cost $** (none)
- Expand the use of contractual services to include telemedicine **FY-2001-02 Cost $ 774,780**
  FY-2002-03 Cost $ 798,023

Short-term Action

- Develop a 5-year phase-in plan for SCDC mental health services. **Cost $ 150,000**
- Improve mental health training for SCDC correctional officers and staff. **Cost $** (covered)
- Improve and expand treatment services for sex offenders **Cost $** (covered)
- Develop a stronger staff and clinical information liaisons between SCDC and SCDMH.

  Cost $ (to be determined by 5-year phase-in plan)
- Improve security on units that house inmates with mental illnesses.

  Cost $ (to be determined by 5-year phase-in plan)

Long-term Action

- SCDMH to develop initiatives for the prevention and reduction of recidivism[1] **Cost $ 20 million**
- Construct a new SCDMH facility for sexually violent predators on SCDC Property (included in SCDMH FY-2002 budget request) **Cost $ 22.5 million**
- Construct a new Psychiatric hospital for SCDC inmates

  Cost $ (to be determined by 5-year phase-in plan)

[1]See Appendix J

Current Conditions

The S.C. Department of Corrections houses approximately 21,000 inmates in 38 statewide institutions with a five-year projected population of 23,000. This figure does not include persons held in local and county detention centers or persons under 18 years of age who are held in juvenile justice system facilities. Of the 21,000 inmates in the SCDC system, approximately 2,200 have a documented mental illness. The word "documented" is important because the stress of incarceration will sometimes result in previously stable persons becoming mentally unstable and requiring services.

In addition to the 2,200, the SCDC houses approximately 2,283 sex offenders, 78 inmates with HIV-related mental illness (out of a total HIV-positive population of 582) and 844 inmates diagnosed with drug and alcohol addictions who are currently receiving services. (The actual number of inmates with drug and alcohol abuse or dependence is much higher and will be discussed in a later section.)

Treatment programs for mentally ill inmates historically have been the responsibility of the S.C. Department of Corrections. As SCDC directors have come and gone, so have treatment programs and philosophies regarding service delivery. In the recent past, a decision was made to dismantle internally staffed treatment programs in favor of privatization of these services. A firm called Correctional Medical Services received an SCDC contract to provide the majority of mental health services in 10 SCDC institutions. Many of the existing mental health staff positions were converted into security positions. When the contract with CMS was terminated on Feb. 1, 2000, the institutions were left with a serious shortage of mental health staff and services. Deficiencies exist not only in staff and services but also in related functions such as medical records documentation, training and organization, interface with medical services, medication availability and security. Furthermore, many of the service facilities lack adequate treatment space for providing care to mentally ill inmates.

Recommendations

Currently, SCDC spends approximately $7 million annually on all mental health services for a total inmate population of 21,000 (see *Appendix G*), which represents one of the lowest state expenditures for these services in the nation. Georgia spends about $20.7 million annually for mental health services (does not include services for sex offenders or substance abuse or mental health counselor salaries) and has approximately 50,000 inmates; North Carolina spends more than $19 million a year on a prison population of about 53,000; and Ohio (a state that underwent a class action lawsuit on behalf of inmates with mental illnesses) spends $67 million annually and has 62,000 inmates. Colorado, which has fewer inmates with mental illness, spends about $10 million to staff a psychiatric prison treatment center to care for 250 of its chronically mentally ill and developmentally delayed inmates.

The Proviso Committee members recognize that it will take time to implement a long-range plan to address all of the issues concerning adequate and humane care for mentally ill inmates. However, some steps must be taken immediately to address the current crisis. The recommendations therefore are divided into 'immediate,' 'short-term' and 'long-term.'

The committee believes that the S.C. Department of Corrections (SCDC) has primary responsibility for the security, control, care and treatment of mentally ill inmates. However, the committee also believes that SCDC should seek legislative funding to develop and expand contractual relationships with the S.C. Department of Mental Health (SCDMH), the U.S.C. School of Medicine and the Medical University of South Carolina to assist in providing services to these inmates. SCDC would retain responsibility for monitoring and directing these services, and would own and operate any future facilities built to house and treat mentally ill inmates.

SCDC already has taken some initial steps to improve mental health services in its institutions. The clinical staff has requested and is receiving training in rehabilitative treatment techniques from the S.C. Department of Mental Health. SCDC has also negotiated a contract with the Medical University of South Carolina's Department of Psychiatry to provide services in two low-country prisons and develop a telemedicine program to deliver faster, more efficient psychiatric services to prison sites in the state.

But this is not enough.

Immediate Action

1. **The single most important need for SCDC Mental Health Services is the immediate hiring of specialized staff** (see *Appendix E and F).*

Cost: $2,796,193

The Proviso Committee recommends that an additional **140 FTE's** be hired throughout the SCDC system (see *Appendix A, B, C, D, E & F)* at a cost of **$2,796,193 in FY-2001-02 (annualized in FY-2002-03 at $4,062,887)**. The staffing ratios requested are based on an analysis of South Carolina's current needs, and are similar to those in other states which have undergone recent class action lawsuits involving mental health services for inmates or have responded to the threat of such lawsuits (*Juan Dunn, et. al. v. State of Ohio, 1995*).

Staff shortages exist in each of the 38 prison sites and include all professional positions, from social workers and nurses to psychologists and psychiatrists. Physician shortages result in delays in diagnosis and treatment. Nursing shortages result in missed medication dosages and worsening of symptoms. Social worker shortages result in inadequate discharge planning, which means lack of mental health follow-up in the community and thus increased recidivism. Deleting mental health counselor positions on lock-up units has resulted in more acting out by mentally unstable inmates, more transfers

to the acute care psychiatric hospital and longer, more costly stays. Inmate assaults have increased in the four years since counselors were removed from SCDC institutions.

Funding for increased mental health services staff was included in last year's SCDC budget request but was deleted by the Senate Finance Committee in final budget cuts.

2. Female inmates with mental illnesses currently housed at the Women's Correctional Institution in Columbia should be moved to a more suitable facility to alleviate the current state of overcrowding and lack of adequate services and security. **Cost $1,095,000**

The Proviso Committee recommends that female inmates with acute mental illnesses be temporarily moved to the DMH-owned prison hospital operated by a private company called "JUST CARE", and that the number of acute beds be increased from four to 20. This cost is an estimate based on a rate of $150 per day per inmate for room and board and security provided by "JUST CARE", with treatment staff drawn from SCDC staff as requested elsewhere in this report.

More than 40 percent of the 1434 female inmates in South Carolina's prison system have some form of mental illness compared to about 10 percent of the male population, making them particularly vulnerable to sexual and physical abuse while incarcerated. SCDC currently contracts with SCDMH for four acute female beds at William S. Hall Psychiatric Institute's forensic facility on Bull Street in Columbia. The W.S.H.P.I. facility is in extremely poor physical condition. SCDMH needs a new forensic facility (requested in FY-2002 budget) and SCDC needs more than four acute female beds to adequately treat this population.

3. The most acutely mentally ill patients currently housed at Gilliam Psychiatric Hospital at Kirkland Correctional Facility in Columbia should be moved immediately to a more suitable facility.

Cost $4,708,500

The Proviso Committee recommends that the 86 male inmates with acute mental illnesses who are currently treated at the Gilliam Psychiatric Hospital be temporarily moved to the DMH-owned prison hospital operated by a private company called "JUST CARE". This cost is an estimate based on a rate of $150 per day per inmate for room and board and security provided by "JUST CARE", with treatment staff drawn from SCDC staff as requested elsewhere in this report.

Current conditions at Gilliam are essentially deplorable. Mentally ill male inmates with psychotic disorders who need clean, quiet environments and intensive staff intervention are locked in 4x6-foot cells 24 hours a day, seven days a week. The unit is noisy and chaotic. One Correctional Officer is assigned to each of the two 43-bed cellblocks, which endangers staff and patients alike and prevents patients from leaving their cells to attend treatment groups. Critical staff shortages make it difficult to adequately observe and treat the patients, and the nursing station is located in an adjacent area away from the patients.

If the acutely mentally ill are moved out, then Gilliam can be used instead as 1) short-term housing for high management inmates who are antisocial and aggressive or 2) sexually violent predators.

4. Move inmates with developmental disabilities to a single unit and provide specialized services to this population.

Cost $(no additional)

The Proviso Committee recommends that inmates with developmental disabilities be immediately moved temporarily to a more suitable housing unit separate from the general inmate population, and that the unit be staffed and equipped to manage the special needs of this population. These needs include, but are not limited to, case management; individual, family and group therapy; psychological assessment; vocational training; and discharge planning. Enhanced staffing for this population is included above in the recommendations for additional staffing. (See #1 under Short-term Action.) This move will require furniture, computers, supplies and minor renovations to re-configure a more suitable building at the Manning Correctional Institution in Columbia for the male inmates. The associated costs would be minor and easily accomplished with existing funds.

Approximately 120 inmates in the SCDC system have developmental disabilities such as mental retardation, which increases their vulnerability to physical and sexual abuse while incarcerated and complicates their release into the community. These individuals are currently housed among the general prison population in multiple institutions.

Male inmates with developmental disabilities should be moved temporarily to the dormitory at Manning Correctional Institution that currently houses inmate construction workers until a new building is constructed at Kirkland. Construction of such a facility has already been approved, and scheduled for completion in the spring of 2002. Planning for female inmates must be considered as part of the 5-year Phase-in plan.

5. Add new medications to existing formularies. Cost $1,030,000

The Proviso Committee recommends expanding the formulary to include newer medications.

Currently, some medications needed to treat potentially life-threatening side effects of psychotropic drugs are not available due to a lack of sufficient funds. In addition, many of the new psychotropic medications, which are more effective and have fewer adverse side effects, are not available on the approved SCDC medical formularies. Having these medications available could, in many cases, result in a faster resolution of symptoms and shorter stays in the prison's acute psychiatric hospital.

6. Develop a unified mental health services delivery system that coordinates all behavioral health services. Cost $(no additional)

The Proviso Committee recommends that all behavioral health services (to include programs for addictions, the HIV mentally ill, developmentally disabled, sexual offenders, and chronically mentally ill, as well as social work services for the general population) be placed under one division.

Currently, addictions services, programs for sex offenders, and services for the HIV-positive mentally ill are managed by a non-medical division. This creates problems with communication and cooperation between divisions and makes it difficult for mentally ill inmates to access needed services.

For instance, although the lifetime prevalence of substance-related disorders is between 70% and 80% in prison inmates in general and inmates with mental illnesses in particular (Reiger, 1990, *JAMA*, National Institute of Mental Health Epidemiologic Catchment Area Program Study), mentally ill inmates with substance abuse problems are unable to access SCDC's addictions services. Placing the addictions and mental health services under one division, or providing a liaison between the two divisions, would help address this problem.

Aggressively treating inmate addictions is important when one considers that substance abuse increases up to five times the rate of violence among discharged mentally ill

inmates (Steadman, 1998, *Arch Gen Psychiatry*). In fact, substance abuse is a much greater risk factor for violence than is mental illness. At least 35% of convicted offenders were under the influence of alcohol at the time of their offense (Pihl, 1997, *Psychiatric Annals*). An additional percentage of offenders were using other drugs at the time of their offenses (Hood, 1990, *Journal of Forensic Science*).

7. **Expand the use of contractual services for SCDC mental health services to include telemedicine.** **Cost $774,780 (FY-2001-02)**
Cost $798,023 (FY-2002-03)

Telemedicine has proven to be an effective, low cost means of providing mental health treatment services to a geographically dispersed population. In fact, at least 25% of all telemedicine services currently used in the nation are prison-related.

SCDC has already contracted with MUSC's Department of Psychiatry to provide mental health services at two low-country correctional facilities and to explore the possibility of providing these services via telemedicine to other correctional facilities in the state (See 'Contractual Services', *Appendix G*). Likewise, SCDMH is using telemedicine in county detention centers to conduct competency and suicide evaluations, saving the state thousands of dollars each year in physician travel time. The telecommunication equipment required for such services is already on site at SCDC facilities and at the USC School of Medicine. Expanding the role of telemedicine could potentially reduce the need for psychiatric consultation on nights and weekends, and allow for psychiatrist coverage at all 38 correctional institutions without having to individually contract for these services at each site. Additional funds as included above should be ear-marked by SCDC to contract with South Carolina's two medical schools to provide these clinical services state-wide, as well as to provide technical assistance and guidance to SCDC regarding mental health program development and the management of the most seriously ill inmates.

Short-term Action

1. **Develop a comprehensive 5-year phase-in plan for SCDC mental health services that addresses all sub-populations of inmates and levels of care, streamlines program and facility expenditures, and provides humane treatment to mentally ill inmates.** **Cost $150,000**

The Proviso Committee recommends that an outside consultant be retained to work with SCDC, SCDMH, and the departments of psychiatry from the USC School of Medicine and MUSC to develop a comprehensive five-year plan that addresses all aspects of mental health care in the S.C. Department of Corrections. National standards, such as

those published by the National Commission on Correctional Health Care, should be used as guidelines for developing this plan.

While the committee believes that the immediate expenditures listed above are needed to address the current crisis, it also believes that SCDC needs to develop a rational, detailed long-term plan for providing necessary services to inmates with all types of mental illnesses and behavior problems. Having such a plan in place will help SCDC avoid the haphazard, crisis-oriented approach to mental health care likely to occur each time the agency's leadership philosophy changes.

Facility needs are different for inmate with mental illness than they are for non-mentally ill inmates, and these specialized needs must be considered when new facilities are designed and constructed. New facilities for the mentally ill are no doubt needed.

Current plans call for constructing three new buildings within the Kirkland Correctional Institution perimeter in Columbia and using at these buildings to house inmates with mental illnesses. However, it is apparent after reviewing the blueprints that the building design is inadequate from a mental health services standpoint. The design does not include enough treatment space or offices for necessary staff and has other design flaws that will cause a repetition of the current deficiencies in existing facilities. Mistakes such as this one can be avoided by taking the time to develop a rational, long-term strategic plan and include in the planning process the people who will actually be working in these facilities.

2. Contract with South Carolina's two medical schools and the S.C. Department of Mental Health to provide specialized mental health services to SCDC institutions.

Cost $370,500 (FY-2001-02)
Cost $702,000 (FY-2002-03)

The Proviso Committee recommends that SCDMH, MUSC, and USC help SCDC recruit the three psychiatrists. The Proviso Committee also recommends that SCDC collaborate with the Department of Psychology at the University of South Carolina to create three licensed psychologist positions, one each at Gilliam Psychiatric Hospital in Columbia, Lieber Correctional Institution in Charleston and Perry Correctional Institution in Greenville. The costs are included in the total staffing cost proposal, and itemized in Appendix F and G.

Psychiatrists and licensed psychologists have been especially difficult for SCDC to recruit and retain due to issues relating to pay, workload and work environment. Funding should be provided to allow SCDC to collaborate with the medical schools to create three faculty psychiatrist positions (funding for the positions is already included under #1 of 'Immediate Action' section), one at Gilliam Psychiatric Hospital in Columbia, one at Perry Correctional Institution in Greenville and one at Lee Correctional Institution in Bishopville. The ability to tie medical school faculty appointments to prison psychiatrist

positions not only is an effective recruiting tool but also would attract and retain more experienced and qualified applicants.

3. Improve continuity of care by developing a stronger liaison between SCDC and SCDMH to ensure that inmates with mental illnesses receive adequate mental health care.

Cost $ (to be developed in the 5-year phase-in plan)

The Proviso Committee recommends that SCDC and SCDMH develop a reliable system of communication and referral to track inmates with mental illnesses through the two systems and ensure that they comply with mandatory treatment. This will require networking with other agencies, including Vocational Rehabilitation, local law enforcement, DAODAS, the S.C. Alcohol and Drug Commission and the S.C. Department of Probation, Pardon and Parole. In the interest of public safety and to comply with the victim rights Act 141 passed in 1997, it is crucial that crime victims be notified before the inmates who committed those crimes are released into the community.

Liaison services between SCDC and SCDMH need to be strengthened in two primary areas: 1) Day-to-day communication between mental health staff at SCDC and the SCDMH community mental health centers and 2) Discharge planning. Effective day-to-day communication between the two departments (SCDMH and SCDC) requires an accessible information management system, which means the purchase of necessary hardware (computer systems) and software and some means of linking the two departmental systems. This is beyond the purview of the Proviso Committee and should be addressed by the outside consultant (see Short-term Action #1).

Discharge planning takes two forms: 1) discharge from a psychological unit to the general prison population, and 2) discharge to the community. Currently, no system is in place to notify SCDMH that an inmate with a diagnosed mental illness is being released into the community. Nor is there a system in place to ensure that mandatory mental health clinic attendance be a condition of such an inmate's parole. These flaws in the system increase the probability that some inmates will deteriorate mentally once released, and consequently require admission to a SCDMH inpatient facility or reentry into the criminal justice system.

The relationships between SCDC, SCDMH, the S.C. Department of Probation, Pardon and Parole, the S.C. Department of Disabilities and Special Needs (SCDDSN), DAODAS and the S.C. Alcohol and Drug Commission need to be clarified with regard to issues involved in inmate discharge planning. Memoranda of Agreement should be developed between these agencies to clarify various services that will be provided both before and after release of inmates with mental illness from SCDC. Current state statutes may have to be amended in order for all concerned parties to have access to pertinent clinical

information. Every inmate legally eligible for release from SCDC should be returned to the community with a discharge plan that focuses both on public safety and the social and treatment needs of the inmate. (See *Appendix J*, Prevention Of Recidivism for Inmates With Mental Illness.)

4. Improve training programs for SCDC correctional officers and staff assigned to mental health units in the correctional facilities.

Cost $(addressed under staff costs)

The Proviso Committee recommends that SCDMH assist SCDC in developing training programs to address these issues, and that all mental health staff and correctional officers who work with mentally ill inmates be required to attend such programs when they are initially hired. Annual training should be required of each employee.

Many incidents of inmate aggression and behavioral disturbances can be avoided with timely use and knowledge of behavior de-escalation techniques. Without such training, correctional officers can unwittingly contribute to inmate aggression, placing themselves, the inmates and staff in danger and causing chaos on the unit. Conversely, mental health professionals need to have respect for and understanding of security concerns.

5. Improve security on units that house inmates with mental illnesses.

Cost $ (to be developed in the 5-year phase-in plan)

The Proviso Committee recommends that SCDC review its security coverage and officer pay scales and work with the S.C. Legislature to address overall prison security concerns.

Many cellblocks that house inmates with mental illnesses do not have enough security cameras to adequately monitor activity, which endangers staff and inmates. The recent incident at Richland County Detention Center in which inmates overpowered and killed a guard is an example of the danger that results from inadequate electronic monitoring. In addition, the current 12-hour shifts for officers who work with mentally ill inmates (changed from previous 8-hour shifts) contribute to officer burnout, as does low pay and stressful working conditions.

6. Improve and expand treatment services for sex offenders.

Cost $ (addressed under staff costs and contracts)

The Proviso Committee recommends that SCDC contract with SCDMH to plan and, in some instances provide, evaluation and treatment services for sex offenders. (See *Appendix H and I* for recommendations concerning sex offender treatment.)

SCDC currently houses 2,283 identified sex offenders in multiple institutions across the state, which is a different population from the 2,150 inmates with identified mental illnesses. Of the 2,283 identified sex offenders, 290 have mental illnesses or developmental delays (i.e., mental retardation), 67 are youthful offenders, and 68 are HIV-positive. Approximately 300 sex offenders are released into the community each year, while about the same number enter the corrections system. The 2,283 sex offenders do not include those who have "plead down" from more serious sexual assault charges, or who were sentenced for non-sex related charges but who may also have been guilty of sex offenses.

Staff shortages have limited treatment services to the sex offender population. (The staffing issue is addressed under #1 in the 'Immediate Action' section; see *Appendix A.*) If expanded treatment for this population is not addressed, the committee foresees a future increase in the sexually violent predator population and an increased risk to the communities into which at least 50 percent of these inmates will eventually return.

Long-term Action

1. Develop initiatives to reduce recidivism. **Cost $20 million**

SCDMH must develop initiatives to prevent persons with mental illness from entering the criminal justice system, and the S.C. Legislature should fund the necessary programs to allow this to happen. A comprehensive and continuous community-based system of care is needed, which should include pre- and post-booking alternatives to incarceration for nonviolent, mentally ill offenders.

SCDMH should collaborate with advocacy groups for the mentally ill to pass model laws for assisted treatment. Current federal and state policies hinder treatment of mentally ill individuals most at risk for arrest. As a result, more mentally ill individuals are being incarcerated rather than treated when they become symptomatic.

SCDMH has developed initiatives to expand emergency and community mental health programs (see *Appendix J*) and will continue to ask the S.C. Legislature for the necessary funds to implement these initiatives.

2. Construct a new Psychiatric hospital for SCDC inmates

Cost $ (to be developed in the 5-year phase-in plan)

The Proviso Committee recommends that the outside consultant (see #1 Short-Term Action) be directed to undertake a thorough study of facility needs and make recommendations to the directors of SCDC and SCDMH before any new facilities are planned or constructed.

Current psychiatric services for inmates include:

- Acute Care at Gilliam Psychiatric Hospital at Kirkland Correctional Institution in Columbia for inmates considered dangerous to themselves or others
- Intermediate Care Services at Lee Correctional Institution in Bishopville for chronically mentally ill males
- Intermediate Care Services at the Women's Correctional Institution in Columbia for chronically mentally ill females
- Outpatient/Low Intensity Management Services at 10 SCDC institutions for inmates with behavioral disturbances and short-term crises not requiring medication or physician management (these services are needed at each of the 38 institutions).

In addition, programs for the HIV-positive inmates with mental illnesses, sex offenders and drug and alcohol addictions are coordinated by the Program Services Division of SCDC and are scattered throughout the system.

It is inevitable that a new prison psychiatric facility will have to be constructed. However, in order to prevent facility design flaws and to minimize capital expenditures, it is imperative that an outside consultant (#1 in Short-Term Action) conduct a careful, detailed study of facility needs for inmates with mental illnesses.

The most reasonable and cost-effective solution to the facilities dilemma may be to construct one central state-of-the-art treatment facility in a centralized urban location (important in attracting white-collar, professional staff), rather than construct multiple smaller facilities for the different sub-populations requiring mental health services. A centralized facility could have several wings with a common treatment mall to provide a variety of continuous therapeutic activities geared toward individual inmate needs.

2. Support the SCDMH FY-2002 budget request to build a new facility for sexually violent predators if no other housing alternative is found.

Cost $22.5 million

The Proviso Committee supports the SCDMH in their current request for funding for a new facility for the sexually violent predators if no other housing alternatives can be found. However, the committee also recommends that the outside consultant (see #1, Short-Term Action) review the plans before any new facilities are constructed.

SCDMH has a legislative mandate to provide treatment for inmates classified as sexually violent predators. Currently, 24 people have been adjudicated as sexually violent predators. This population is expected to grow exponentially over the next decade by 10-15 inmates annually, with few discharges expected into the community.

These 24 patients are being housed temporarily in a 48-bed unit in the Edisto Building of the Broad River Correctional Institution in Columbia. The facility is inadequate from both a security and programmatic standpoint, and the Proviso Committee agrees with SCDMH and SCDC that a new facility is needed.

Because SCDMH is under a legislative mandate to provide treatment to sexually violent predators, the Proviso Committee agrees that separate funding must be provided to SCDMH for program services and staffing, and to SCDC for the operation, maintenance and security of the facility.

Appendix A
MENTAL HEALTH COUNSELING STAFF

INSTITUTION	Total Population/MI [1]		99-00 [2]	NEW MI [3]	NEW GP [4]	TOTAL [5]
Allendale	1020	51	2	0	5	7
Broad River	937	106	15*	4	0	19
Evans	1305	53	3	0	7	10
Kershaw	1415	62	3	0	7	10
Leath	523	159	3	1	2	6
Lee	1465	386	17	0	5	22
Lieber	1221	266	5	2	6	13
MacDougall	553	18	1	0	2	3
Manning	780	87	4	1	4	9
McCormick	1150	73	3	0	3	6
Perry	846	215	6	1	4	11
Ridgeland	1156	55	2	0	4	6
State Park	432	45	0	1	1	2
Trenton	696	15	0	1	0	1
Turbeville	1242	144	3**	4	0	7
Tyger River	1289	64	2	0	4	6
Wateree River	798	43	0	2	0	2
Women's	456	202	11	1	2	14
TOTALS	**20902**	**2228**	**80**	**18**	**56**	**154**

1 #'s are approximates of total inmate population/Mentally Ill inmates as of 10/30/00 (Totals are not sum of rows but reflect other facilities not shown).

2 Counseling staff/social workers currently provide care to all inmates, concentrating on the Mentally Ill.

3 New counseling staff/social workers to be added for Mentally Ill population.

4 New counseling staff/social workers to be added to work with Lock-Up, Crisis Intervention, Sex Offenders, and the general inmate population.

5 Totals of new counseling staff/social workers to cover entire institution.

* Current staff covers HIV+, Sex Offenders, and General Population only.

** Current staff covers Sex Offenders only.

Appendix B
ADDITIONAL REGIONAL STAFFING[6]

POSITION	COLUMBIA (1)	LOW COUNTRY (2)	PEE DEE (3)	UPSTATE (4)
Administrative Support (For Region)	1	1	1	2
Licensed Psychologist[5]	1	1	0	1
Psychiatric Nurses	0	2	4	2
Human Services Coordinator II (To supervise Region)	1	1	1	0
Human Services Coordinator I	3 *	1 *	1 *	3 *
TOTAL (NEW FTE's)	**5**	**5**	**7**	**5**

[1]Based at Kirkland and Broad River Correctional Institutions - Covers Women's Center, State Park, Leath, Manning, Broad River, Campbell, Stevenson, Walden, Watkins, and Trenton
* - (Covers Campbell, Stevenson, Walden and Watkins).

[2]Based at Lieber Correctional Institution - Covers Allendale, Ridgeland, Coastal, Lieber and MacDougall.
* - (Covers Coastal)

[3]Based at Lee Correctional Institution - Covers Lee, Evans, Wateree. Turbeville, Palmer Work Release and Kershaw
* - (Covers Palmer and provides back-up at other institutions)

[4]Based at Perry Correctional Institution - Covers Perry, Tyger River, McCormick, Givens, Livesay, Catawba, Lower Savannah and Northside
* - (Covers five of the eight facilities)

[5]Licensed Psychologists are listed separately in Appendix E, F, and G.

[6]All staff to provide services to the entire inmate population, including mentally ill, sex offenders, etc.

Appendix C
SPECIAL FUNCTIONS STAFFING

MENTAL HEALTH SERVICES - CENTRAL MANAGEMENT

POSITION	CURRENT	NEW	TOTAL
Director	1	0	1
Program Manager	3	1	4
Human Services Coordinator II	0	3	3
Administrative Support	2	0	2
TOTAL	**6**	**4**	**10**

RECEPTION & EVALUATION CENTER

POSITION	CURRENT	NEW	TOTAL
Administrative Manager	1	0	1
Human Services Coordinator II	1	0	1
Human Services Coordinator I	3	3	6
Psychologist	1	0	1
TOTAL	**6**	**3**	**9**

MAXIMUM SECURITY UNIT - KIRKLAND

POSITION	CURRENT	NEW	TOTAL
Human Services Coordinator II	1	1	2
LPN	1	1	2
TOTAL	**2**	**2**	**4**

Appendix D
GILLIAM PSYCHIATRIC HOSPITAL

POSITION	CURRENT	NEW (2001-2002)	TOTAL
Management	2	1	3
Human Services Coordinator II	4	5	9
Human Services Coordinator I	14	10	24
Human Services Specialist II	7	2	9
Nurse Administrator	1	0	1
Registered Nurse II	3	1	4
Registered Nurse I	5	3	8
Licensed Practical Nurse	5	2	7
Activity/Recreation Specialist	0	4	4
Licensed Psychologist	1	0	1
Administrative Support	3	1	4
TOTAL	**45**	**29**	**74**

- Critical Areas - Office and Programming space are needed to support current and future staffing and programming services.

Appendix E
STAFFING SUMMARIES

POSITION	CURRENT	NEW	TOTAL
Counselors for Mentally Ill [1]	80	18	98
Counselors for General Population and Lock-Up [1]	0	56	56
Regional Staffing [2]	0	22	22
Administration and Special Areas [3]	14	9	23
Gilliam Psychiatric Hospital [4]	45	29	74
Psychiatrists [5]	1	3	4
Psychologists [5]	0	3	3
TOTAL	**139**	**140**	**280**

1 See Appendix A
2 See Appendix B
3 See Appendix C
4 See Appendix D
5 See Appendix F & G

Appendix F

STAFFING ENHANCEMENT GOALS AND COSTS [1]

FISCAL YEAR 2001-2002

1st Quarter

POSITION	TOTAL#	COST
Counselors for Mentally Ill	18	$ 785,561.00
Administrative and Special Areas	9	$ 339,064.00
Gilliam Psychiatric Hospital	7	$ 225,189.00

2nd Quarter

POSITION	TOTAL#	COST
Counselors for General Population	19	$ 414,602.00
Gilliam Psychiatric Hospital	7	$ 150,126.00
Regional Staffing	8	$ 188,213.00
Psychiatrist	1	$ 78,000.00
Psychologist	1	$ 58,500.00

3rd Quarter

POSITION	TOTAL#	COST
Counselors for General Population	18	$ 196,390.00
Gilliam Psychiatric Hospital	7	$ 75,063.00
Regional Staffing	7	$ 82,343.00
Psychiatrist	1	$ 39,000.00
Psychologist	1	$ 19,500.00

4th Quarter

POSITION	TOTAL#	COST
Counselors for General Population	19	$ 69,190.00
Gilliam Psychiatric Hospital	8	$ 28,595.00
Regional Staffing	7	$ 27,447.00
Psychiatrist	1	$ 13,000.00
Psychologist	1	$ 6,500.00

TOTAL ADDITIONAL STAFF COSTS –FISCAL YEAR 2001-2002: $ 2,796,193.00
STAFF COSTS ANNUALIZED————FISCAL YEAR 2002-2003: $ 4,062,887.00

[1] - Expenditures for all staff include salaries and 30% fringes

Appendix G
EXPENDITURES FOR MENTAL HEALTH SERVICES [5]

POSITION	CURRENT EXPENDITURE (FY 99-00)	REQUESTED ADDITIONAL (FY 01-02)	TOTAL EXPENDITURE (FY 02-03)	REQUESTED ADDITIONAL (FY 02-03) [1]	TOTAL (FY 02-03)
Counselors for Mentally Ill	$ 2,899,193	$ 589,171	$ 3,488,864	$196,390	$ 3,685,254
Counselors for General Population	0	$ 680,092	$ 680,092	$ 1,763,877	$ 2,443,969
Regional Staffing	0	$ 298,003	$ 298,003	$ 737,170	$ 1,035,173
Administrative and Special Areas	$ 777,794	$ 339,064	$ 1,116,858	$ 113,021	$ 1,229,879
Gilliam Psychiatric Hospital	$ 1,646,277	$ 478,973	$ 2,125,250	$ 764,929	$ 2,890,179
Psychologists [2]	0	$ 84,500	$ 84,500	$ 149,500	$ 234,000
Psychiatrists [2]	$ 156,000	$ 130,000	$ 286,000	$ 338,000	$ 624,000
TOTAL (Salaried Positions)	**$ 5,499,264**	**$ 2,796,193**	**$ 8,295,457**	**$ 4,062,887**	**$ 12,358,344**
Medications [4]	$ 770,000	$ 1,030,000	$ 1,800,000	$ 250,000	$ 2,050,000
Operating Expenses	$ 75,874	$ 338,898	$ 414,773	$ 23,243	$ 798,023
Contractuals	$ 752,214 [3]	$ 22,566	$ 774,780	$ 23,243	$ 798,023
TOTAL SPENDING (on Mental Health)	**$ 7,097,352**	**$ 4,187,657**	**$ 11,285,009**	**$ 4,336,130**	**$ 15,621,139**

[1]Personnel costs (salaried positions) for new requested FTE's are annualized in FY 02-03

[2]To be included in a contract between SCDC, SCDMH, USC/SOM, and MUSC

[3]This amount was paid under a contract now terminated. Money now proposed for contracts between SCDC and MUSC and USC/SOM

[4]Additional requested funding for medications includes a one-time adjustment of $ 260,000 to account for lack of annualization of the 1999-00 medication budget, and $ 770,000 to **add new medications to the Formulary** under immediate actions

[5]Expenditures for all staff includes salaries and 30% fringes

Appendix H
SEX OFFENDERS

Existing SCDC Sex Offender Program

Phase I Basic psycho-education group program for all convicted sex offenders, lasting four months, and mandated by SCDC.

Phase II Intensive residential treatment provided in two residential units:
1) a 30-bed adult unit at Broad River Correctional Institution
2) a 50-bed youthful offenders unit at Turbeville Correctional Institution

Existing SCDC Strategic Goals Related to Sex Offenders

1. **Provide appropriate sex offender programs to high risk and special needs offenders in SCDC by:**
    - Increasing dedicated treatment space in residential units.
    - Increasing availability of all phases of sex offender treatment to this population.
    - Identifying high risk and repeat offenders.
    - Increasing program staff to achieve a 1:10 counselor/inmate ratio in residential treatment and a 1:80 counselor/inmate ratio in institutional treatment.
    - Providing intensive group sex offender treatment at designated institutions for youthful offenders and offenders with mental illnesses.

2. **Improve screening, evaluation and referral procedures to assess inmates for sex offender programs by:**

    - Increasing funding for additional professional staff
    - Increasing administrative support
    - Implementing standardized sex offender testing (Abel Screen, Penile Plethysmograph).
    - Increasing technological support of this process by providing necessary hardware and software to be able to adequately screen, evaluate and refer inmates to sex offender programs.

3. **Prepare sex offenders for transition to the community by:**
    - Increasing resources and training in relapse prevention programs for sex offenders.
    - Providing pre-release programs for sex offenders.

Appendix I

SCDMH Proposal for Sex Offender Treatment

The S.C. Department of Mental Health has reviewed SCDC's strategic goals (see *Appendix H*) and has recommended the following proposal for evaluation and treatment of sex offenders. The Proviso Committee notes that a final decision about program format and funding is subject to revision after the proposed review by the outside consultant (see #1 under Short-term Action).

I. Evaluation and Treatment Services for Sex Offenders With Mental Illness And/Or Developmental Disabilities: (Current population:290)

A psychiatrist or psychologist who has specific expertise in the evaluation of sexual disorders in persons with mental illness and developmental disabilities would conduct the evaluation. The evaluation would include:

- Impact of the disability on the inmate's offending behaviors
- Impact that effective treatment would have on re-offense risk
- A thorough psycho-social-sexual history
- A review of previous and current mental health treatment
- Intensive follow-up by the assigned case manager
- Referral for Abel Screening or Penile Plethysmography, when appropriate

II. Evaluation and Treatment Services for Sex Offenders Without Mental Illness And/Or Developmental Disabilities: (Current population :1,926)

A psychiatrist or psychologist who has specific expertise in the evaluation of sexual disorders would conduct the evaluation, which would include:

- A thorough psycho-social-sexual history
- Psychological testing
- Psychiatric referral for inmates with personality or mood disorders who require specialized interventions and treatment planning
- Referral for Abel Screening or Penile Plethysmography, when appropriate.

III. Proposed Treatment Program for Sex Offenders

Sex offenders would begin the program in the last half of their sentence or in the last five years of their incarceration. The program has six phases, each of which must be completed before the inmate is allowed to progress to the next phase.

Appendix I
(continued)

Phase I Inmate must admit to offending behavior before progressing to the psycho-educational group, and must undergo penile plethysmography and an Abel Screen.

Phase II Inmate must complete assigned tasks, which include journaling, writing an autobiography and assuming basic ownership of the problem. During this phase, a case manager is assigned and the inmate attends psycho-educational and process groups.

Phase III Inmate must complete assigned tasks, which include advanced ownership and completing a Cycle of Abuse exercise. During this phase, the inmate continues to attend the psycho-educational and process groups.

Phase IV Inmate must complete assigned tasks, which include victim personalization and restitution. During this phase, the inmate continues to attend the psycho-educational and process groups.

Phase V Inmate must complete assigned tasks, which include relapse prevention exercises. During this phase, the inmate continues to attend the process group and begins the relapse prevention group.

Phase VI Inmate must complete assigned tasks, which include formulating a relapse prevention plan. During this phase, the inmate continues to attend the relapse prevention group and begins the community reintegration group.

Appendix J

Prevention of Recidivism For Inmates With Mental Illnesses

For persons with mental illnesses, prevention of entry into the corrections system and recidivism once released is crucial. A comprehensive community-based system is needed which includes pre- and post-booking alternatives for nonviolent offenders. Also needed is a communication system, which would allow agencies that interact with mentally ill offenders (i.e., SCDMH, SCDC, DAODAS, S.C. Department of Probation, Pardon & Parole, etc.) to share information and monitor their treatment and progress regardless of the offender's location.

The following is a proposed model for prevention of recidivism for inmates with mental illnesses. SCDMH would be responsible for staffing the program if funding were to be approved by the S.C. Legislature. The approximate staffing costs for this proposal is $20 million. A summary of this plan is included here. Details may be obtained from SCDMH.

Primary Prevention

- **County Respite Housing.** Respite houses capable of accommodating 4 to 8 persons with mental illness would be staffed in each county for short-term lodging (30 to 60 days) and meals. Residents would be required to have meaningful day activities, either employment or seeking employment.

- **Regional Transitional Housing.** Residential houses capable of accommodating 6 to 8 persons with mental illness would be staffed in designated regions for long-term housing (1 to 2 years). Similar housing would be provided separately for youthful offenders (8 to 10 bed units) in each region. Each resident would be required to undergo psycho-social-rehabilitative treatment in order to attain the social, vocational and personal skills needed to live independently.

- **Regional Triage and Crisis Units.** These locked units would allow 24-hour observation and stabilization for persons in crisis, with referral to community treatment services once stabilized. Units such as these save lives and money in the long run by avoiding costly hospitalizations and/or incarceration.

- **Regional Crisis Mobile Units.** Crisis response teams would be set up in four counties (Richland, Spartanburg, Horry and Greenville counties) to provide treatment and transportation to respite houses or hospitals. Charleston County has a mobile unit in place already consisting of mental health professionals and law enforcement personnel to respond to persons in crisis.

Appendix J
(continued)

- **Preventive Crisis Outreach Teams**. Each county mental health center would designate a team of professionals to interface with local jails, state correctional facilities and the S.C. Probation, Pardon & Parole Board to monitor individuals' mental health treatment compliance and coordinate services to ensure continuity of care.

- **Memorandum of Agreements (MAOs)**. These agreements would be negotiated between SCDC, SCDMH's community mental health centers and local jails to facilitate communication and provide continuity of care for persons with mental illness.

Secondary Prevention

Individuals with mental illness who enter the corrections system require specialized care once incarcerated to treat the mental illness and prevent recidivism once they are released from prison. The following services are needed:

- **Assessment Services**. Inmates with mental illnesses must be identified within the first 30 days of incarceration.

- **Treatment Services**. Inmates with mental illnesses should be separated from the general prison population and placed in a facility designed to stabilize and treat their illnesses.

- **Prevention Services**. Designated liaison staff in SCDC and SCDMH mental health centers would jointly develop a follow-up plan once the person is released to the community. This plan would include an assessment of the individual's needs and community resources available to meet those needs, and referrals and follow-up with appropriate agencies. Individuals may also require financial assistance to obtain necessary psychotropic medications until they are able to obtain employment or benefits.

Appendix K

Proviso/Membership

Proviso 10.11. (DMH: Jt. Study with Dept. of Corrections) A joint committee shall be established by the South Carolina Department of Mental Health and the Department of Corrections to study the ongoing needs of mentally ill inmates, including sexual predators, and develop an in-depth plan to address programmatic, budgetary and capital building needs. This committee's membership will be comprised of the following individuals and groups: the Director of the Department of Mental Health or his designee, the Director of the Department of corrections or his designee, the Chairman of the USC School of Medicine Department of Psychiatry or his designee, the Chairman of the Medical University of South Carolina Department of Psychiatry or his designee and three appointees each from the Speaker of the House and the President Pro Tempore of the Senate. House and Senate appointees must be drawn from the following constituent advocacy groups: a representative of the South Carolina Mental Health Association, a representative of Protection and Advocacy for People with Disabilities, a representative of the South Caroline Self-Help Association Regarding Emotions, a representative of the National Alliance for the Mentally Ill of South Carolina, a representative of the South Carolina Victim Assistance Network and a representative of the South Carolina Coalition Against Domestic Violence and Sexual Assault. The committee will be co-chaired by the Directors of Mental Health and Corrections, or their designees. The committee will provide their report to the House Ways and Means and Senate Finance Committees by October 15, 2000.

Proviso Committee Membership

David Almeida	NAMI of South Carolina
Richard Ellison, M.D.	S.C. Department of Corrections
Laura Hudson	South Carolina Victim Assistance Network
John Magill	M.U.S.C., Department of Psychiatry
Becky Miles	Mental Health Association
John A. Morris	U.S.C. School of Medicine, Department of Psychiatry
Nita O'Brien	S.C. Coalition Against Domestic Violence & Sexual Abuse
Bonnie Pate	S.C. SHARE
Gloria Prevost	S.C. Protection & Advocacy
David A. Rosin, M.D.	S.C. Department of Mental Health

The Proviso committee gratefully acknowledges David Jordan and Dr. Kathleen Powell from SCDC, and Geoff Mason and Dr. Peggy Wadman from SCDMH for their technical assistance and guidance in the preparation of this report.

EXHIBIT B

U. S. Department of Justice

National Institute of Corrections

Washington, DC 20534

DISCLAIMER

RE: NIC TA No. 2000P1052

This technical assistance activity was funded by the Prisons Division of the National Institute of Corrections. The Institute is a Federal agency established to provide assistance to strengthen state and local correctional agencies by creating more effective, humane, safe and just correctional services.

The resource person who provided the on-site technical assistance did so through a cooperative agreement, at the request of the South Carolina Department of Corrections, and through the coordination of the National Institute of Corrections. The direct on-site assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of Dr. Raymond Patterson. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

Technical Assistance Report
TA #00P1052

Raymond F. Patterson, M.D.

This report is with regard to the National Institute of Corrections (NIC) sponsored request for technical assistance to the South Carolina Department of Corrections regarding mental health services. This report will follow the suggested NIC format and will address those areas specified in that format. I will also address issues that were discussed on site and noted in correspondence from the Department.

1. General Overview: The request for technical assistance was generated because of interest and concern within the Department of Corrections regarding mental health services. This included a request for a review of operations, policies and procedures of Gilliam Psychiatric Hospital (GPH), and of medical/mental health issues as they related to the maximum-security unit located in Kirkland Correctional Institution. The request was also to assist the Department in identifying strengths and weaknesses of the GPH program and MSU operations. Thirdly, the assistance was requested to advise the Department as to the personnel and resources that might be required to move the mental health programs close to national and/or community standards.

2. The initial contact to this consultant was by Richard A. Ellison, M.D., Director of Behavioral Medicine, initially in a verbal discussion in approximately May 1999, followed by a letter dated August 16, 1999. The gist of the request is described in Number 1 above and is supplemented by a request that all information be provided to Richard P. Stroker, General Counsel for the Department.

3. The South Carolina Department of Corrections houses approximately 20,000 prisoners. The Department of Corrections includes a mental health system, comprised of Gilliam Psychiatric Hospital, regional centers, ICS's, and outpatient services. These services are for inmates in approximately 38 institutional settings (Please see Attachment 1). Of considerable importance is the reality that the ten institutions providing the great majority of mental health services had been receiving contractually provided services from Correctional Medical Services through January 31, 2000. Effective February 1, 2000, the contract with CMS had been terminated; and, at the time of this consultation, there was essentially no mental health staff with the exception of staff at GPH, Dr. Richard Ellison, and minimal counseling and nursing staff in the facilities. Efforts have been underway to hire new staff and to base projections of staff requirements on levels of staffing provided by the previous contractor as well as staffing ratios that had been established prior to the contractor's arrival. This deficiency in mental health services, primarily staffing and related functions including medical records documentation, quality improvement activities, pharmacy and therapeutic reviews, training for mental health and custody staff, and interface with medical services demonstrates insufficient resources to meet the needs of inmates in the system. A description of the problem, after I arrived on site, was quite consistent with the problems noted above, and physical plant problems (housing and activities) as well as lack of accessibility to services were identified.

In addition to reviewing the GPH, the ICS program at Lee Correctional Institution, and the maximum security unit at Kirkland, I also had the opportunity to meet with several key participants and stake holders in the system as described in Section 4 below.

4. The technical assistance activities included review of policies and procedures of the mental health program in effect throughout the system prior to arrival on site. In addition, after arrival on site, the technical assistance activities included following an agenda and itinerary prepared by Dr. Ellison (See Attachment 2) which included meetings with key participants and stake holders in the system, including the following:

    A. Director of the South Carolina Department of Corrections, Mr. Catoe

    B. General Counsel, Mr. Stroker and Mr. Peterson,

    C. Health services personnel, Dr. Blackwell, and Ms. Green

    D, Lead correctional institutional staff

    E. GPH counseling, administrative, and nursing staff

    F. maximum security unit warden, Mr. McCanns

    G. State-wide mental health supervisors

    H. Protection and advocacy representatives, Ms. Prevost, Ms. Ross, and Ms. McCanns

Finally, there was an Exit Conference held with Dr. Ellison, Mr. Stroker, Mr. Peterson, and other administrative and mental health staff. Please see Attachment 3 for the listing of participants and stake holders interviewed during these meetings.

5. The technical assistance did not include formal training and therefore there is no list of trainees for this site visit.

6. My analysis and specific recommendations regarding the mental health services provided to inmates in the South Carolina Department of Corrections are as follows: In my opinion, the system is currently in crisis and immediate efforts to rectify the inadequate resource provision to the mental health system must be undertaken. The efforts to establish and maintain an adequate mental health system require the following considerations and actions:

    A. operations at GPH were inadequate to meet the mental health needs of inmates in the system; policies and procedures require further development and implementation cannot occur without increases in resources; the maximum-security unit at Kirkland does not have adequate mental health services;

B. an immediate hiring of mental health professionals in all disciplines is necessary to provide adequate staffing and programming throughout the system;

C. securing a new contract with another established mental health provider should be considered to establish and maintain an adequate mental health system;

D. establishing a collaborative relationship with the Department of Mental Health and possible university affiliations to provide adequate staffing and

programmatic activities to develop and maintain an adequate mental health service delivery system should be considered;

E. Lastly, based on my experience as noted above, I am recommending that standards, such as those published by the National Commission on Correctional Heath Care (NCCHC), should be utilized as guidelines for system development and implementation.

7. In conclusion, while I was greatly encouraged by the leadership of the Department of Corrections and within the mental health service delivery system, I am greatly concerned by the lack of resources currently available at all clinical levels and in all facilities. My impression was that the Director of the Department, Director of Behavioral Medicine, and the General Counsel were aware of the need to rapidly develop and implement an adequate mental health program, and I would encourage, once again, that this process proceed with whatever departmental, legal and/or legislative support necessary to rectify this profound crisis in mental health service delivery for inmates with mental health needs.

ATTACHMENT 1

Inmates in SCDC Institutions as of 1/24/2000
Breakdown by Custody Level for Each Institution

INMATES IN SCDC INSTITUTIONS AS OF 1/24/2000
BREAKDOWN BY CUSTODY LEVEL FOR EACH INSTITUTION

- TABLE OF INSTDESC BY CUST

INMATES IN SCDC INSTITUTIONS AS OF 1/24/2000
BREAKDOWN BY CUSTODY LEVEL FOR EACH INSTITUTION

TABLE OF INSTDESC BY CUST

INSTDESC	CUST													
FREQUENCY	CL	DR	IN	ME	MI	MO	MR	MX	PC	SD	SK	SP	ST	TOTAL
ALLENDALE	5	0	0	213	780	0	4	0	0	69	0	1	2	1074
BROAD RIVER	52	0	0	63	750	0	53	0	0	68	0	0	6	992
CAMPBELL	0	0	0	0	0	239	1	0	0	0	0	0	0	240
CATAWBA	0	0	0	0	1	180	0	0	0	0	0	0	0	181
COASTAL	0	0	0	0	0	126	1	0	0	0	0	0	0	127
CROSS ANCHOR	31	0	0	40	548	0	9	0	0	75	0	0	1	804
DUTCHMAN	1	0	0	48	570	2	6	0	0	22	0	0	3	652
EVANS	245	0	0	182	783	2	12	0	0	71	0	4	15	1314
GILLIAM PSY	5	0	16	8	37	1	2	4	0	15	0	0	5	93
GIVENS	0	0	0	0	0	116	5	0	0	0	0	0	0	121
GOODMAN	0	0	0	0	1	433	5	0	0	0	0	0	0	439
KERSHAW	254	0	0	124	842	0	5	0	0	80	0	0	15	1421
KIRKLAND	1	0	368	1	159	5	19	0	0	0	0	0	0	553
KIRKLAND INFRM	0	0	3	1	4	2	0	0	0	0	0	0	0	10
KIRKLAND MAX	0	0	0	0	0	0	0	44	0	0	0	0	0	44
LEATH	22	0	0	38	381	25	8	0	0	4	0	0	2	478
LEE	261	0	2	103	903	4	13	0	0	121	15	15	9	1446
LIEBER	4	84	0	123	910	2	2	0	0	63	0	0	13	1181
LIVESAY	0	0	0	0	0	153	0	0	0	0	0	0	0	153
TOTAL (CONTINUED)	886	84	450	1512	12206	3228	1439	48	12	737	15	24	170	20791

CL = CLOSED CUSTODY
DR = DEATH ROW
IN = INTAKE STATUS
ME = MEDIUM
MI = MINIMUM IN
MO = MINIMUM OUT
MR = MINIMUM OUT RESTRICTED
MX = SUPERMAX
PC = PROTECTIVE CUSTODY
SK = SAFE-KEEPER
SP = PROTECTIVE CONCERNS
ST = SHORT TERM LOCK-UP

INMATES IN SCDC INSTITUTIONS AS OF 1/24/2000
BREAKDOWN BY CUSTODY LEVEL FOR EACH INSTITUTION

TABLE OF INSTDESC BY CUST

INSTDESC / FREQUENCY	CUST CL	DR	IN	ME	MI	MD	MX	MX	PC	SD	SK	SP	ST	TOTAL
LOWER SAVANNAH	0	0	0	0	0	214	1	0	0	0	0	0	0	215
MACDOUGALL	0	0	1	34	423	17	140	0	0	0	0	0	0	615
MANNING	2	0	0	109	523	15	28	0	0	0	0	0	13	[redacted]
MCCORMICK	4	0	0	182	876	0	20	0	0	73	0	0	20	1155
NORTHSIDE	0	0	0	0	1	387	7	0	0	0	0	0	0	395
PALMER	0	0	0	0	0	223	0	0	0	0	0	0	0	223
PERRY	4	0	0	127	826	1	6	0	12	108	0	0	6	890
RIDGELAND	2	0	0	123	936	10	54	0	0	15	0	0	9	1149
STATE PARK PLM	0	0	0	0	3	254	23	0	0	0	0	0	0	280
STATE PARK WRK	0	0	0	0	0	135	13	0	0	0	0	0	0	148
STEVENSON	0	0	2	0	3	170	65	0	0	0	0	0	1	241
TRENTON	0	0	0	0	252	10	273	0	0	0	0	0	17	552
TURBEVILLE	0	0	0	5	1070	1	37	0	0	16	0	1	23	1153
WALDEN	0	0	0	0	0	360	7	0	0	0	0	0	0	367
WATEREE	0	0	0	0	298	88	387	0	0	0	0	0	8	[redacted]
WATKINS	0	0	0	0	0	17	196	0	0	0	0	0	0	213
WOMENS CENTER	22	0	1	14	279	1	0	0	0	0	0	0	0	317
WOMENS R&E	1	0	55	0	47	15	26	0	0	7	0	0	0	151
WOMENS SIU	0	0	0	1	13	0	0	0	0	0	0	0	0	14
TOTAL	886	64	450	1512	12206	3228	1439	48	12	737	15	24	170	20791

(CONTINUED)

ATTACHMENT 2

Agenda and Itinerary
Prepared by Richard Ellison, M.D.

RAYMOND PATTERSON, M.D.
ITINERARY

Monday, February 7, 2000

8:00 a.m.	Meet with Dr. Ellison at hotel for transport to SCDC
8:30 a.m.	Director Catoe
9:00 a.m.	General Counsel - Mr. Stroker and Mr. Peterson
9:30 a.m.	Health Services - Dr. Blackwell and Ms. Green
10:30 a.m.	Tour of Gilliam Psychiatric Hospital
11:00 a.m.	Gilliam Psychiatric Hospital Nursing staff
12:00 noon	Lunch with Staff
1:30 p.m.	Depart for Lee Correctional Institution
2:30 p.m.	ICS Tour and Staff Conference
4:00 p.m.	Depart for Columbia

Tuesday, February 8, 2000

8:00 a.m.	Meet with Dr. Ellison at hotel for transport to SCDC
8:30 a.m.	GPH Counseling Staff
9:45 a.m.	Statewide Mental Health Supervisors
11:00 a.m.	Review of MSU and GPH Records Inmate/Staff Interviews
12:00 noon	Lunch with Staff
1:00 p.m.	Meet with Protection & Advocacy (Ms. Robinson, Ms. Prevost, and Ms. Ross)
2:00 p.m.	Final Review of GPH
3:00 p.m.	Exit Interview - Dr. Ellison and Staff

ATTACHMENT 3

Listings of Participants and Stake Holders

SCDC 2-8-00

GPA

JOAN WAGGONER RN

Susan Ullrich RN DON

KATHLEEN F. POWELL

SARAH A. SMITH

Jim Pace

SAMUEL DAVIS

Ernest Shaw, MSW

RICHARD ELLISON, MD

Ed Wescom, Ph.D

SCDS 2-8-00

Substance Mental Health Supervisors

Ann Dwyer, Coordinator, MH Services for Women
T. Teresa Yates, HSC II (Lee, Evans, Kershaw, Waccamaw)
Brenda Mickens, HSC II, Sexual Preditators Program
Linda W. Fasham, HSC II Area Coordinator
Reggie Weeks HSC II Hab Unit
Kathleen [illegible] Powell PRC
Jim Page HSC II
SHERENE CUPSTID, ADMIN. COOR.
Martha Sue Hope, HSC II (Lieber, Allendale, Pre-Release Coastal, Ridgeland, MacI
Richard Wilson, State Assessment Coordinator

Gillian Psychiatric Hospital

Kathleen E. Powell Manager Mental Health Div Comm.
Jim Page Hospital Administrator
Richard Wilson - Former Director
Susan Ullrich - Director of Nursing
John Waggoner RN, Head Nurse

Lee ICS
Teresa Yates, HSC II - Behavioral Medicine
LeAnn Vogt, PROGRAM MANAGER ICS
Aunra B. Hudley - Behavioral Medicine
Robbin M. Harmon Rn - Health Care Authority

EXHIBIT C

MEMORANDUM

July 11, 2003

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

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

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

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

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

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

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

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

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

I will wait to hear from you about future directions.

Respectfully submitted,

Diane Cavenaugh, MSW, Program Manager I

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH PROGRAM

MISSION STATEMENT

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

VISION STATEMENT

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

GOALS

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

ORGANIZATION

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

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

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

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

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

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

PROGRAM DESCRIPTIONS

Service
RECEPTION AND EVALUATION (R & E)

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

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

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

Exclusion Criteria

An inmate of SCDC who:

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

Programming

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

Staffing

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

Outcome Measures

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

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

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

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

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

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

Exclusion Criteria
An inmate of SCDC who:

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

Programming

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

Staffing/GPH

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

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

Outcome Measures

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

Service

Behavior Management Unit (BMU)

Purpose

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

Goals

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

Inclusion Criteria

An inmate of SCDC who:

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

Exclusion Criteria

An inmate of SCDC who:

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

Programming

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

Staffing

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

Outcome Measures

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

Service

Intermediate Care Services (ICS)

Purpose

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

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

Goals

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

Inclusion Criteria

An inmate of SCDC who:

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

Exclusion Criteria

An inmate of SCDC who:

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

Programming

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

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

Staffing

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

Outcome Measures

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

Service
Area Mental Health Services (AMH)

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

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

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

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

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

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

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

Staffing

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

Outcome Measures

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

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

Service
Outpatient Mental Health (OMH)

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

Outpatient Mental Health services are provided throughout the SCDC system.

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

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

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

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

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

Staffing

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

Outcome Measures

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

QUALITY ASSURANCE/IMPROVEMENT PROCESS (QA/I)

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

The QA/I process includes:

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

SAMPLE SCHEDULE FOR INTERMEDIATE CARE SERVICES PROGRAMS

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

NOTE:

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

INTERMEDIATE CARE SERVICES SAMPLE PROGRAMMING DESCRIPTIONS

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

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

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

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

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

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

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

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

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

FREE TIME — Various Times, Monday through Friday

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

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

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

ONE TO ONE — Various Times Throughout the Week

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

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

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

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

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

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

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

SAMPLE SCHEDULE FOR GILLIAM PSYCHIATRIC HOSPITAL

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

NOTE:

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

GILLIAM PSYCHIATRIC HOSPITAL SAMPLE PROGRAMMING DESCRIPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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