SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF HEALTH SERVICES

INMATE HEALTH RECORDS GENERAL GUIDELINES

Number: H.S. 19.14
Related SCDC Policy: HS-18.7
Date: June 1, 2016

POLICY STATEMENT: The agency is committed to upholding the confidentiality and privacy of an inmate's medical history. Therefore, an inmate's medical history/record will be accessible to authorized SCDC personnel and others for duly authorized purposes only in accordance with applicable agency policies/procedures, and state and federal statutes.

PURPOSE: To promote consistency and accuracy when documenting in and securing and offender's medical record.

GOAL: A health record shall be maintained for each inmate under the custody of the SCDC. This record shall contain accurate, cumulative documentation of all health care services and encounters provided throughout the period of incarceration. There shall be an automated medical record as well as a hard copy medical record.

DEFINITIONS:

Contract Medical Consultant: The physician, dentist or the nurse hired under contract to the SCDC to provide or assist with medical treatment.

Deputy Director of Health Services: The position assigned to the Health Services Division responsible for the coordination of medical and mental health service delivery to inmates.

Director of Health Records: Individual with a minimum of a BA in Health Information Management or a certified Medical records Administrator who is responsible for the management of health records including mental health records throughout the SCDC system. They are also responsible for training and supervision of medical record administrators at the institutional level.

Documentation Standards Committee: refers to an interdisciplinary group of health professionals who will determine guidelines for documenting information in the medical/health record. The Committee will be responsible for approving standard abbreviations, documentation format (e.g., D.A.P., S.O.A.P.), structural documentation guidelines (e.g., black ink, yellow highlighters, proper error correction, etc.), new and revised forms, and required content to meet professional and legal standards. This Committee will be appointed by the Deputy Director of Health services.

Facility Records Office: The secure office where current medical records are kept.

Health Information Central Office Manager: The position assigned to the Health Services Division responsible for the storage of the medical and mental health records for inmates that are released or discharged to probation or a designated facility.

Health Insurance Portability and Accountability Act or HIPAA - A U.S. law designed to provide privacy standards to protect patient's healthcare records and other health information provided to health plans, doctors, hospitals, and other health care providers. Developed by the Department of Health and Human Services, these standards provide patients with access to their healthcare records and more control over how their personal health information is used and disclosed.

Health Record: Medical and mental health information maintained and secured by the health care provider and contained in the form of electronic or paper media.

Inactive Health Record: medical, dental and mental health records of all offenders discharged from sentence or released to post-incarceration supervision are sent to HIR 30 days after their release to be held until they are disposed of or re-incarcerated then the record is sent to Kirkland R & E or Camille Graham R & E.

Inactive Offender Records Repository: A centralized inactive records section for the SCDC.

Medical Director: The medical director of the agency responsible for the provision of health care for the South Carolina Department of Corrections.

Medical/Health Record/Automated Medical Record (AMR): refer to health information and medical forms (automated or hard copy) maintained by the Agency on each inmate admitted to the SCDC. The terms "health record," "medical record," and AMR are used interchangeably throughout this policy and related procedure.

Medical/Mental Health File: Reflects all medical, dental and mental health initial assessment orders and treatments provided, including consultations and X-ray films.

Mental Health File: Raw Psychological Testing Data File. Reflects all mental health and psychiatric testing material.

Medical Record Administrative Support Person: Staff member at the institution level responsible for the management of health records/ mental health records,

Nursing Supervisor: The nurse responsible for the provision of health care services at a facility.

Protected Health Information: refers to all individually identifiable health information transmitted or maintained by a covered entity, hybrid entity, or business associate, regardless of form.

Transfer: for the purposes of this policy/procedure, refers to an inmate and/or his/her health record moving from one area of medical coverage to another, whether it be temporary (inpatient infirmary stay, court appearance, etc.) or permanent (reassignment to another institution).

GENERAL PROVISIONS:

1. The Deputy Director of Health Services will appoint an interdisciplinary group of Healthcare professionals to a Documentation Standards Committee. This committee is made up of the Director of Nursing, the Regional Nurse Coordinators, the Director of Health Information Records, the Medical Director, the Chief Psychiatrist, the Director of Pharmacy, the Director of Laboratory Services, and the Assistant Deputy Director. This committee will be tasked with developing guidelines for documenting information in an inmate's medical record. The Documentation Standards Committee will be chaired by the Director of Health Information Records, and will be responsible for developing and updating guidelines for medical documentation and compiling the health record.

2. The inmate's complete health record may consist of the medical hard chart, the Infirmary hard chart, the Gilliam Psychiatric Hospital (GPH) hard chart, and the automated medical record (AMR), and shall accompany the inmate upon transfer to another SCDC facility.

3. The health record may never be removed from the facility where the inmate is housed for healthcare purposes. If an outside treatment facility requires information from the medical record for care, then copies of the information required are made and sent with the inmate to the provider conducting the offsite care/treatment.

4. When an inmate is released to post incarceration supervision, all healthcare records shall be forwarded, with case management records, to Health Information Resources central office for storage, retention and disposition.

PROCEDURE:

A. ESTABLISHMENT OF THE HEALTH RECORD

1. The medical staff at the Kirkland R & E center shall be responsible for initiating a hard chart health record at the time of the inmate's reception into SCDC custody. Additional hard charts are created when an inmate is admitted to a SCDC Infirmary or SCDCs Gilliam Psychiatric Hospital. The automated chart is created through security staff once the inmate is issued a SCDC number.

2. The Administrative Specialist/Certified Nursing Assistant (CNA)/or nursing staff at each institution will be responsible for maintaining the medical records and medical records area at each facility. All health records for each incarceration shall be brought forward and filed under the inmate's current assigned SCDC number. However, psychological raw test data will be housed separately with the Chief Psychologist.

B. CONTENTS OF THE MEDICAL/INFIRMARY/GPH/AMR FILE

The hard chart health record shall be established and maintained according to standards set forth in Health Services Procedures (HSP) 3000.5. The final organization of the chart is as follows:

I.Section I: (Interfile in reverse chronological order)

***	DO NOT RESUSCITATE (DHEC form #3462)
M-30	Information for Released Inmate (yellow copy)
M- 110	Medical Clearance for Institutional Transfer
M-16	Sick Call Clinic Notes
M-45	Discharge Information
M-52	Neurological Exam Record
M-74	Physical Assessment of Suspected Chemical User
M-83	SCDC Emergency Room Record (for inmates not admitted to the hospital or infirmary.)

II. Section II: PROBLEMS, MEDS, INPATIENT (Group file in reverse chronological order)

M-1 16	Appointment/Information Card (may be discarded when full)
M-76	Problem List
M- 123	Health Summary for Classification/Assignment
SCDC 24-155	HIV Patient Education and Counseling Record
M- 113	Chronic Infectious Disease Monitor
M-1 12	Data Collection for Persons with Positive HIV Tests
M-88	Medication Profile
M- 10	Daily Medication Administration Record
M-41	Diabetic Care Record
M-103	Cardiovascular Follow-up Record
M-119	Evaluation for Active TB
M-99	Tuberculosis Preventive Treatment Record
M-100	Tuberculosis Treatment Record
***	All inpatient records with newest admission on top. This includes SCDC infirmary records and inpatient records from hospitalizations that were generated while the

inmate was incarcerated. This does not include old outside hospital records from before incarcerations.

III. Section III: DENTAL CLINIC, MENTAL HEALTH

DENTAL	(Interfile in reverse chronological order)
M-19, A&B	Dental Health Records
***	(Panorex, other dental X-rays, old dental card in pocket)
M-38	Dental Statement of Responsibility

MENTAL HEALTH (Interfile in reverse chronological order). This record will include all entries documenting mental health services.

M-122	Referral/Action Taken Form
M- 121	Request for Behavioral Medicine Services
#26-40	Initial Interview (Data Sheet). (This form **is now computerized,** but may still be found in older records)
***	Gilliam Psychiatric Hospital Discharge Summaries (Copy only... Original will be in the GPH 2 record.)
***	Psychological Evaluations
***	ICS (ICU) forms
***	All other mental health information M-107 Consent for Neuroleptic Medication
M-108	Consent or Denial of Consent to Use Neuroleptic Medication in Patients with Tardive Dyskinesia
M-120	Mental Health Observation
M-65	Consent for Gilliam Psychiatric Center Treatment Copies of SCDMH forms for Admission to GPH
***	GBMI Court Order
M- 16	Sick Call Clinic Notes (for Mental Health progress notes only)

IV. Section IV: LAB, RADIOLOGY, EKG

LAB (Interfile laboratory reports in reverse chronological order. This may include the old M-20, M-57, M-71,
M-80, M-84 forms that are no longer in use.) (NOTE: if the laboratory returns a requisition with "RECOLLECT" written on it, that lab requisition must be filed as any other lab slip as part of the permanent medical record.).

RADIOLOGY	(Interfile in reverse chronological order)
M-55	X-ray Requisition and Report (NOTE: remove temporary fax! photocopy of report when original is filed).
***	Radiology, ultrasound, CT, MM, etc., reports from community sources

EKG

***	EKGs (NOTE: If the EKG is on thermal paper, make a copy and file the photocopy only. Thermal paper reports fade with age.)

V. Section V: CONSULTS, CORRESPONDENCE, MISCELLANEOUS (Interfile in reverse chronological order)

M-7, A&B	Physician's Transfer Note or Consultation
M-122	Referral/Action Taken Form (only if used for non-Mental Health referrals)
M-62	Analytical Eye Record
***	Dictated notes from community physicians, health care providers
M-42	Outside Elective Health Care Request
M-79	Request for Special Housing for Physically Disabled Inmates
***	Letters/Memos sent or received with pertinent medical information, other miscellaneous correspondence. (NOTE: No CRT messages, e-mails, grievances, billing authorizations, security clearances, etc.)
M-43	Authorization for Procedure and/or Administration of Anesthesia
9-11	Inmate/Resident Release of Information Consent
M-53	Refusal of Medical Advise Form
***	Approval for Prosthesis and Release of Liability for SCDC
20-67	Dietitian Visitation Report
M-13	Release of Medical Information to SCDC (yellow copy) (NOTE: when the community records are received, they should be stapled to form M-13, if not already sent with a copy. Be sure to file these by the date of the contents, not the date the record is requested or received. These will normally be on the bottom of this section, as their dates will be normally prior to incarceration.)

VI. Section VI: PERSONAL DATA (Group file in reverse chronological order)

M-109	Periodic Physical Assessment (old form, used only if AMR unavailable)
M-17 A&B	R&E Centers Medical Examination (used only if AMR unavailable)
M-14	Medical Screen
M-6	Health Related Supplies

The Infirmary hard chart record shall be established and maintained according to standards set forth in Health Services Procedures (HSP) 3000.6. This record will be maintained as a separate record while an inmate is in the Infirmary.

SECTION I (top to bottom)

1. Discharge Summary
2. Patient Information Sheet (H&P)
3. Consultations (group filed in reverse chronological order)

SECTION II

1. Physicians Progress Notes (group filed in reverse chronological order)
2. Physician's Orders (group filed in reverse chronological order)
3. Inmate Refusals (group filed in reverse chronological order)

SECTION III

1. Lab (group filed or interfiled in reverse chronological order)
2. X-rays (group filed or interfiled in reverse chronological order)

3. EKG's (group filed or interfiled in reverse chronological order)
4. Scans etc. (group filed or interfiled in reverse chronological order)

SECTION IV

1. MARS (in reverse chronological order)

SECTION V

1. Graphics (group filed in reverse chronological order)

2. The GPH hard chart record shall be rust colored with six sections, as are the health and Infirmary charts. However, the forms used during each hospital stay will be filed together in each section.

3. The Automated Health Record (AMR) is divided into five main sections:

   Section I: Initial Physical Examination F2
   Section II: Prescription Medications F5
   Section III: Chronological Healthcare Encounters F3
   Section IV: Allergies F8
   Section V: Vaccinations F6

4. Only Healthcare personnel shall have input, when appropriate, into the medical files. Each entry documented within the health record shall contain a printed name, title, date, and signature of the Healthcare staff member entering the information.

C. HEALTH RECORD MAINTENANCE AND REVIEW

1. The Nursing Supervisor of the facility in which the inmate is housed shall ensure that each health record is maintained consistent with SCDC policy to ensure charts:

   (a) Serve as a basis for planning individual care.

   (b) Facilitate continuity of evaluation, treatment, and any changes in condition.

   (c) Facilitate evaluation of care.

   (d) Protect the legal interests of the SCDC.

   (e) Serve as a basis for statistical analysis and clinical data for use in program planning, education and approved research.

   (f) Facilitate communication between the responsible physician and other healthcare providers.

2. The Health Information Records Director shall conduct **quarterly audits** of health records at each facility. This audit shall be for the purpose of ensuring accuracy and completeness of information, organizational conformity, and storage security.

D. PRIVACY AND CONFIDENTIALITY OF MEDICAL/HEALTH RECORDS

1. The health record is confidential, and will be maintained separately from the confinement record.

   a. Access to health records should be safeguarded by the medical staff.
   b. Records rooms are to be locked when medical staff aren't present.

c. Records, whether hard copy or electronic, are not to be left accessible to inmates or non-medical staff members.

2. Each employee who has access to protected health information will keep such information confidential. Employees who fail to follow the Agency's standards for protecting the security and confidentiality of protected health information will be subject to corrective action as outlined in SCDC Policy/Procedure ADM-11.04, "Employee Corrective Action."

3. The division of Resource Information Management (RIM) will ensure that employees are only given access to the AMR when approval is provided through the on-line Access Requests System.

4. Statutory authority of confidentiality of drug abuse patient record must fall within applicable federal laws (42 CFR Part 2). Records of the identity, diagnosis, or treatment of any patient which are maintained in connection with performance of any drug treatment program shall be confidential and be disclosed only for the purposes and under the circumstances outlined below:

   a. Written consent from the patient
   b. Medical personnel to the extent necessary to meet a bona fide medical emergency
   c. To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation. Such information may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

   Prohibition against use of record in making criminal charges or investigation of patient. Except as authorized by a court order, no record may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

5. South Carolina Department of Corrections will protect the privacy of an individual's Protective Health Information in accordance with HIPAA and other federal and state statues regarding privacy.

6. Uses and Disclosures of HIV/AIDS information: HIV/AIDS records may be disclosed to another health care provider for treatment purposes only when SCDC has provided direct medical care to the individual and refers the person to or consults with the health care provider to whom the information is released. **Test results are confidential**. Under state statue, confidential HIV/AIDS information can only be given to people whom the person in lawful custody allows to have it by providing written authorization, or to people who need to know the person's HIV status in order to provide medical care and services. The law allows HIV information to be released under limited circumstances; by special court order and to public health officials as required by law.

E. Release of Information

1. The request to release information is sent to Health Information Records to ensure that any health record information is released in a manner consistent with statutory requirements and accepted standards of care and security:
   a. Protected health information may only be released to individuals, other than the inmate, by the director of Health Information Resources (HIR) or designee, with the inmate's written permission or pursuant to a court order.
   b. An administrative fee, determined by HIR, will be charged for copies of a health record as specified in HSP 2000.1.
   c. Copies of health records will be provided at no charge to a physician or health care provider for continuation of treatment for a specific condition or conditions.

2. Information will be released upon receipt of a properly executed court order or subpoena. All court orders or subpoenas for inmate health records by any of the institutions should be forwarded immediately to HIR for processing within 24 hours of receipt or notification. Information will be released to the General Counsel's Office (or designee) upon request.

3. The Nursing Supervisor (NS)/designee will be permitted to share information with the appropriate correctional authorities on a need to know basis as it pertains to: an inmate's medical management, security, or his/her ability to participate in programs. If a non-medical staff member is given medical information about an inmate because of a particular need to know, e.g., post-exposure care, transportation, grievance, investigation, etc., that staff member must uphold the confidentiality of that medical information. (Refer to Health Services Procedure 2000.03, "Internal Affairs Access to Health Records," should be referred to our legal department.

4. Information regarding communicable diseases may be released by the director of Laboratory Services, HIR or NS/designee to county health departments or to DHEC in accordance with state and federal laws.

5. When an inmate is referred to health care providers outside of the SCDC, appropriate health information will be shared with those providers in accordance with HIPPA laws.

6. Information will be released to designated parties or agencies with a legitimate need for information (e.g., the inmate's attorney, a physician, including an elective outside medical care physician, a medical facility in the community, the Vocational Rehabilitation Department, or the Social Security Administration) by the Central HIR staff when the inmate provides his/her consent on SCDC Form 9-11, "Inmate/Resident Release of Information Consent" or a consent form provided by that agency or designated party.

7. When faxing or mailing protected health information to attorneys, outside physician's offices, etc., a cover sheet must be used. All electronic communication containing protected information must be sent encrypted.

8. SCDC medical clinics will offer inmates SCDC Form M-152, "Consent to Release Medical Information" so that an inmate may designate a family member or other person to whom medical information may be shared. When an inmate's family member or other individual contacts SCDC staff with questions or concerns regarding health care issues, protected health information will only be shared if a consent form has been signed by the inmate allowing disclosure to that individual.

F. An Inmate's Access to His/Her Own Medical Record (2000.1)

1. An inmate's medical record belongs to SCDC, but the information contained in the record may be made available to that inmate in accordance with the following guidelines: (See Health Services Procedure 2000.01, "Inmate Access to His/Her Own Health Records," for specific guidelines.)

2. An inmate may make an appointment (using SCDC Form 19-11 "Request to Staff Member") with medical staff to review his/her health record and may take notes in the presence of this staff member.
   a. The inmate may view encounters in the automated medical record (AMR) in the presence of a medical staff member at the discretion of that staff member. (This will exclude mental health information unless permission is given by the Chief Psychiatrist or designee. (See Paragraph 4.2, below.)

3. An inmate may request to review portions of his/her psychiatric or psychological records using SCDC Form 19-11, "Request to Staff Member." These requests will be evaluated by the Chief of Psychiatry or designee before the inmate will be given an appointment to review the record in the presence of a mental health professional.

4. An inmate may request a single copy of his/her HIV report and/or Analytical Eye Record using SCDC Form 19-11, "Request to Staff Member." A copy will be made by the medical staff, who will note in the AMR that the inmate was given a copy of the HIV report and/or Analytical Eye Record.

   An inmate may request copies of his/her health record or portions thereof on SCDC Form 19-11, "Request to Staff Member." Each request will be forwarded to the director of HIR or designee for evaluation on a case-by-case basis. Once the request is received, the inmate will be sent an MR-1 form agreeing to the cost of the records. If copies are made, the inmate will be charged a fee in accordance with HSP 2000.1.

G. REQUESTING INFORMATION FROM OUTSIDE PROVIDERS: (2000.5)

When an SCDC physician requires copies of an inmate's non-SCDC medical records, Health Services staff will have the inmate sign SCDC Supply M-13, "Release of Medical Information to the South Carolina Department of Corrections," and fax that signed form to the outside facilities records office in order to obtain the records. (Refer to Health Services Procedure 2000.05, "Request for Information from Outside Providers," for further details.)

H. TRANSFER OF HEALTH RECORDS: (2000.6)

1. The inmate's health record will be transferred with them when s/he is transferred from one area of medical coverage to another, to ensure continuity of care.

2. When permanent hard copies of medical records are transferred from one institution to another, appropriate AMR (automated medical record) entries will be made by both the sending and receiving institutional medical staff. The hard copy of the record will be transported in a SEALED envelope labeled "CONFIDENTIAL." (Refer to Health Services Procedure 2000.06 "Transfer of Medical Records" for further details.)

3. If an inmate is transferred to a community facility (physician appointment, outpatient procedure, emergency room, or hospital admission), the medical record will stay at the inmate's assigned institution. *Only pertinent copies may accompany the inmate. After the appointment, procedure, or admission, if the inmate is returned to a different SCDC facility/infirmary, the original record will be forwarded to that facility/infirmary.*

4. When an inmate is transferred for emergency care within the agency, the hard copy of the medical record will initially remain at the inmate's assigned institution. The SCDC ER medical staff will document their care in the AMR. If the inmate is admitted to the infirmary, the infirmary staff will request the hard copy of the medical record from the sending institution (may be the next working day, as appropriate).

5. If an inmate is admitted to an SCDC infirmary, the charge nurse or designee will send the medical record to the infirmary. The health record will accompany the inmate when s/he is discharged from the SCDC infirmary to return to his/her assigned institution.

6. If an inmate transfers for a court hearing, the medical staff will review the record and send pertinent copies (e.g., Problem List, Medication Administration Record, etc.), as applicable, along with the inmate's medication. The original medical record will remain at the inmate's assigned institution.

I. INMATE DEATH (200.4)

1. If an inmate death occurs, the nurse or designee will notify the Central HIR office according to procedures outlines in SCDC Policy/Procedure 200.4, "Inmate Death."

2. The medical staff will forward all appropriate volumes of the inmate's medical record, including the sick call notes documenting the incident, the current infirmary record, and the GPH record, if applicable, to the contracting pathologist, as outlined in Health Services Procedure 2000.06. Central HIR staff will be responsible for retrieving the record from the pathologist.

3. If an autopsy is not required, the inmate's complete medical record (including all medical, infirmary and GPH volumes) will be sent to the central HIR office by the institutional medical staff where the death occurred.

J. ESCAPE:

In the event of an inmate escape, the medical record will be held in the inmate's assigned institution for five (5) days. If the inmate has not been apprehended after this time, his/her medical record will be sent to the central HIR office.

K. RELEASE:

When an inmate is released, the medical record will be sent to the central HIR office.

L. INACTIVE HEALTH RECORDS:

1. Inactive health records will be maintained by the central HIR office in hard copy form for 10 years or on microfilm and/or on electronic media for eighty (80) years.

2. If an inmate re-enters SCDC, the R&E medical records staff will be sent the old health record from central HIR to combine the old and new record.

M. QUALITY MANAGEMENT

Annually and as needed, the Director of HIR or designee will conduct audits of 10% of the health records at each institution. In addition, the storage site with be audited for maintenance and security. A report of these audits will be distributed to the Documentation Standards Committee members.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF BEHAVIORAL/MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

INTERMEDIATE CARE SERVICES (ICS)

Number: HS - 19.12
Date: June 01, 2016

Location

The Intermediate Care Services (ICS) is part of the residential mental healthcare services provided for SCDC inmates. It serves inmates with various security needs in locations that can support both therapeutic programming and safety for inmates and staff.
Both male and female ICS programs are located at facilities in Columbia, SC. The program for males has a minimum of 128 rooms dedicated to the ICS inmates, while the program for females as a maximum capacity of 80 beds.

Modified ICS services will also be made available to inmates who meet the mental health criteria for ICS but, based on their security designation, are not able to be housed in the ICS-designated housing.

Mission Statement:

The Intermediate Care Services (ICS) is a residential mental health program, provided in a therapeutic environment within the South Carolina Department of Corrections (SCDC) and is a part of the Division of Behavioral/Mental Health and Substance Abuse Services. The mission of the ICS is to provide residential services for inmates with serious, persistent mental illness who require intensive treatment, monitoring and care but do not need psychiatric hospitalization. Inmates receive medication therapy, counseling services, and educational interventions aimed at managing psychiatric symptoms, improving basic coping skills, and developing general self-care skills. All services are provided by, or under the supervision of, licensed professional mental health staff.

I. **PROGRAM STAFFING**

	Male Program	Female Program
Psychiatry	1.5 FTE	1 FTE
Psychology	1 FTE	1 FTE
QMPH	13 FTE	4 FTE
Mental Health Techs	5 FTE	4 FTE
Activity Therapy	1 FTE	1 FTE
Nursing	15 FTE (RNs/LPNs)	24 FTE (RNs/LPNs)

Adequate security staff will be assigned to ICS to maintain a safe treatment environment for inmate patients, a safe working environment for staff, and to support activities and movement in all areas of the unit.

Comment [A1]: Does the women's ICS have two sides also, so that "both" is appropriate wording? How about "in the unit" or "in all areas of the unit?"

Hours of Coverage:

Monday to Friday 7:00 a.m. – 4:00 pm (daily mental health programs)

Weekends 7:00 a.m. – 3:00 pm (weekend coverage mental health staff)

II. **ADMISSION CRITERIA**

A. Admissions Process

1. The Mental Health Referral Form (Attachment # 1) is completed and forwarded to the ICS program manager, who is a licensed psychologist. If it is approved, the program manager or designee will notify the Division of Classification and Inmate Records of the approval and coordinate transferring the inmate to ICS.

2. General diagnostic guidelines for admission to ICS include: diagnosis of schizophrenia and other psychotic disorders, severe mood disorders (bipolar, major depression), severe anxiety-related disorders, major neurocognitive disorders with behavioral disturbances, dissociative disorder, dually diagnosed inmates wherein a severe mental illness is the primary problem, or personality disorders when symptoms cause serious and persistent disturbances that require structured treatment.

3. Mentally ill inmates with the following characteristics are appropriate for ICS services:

   a. Serious symptoms (chronic mood instability, severe anxiety-related disorders, impaired reality testing, impaired judgment, impaired thought processes, impaired social functioning, or impaired communication skill, when these conditions substantially impede an inmate's ability to reside safely within the general population).

   b. Poor symptom control even with medication therapy and chronically non-compliant with medication.

   c. Failure to stabilize at lower levels of care or having a poor history of adjustment, usually reflected in multiple hospitalizations.

   d. Requiring a highly structured environment.

III. MENTAL HEALTH SERVICES

A. Case Management

Qualified mental health professionals (QMHP) provide all case management services and serve as the primary counselors to assigned inmates. The primary QMHP works in conjunction with the psychiatrist, psychologist, nursing, and security to ensure that inmate's needs are met.

1. Upon admission to ICS, inmates receive an initial assessment and are assigned a primary QMHP. The primary QMHP serves as the case manager and completes an intake assessment.

2. The primary QMHP, the inmate, and the treatment team develop an individualized treatment plan (Attachment # 2). In turn, the primary QMHP refers the inmate to groups and may request psychological testing.

3. During the first four weeks of the ICS program, the primary QMHP provides individual counseling to the inmate once per week or more often, as clinically indicated. After four weeks, the primary QMHP conducts individual sessions no less than twice monthly, but these sessions may occur more often as clinically indicated. The QMHP will continue to see all inmates on his or her caseload at least weekly in a group format.

4. A psychiatrist is assigned to the inmate. The psychiatrist determines psychiatric medication needs and ensures that medical needs are addressed. The psychiatrist assesses the inmate every 30 days, or more often as clinically indicated.

5. The primary QMHP serves as the inmate's staff representative to the treatment team.

6. The primary QMHP acts as a liaison with family and significant others. With appropriate releases of information, the inmate's family members and significant others may be contacted to provide background information pertinent to the inmate's treatment at ICS.

7. Treatment services include, but are not limited to, psychopharmacology, individual counseling, group therapy, activity therapy, referral services, and discharge planning. The primary QMHP meets with the inmate according to the treatment plan schedule and guides the inmate through the treatment process. The primary QMHP in conjunction with the treatment team assigns the inmate to groups, updates the treatment plan as necessary, and documents all treatment activities.

B. Treatment Planning Process

1. The treatment team consists of the primary QMHP, assigned psychiatrist, psychologist, other ICS-assigned QMHPs, a nurse, an activity therapist, and operational staff.

2. Upon admission to ICS, the assigned primary QMHP completes an intake assessment. The psychiatrist completes an initial assessment within 72 hours. Within the first week, the primary QMHP completes a psychosocial assessment. In conjunction with the inmate, the primary QMHP and the treatment team develop an initial treatment plan that contains individualized treatment goals and objectives.

3. The primary QMHP presents the initial plan to the treatment team during the week following admission to ICS. A 90-day review of treatment plans is required, but revisions are made throughout the treatment process as clinically indicated in consultation with the treatment team. The primary QMHP uses the "Treatment Team Comment Sheet" (Attachment # 3) to record decisions made during the 90-day review. The information is also documented in the automated medical record (AMR).

4. Identification of resolved goals, revisions to existing goals, and the addition of new goals may occur as needed and these updates are documented on the Treatment Plan.

5. Treatment Plan hard copies are stored in the mental health section of the medical record. The treatment planning process is documented in the mental health section of the AMR.

C. Psychopharmacological Therapy

A psychiatrist or qualified mid-level practitioner guide and monitor inmates treated with medication(s). Medical personnel (RN or LPN with supervision) administer all prescribed medications. Patient education regarding medication is an integral part of treatment. Inmates are taught the importance of psychopharmacological therapy adherence, the side-effects of medications, and the importance of disclosing side-effect occurrences. The nursing staff monitors the inmate's compliance with medications and possible side effects. The nursing staff is responsible for documenting compliance with medication(s) and side effects in the AMR.

D. Counseling Services

ICS inmates are provided ten hours of structured out-of-cell activities weekly, which take place Monday through Friday. ICS inmates are allowed a minimum of ten hours of unstructured out-of-cell time per week.

1. Group Therapy – led by a QMHP and provided primarily Monday through Friday with limited group offerings on weekends.

   ICS offers a wide variety of groups to improve symptom management and teach cognitive/behavioral decision making and emotional coping skills. The goals of group are to improve symptom management, reduce problematic behaviors, improve self-care skills, and promote relapse prevention. Group topics may include, but are not limited to:

   Activities of Daily Living
   Alcohol/Substance Abuse/Relapse Prevention
   Anger/Stress Management
   Educational Services
   Library Services
   Living with Schizophrenia
   Medication Education
   Music Therapy
   Personal Hygiene
   Pre-Release Planning
   Rational Behavior Therapy
   Hobby Craft
   Socialization Skills
   Work Assignments

2. Recreation Therapy - The activity therapist plans, directs and coordinates recreation programs for inmates. Structured activities are conducted throughout the week and on weekends.

- The activity therapist, either directly, or through supervision of mental health technicians, observes, analyzes, and records patients' participations, reactions, and progress during treatment sessions, and modifies treatment programs as needed.
- Activity therapy treatment plan goals are based on a needs assessment, patient interests and objectives of therapy and are documented on the treatment plan.
- The activity therapist and mental health technicians under his/her direction encourage inmates to acquire new skills and get involved in health-promoting leisure activities, such as sports, games, arts and crafts, and gardening.
- The activity therapist collaborates with members of the treatment team to plan and evaluate therapy programs.

3. Individual Counseling

   Individual counseling provides confidential therapeutic interactions between the inmate and the primary QMHP in which to focus on treatment plan goals and objectives, practice adaptive coping skills, and confront obstacles to goal attainment. Individual counseling provides a forum for addressing symptom monitoring and managing, medication adherence, and relapse prevention efforts. Individual counseling also affords opportunities to promote personal care skills, and assist inmates in adapting to institutional living while attending to their individual psychological challenges. Individual counseling is provided no less than once per week during the first month at ICS. Thereafter, individual counseling is provided as needed, but not less than twice monthly.

4. During the first four weeks of the ICS program, the primary QMHP provides individual counseling to the inmate once per week or more often, as clinically indicated. After four weeks, the primary QMHP conducts individual sessions no less than twice monthly, but these sessions may occur more often as clinically indicated. The QMHP will continue to see all inmates on his or her caseload at least weekly in a group format.

V. Milieu Therapy

ICS mental health personnel collaborate with security, medical, and other institutional staff to maintain a safe, clean, and quiet environment that is conductive to positive behavioral changes. Specific problematic inmate behaviors are formally addressed in treatment team. Community meeting is also a part of the ICS milieu. The community meeting is a forum for exchanging relevant and useful information between inmates, security, medical, and mental health staff. At the community meeting, inmates are provided appropriate institutional information and are afforded an opportunity to voice their thoughts and concerns. In addition to the community meeting:

A. Level System: The ICS structure includes multiple supervision levels. The level system is designed to promote inmate adherence to program rules and recommendation, and encourage progress on treatment goals. The level system provides incentives for adherence to rules of conduct within the ICS program. Inmates admitted or transferred into the ICS program are assessed and assigned a level.

1. Level assignments adjusted based upon changes in symptom severity, appropriateness of social behaviors, and adherence to treatment goals and recommendations. Level Three is the least restrictive level and Special Level is the most restrictive (See attachment #4).

2. Levels can be reviewed in weekly treatment team meetings. Level assignment changes are as a result of changes in behavior and symptom presentation.

B. Pre-Hearing Detention

1. Inmates charged with serious (level I or 2) violations of SCDC policy are placed on pre-hearing detention (PHD) status by operational staff. Inmates on PHD are placed in RHU but continue to be seen weekly, or more often if clinically indicated, by their primary (or on-call) QMHP.

2. The ICS Program Manager regularly consults with the disciplinary hearing officer (DHO) as part of the inmate hearing process, and disciplinary hearings are held weekly.

C. Crisis Intervention (CI), Suicide Precautions (SP)

1. Crisis intervention (CI) is utilized to allow observation and assessment, while providing a safe environment for inmates who are depressed, exhibiting acting out or self-injurious behaviors, feel unsafe, or need temporary removal from the environment, but do not require hospitalization. Suicide precautions (SP) status is utilized to provide constant observation, in a safe environment to inmates expressing or exhibiting suicidal behaviors. Procedures for initiating and discontinuing CI and SP are outlined in SCDC Policy HS-19.02.

2. ICS assigned inmates requiring placement on CI or SP are transferred within 24 hours to the Crisis Stabilization Unit (CSU), which is also located on the Broad River CI campus. ICS inmates released from the CSU receive crisis assessments for three consecutive days, and weekly follow-up crisis assessments continue for four weeks post CI or SP status.

D. Inpatient Hospitalization (Gilliam Psychiatric Hospital or Columbia Regional Care Center)

1. Inmates experiencing acute escalation of symptoms, presenting as a danger to self or others, experiencing self-care problems due to mental illness, demonstrating substantial impairment in their capacity for reality testing, or an inability to communicate may be referred for inpatient mental health services. Male inmates will be hospitalized at Gilliam Psychiatric Hospital (GPH) and females inmates at Columbia Regional Care Center (CRCC). Admission to GPH/CRCC may be voluntary or involuntary (Attachment #5). The referral procedures are outlined in SCDC Policy/Procedure HS-18.13.

2. A psychiatrist approves inmate referrals to GPH/CRCC, and the inmate's primary QMHP, or designee, coordinates with appropriate GPH/CRCC personnel to facilitate admission. Inmates who return to ICS from GPH/CRCC are seen no less than weekly for the first four weeks and more often as clinically indicated.

E. *ICS Services in lock-up units*

Inmates who qualify for ICS services but who are housed in various RHU's state-wide will have their treatment plans updated to provide an appropriate level of services as can best be managed at their institution's RHU.

V. Discharge Planning

Discharge planning begins at admission and the assessment reflects that discharge planning has been addressed. The Discharge Needs Assessment (Attachment # 6) is completed at admission for inmates whose max out date is one year or less. When an inmate is transferred to another facility, the Discharge Needs Assessment is forwarded to the assigned counselor at the receiving institution.

A. Discharge to Area/Outpatient Mental Health Services

1. When an inmate has improved and may no longer require the structured, residential mental health treatment at ICS, the inmate is presented at the treatment team meeting for discharge consideration to Area/Outpatient Mental Health Services. The primary QMHP, or designee, presents the inmate's progress to the treatment team for a decision regarding discharge. The inmate must attend this meeting. Upon recommendation of the treatment team and a written order from the assigned psychiatrist, discharge from ICS is initiated and an appropriate transfer referral is made. To qualify for discharge consideration, the inmate must be compliant with medication and without acute symptoms or medication side effects that require frequent monitoring.

B. Community Discharge

1. Within six (6) months of the inmate's max out date, the QMHP who is handling case management will coordinate and document all discharge planning services. All contacts relevant to aftercare planning are documented in the designated area of the AMR. The QMHP writes a

discharge summary (Attachment #7) addressing recommendations for continued mental health care. Discharge planning content will generally include the following areas;

a. Assessing Community Resources
b. Communication Skills
c. Benefits: (SSI/SSDI – Social Security Administration); South Carolina Department of Vocational Rehabilitation (Voc. Rehab.); Veterans' Administration (VA); Department of Social Services (DSS) and the Department of Mental Health (SCDMH)
d. Money Management
e. Family Reunification
f. Goal Setting (short/long term)
g. Job Seeking and Survival Skills

2. Specific Procedures

a. Six months prior to max-out
   1. Inmates are assigned to the discharge planning group
   2. Primary QMHP completes a discharge needs assessment
   3. Living arrangements and family support are verified
   4. Arrangements must be made for admission to a SCDMH hospital if the case manager and treatment team conclude that psychiatric hospitalization is necessary due to the inmate's mental illness. Consultation with SCDC personnel assigned to facilitate admission to an SCDMH facility must be initiated.

b. Four months prior to max-out
   1. The Primary QMHP reviews the Discharge Needs Assessment with the inmate and makes changes as needed.
   2. Housing arrangements are finalized.
   3. For inmates with deficits in self-care skills, the primary QMHP contacts the SCDMH liaison for assistance with residential placement.
   4. SSI/SSDI paperwork is completed.

c. One months prior to max-out

   1. The primary QMHP notifies medical of the pending max out date to facilitate ordering a five-day supply of medications that are provided to inmates upon release from SCDC.

   2. The primary QMHP schedules post release appointments (mental health, vocational rehabilitation, substance abuse, VA, etc.).

   3. The primary QMHP finalizes plans with families and the SCDMH liaison.

d. Two days prior to max-out

   1. On the day of max out, inmates are given at least a five-day supply of medications as ordered by the ICS psychiatric and medical physicians. The inmate also receives prescriptions for a 30-day supply of each medication.

   2. The inmate is given a copy of all scheduled appointments, which includes the dates, times, addresses, telephone numbers and names of contact persons. A copy of the appointment information may be mailed or disclosed to a family member/guardian with the inmate's written permission.

VI. Quality Assurance

A. The ICS program will be audited by the quality assurance manager and assistants through a continuous Quality Management auditing process with reports generated on at least a quarterly basis

B. The ICS program director will conduct internal audits of each counselor assigned to the ICS twice annually to ensure that services are being delivered. The internal audits will consist of evaluation of groups, individual sessions, and whether the program is meeting the required standard hours of structured and unstructured activities. The program director will observe at least one group per month by each individual counselor and at least one individual session. Random inmate files will be selected for auditing in order to ensure that clinical documentation and treatment plans are being completed and updated in accordance with applicable policies.

Definitions

AMR - Automated medical record

Community Meeting - a forum for exchanging relevant and useful information between inmates, security, medical and mental health staff

Crisis Intervention (CI) - utilized to allow observation and assessment, while providing a safe environment for inmates who are depressed, exhibiting acting out or self-injurious behaviors, feel unsafe, or need temporary removal from the environment, but do not require hospitalization.

Intermediate Care Services (ICS) - ICS provides residential services for inmates with serious, persistent mental illness who require intensive treatment, monitoring and care, but do not need psychiatric hospitalization.

Level System - designed to promote inmate adherence to program rules and recommendation, and encourage progress on treatment goals. Level assignments are adjusted based upon changes in symptom severity, appropriateness of social behaviors, and adherence to treatment goals and recommendations. The Level System provides incentives for adherence to rules of conduct within the ICS Program. Level Three is the least restrictive level.

Pre-Hearing Detention (PHD) – security status for inmates awaiting a Disciplinary Hearing. ICS inmates on PHD status are placed in placed in a restricted housing unit (RHU).

Primary QMHP - QMHP assigned as an inmate' case manager

Qualified Mental Health Professional (QMHP) - Psychiatrist, Licensed Psychologist, Licensed Professional Counselor, Licensed Professional Counselor-Supervisor, Licensed Independent Social Worker, Licensed Martial Family Therapist (LMFT), Psychiatric Nurse Practitioner. Also, includes Licensed Master Social Worker, LMFT-Intern, and Licensed Professional Counselor-Intern with appropriate supervision.
Suicide Precautions (SP) - intervention measures to reduce physical self-harm by an inmate identified as a risk for suicidal behavior. These measures include placement of the inmate into a safe cell under constant observation.

Treatment Team - primary QMHP, a psychiatrist, a psychologist, other ICS-assigned QMHPs, a nurse, an activity therapist, and security staff.

Appendix

ATTACHMENTS

# 1	Mental Health Referral Form
# 2	Treatment Plan
# 3	Treatment Team Comment Sheet
# 4	Special Level Restrictions
# 5	Application for Involuntary Emergency Hospitalization for Mental Illness
# 6	Discharge Needs Assessment
# 7	Discharge Summary

Attachment # 1

South Carolina Department of Corrections
Division of Behavioral/Mental Health & Substance Abuse Services

Mental Health Services Referral Form

Referring Staff: _____ Date of Referral: _____
Referring Institution: _____ Referring Program: _____
INMATE INFORMATION:
Name: _____ SCDC#: _____
Institution: _____ Age: _____ Sex: M ____ F ____
Current Offenses: _____
Sentence: _____ Max-Out Date: _____
GAMA/Beta Score: _____ WAIS Score: _____ On Lock-Up/SD?: _____

REFERRAL TO:

Referral Program & Eligibility Criteria

☐ **Intermediate Care Services (ICS):** Inmates with chronic, debilitating mental illnesses that are not serious enough to require hospitalization but require intensive treatment and monitoring. Inmates admitted to this program normally have serious mental illness and chronic or serious disturbances in the ability to function normally on a daily basis, have multiple hospitalizations, and a need for a more structured environment.

☐ **Habilitation Services Program (HSP):** Inmates with a diagnosis of Intellectual Developmental Disorder, or other serious cognitive disorders. These inmates must meet DSM5 criteria for significant intellectual deficits and significant adaptive functioning deficits. Inmates admitted to this program must demonstrate significant limitations in at least three major life areas: self-care, self-direction, learning, capacity for independence living, economic self-sufficiency, hearing/speech/language, and receptive/expressive language.

☐ **Outpatient Care:** Inmates who have mild to moderate symptoms of mental illness, and who require frequent or ongoing access to psychiatric consultation. Specify higher or lower intensity. _____

☐ **Behavioral Management Unit (BMU):** Inmates with chronic, repetitive, self-mutilation behaviors that require frequent hospitalizations and intensive treatment and monitoring. This therapeutic treatment program targets mentally ill male inmates in Restrictive Housing units with an extensive amount of lock-up time. Inmates diagnosed with a personality disorder and those demonstrating persistent disruptive behavioral patterns are eligible for placement consideration. The program allows inmates to receive out of cell treatment while serving their lock up time within a highly structure therapeutic setting.

☐ **Institutional Mental Health Program (IMH):** Inmates with a mental illness designation assessed as capable of living independently and functioning normally on a daily basis among the general population. These inmates are treatment and/or medication compliant.

☐ **OPH – Outpatient Evaluation:** Inmates in need of psychiatric consult/evaluation for medications and diagnostic clarification.

REASON FOR REFERRAL: _____

_____

_____

MENTAL HEALTH HISTORY: _____

_____

MEDICAL HISTORY & CONDITION: _____

_____

_____

_____

DIAGNOSES:

_____

_____

_____

_____

MEDICATIONS:

_____

_____

MENTAL HEALTH RECOMMENDATIONS:

_____ Approved _____ Disapproved By: _____ _____
Psychiatrist Date

_____ Approved _____ Disapproved By: _____ _____
Licensed Psychologist Date

_____ Approved _____ Disapproved By: _____ _____
Primary QMHP Date

REASON FOR DISAPPROVAL: _____

_____

_____

Final Disposition: _____
Approved/Disapproved

Date: _____

Distribution:
Mental Health Services (MHS) Referred MHS Program Medical Record

Attachment # 2

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
KIRKLAND R&E/INTERMEDIATE CARE SERVICES
Treatment Plan

Name: _____ SCDC #: _____ Admission Date: _____ Discharge Date:_____

Medication(s): _____

Diagnosis: _____

Strengths: _____

Reason for Referral: _____

Date	Staff Assessment of Problem/Presenting Symptoms	Objective(s)	Approaches
		Next Review Date:	
		Next Review Date:	

		Next Review Date:	
		Next Review Date:	

Signatures

Inmate: _____ Primary QMHP: _____

Psychiatrist _____ Psychologist: _____

Nurse: _____ Activities Therapist: _____

APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

IMPORTANT NOTICE: All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Present Name		Full Name at Birth if Different From Present	
Education Level	Social Security Number	Occupation	Monthly Income

Employer's Name	Address	If not employed, source of income:		
		Retirement	Public Assistance	Other
		$	$	$

HOSPITALIZATION INSURANCE Coverage including group insurance, Medicare, Medicaid, Military medical care, etc.

Policy No. or HIB	Name of Insurance Co.	Address	If group insurance, name & address of firm

MILITARY SERVICE

Branch	Service Number	Dates of Service	Type Discharge	Monthly Pension	VA Claim No.
				$	

FINANCIAL REPRESENTATIVE Please list the name, address and telephone numbers of the person to receive financial statements and other media related to the personal financial affairs on behalf of the patient

Last Name	First Name	Middle Initial	Relation to Patient	Street Address or Rural Route & Box	Telephone
				City, State, Zip	Telephone

LIST OF SCDMH PSYCHIATRIC HOSPITAL

Division of Inpatient Services G. Werber Bryan Psychiatric Hospital 220 Faison Drive, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-7143 – All Hours	Division of Inpatient Services Bryan Psychiatric Hospital Wellspring 2100 Bull Street, Columbia, S.C. 29202 For information and prior to all admissions call: (803) 898-2038 – All Hours	Division of Inpatient Services William S. Hall Psychiatric Institute 1800 Colonial Dr., P.O. Box 202 Columbia, S.C. 29202
Patrick B. Harris Psychiatric Hospital P.O. Box 2907, Anderson, S.C. 29622 For information and prior to all admissions call: (864) 231-2600 – All Hours	Division of Inpatient Services Forensics Evaluation and Treatment Services 7901 Farrow Road, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-6334 or (803) 898-2038 – All Hours	Psychiatry Unit Forensic Unit Children's Unit For information and prior to all admissions call: (803) 898-1662 – All Hours

NOTE: ADMINISTRATIVE PROCEDURE – FORMS:

"Application for Emergency Admission, Part I", and "Certificate of Licensed Physician, Part II", must be completed in triplicate and accompany the patient to the receiving hospital. The hospital must forward one copy to Judge of Probate of the county in accordance with 44-17-410(3) and retain one copy in the person's hospital record. ADMISSION MUST BE WITHIN SEVENTY-TWO HOURS OF THE DATE OF THE CERTIFICATION OF THE LICENSED PHYSICIAN, (PART II).

NOTE: TO LICENSED PHYSICIAN:

1. The licensed physician must consult with the local State Community Mental Health Center regarding the commitment/admission process and the available treatment options and alternatives in lieu of hospitalization at a state psychiatric facility. (Section 44-17-460, S.C. Code, 1976, as amended).
2. The licensed physician must also consult via telephone with the admitting physician of the receiving hospital regarding the appropriateness of admission and the persons mental and physical treatment needs.

NOTE: TO POLICE AND OTHER OFFICERS OF THE PEACE:

The certificate of a licensed physician authorizes and requires taking the proposed patient into custody. Section 44-17-440, South Carolina Code of Laws, 1976, as amended: "The certificate required by item 2 of Section 44-17-410 shall authorize and require any officer of the peace, preferably in civilian clothes, to take the individual into custody and transport him to the hospital designated by the certification. No person shall be taken into custody after the expiration of three days from the date of the certification. Any friend or relative may transport the individual to the mental health facility designated in the application, provided such friend or relative has read and signed a statement on the certificate which clearly states that it is the responsibility as an officer of the peace to transport the patient shall not be entitled to reimbursement from the State for the cost of such transportation. Any officer acting in accordance with the provisions of this article shall be immune from civil liability."

NOTE: TO FRIENDS AND RELATIVES:

It is the responsibility of an officer of the peace to provide timely transportation of the person alleged to be mentally ill to the designated mental health facility. However, by freely signing this statement, you can choose to assume that responsibility. Transportation must begin immediately. This form must be hand delivered by you to the admissions office of the designated mental health facility at the time of admission.

Date Signature of Friend or Relative/Relationship

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

NAME OF PERSON EXAMINED | AGE | COUNTY OF RESIDENCE

PLACE OF EXAMINATION | HOUR AND DATE OF EXAMINATION

I, THE UNDERSIGNED LICENSED PHYSICIAN, have examined the above-named person and am of the opinion that the said individual:

☐ IS MENTALLY ILL AND because of this mental condition CURRENTLY POSES A SUBSTANTIAL RISK of physical harm to self and/or others to the extent that INVOLUNTARY EMERGENCY HOSPITALIZATION is recommended.

My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate mental illness and probable risk of harm:

The person is therefore to be transported to _____
NAME OF SCDMH PSYCHIATRIC HOSPITAL

or to _____ for involuntary emergency admission.
NAME OF NON-SCDMH HOSPITAL

For admission to SCDMH hospital, Physician must complete Part II, Page 2, over.

_____, M.D. | _____
SIGNATURE OF LICENSED PHYSICIAN | S.C. LICENSE NUMBER

_____, M.D. | _____
TYPED OR PRINTED NAME | PHONE NUMBER

ADDRESS

All information MUST be typed or clearly printed

Attachment # 6

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
INTERMEDIATE CARE SERVICES UNIT
DISCHARGE NEEDS ASSESSMENT

Date: _____

Name: _____ SCDC #: _____ Dorm: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Parole Eligibility Date: _____ Max-Out Date: _____

Previous Home Address: _____

_____ Telephone #: _____

Please answer the following questions:

1. With whom and where do you plan to live upon release? _____

   _____

2. Is the person(s) with whom you plan to live, aware of your parole/max out date? _____

3. How many previous releases, if any (supervised furlough, parole or max out, etc.) have you had on this or any other sentence? _____

4. The relationship with your family is: Good _____ Fair _____ Poor _____

5. Do you receive visits/correspondence from family or friends? Yes _____ No _____

6. Have you ever received welfare payments? Yes _____ No _____

7. What is the highest grade completed in school? _____

8. Were you employed at the time of your arrest? Yes _____ No _____

9. List the last two employers before your arrest and the length of time you spent on each job: _____

   _____

10. List any job skills or special training or certificates: _____

Discharge Needs Assessment
Page 2

Name: _____ SCDC #: _____

11. What type of work would you like to do upon release? _____

_____

12. Do you have any present health problems? Yes _____ No _____

If yes, explain: _____

13. Do you have any physical limitations? Yes _____ No _____

If yes, explain: _____

14. Are you presently on any medication(s)? Yes _____ No _____

If yes, explain: _____

15. Have you ever participated in an alcohol/drug program prior to and/or during your incarceration?
Yes _____ No _____ If yes, list where and for how long? _____

16. Do you feel the need to continue treatment if released? Yes _____ No _____

17. Have you ever received psychiatric treatment prior to incarceration? Yes _____ No _____

18. Are you presently taking any psychotropic medication? Yes _____ No _____

If yes, what type? _____

19. Do you know your Social Security number? Yes _____ No _____

If yes, please list the number: _____

Do you have a Social Security card? Yes _____ No _____

20. Military Status/Service: _____

VA Benefits Received: _____

Discharge Needs Assessment
Page 3

Name: _____ SCDC #: _____

21. List any needs/problems you feel you may have when released: _____

_____

_____

_____

_____

22. ICS Recorded Diagnosis: _____

_____

_____

COMMUNITY REFERRALS NEEDED

_____ Vocational Rehabilitation

_____ Dept. of Mental Health

_____ Alcohol/Drug Abuse

_____ Dept. of Social Services

_____ Social Security

_____ Job Service

_____ Community Action Agency

_____ JTPA

_____ Adult Education

_____ Alston-Wilkes

_____ Veterans' Administration

_____ Family Service Center

_____ County Health Dept.

_____ Picture ID

_____ Housing Authority

_____ Other

Attachment # 7

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
DISCHARGE SUMMARY

NAME: _____ SCDC#: _____

Assigned Institution: _____ Assigned Program: _____

DOB: _____ Report Date: _____ SCDC Classification: _____

DISCHARGE TO: _____ Another Program: _____; _____ General Population
(Name of Gaining Program)

_____ Society: _____
(Date Released)

IDENTIFYING DATA:

Inmate _____ is a _____ year old single/married/_____,

Male _____ Female _____ from _____ serving a _____ year/month

sentence for _____.

His sentence began _____ and is scheduled to end _____.

CRIMINAL HISTORY:

Previous Convictions: None ____ 1 ____ 2 _____ 3 _____ 4 _____ 5 or more _____

SCDC Disciplinary: None ____ 1 ____ 2 _____ 3 _____ 4 _____ 5 or more _____

Summary: _____

_____

_____

PSYCHIATRIC/SUBSTANCE USE HISTORY:

Treatment Prior to Prison: Mental Health ___ Yes __ No Substance Abuse ___ Yes ___ No

_____

_____

PROGRAM SERVICES RECEIVED & RESPONSIVENESS TO PROGRAMS:

____ Individual Counseling ____ Group Counseling ____ Other: _____

Responsiveness to Programs & Services: Excellent ____ Good ____ Fair ____ Poor ____

Summary: _____

_____

_____

_____

_____

_____

_____

PSYCHIATRIC CONDITION AT DISCHARGE:

Attitude:	Good ____ Poor ____	Note:
ement:	Good ____ Poor ____	Note:
Symptoms of Mental Illness:		

Mental Status: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL CONDITION AT DISCHARGE:

_____

_____

_____

_____

RECORDED DIAGNOSIS:

_____

_____

_____

_____

_____

DISCHARGE MEDICATIONS: _____

_____

_____

_____

DISCHARGE TO SOCIETY PREPARATIONS:

SSI Applications Prepared ____ DDSN Referral ____ Mental Health Appointment Date: _____

Vocational Rehabilitation Referral ____ Date: _____ Substance Abuse Treatment Referral _____

Job Service Referral ____ Living Arrangements: Family/Home _____ Halfway House _____

Residential Facility ____ Treatment Facility ____ Out of State Address ____ Other ____

Describe planned living arrangements below: _____

_____

_____

Release of Information Signed: Yes __ No __ Attended Discharge Planning Group: Yes ___ No ___
Coordination for medical packets if applicable made with medical personnel: _____

RECOMMENDATIONS:

Inpatient Treatment: Yes ____ No ____ Outpatient Treatment: Yes ____ No ____

Identify Hospital or Treatment Facility: _____

Recommended Groups: (include referrals to other agencies and dates/times of appointments) _____

_____

Other Referrals & Recommendations: _____

_____

_____

_____

_____

_____

_____

ommendations for Future Treatment: _____

_____

_____

MENTAL HEALTH PROFESSIONAL: _____
(Signature)

Printed Name: _____ Phone #: _____

Correctional Facility: _____

Position Title: _____

MENTAL HEALTH SUPERVISOR: _____
(Signature)

_____
(Printed Name)

SCDC POLICY

NUMBER: HS-19.06

TITLE: MENTAL HEALTH SERVICES - DISCIPLINARY DETENTION FOR INMATES CLASSIFIED AS MENTALLY ILL – REVISION 05/12/2016

ISSUE DATE: ***March 17, 2016***

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

OPERATIONS MANUAL: HEALTH SERVICES

SUPERSEDES: SCDC POLICY HS-19.02 (dated July 1, 2008) - NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES: 4-7, 19-29A

ACA/CAC STANDARDS: 4-ACRS-5A-08, 4-ACRS-6A-11, 4-ACRS-7D-07, 4-4095, 4-4098, 4-4099, 4-4256, 4-4277, 4-4285, 4-4286, 4-4305, 4-4351, 4-4368, 4-374, 4-4399, 4-4428, 4-4429, 4-4430, 4-4431, 4-4433, 4-4434, 4-4435, 4-4436, 4-4438, 4-4439, 4-4440, 4-4441, 4-4442, 4-4446

STATE/FEDERAL STATUTES: None

PURPOSE: To provide additional guidelines for the administration and application of the South Carolina Department of Correction's (SCDC) Inmate Disciplinary Policy (OP-22.14) for inmates who are classified as mentally ill.

POLICY STATEMENT: SCDC will strive to render the optimum standard of care and services to inmates who are classified as mentally ill and receive disciplinary detention. Every effort will be made by the Agency to ensure that inmates who are classified as mentally ill and are sentenced to disciplinary detention are: 1) granted access to appropriate levels of mental health care as needed; 2) afforded consistent, timely access to mental health staff as required; 3) secured in safe, decent, and sanitary housing units; and 4) considered for alternative sanctions that are conducive to positive therapeutic change.

TABLE OF CONTENTS

SPECIFIC PROCEDURES:

1. PROCEDURAL GUIDELINES:

1.1 All inmates classified as Mentally Ill and receiving higher levels of care (Classification L1, L2, L3, LC and/or MR) and any inmate who suffers from or presents with a serious mental illness, regardless of classification, who is presented before a Disciplinary Hearing Officer (DHO) due to an infraction that could lead to level one or two formal charge, will be assessed by a Qualified Mental Health Professional (QMHP) to determine what impact, if any, the inmate's mental health state should carry in regard to disciplinary sanctions. The QMHP completing the disciplinary statement will, whenever possible, not be the primary counselor assigned to the inmate.

1.1.1 Within three (3) business days after receiving SCDC Form 19-29A, "Incident Report," the QMHP will assess the mentally ill inmate who has been charged with the infraction, through an in-person interview and review of pertinent records.

1.1.2 The QMHP will review the inmate's current treatment plan, treatment compliance, historical data, diagnoses, behavior that was occurring at the time of the charge, and recent medical record entries to assist in making the above determination.

1.1.3 The questions to be assessed are whether the inmate's charged disciplinary behavior was related to mental illness; if so, how; and what treatment interventions might be indicated to address the behavior.

1.1.4 All QMHPs involved in these assessments will complete training on conducting this type of assessment.

1.2 After completion of the above noted steps and based upon an evaluation, the QMHP will forward an opinion to the DHO utilizing Addendum A, "Mental Health Services Procedures, and Addendum B, "Disciplinary Mental Health Statement". Possible findings in each case include that:

- A) the inmate is not guilty of the charged infraction due to his mental state at the time of the infraction;
- B) the inmate is guilty and mentally ill and mitigating circumstances have been identified and should be considered by the hearing officer. In other words, the inmate has a mental illness which contributed to the behavior to a degree that justifies consideration of modified sanctions; or
- C) no mitigation secondary to mental illness has been identified; the inmate has a mental illness but the mental illness did not contribute to the alleged rule infraction.

1.3 The QMHP will complete and sign the Disciplinary Mental Health Statement and get the co-signature of the Mental Health Services Regional/Program Supervisor or Program Manager. Psychologist/Clinical Supervisor for Mental Health will also sign the Disciplinary Mental Health Statement if sections A, B, or C are indicated for inmates with a Mental Health Classification of L1, L2, L3, LC and/or MR or any other inmate with serious mental illness. The QMHP will submit the Disciplinary Mental Health Statement to the appropriate DHO within three (3) business days. If the inmate has a Mental Health Classification of L4 (*Outpatient*) without a serious mental illness, and the DHO determines that a mental health statement is necessary, a mental health statement can be provided upon request.

1.4 The Institution will provide QMHP with a copy of the incident report.

1.5 The DHO will hear the case and determine whether a sanction is appropriate.

1.6 Examples of Modified Sanctions the DHO may consider include, but are not limited to:

- Behavior Modification Contract;
- waive restitution fee for medical cost of self-inflicted injuries or injuries to others;
- extra duty or chores up to 40 hours;
- limit time in segregation with regular visits from QMHP;
- disrespect sanction (72 hours cell time);
- use of informal resolutions;
- limited telephone restriction;
- limited visitation restriction;
- restriction of recreation time;
- restriction of canteen privileges;
- Behavioral Incentive Plan (focused on gaining privileges back).

1.7 All MH classified inmates who fall in ~~one of the second two~~ categories A or B of section 1.2 above *~~if~~ and the inmate has a Mental Health Classification of L1, L2, L3, LC, and/or MR*), will be reviewed by the Mental Health Disciplinary Treatment Team (MHDTT), which will consist of the QMHP, the Mental Health Services Regional/Program Supervisor or Program Manager, Psychiatrist, Psychologist, Warden, Associate Warden and/or Major. The MHDTT serves the primary function of reviewing sanctions given to mentally ill inmates to determine if they can be more aligned with therapeutic practices.

1.8 All inmates classified as mentally ill and placed on lockup status will be offered a confidential mental health assessment by a QMHP monthly or more frequently as clinically indicated, until they are removed from lockup status.

2. DEFINITION(S):

Convicted refers to when an inmate is/was found guilty of, or pled guilty to, the charge infraction.

Disciplinary Hearing refers to a formal proceeding conducted by a Hearing Officer to process serious rules violations.

Disciplinary Hearing Officer (DHO) refers to an individual conducting a disciplinary hearing.

Not Guilty Due To Mental Illness (NGMI): refers to when a mentally ill inmate commits a disciplinary infraction and the Qualified Mental Health Professional (QMHP) determines that the inmate was not accountable for his/her action(s), and the Hearing Officer finds the inmate guilty through a preponderance of the credible evidence presented. Therefore, the inmate should be found not guilty due to mental illness. This case will be referred back to the QMHP and designated institutional staff for appropriate intervention.

Guilty and Mentally Ill refers to when the inmate suffers from a mental illness which may have contributed to current acting out behaviors. The hearing officer will consider the mitigating circumstances in both his/her findings and disposition.

Guilty - Although classified as mentally ill, the inmate was able to understand the nature and quality of the act committed. This inmate will be subject to any sanctioned imposed by the DHO at the conclusion of the hearing in accordance with SCDC policy OP.22.14 Inmate Disciplinary System.

Qualified Healthcare Practitioner (QHP) refers to a Physician, Physician's Assistant, or Nurse Practitioner.

Qualified Mental Health Professional (QMHP) refers to a Psychiatrist, licensed Psychologist, licensed Professional Counselor, licensed Professional Counselor-Supervisor, licensed Independent Social Worker, Psychiatric Nurse Practitioner, and also includes a licensed Master Social Worker and licensed Professional Counselor-Intern with appropriate supervision.

SIGNATURE ON FILE

s/Bryan P. Stirling, Director

Date of Signature

ORIGINAL SIGNED COPY MAINTAINED IN THE OFFICE OF POLICY DEVELOPMENT.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

ADDENDUM A
MENTAL HEALTH SERVICES PROCEDURES

Disciplinary Detention for Offenders Classified as Mentally Ill
Number: 700.33
Related SCDC Policy: HS-19.02, OP-22.14
Date: March 1, 2014

Purpose: To provide additional sentencing guidelines for the administration and application of the South Carolina Department of Corrections' (SCDC) Inmate Disciplinary System for Offenders who are classified as mentally ill.

Procedure Statement: SCDC will strive to render the optimum standard of care and services to inmates who are classified as mentally ill and receive disciplinary detention. Every effort will be made by the Agency to ensure that offenders who are classified as mentally ill and meet the criteria for disciplinary detention are: 1) granted access to higher levels of hospital care as needed; 2) afforded consistent, timely access to as required; 3) secured in safe, decent and sanitary housing units; and 4) considered for alternative sanctions that are conducive to positive therapeutic change.

Procedural Guidelines:

1. All offenders classified as Mentally Ill (Mental Health Classification L1, L2, L3, LC and/or MR) and presented before a Disciplinary Hearing Officer (DHO) due to an infraction that could lead a formal charge will be assessed by a QMHP at his/her respective institution. The following should occur in order to therapeutically evaluate the mentally ill offender's mental competency:
    - Within three business days after receiving an Incident Report (SCDC Form 19-29A), the QMHP will assess the mentally ill offender who has committed the infraction, and
    - Review the offender's medical compliance, historical data, offender's diagnosis, current medications, recent encounters, and DAP notes.

2. Then after completion of the above noted steps and based upon an evaluation of the offender's history it is determined based on the QMHP's professional opinion that:
    A. The offender has a mental illness which likely contributed to an inability to control his/her behavior (Definition - ~~Guilty but not accountable~~ Not Guilty Due To Mental Illness); or
    B. The offender suffers from a mental illness which may have contributed to behaviors (Definition -Guilty with mitigating circumstances due to the offender lacking the capacity to understand the act committed or the inability to control impulsive behaviors). *(See attachment for requested consideration of modified sanctions)*; or
    C. Although classified as Mentally Ill, was able to understand the nature and quality of the act committed (Definition – Guilty of the charge).

3. Once the DHO hears the case, and if the MH classified inmate falls in any one of the categories above, the QMHP in consultation with the Mental Health Services Regional or Program Manager or Program Supervisor, Warden, Associate Warden and/or Major will process the offense as a Mental Health Disciplinary Treatment Team (MHDTT) to determine a proper resolution for the offender as it relates to sanctions versus treatment. *(This is for <u>all</u> cases and <u>does not</u> require the presence of the Mental Health Services Regional or Program Manager or Program Supervisor; however, they should be available for consultation.)*

4. The QMHP will complete and sign (Mental Health Services Regional or Program Manager or Program Supervisor will also sign the Disciplinary Mental Health Statement if sections A or B are indicated) the Disciplinary Mental Health Statement and submit their statement to the DHO at the respective institution within three business days.

5. The Institution will notify the QMHP of the offender's disciplinary hearing date and time.

6. If it is determined that an offender has:
   A. A mental illness which likely contributed to an inability to control his/her behavior (Definition - Guilty but not accountable Not Guilty Due To Mental Illness); or
   B. A mental illness which may have contributed to behaviors (Definition -Guilty with mitigating circumstances due to the offender lacking the capacity to understand the act committed or the inability to control impulsive behaviors). *(See attachment for requested consideration of modified sanctions)*

   Then, after the disciplinary hearing has been conducted:
   i. The QMHP along with the Mental Health Services Regional or Program Manager or Program Supervisor, Warden, Associate Warden and/or Major will process the nature of the offense as a team to determine a proper resolution for the offender.
   ii. If an agreement can not be reached, all documentation will be forwarded to the Division Director of Behavioral/Mental Health and Substance Abuse Services and the Division of Operations Regional Director to determine the best course of treatment versus sanctions for the inmate.
   iii. All offenders classified as mentally ill and placed on lock-up status will receive a mental health assessment by a QMHP every 30 days until they are removed from lock-up status.
   iv. Every 30 days, the QMHP, Mental Health Services Regional or Program Manager or Program Supervisor, Warden, Associate Warden and/or Major will review the lock-up status for offenders classified as mentally ill to determine if the offender can return to the institutions general population.

7. Examples of Modified Sanctions include but are not limited to:
   - Behavior Modification Contract
   - Waive Restitution fee for medical cost of self-inflicted injuries or injuries to others.
   - Extra duty or chores up to 40 hours.
   - Limit time in segregation with weekly visits from QMHP.

- Disrespect (72 hours cell time).
- Use of informal resolutions
- Limited telephone restriction
- Limited visitation restriction
- Restriction of recreation time
- Restriction of canteen privileges
- Behavioral Incentive Plan (Gaining Privileges Back)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS (SCDC)
ADDENDUM B
DISCIPLINARY MENTAL HEALTH STATEMENT

INSTITUTION: _____ **Today's Date:**_____

SCDC Mental Health Services assist in the disciplinary hearing process by providing a statement regarding an offender's mental status at the approximate time the offense occurred. This form must be completed in its entirety and returned to the appropriate disciplinary hearing personnel within 3 business days from the date the incident report is received by the Qualified Mental Health Professional).

Qualified Mental Health Professional: _____ Date: _____
(Print Name of Assigned QMHP) *(Date Incident Report Rec. by QMHP)*

_____ SCDC#: _____ has been charged
(Print Name of Offender)

with an infraction of rules and/or regulations set forth by the SCDC based on _____,
(Disciplinary Code(s)

_____ and SCDC 19-29 "Incident Report" _____ at
(Description of Violation) *(Date of Incident/Date of Discovery)*

_____by Reporting Official _____.
(Time of Incident) *(Print name of Reporting Official)*

The assigned QMHP completed the following:

_____ _____ Interview and Clinical Assessment of the inmate's current mental health status.
(QMHP Initial) *(Date)*

_____ _____ Medication Compliance Review (MARS)
(QMHP Initial) *(Date)*

_____ _____ Review of historical data, recent encounters and notes.
(QMHP Initial) *(Date)*

After a thorough review of the items listed above it is the professional opinion of this Qualified Mental Health Professional the:

_____ A. Offender has a mental illness which likely contributed to their inability to control his/her behavior. (Definition - Guilty but not accountable Not Guilty Due To Mental Illness); ***{Follow MH Procedure}***

_____ **B. Offender suffers from a mental illness which may have contributed to behaviors. (Definition - Guilty with mitigating circumstances due to the offender lacking the capacity to understand the act committed). (See attachment for requested consideration of modified sanctions) {Follow MH Procedure} Request consideration of modified sanctions for the following reasons:** _____

_____.

_____ C. Offender, although classified as Mentally Ill, was able to understand the nature and quality the act committed.

Should you have questions or require additional information please contact me at your convenience.

_____ _____
(Signature) Qualified Mental Health Professional *(Signature & Title of MH Services Regional or Program Manager or Program Supervisor only if A or B indicated)*

_____ _____
(Date) *(Date)*

_____ _____
(Phone # and/or ext.) *(Phone # and/or ext.)*

Level 1 Offenses

List of Offenses	List of Modified Sanctions
801 Assault and/or Battery of an SCDC Employee or other Government Employee, Contract Employee, Volunteer, or Member of the Public with Means/and/or Intent to Kill or Injure	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
802 Sexual Assault	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
803 Riot	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
804 Homicide	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
805 Hostage Taking	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
806 Any Act Defined as Felony Acts by SC Laws	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
857 Assault and/or Battery of an Inmate with Means and/or Intent to Kill or Injure	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
896 Unauthorized wearing, possession and/or providing Agency uniform	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense > Restriction of recreation time
897 Possession of Security Equipment/Property	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense 180-360 Days Lock up 2nd or Subsequent Offense
898 Possession of Any Communication Device	0-180 Days No privileges during term of Disciplinary Detention 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
901 Class I Escape	> 18 months Lock up (DD/SD)
902 Class II Escape	> 12 months Lock up (DD/SD)
903 The trafficking, Use, and/or Possession of Narcotics, Marijuana, or Unauthorized Drugs, including prescription drugs, or Inhalants	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
904 Possession of Escape Tools and/ or Paraphernalia	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense
905 Creating and/or Assisting with a Social Networking Site	> 0-180 Days No privileges during term of Disciplinary Detention > 0-180 Days Lock up 1st Offense > 180-360 Days Lock up 2nd or Subsequent Offense

Level 2 Offenses

List of Offenses	List of Modified Sanctions
807 Striking an SCDC Employee or other Government Employee, Contract Employee, Volunteer, or Member of the Public	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense
808 Fighting with a Weapon	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense
809 Threatening to Inflict Harm on/Assaulting an Employee and/or Member of the Public	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense
810 Striking an Inmate with or without a Weapon	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense
811 Possession of a Weapon	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense
812 Robbery with Force	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense
813 Throwing of any Substance or Object on an SCDC Employee or other Government Employee, Contact Employee, or Volunteer	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense
814 Inciting/Creating a Disturbance	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense > 24 hours of cell time
820 Damage, Loss, Destruction, or Defacing of Property Valued at 100.00 or more	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense > No financial fees charged to offender > Behavioral Modification Contract
822 Sexual Misconduct	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense > Behavioral Modification Contract

(Level 2 Offenses – continued)

List of Offenses	List of Modified Sanctions
854 Exhibitionism and Public Masturbation	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense > Behavioral Modification Contract
855 Smuggling and/or Conspiracy to Smuggle in Contraband	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense > Behavioral Modification Plan
858 The Use or Possession of Practice GED Cheat Sheet, the Official GED Test or Materials Not Authorized for Use by the Inmate	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense > Behavioral Modification Plan > Informal Resolutions
895 Inmate ID Card Violations	> 0-90 Days Lock up 1st Offense > 90-180 Days Lock up 2nd or Subsequent Offense > 0-90 Days Loss of privileges > 0-90 Disciplinary Detention 1st Offense > 90-180 Disciplinary Detention 2nd Offense > Informal Resolutions > Behavior Modification Plan

Level 3 Offenses

List of Offenses	List of Modified Sanctions
815 Evading a Security Device	> 0-30 Days Lock up 1st Offense > 0-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
816 Trafficking and Trading	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
817 Possession of Contraband	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > Extra duty up to 25 hours
818 Use of Obscene, Vulgar or Profane Language or Gestures	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 24 hours of cell time > Extra duty up to 20 hours
821 Gambling and Loan Sharking	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours cell time
823 Fighting Without a Weapon	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > Extra duty up to 40 hours
824 Threatening to Inflict Harm, Physical or Otherwise/Assault, on Another Inmate	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours cell time
825 Refusing or Failing to Obey Orders	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours of cell time > Extra duty up to 20 hours

(Level 3 Offenses – continued)

List of Offenses	List of Modified Sanctions
826 Refusing to Work	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > Extra duty up to 20 hours
827 Refusing to Attend the Compulsory (Mandatory) Program	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
828 Out of Place	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours of cell time
829 Failure to Work	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours of cell time
830 Mutiny	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours cell time
831 Lying to an Employee or Knowingly Making False Statements	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours cell time
832 Unauthorized Inmate Organization Activity or Participation in a Security Threat Group (STG)	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
833 Abusive Treatment of an Animal, Including Carnal Relations with an Animal	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
834 Any Act Defined as Misdemeanor by SC Laws	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours cell time
835 Forgery or Possession of Any Forged Document	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense

(Level 3 Offenses – continued)

List of Offenses	List of Modified Sanctions
836 Disrespect	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > Informal Resolutions > 72 hours of cell time
837 Interfering with Count	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
838 Soliciting Improper Relationships: Assistance from an Employee or an Inmate to Violate an Agency Rule or an Employee Rule	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 72 hours cell time
853 The unauthorized use of an inmate's telephone personal identification number (PIN)	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
856 Damage, Loss, Destruction, or Defacing of Property Valued at Less than $100.00	> 72 hours cell time > 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense
859 Disorderly Conduct	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense > 48 hours cell time
899 Use, Possession, or Distilling and/or Brewing of any Alcoholic Beverage	> 0-30 Days Lock up 1st Offense > 30-60 Days Lock up 2nd or Subsequent Offense > 0-60 Days Loss of privileges > 0-30 Disciplinary Detention 1st Offense > 30-60 Disciplinary Detention 2nd Offense

Level 4 Offenses

List of Offenses	List of Modified Sanctions
839 Mutilation	> 0-20 Days Lock up 1st Offense > 20-45 Days Lock up 2nd or Subsequent Offense > 0-30 Days Loss of privileges > 0-20 Disciplinary Detention 1st Offense > 20-45 Disciplinary Detention 2nd Offense > No Medical Cost > Behavioral Modification Contract > Behavioral Incentive Plan
840 Failing or Refusing to Respond to an Employee's Question	> 0-20 Days Lock up 1st Offense > 20-45 Days Lock up 2nd or Subsequent Offense > 0-30 Days Loss of privileges > 0-20 Disciplinary Detention 1st Offense > 20-45 Disciplinary Detention 2nd Offense > 72 hours cell time
841 Malingering	> 0-20 Days Lock up 1st Offense > 20-45 Days Lock up 2nd or Subsequent Offense > 0-30 Days Loss of privileges > 0-20 Disciplinary Detention 1st Offense > 20-45 Disciplinary Detention 2nd Offense > Behavioral Modification Contract
842 Use or Possession of Tattooing Paraphernalia	> 0-20 Days Lock up 1st Offense > 20-45 Days Lock up 2nd or Subsequent Offense > 0-30 Days Loss of privileges > 0-20 Disciplinary Detention 1st Offense > 20-45 Disciplinary Detention 2nd Offense > Behavioral Modification Plan
843 Refusing Medical Treatment for a Communicable Disease	> 0-20 Days Lock up 1st Offense > 20-45 Days Lock up 2nd or Subsequent Offense > 0-30 Days Loss of privileges > 0-20 Disciplinary Detention 1st Offense > 20-45 Disciplinary Detention 2nd Offense > 48 hours cell time
844 Interfering with the Duties of any Person	> 0-20 Days Lock up 1st Offense > 20-45 Days Lock up 2nd or Subsequent Offense > 0-30 Days Loss of privileges > 0-20 Disciplinary Detention 1st Offense > 20-45 Disciplinary Detention 2nd Offense > 48 hours cell time > Informal Resolutions

Level 5 Offenses

List of Offenses	List of Modified Sanctions
601 Court Ordered Credit Loss: Pursuant to 24-27-200	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense > 48 hours cell time
845 Unauthorized Services/Piddling (Handicrafts)	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense > 48 hours cell time > Behavioral Incentive Plan
846 Creating Unnecessary Noise	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense > 48 hours cell time > Behavioral Modification Contract
847 Abuse of Privileges	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense > Behavioral Modification Plan > 48 hours cell time > Informal Resolutions
848 Exerting Any Authority Over Another Inmate	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense > 48 hour cell time > Informal Resolutions
849 Disregarding Safety Regulations	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense > 48 hour cell time > Informal Resolutions
850 Violation of a Written or Posted Institutional Rule Not Contained in These Rules, But Consistent with These Rules:	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense > 48 hour cell time > Informal Resolutions
851 Supervised Furlough II Violation	> 0-10 Days Lock up 1st Offense > 10-15 Days Lock up 2nd or Subsequent Offense > 0-15 Days Loss of privileges > 0-10 Disciplinary Detention 1st Offense > 10-15 Disciplinary Detention 2nd Offense

SCDC POLICY

NUMBER: HS-19.04

TITLE: MENTAL HEALTH SERVICES - GENERAL PROVISIONS

ISSUE DATE:

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

OPERATIONS MANUAL: HEALTH SERVICES

SUPERSEDES: SCDC POLICY HS-19.02 (dated July 1, 2008) - NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES: 19-11, 19-29, 19-45, 21-6, M-53, M-122, M-123, M-131, M-132, M-140

ACA/CAC STANDARDS: 4-ACRS-5A-08, 4-ACRS-6A-11, 4-ACRS-7D-07, 4-4095, 4-4098, 4-4099, 4-4256, 4-4277, 4-4285, 4-4286, 4-4305, 3-4330, 334336, 3-4344, 3-4350, 3-4355, 3-4367, 3-4369, 3-4377, 4-4428, 4-4429, 4-4430, 4-4431, 4-4433, 4-4434, 4-4435, 4-4436, 4-4438, 4-4439, 4-4440, 4-4441, 4-4442, 4-4446

STATE/FEDERAL STATUTES: None

PURPOSE: To provide information and assurance for the care and management involving inmates in need of mental health services within the South Carolina Department of Corrections (SCDC).

POLICY STATEMENT: SCDC is committed to providing all inmates access to mental health care based on documented policies and procedures. Provisions of mental health services include inmate assessment and evaluation, suicide prevention, special needs care, referrals for care, ongoing care, and discharge planning.

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SPECIFIC PROCEDURES:

1. GOAL AND INTENT:

1.1 The goal of SCDC is to diagnose and treat mentally ill inmates, and work with inmates in developing plans of care designed to minimize symptoms and reduce adverse effects of mental illness, maximize wellness, and promote recovery. The Agency intends to achieve the goal through the establishment and operation of programs promoting recovery oriented, individualized approaches to care that utilize evidence-based practices and maximize an inmate's abilities; minimize symptoms, adverse effects, and/or consequences of mental illness; and maintain and promote inmate integration into the general population and/or the community.

1.2 Mental Illness at SCDC: SCDC recognizes a mental disorder as outlined in the **most recent edition of the** Diagnostic and Statistical Manual (DSM) by the American Psychiatric Association. A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities (*an expectable or culturally approved response to a common stressor or loss, such as*

death of a loved one, is not a mental disorder). Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Serious mental illness can include diagnoses such as schizophrenia spectrum and other psychotic disorders, bipolar disorders, depressive disorders, and anxiety disorders, trauma and stress related disorders, neurodevelopmental disorders, neurocognitive disorders, and severe personality disorders that result in significant dysfunction and the ability to function in the general population. Inmates who experience significant functional impairment involving acts of self-harm or other behaviors that have a serious adverse effect on life may also fall into this category.

Unless otherwise noted, policy information is applicable to both male and female inmates.

1.3 Mental health services at SCDC include, but are not be limited to: assessment, case management, treatment, and discharge planning. Mental health services are provided to all inmates classified as mentally ill. Inmates classified as non-mentally ill receive mental health services as clinically warranted.

2. INSTITUTIONS - IDENTIFY LEVELS OF CARE:

2.1 The following SCDC institutions currently provide mental health care for mentally ill inmates:

1) Kirkland Reception and Evaluation (L2, L3, L4)
2) Broad River Correctional Institution (L4)
3) Camille-Graham Correctional Institution (L2, L3, L4)
4) Perry Correctional Institution (L3, L4)
5) Tyger River Correctional Institution (L4)
6) McCormick Correctional Institution (L4)
7) Leath Correctional Institution (L4)
8) MacDougall Correctional Institution (L4)
9) Gilliam Psychiatric Hospital (L1)
10) Manning Correctional Institution (L4, L5)
11) Lee Correctional Institution (L3, L4)
12) Evans Correctional Institution (L4)
13) Kershaw Correctional Institution (L4)
14) Turbeville Correctional Institution (L3, L4)
15) Ridgeland Correctional Institution (L4)
16) Lieber Correctional Institution (L3, L4)
17) Allendale Correctional Institution (L4)

18) Contract Hospital Facility/females (L1)

3. RECEPTION AND EVALUATION (R&E) - *See Health Services Procedure, 700.10 "Reception and Evaluation":*

3.1 Upon entry, inmates committed to SCDC have access to mental health services. As part of SCDC's intake process, **ALL** inmates receive an initial mental health screening to identify any mental health needs. If warranted, inmates may also receive supplementary psychiatric screenings and evaluations. The information obtained will determine an inmate's level of care needs and mental health classification.

4. REFERRALS:

4.1 A Mental health referral can occur at any time during the inmate's incarceration and may come from a variety of sources to include, but not limited to:

- P-SERC process;
- sick call;
- request from staff;
- correctional personnel or legal representation; and
- friends and family members.

4.2 When mental health staff receive a referral, the inmate is screened and evaluated for determination of clinically indicated services.

5. REFUSAL OF MENTAL HEALTH TREATMENT:

5.1 An inmate has the right to refuse any or all proposed mental health treatment.

An inmate's refusal of mental health treatment does not equate to a lack of classification for mental health services.
An inmate does not waive his or her right to subsequent mental health care by refusing treatment at a particular time.
If an inmate refuses treatment but his/her mental health deteriorates to the point the inmate is no longer stable, the inmate will be evaluated for involuntary treatment, emergency intervention, and/or inpatient hospitalization.
If an inmate has a documented history of prior episodes of mental health care, the following steps should be followed:

- document the refusal in the medical record;
- provide a description of the service being refused;

- provide evidence that the inmate has been made aware of any consequences to his/her mental health that may occur as a result of the refusal; and
- obtain the signature of the inmate and the date on any applicable form, along with the signature of any required witness.

5.2 All cases of refusal with a documented history of prior episodes of care are staffed with the Clinical Supervisor and/or Psychiatrist to determine what if any monitoring is warranted.

6. CLINICAL ADMINISTRATION:

6.1 Staffing: SCDC mental health staff is comprised of a diverse group of licensed, credentialed and qualified mental health professionals that include Psychiatrists, Clinical Supervisors, QMHP's, Mental Health Technicians, and others that offer on-site mental health care and case management on a daily basis to all SCDC inmates as needed. Services include but are not limited to:

- Mental health screening at intake;
- Psychological evaluation;
- Psychiatric evaluation, medication, evaluation and management;
- Psychological assessment;
- Suicide prevention and intervention;
- Crisis intervention;
- Individual and group treatment; and
- Cognitive behavioral treatment.

6.1.1 Qualified Mental Health Professionals (QMHP) are available either onsite or on call 24 hours a day for every institution.

6.1.2 Psychiatrists, Clinical Supervisors, and other QMHP are available to provide diagnostic impressions, evaluations, treatment, and other therapeutic mental health services.

6.1.3 Other Qualified Mental Health Professionals (QMHP) hold a Master's degree in counseling or a counseling related field, and are licensed in the state of South Carolina. They provide treatment and case management services to all inmates classified as mentally ill and any inmate receiving suicide precaution (SP) or crisis intervention (CI) services. QMHPs assist inmates in meeting and maintaining mental health treatment goals and objective through advocacy, on-going assessment and evaluation, planning, communication, education, resource management, and service facilitation. Those mental health providers who are

not licensed to practice independently as mental health professionals will be supervised with monthly documentation.

6.1.4 Nurses provide a wide range of duties including caring for and educating inmates about their medical and mental health needs. They administer medications and provide other medical and mental health treatment interventions as authorized or credentialed.

6.1.5 Mental Health Technicians are individuals who have a bachelor's level degree in counseling or other mental health related area. They are considered to be clinical, non-uniformed staff who assist with care and treatment of the mentally ill inmates.

6.1.6 Activity Therapists are clinical staff members with a degree in recreational therapy, physical education, art therapy, music therapy or associated area who provide treatment planning, education, supervision, and oversight of therapeutic activities for inmates with a mental health classification.

6.1.7 An annual staffing needs assessment is performed by the Deputy Director of Health Services, Division Director of Behavioral/Mental Health and Substance Abuse Services, Chief Psychiatrist, Director of Nursing, Medical Director and Quality Management Director to ensure adequate coverage, licensure/credentialing requirements are maintained and service gaps and trends are identified.

6.2 Inmate Screening/Evaluation/Treatment:

6.2.1 Screening: All inmates receive mental health services orientation and mental health screening upon commitment to SCDC (*see Health Services Procedure 700.10, "Reception and Evaluation"*), and again at any time during the inmate's prison term as needed or requested. Mental health screening can be expedited based on the results of intake screenings conducted by case management and medical staff. Mental Health Screenings are completed as follows:

- Routine: completed within three (3) business days.;
- Urgent: completed within twenty-four (24) hours.;
- Emergent: completed within four (4) hours, and the inmate is kept under direct observation until the evaluation is completed.

6.2.2 Evaluation: Inmates who present with mental health concerns as identified through screening may receive routine, urgent or emergent referral for further evaluation (dependent on their symptom presentation and/or history). Further evaluation includes a confidential clinical evaluation, suicide risk assessment, psychiatric assessment, and psychological testing, when necessary:

- Routine evaluations are completed within fourteen (14) days;
- Urgent evaluations are completed within twenty-four (24) hours;
- Emergent evaluations are completed within four (4) hours, and the inmate is kept under direct observation until the evaluation is completed.

6.3 Classification: Classification will determine inmate placement in accordance with an inmate's level of care, risks and security requirements. Identifying existing mental health problems and potential mental health concerns will allow classification to provide proper placement of inmates classified as mentally ill. Inmates are considered admitted to Mental Health Services after the Health Summary has been revised to indicate LOC status. They will subsequently be assigned to institutions that provide the appropriate level of mental health care.

6.3.1 Psychiatrists will complete a mental health evaluation to render a diagnostic impression, make treatment recommendations, and determine need for further psychological, neurological, medical and laboratory testing to ensure an inmate receives the proper level of care. A psychiatric evaluation is completed prior to a mental health classification being assigned. The classification is determined by the evaluating psychiatrist with input from other QMHPs.

6.3.2 Psychotropic medications are generally prescribed by a psychiatrist or a psychiatric mid-level practitioner. Psychiatric medication may also be initiated or monitored, on a shorter term or interim basis as needed by a general medical physician or mid-level practitioner with appropriate experience and training. Informed consent is required for any inmate voluntarily taking psychiatric medication. Inmates receive medication, education, compliance monitoring and drug toxicity monitoring by psychiatrists, mid-level practitioners, nursing staff and pharmacy staff as dictated by their treatment regimen.

6.3.3 Individual counseling services are private through confidential sessions between the inmate and his/her assigned QMHP, Clinical Supervisor, Psychiatrist or other mental health professional. Counseling sessions provide a supportive environment for the inmate to address feelings, thoughts, and

behaviors associated with their mental illness and identify goals, objectives and strategies that foster changes in thinking patterns, an understanding of self-actualization, learning new skills, and/or ways to diminish problem behavior.

6.3.4 All inmates identified as mentally ill (Mental Health Classification L1, L2, L3, L4, or L5) must be monitored by mental health staff regardless of whether or not psychotropic medication is prescribed, or whether or not the inmate is compliant with his/her prescription medication.

- **L1** Hospitalization - Male inmates are placed in Gilliam Psychiatric Hospital. Female inmates are placed in a contract facility. Mental health professionals see the inmate at least weekly or more routinely if clinically indicated.

- **L2** Intermediate Care Services (ICS) - Inmates ability to function is severely impaired due to mental illness. There are active symptoms of major mental illness with impaired reality testing or multiple failures to conform behavioral functions in a lowered level of care. Inmates are seen at a minimum of twice a month by a Qualified Mental Health Professional or more routinely if clinically indicated.

- **L3** Higher Intensity Outpatient Treatment - Inmates' ability to function in a general population is moderately impaired due to mental illness. They are easily overwhelmed by everyday pressures, demands, and frustrations, resulting in disorganization, impulsive behavior, poor judgment, delusions, hallucinations or other exacerbations. They are seen by Qualified Mental Health Professionals at least monthly or more routinely if clinically indicated and require a treatment plan update every three months.

- **L4** Outpatient - Inmates may be housed in general population or structured living unit. Inmates' ability to function in general population is mildly impaired or needs monitoring due to change in medication, recent move from higher level of care, or history of self-injurious behavior. They are seen by Qualified Mental Health Professionals at least every 90 days or more often if clinically indicated and require a treatment plan update every 6 months.

- **L5** Work release eligible - Inmates carry a mental health diagnosis,

symptoms in remission, eligible for KOP (carry on person) medication. Inmates' ability to adjust and function in general population is not impaired due to mental illness. They are seen by Qualified Mental Health Professionals at least every six months, or more if clinically indicated, and require a treatment plan annually.

6.4 Case Management: The lead QMHP at the receiving institution will ensure that mentally ill inmates classified as mentally ill at his/her institution have an are assigned a MHP. MHPs will ensure that will provide appropriate treatment/services is provided appropriately to the based on an inmate's individual clinical need(s). Both routine and significant contacts will be documented in the AMR. QMHPs will keep the treatment team informed of each inmate's progress or lack of progress, and will request any additional support as needed.

6.4.1 With the exception of Incidental/Non-Contact notes, all mental health professionals document mental health care services in Data, Assessment, Plan (DAP) format or Subjective, Objective, Assessment, Plan (SOAP) format. (SCDC Procedure 700.5, "Mental Health Clinical Documentation." Types of contact documented include:

- **Routine Contact:** Documentation for regular contact rather than for a special reason (ex: individual therapy progress note);
- **Significant Contact:** Documentation of matters that require immediate attention/action (ex: initial assessments, suicide prevention/precaution);
- **Incidental:** Brief explanation of changes, concerns and/or problems that may or may not involve contact with the inmate;
- **Group Sessions:** Documenting individual progress for participants in group sessions.

6.4.2 Treatment Planning: Once an inmate has been screened, evaluated, and classified to receive mental health services, mental health staff will determine an effective course of action by establishing an individualized treatment plan in conjunction with the inmate. An individual treatment plan provides treatment recommendations that will help the inmate develop the necessary skills for successful adjustment while incarcerated and upon release to the community. Individual Treatment Plans (ITP)'s are completed for each mentally ill inmate. The ITP ensures treatment remains focused on goal attainment and ensures resources are effectively utilized to meet the needs of the inmate who is actively receiving mental health care and services. (*SCDC Policy HS-19.05, "Mental Health Services - Treatment Plans and Treatment Team Meetings").*

6.4.3 Treatment Team meetings are conducted regularly and on an as needed basis at all facilities with inmates classified as being in need of mental health care. Inmates are included in the initial treatment planning process, as well as subsequent treatment plan reviews and discussion, and plans reflect any updates/changes. Inmates are encouraged to attend and participate in their individual treatment team session(s). (*SCDC Policy HS-19.05, "Mental Health Services - Treatment Plans and Treatment Team Meetings"*).

6.4.4 Group counseling services address the mental health needs of the SCDC population by instruction and discussion of topics such as anger management, medication management, victim impact, etc. Mentally ill inmates are encouraged to participate in group counseling as part of the treatment process. Some groups are limited to participation of mentally ill inmates only. Others are open and welcome to all inmates. Groups may be closed or open ended in structure. (SCDC Procedure 700.5, "Mental Health Clinical Documentation."

6.4.5 Restraints - *See SCDC Policy HS-19.08, Mental Health Services - "Clinical Use of Restraints for Mental Health Purposes".*

- Restraints are used only when there is imminent danger of the inmate harming him/herself or others that cannot be resolved by a less restrictive method;
- Prior to using restraints, all other less intrusive methods are utilized/considered to protect the individual(s) from harm. Restraints are used as a last resort;
- Restraints are not used for the purpose of punishment or discipline;
- Use of restraints requires a physician's order;
- Any inmate placed in restraints is kept under constant observation. The order for continued restraints will be reviewed at least every four (4) hours;
- The inmate is assessed for circulatory problems, onset of medical concerns, and toileting needs every two (2) hours or more often if needed and has meals served on a regular schedule.

7. LEVEL OF CARE (LOC) CLASSIFICATION AND PROGRAM CODES:

7.1 Classification: SCDC mental health level of care classification and coding system is hierarchical, ranging from (L5), representing inmates who are able to function with minimal assistance from mental health staff, to (L1), representing hospitalization and the greatest need for mental health care. Inmates not requiring current mental health care are classified as NMH.

7.1.1 Hospitalization: Male inmates are placed in Gilliam Psychiatric Hospital. Female inmates, and occasionally male inmates, are placed in a contract facility. (*LOC Classification Code: L1*).

7.1.2 Residential Care: Residential mental health services are provided for inmates with moderate to severe symptoms who need frequent, ongoing mental health care and services in a therapeutic environment. Each Residential Care Program has its own LOC identifier.

- Substance Abuse Treatment - LOC Classification Code: SA
- Habilitation Program - LOC Classification Code: ID
- Behavior Management Unit - LOC Classification Sub: BU
- Intermediate Care Services - LOC Classification Code: L2
- Self-Injurious Behavior Program - LOC Classification Code: LC

7.1.3 Outpatient: Inmates who have the ability to function in general population may be housed in general population or structured living units. Outpatient inmates are mildly to moderately impaired and/or need monitoring due to a need for medication management, recent move from higher level of care, history of self-injurious behavior or mild/moderate symptoms present, and/or to maintain stability. There are two (2) levels of outpatient care:

- Higher Intensity Outpatient Treatment: LOC Classification Code: L3; and
- Lower Intensity Outpatient Treatment: LOC Classification Code: L4.

7.1.4 Assignment will be based on review of treatment needs. Inmates who are on more complex medication regimens, viewed as being less stable or more needy, are classified as Higher Intensity. Institutions designated as suitable for housing Higher Intensity Outpatients will be staffed at a higher level to accommodate additional mental health programming.

7.1.5 Work Release Eligible: Inmate has one or more mental health diagnoses; however, the individual's symptoms are in remission and/or well controlled with treatment. If a mentally ill inmate is considered eligible for work release, their case is reviewed on an individual basis by the treatment team and the chief psychiatrist to determine if their treatment plan can be continued in a work release program. LOC Classification Code L5.

7.1.6 Non-Mental Health: Designated code for inmates who have no current need for mental health services. LOC Classification Code: NMH

7.2 Special Program Codes: Program and service codes help to identify and track the progress of mentally ill inmates who participate in several programs, services, and opportunities provided to assist in psychiatric rehabilitation, substance abuse treatment, sex offender treatment and therapeutic group sessions designed to educate inmates in several areas of life management. Inmates may be assigned one or more of the following codes:

- Sex Offender Treatment Program Code: 310;
- Crisis Intervention Services Code: 079;
- Individual Therapy Services Program Code: 080;
- Group Therapy Services Program Code: 081.

8. PROGRAMS AND SERVICES:

8.1 Inpatient Psychiatric Care:

8.1.1 An inmate experiencing significant, acute or severe psychiatric or emotional difficulties, whose care requires a healthcare setting and cannot be accomplished in a less intensive treatment setting, may be admitted to the hospital for further evaluation and care. Admission is voluntary, by court order, or considered emergency while the court order process is being initiated.

8.1.2 Routine referrals for inpatient care will be made to the chief psychiatrist or designee. Emergency referrals will be handled by the psychiatrist on call.

8.1.3 A medical examination, including updated physical exam and clinically appropriate laboratory studies, will be conducted within **twenty-four hours of admission**.

8.1.4 Voluntary Admission - Institutional medical staff and/or QMHP will coordinate admission for inmates who voluntarily agree to inpatient treatment. Males requiring in-patient psychiatric care will generally be admitted to Gilliam Psychiatric Hospital. Females requiring in-patient psychiatric care will be admitted to a contract facility. Voluntary participants sign a consent form informing them of their right to withdraw from hospitalization at any time. However, if the need for continued treatment is warranted, a psychiatrist will file a petition with Richland County Probate Court for involuntary judicial commitment.

8.1.5 Involuntary Admission - If an inmate refuses a referral for inpatient treatment, the psychiatrist will determine if the inmate is best served by either completing an application for emergency hospitalization to secure inpatient

hospitalization on an involuntary basis or filing a petition with Richland County Probate Court for involuntary judicial commitment. Women requiring inpatient psychiatric care will be admitted to a contract facility for involuntary admission. Males requiring psychiatric care are admitted to Gilliam Psychiatric Hospital.

8.1.6 Inmates who are hospitalized have access to short-term and long-term inpatient psychiatric care with the goal of stabilization for transition to a less restrictive environment within SCDC.

8.2 Crisis Intervention (CI)/Suicide Precaution (SP) Possibly MH CI Policy 19.03.

8.2.1 Provided for any inmate arriving with or developing a condition that warrants an immediate response due to being a danger to him/herself or others are placed in a healthcare setting and receive suicide precaution/crisis intervention services immediately. This level of care is prescribed and discontinued by order of a licensed independent practitioner credentialed to order CI/SP status (psychiatrist, mid-level psychiatric practitioner or doctoral level Clinical Supervisor).

8.2.2 Emergency intervention and prevention measures are utilized when inmates display suicidal tendencies/actions, homicidal tendencies/actions, self-injurious behaviors, or other conditions that may cause harm to themselves or others.

8.2.3 Each institution has designated specific safe cells that are appropriately secure and suicide resistant to allow inmates, at least temporarily, to be placed on special status under direct observation by uniform staff with qualified health and mental health professionals performing scheduled and unscheduled observation and evaluation. Inmates placed in safe cells will be subject to the same conditions, restrictions, and privileges set forth for CI/SP inmates in SCDC Policy HS-19.03.

8.2.4 The Chief Clinical Supervisor will coordinate the CI/SP program within SCDC.

8.3 Residential Mental Health Care:

8.3.1 Intermediate Care Services (ICS) 19.11:

- Provides therapeutic environment for mentally ill inmates with serious, persistent mental illness who need frequent or ongoing mental health

services, including monitoring due to potential medication management issues and/or a condition or circumstance requiring more extensive monitoring, treatment or case management short of hospitalization.

- Inmates meeting specific program admission criteria for ICS may be identified during R&E processing or at any time during their period of incarceration. A mental health services referral packet is completed for review by the Program Supervisor/Coordinator to determine suitability for program participation.
- If the inmate is accepted into the program, then s/he can either be transferred from R&E upon completion of the intake process, or from their current living unit upon completion of the designation process by the Division of Classification and Inmate Records.
- The inmates Health Summary must be updated by a physician, psychiatrist or nurse practitioner to reflect assignment of the most recent diagnoses.

8.3.2 Habilitation Program (Hab Program):

- Provides social, vocational, and academic skills programming to inmates who demonstrate significant intellectual impairment limiting their ability to adjust to or function in a general correctional environment.
- The inmate's condition is expected to continue indefinitely. The Hab Unit is a mandatory LOC assignment but participation in the treatment programs and services is voluntary.
- Inmates are evaluated for program admission during R&E processing or may be identified and referred from any SCDC institution. Various testing instruments that measure intellectual and cognitive functioning, adaptive behavior, and other clinical issues will be utilized in the evaluation process with any inmate suspected of intellectual impairment.
- Referrals are reviewed by the Habilitation Services Program Manager and program Treatment Team. When approval is granted, LOC is updated to reflect the Hab. Unit assignment.

8.3.3 Self-Injurious Behavior (SIB) Services:

- Provides services for mentally ill, inmates in a therapeutic environment who:
  1) display chronic self-injurious behavior
  2) who have a documented history of acute self-injurious behavior; and/or

3) are identified by a Psychiatrist/Clinical Supervisor as needing placement in the SIB Program (*Males Only*) or provided other SIB specific services.

- **Males**: QMHPs complete a referral package for review by the SIB Program Manager and program Treatment Team who decide to accept, reject, or refer the inmate to another mental health program. If approval is granted, LOC is updated to reflect SIB program assignment.
- **Females:** Inmates identified by a Psychiatrist/Clinical Supervisor as needing more intensive mental health treatment for self-injurious behavior will be referred to a contract facility for inpatient services, if necessary. An individual treatment plan to address follow-up needs in response to continued risk for SIB will be developed.

8.3.4 Substance Abuse Treatment Program:

- Provides services to any inmate with an addiction to drugs and/or alcohol.
- Mentally ill inmates who are dually diagnosed with a substance abuse problem must be cleared psychologically by their current Mental Health Treatment Team to participate in the Substance Abuse Treatment program.
- Inmates dually diagnosed with a mental illness and substance abuse issues, must be psychologically and medically stabilized prior to beginning the Substance Abuse Treatment program.
- Referrals for substance abuse services are outlined in SCDC Policy PS-10.02, "Inmate Substance Abuse Programs."

8.3.5 Behavior Management Unit (BMU): Provides additional assessment and treatment in a therapeutic environment to mentally ill inmates who display or have displayed serious, ongoing behavioral problems resulting in significant lockdown time due to disciplinary infractions.

8.3.6 Sex Offender Treatment Program (SOTP) - SCDC Policy PS-10.11, *"SEX OFFENDER TREATMENT PROGRAM (SOTP)":*

- Voluntary or court ordered service providing educational groups, treatment groups, and relapse prevention groups for inmates with a history of deviant sexual behavior.
- The SOTP Coordinator completes individual evaluations on inmates who are court ordered, referred or requesting entry in the Sex Offender Treatment Program.

- Mentally ill inmates will retain their current LOC classification and evidence of program assignment, and participation will be indicated/coded in the Program Services Summary. Mental health care will not be interrupted due to program assignment.

8.4 Outpatient Care:

8.4.1 Intensive Outpatient Mental Health Services (IOP) - Higher Intensity Outpatient Care:

- Inmates classified as intensive outpatient are inmates who present with moderate symptoms needing frequent or ongoing mental health care, are prescribed psychotropic medication that requires close monitoring, and whose condition or circumstances require a higher level of evaluation, treatment, and/or case management but does not arise to the level of the need for hospitalization or residential care programming.
- When a Psychiatrist indicates IOP Services are needed, a QMHP will update the inmate's medical classification information in the AMR to reflect the current mental health status.
- Inmates requiring IOP care are assigned to an institution with full time mental health staff.

8.4.2 Outpatient Mental Health - Lower Intensity Outpatient Care:

- Inmates classified as Lower Intensity Outpatients must be able to function with limited supervision from mental health staff.
- When a Psychiatrist indicates outpatient mental health services are needed, a QMHP will update the inmate's medical classification information in the AMR to reflect the current mental health status.
- Inmates requiring outpatient care are assigned to an institution with full time mental health staff.

8.5 Services for Non-Mentally Ill Inmates:

8.5.1 Inmates designated as NMH are individuals with no current identified mental health needs.

8.5.2 Mental health services, including suicide precaution/crisis intervention, continue to be available to non-mentally ill inmates. Non-mentally ill inmates can request access to mental health services by utilizing the medical referral/sick call process. Any staff member can also bring concerns about any

inmate's mental health to the attention of any mental health staff member who will initiate a formal referral for evaluation.

8.6 Mental Health Services for Death Row Inmates - *See SCDC Policy OP-22.16, "Death Row"*:

8.6.1 Male inmates on death row are admitted directly to Lieber Correctional Institution (Lieber) and complete the intake process at Lieber. Female death row inmates are admitted directly to Camille Graham Correctional Institution (Camille) and also receive intake services at Camille.

8.6.2 During the intake process, an incoming death row inmate is placed on precautionary SP/CI status and until he/she completes initial R&E mental health screenings and any identified mental health assessments.

8.6.3 Death row inmates receive the same screening, assessments and LOC classification as inmates housed in the general population. Mental health treatment will be individualized. All death row inmates are routinely assessed monthly by a QMHP. If at any time a death row inmate appears to need additional mental health services, a referral is completed to begin supplementary mental health services as clinically indicated.

8.6.4 QMHP are present during the reading of an inmate's death warrant after which the inmate is automatically placed on CI/SP. Mental health personnel monitor the inmate during CI/SP and develop and provide mental health treatment as necessary.

8.7 Specialized Mental Health Care Services:

Beyond the traditional mental health services provided, mental health staff will collaborate with various specialized program areas to provide mental health services as required. Since many inmates receiving specialized program services also have a mental illness and/or a medical diagnosis, their program(s) will be located at a facility that can provide their medical, psychiatric, and mental health care management as required. Mental health and medical personnel will coordinate with program staff to ensure the inmate is receives concurrent services in order to maintain continuity of care.

8.7.1 Inmates receiving specialized program services who also require mental health services, shall have individualized care plans created to ensure that such specialized program services situations do not prevent the inmate from

receiving mental health care as clinically indicated. Examples of specialized programs or services that may present mitigating circumstances and/or require the creation of an individual care plan include, but are not limited to, the following:

- Prison Rape Elimination Act (PREA), SCDC Policy OP-21.12, "Prevention, Detection, and Response to Sexual Abuse/Sexual Harassment;"

- Infirmary Services, Health Services Procedure 400.1, "Infirmary Services";
- Shock Incarceration, SCDC Policy PS-10.12, "Shock Incarceration";
- Guilty But Mentally Ill (GBMI) - Refer to SCDC Policy OP-22.14, "Inmate Disciplinary System," Health Services Procedure 700.2, "Inpatient Psychiatric Admission";
- Protective Custody, SCDC Policy OP-22.23, "Statewide Protective Custody";
- Young Offender Parole and Re-entry Services, OP-22.39;
- Pregnancy-Related Health Care Services, HS-18.15, "Levels of Care";
- Disability Services (Handicapped Unit), HS-18.15, "Levels of Care";
- Hospice Care, HS-18.15, "Levels of Care";
- Chronic/Palliative and Convalescent Care, HS-18.15, "Levels of Care";
- Substantiated Security Risk (SSR), SCDC Policy OP-22.37, "Restrictive Housing Unit";
- Restrictive Housing Unit (RHU), SCDC Policy OP-22.38.

9. DISCHARGE:

9.1.1 From Hospitalization: Inmates discharged to a lower level of care after being hospitalized are assigned to an appropriate institution and/or program to meet their level of functioning. Inmates receive a mental health assessment within 48 hours of arriving at the receiving institution. Hospital discharge information including treatment recommendations, medication, etc., is added to the inmate's treatment plan.

9.1.2. From Mental Health Treatment: Inmates can request removal from mental health services at any time. Inmates can also be recommended for removal from mental health services by their treatment team. Inmates who are requesting or are recommended for discharge from mental health services will have their case reviewed by the institutional Treatment Team, with input from the Regional Manager, Clinical Supervisor, and Chief Psychiatrist.

9.2 Mental Health Discharge Upon SCDC Release:

9.2.1 QMHPs work diligently to provide as many resources as possible to assist inmates in continuing their treatment upon release. Inmates are fully advised of potential assistance programs and program eligibility requirements. Inmates receive assistance completing applications/enrollment for disability, Medicaid/Medicare, etc. A psychiatrist reviews all psychiatric medications prior to discharge and an appointment for follow-up care and management of psychiatric medications will be coordinated to occur within five (5) days of the inmate's release date. The inmate will routinely receive a five (5) day supply and one (1) day refill prescription for medication, if clinically indicated, upon the inmate's release. Exceptions can be made on a case by case basis if follow-up care is not scheduled within five (5) days of release.

10. DISIPLINARY - ***See SCDC Policies OP-22.14, "Inmate Disciplinary System," and SCDC Policy HS-19.06, "Disciplinary Detention for Inmates Classified as Mentally Ill":***

10.1 All inmates classified as Mentally Ill and receiving higher levels of care (Classification L1, L2, L3, and LC) and any inmate who suffers from or presents with a serious mental illness, regardless of classification, who is presented before a Disciplinary Hearing Officer (DHO) due to an infraction that could lead a level one or two formal charge, will be assessed by a Qualified Mental Health Professional (QMHP). The QMHP will determine what impact, if any, the inmate's mental health state should carry in regard to disciplinary sanctions. The QMHP completing the disciplinary statement will not, whenever possible, be the primary counselor assigned to the inmate.

10.2 Within (3) business days, an inmate who is or has been on the mental health caseload within the last six months charged with a major disciplinary infraction will have an evaluation completed by a QMHP with the assistance of a Psychiatrist and/or Clinical Supervisor as needed. This evaluation will include a formal review of mental health history, diagnosis and current treatment. The inmate's competency to understand and any impact their mental health issues may have had on their behavior at the time of the offense is assessed. The evaluation will be completed by a QMHP who is not assigned to the case.

10.3 A Disciplinary Hearing Officer (DHO) will examine investigatory findings and case study information fairly adjudicate the inmate. If a mentally ill inmate receives a "guilty" verdict, an institutional Mental Health

Disciplinary Treatment Team (MHDTT) consisting of a Clinical Supervisor, Psychiatrist, and QMHP or Regional/Program Manager, as well as a Warden, Associate Warden and/or Major, will review the nature of the offense to determine an appropriate penalty or other resolution for the inmate after taking into consideration the mitigating factors reflected in the inmate's mental health assessment.

10.4 The MHDTT will review the status of a mentally ill inmate's disciplinary sanctions to determine if the inmate's privileges can be restored or if the inmate can return to the institution's general population or other suitable housing.

10.5 Mentally Ill inmates receiving a disciplinary infraction are provided ongoing care and service to assure corrective measures remain fair and humane. Every effort is made to ensure inmates classified as mentally ill, with a disciplinary infraction are:

- granted access to needed levels of mental health care;
- afforded consistent, timely access to a clinical correctional counselor,;
- secured in safe and sanitary housing units; and
- considered for alternative sanctions that are conducive to positive therapeutic change.

11. USE OF FORCE:

11.1 Authorized, trained staff members will use the minimum mechanical security restraints and/or minimum reasonable force necessary to gain control of an inmate, after reasonable means of intervention have been exhausted, and use of force will be discontinued when the inmate is under control. The purpose of the appropriate use of force is never to punish but to protect and ensure the safety of the public, staff, inmates, and others; to prevent injury, prevent serious property damage, ensure institutional security and good order.

12. HUNGER STRIKE/EXTENDED FAST *(SCDC Policy OP-22.33), HSP 4000.4, "Medical Management of Malnourished Inmates and Hunger Strike," and HSP 200.6, "Management of Inmate Hunger Strike/Extended Fast"*:

12.1 Mental health clinicians assist uniform staff and medical staff in the management of an inmate on a hunger strike, including the provision of counseling with the inmate to resolve the problem.

12.2 Subsequent mental health evaluations will continue for the duration of the failure to eat behavior.

12.3 Psychiatric hospitalization will be considered if the inmate meets the civil commitment criteria.

13. PRISON RAPE ELIMINATION ACT (PREA) / SEXUAL VICTIMIZATION - *See SCDC Policy OP-21.12, "Prevention, Detection, and Response to Sexual Abuse/Sexual Harassment":*

13.1 Sexual victimization reports are accepted in multiple ways: request to staff, in person to any uniform or non-uniform staff member, PREA Compliance Manager, inmate self-report, and inmate third party reporting.

13.2 Once a sexual victimization report has been received, mental health staff will follow procedures set forth in the mental health sexual victimization screening procedure and will follow protocol outlined in federal PREA standards.

14. DUTY TO WARN:

14.1 Any mental health staff person who, in the course of treating an inmate, has reason to conclude that the inmate poses a threat to a third person, the mental health staff member is obliged by law to take appropriate action to prevent the occurrence of harm.

14.2 If an inmate makes a specific verbal or written threat against an identifiable potential victim and the employee believes that the inmate intends harm to that identifiable potential victim, the employee will immediately inform his/her supervisor and complete SCDC Form 19-29A, "Incident Report," so all appropriate warning steps can be carried out by the Division of Victim Services. (See SCDC Policy GA-01.13, "Duty to Warn.")

15. INFORMED CONSENT - *See Health Services Procedure 200.3, "Informed Consent":*

15.1 The Psychiatrist/Nurse Practitioner must clarify the treatment, alternatives, possible benefits and risks of a treatment to an inmate before starting a psychiatric procedure or treatment. In lay terms, the Psychiatrist/Nurse Practitioner/Medical Doctor must explain the following:

- the treatment, rationale, and possible benefits;
- the nature and severity of material risks, and the likelihood of their occurrence;
- reasonable alternative treatment; and

- possible consequences of withholding consent.

15.2 Informed consent is given when an inmate fully understands treatment, alternatives and risks, is considered competent to give consent, and then voluntarily agrees to a recommended psychological or psychiatric treatment. The process will be documented in the Automated Medical Record (AMR).

15.3 If an inmate is placed on antipsychotic medication, the inmate will be given SCDC Form M-107, "Consent for Neuroleptic Medications," to sign. The form will be signed by the inmate and witnessed by the Psychiatrist/Nurse Practitioner/Medical Doctor. The form will then be filed in the hard copy of the inmate's medical record. In the event the inmate is being evaluated via tele-psychiatry, the form will be provided by QMHP at the time of discussion, who will note the process, and then forward the form for signature by the Nurse Practitioner or Physician.

16. REFUSAL OF TREATMENT:

16.1 An inmate has the right to refuse any or all proposed mental health treatment.

16.2 An inmate does not waive his or her right to subsequent mental health care by refusing treatment at a particular time.

16.3 If an inmate refuses treatment but his/her mental health deteriorates to the point that the inmate is no longer stable, the inmate will be evaluated for involuntary treatment and/or inpatient hospitalization.

16.4 When an inmate refuses a recommended treatment, the inmate must sign SCDC Form M-53, "Refusal of Medical Advice. " Once the form is signed, the form will be forwarded to Mental Health to ensure they are made aware.

16.5 If an inmate classified as mentally ill wishes to be removed from Mental Health Services, the QMHP will inform the treating Psychiatrist who will see the inmate face to face to determine a plan of action, including a decision about how to handle any current prescriptions.. The inmate will continue to be monitored for 90 days. If, at the end of the 90 day monitoring period, the inmate is stable and with the concurrence of the treating Psychiatrist, Treatment Team, and Regional Manager/Program Manager, the inmate can be removed from Mental Health Services.

16.6 Consequences of the refusal are explained to the inmate. The form will be filed in the hard copy of the inmate's medical record and the refusal will be documented in the Automated Medical Record.

16.7 If the inmate refuses to sign the Refusal of Medical Advice form, the verbal refusal will be witnessed by two employees, and the verbal refusal will be documented in the Automated Medical Record.

16.8 If the inmate is unable to sign, the verbal refusal or the inmate's mark will be witnessed by two employees and the verbal refusal will be documented in the Automated Medical Record.

17. ASSESSMENTS FOR INMATES IN RESTRICTIVE HOUSING (RHU):

17.1 Classification Review Assessments (CRA) will be completed by the institution's mental health staff. The institution's classification manager will provide the CRA list to the lead QMHP at least 30 days in advance of the review date. The lead QMHP will ensure that the CRA list is completed and returned to the classification manager one (1) week before the Institutional Classification Committee (ICC) hearing. The CRA may be based on the most recent weekly assessment. The CRA will include:

- the inmate's name and SCDC number, date, and home institution;
- the inmate's approach to the interview, mental status, identified problems areas, and behavioral observations; and
- recommendations as to whether there is a need for mental health treatment.

17.2 All inmates, as part of the intake and initial case management review at RHU, **must** be assessed by a behavioral/mental health staff member. Inmates classified as mentally ill will be assessed within 72 hours of initial placement. All inmates will be assessed/monitored weekly while in RHU. All mentally ill inmates will be assessed and evaluated in accordance with their level of care classification, or more frequently if deemed necessary. Assessments will be documented in the Mental Health Clinic (CCC) section of the Automated Medical Record.

17.3 Mental status rounds will be performed on all inmates housed in RHU weekly. These will be done at cell front to identify inmates who are decompensating or having a difficult time adjusting to being isolated.

17.4 Inmates identified as MI/DD or handicapped and housed in a RHU, regardless of the reason, will not be denied services due to their status. These inmates will have a treatment plan developed that reflects services offered while in an RHU. These services will be provided based on the diagnoses, and the treatment/service plan. Services in addition weekly rounds will be provided as clinically indicated and will be documented in the AMR. Limitations on services will be based on documentable security concerns and/or limitations (e.g., inability to attend groups).

18. CONFIDENTIALITY:

18.1 Every reasonable effort will be made to ensure that an inmate's Mental Health Treatment/Records remain confidential.

18.2 Only authorized Health Services employees will have access to an inmate's Mental Health Records. In the event that Mental Health Records are transported by security, the record will be placed in a sealed envelope to ensure confidentiality.

18.3 Information regarding an inmate's treatment cannot be released to any outside agency or person to include family members without written consent of the inmate. If the inmate agrees to give consent for the information to be released, the inmate must complete SCDC Form M-152, "Release of Information." This form includes the type of information and to whom it can be released.

19. TRAINING ON MENTAL HEALTH SERVICES ISSUES:

19.1 All newly hired SCDC personnel and contract providers receive orientation and training on mental health services and working with mentally ill inmates.

19.1.1 Mental health, medical and uniform personnel receive annual training on suicide prevention strategies, self-injurious behavior, mentally ill inmate care and mentally ill inmate security management. Areas of training also include:

- interpreting and responding to symptomatic behaviors, and communication skills for interacting with inmates with mental illness;
- recognizing and responding to indications of suicidal thoughts;
- conducting proper suicide prevention observation;
- responding to mental health crises, including suicide intervention and cell extractions;
- recognizing common side effects of psychotropic medications;
- professional and humane treatment of inmates with mental illness;
- trauma informed care;
- de-escalation techniques;
- alternatives to discipline and use of force when working with inmates with mental illness and more.; and
- CPR and first aid.

19.1.2 All mental health staff, whether full-time or contract, will be specifically trained regarding the function and structure of mental health services including:

- mental health policies and procedures;

- nature of special programs; and
- unique missions of various facilities.

19.1.3 Each mental health staff member will verify understanding of the above by signing an acknowledgement form that will be kept on record.

20. CONTINUOUS QUALITY MANAGEMENT - *See SCDC Policy HS-19.07, "Mental Health Continuous Quality Management (CQM):*

20.1 The Division of Behavioral/Mental Health and Substance Abuse Services provides systematic and ongoing comprehensive quality management processes for monitoring, evaluating, and improving the quality and appropriateness of mental health care provided for inmates.

20.2 The process identifies indicators that quantify quality and appropriateness of the multiple aspects of care, and organizes the data collected to help facilitate identification of areas in need of administrative change, training, program revision or other modifications.

20.3 Continuous Quality Management indicators examine high risk/high volume activities, self- injurious behavior, and special treatment procedures including, but not limited to, the utilization of mental health watches, restraints, and treatment.

21. DEFINITION(S):

Activity Therapist refers to a Clinical staff member with a degree in recreational therapy, physical education or associated area, art therapy or music therapy, who provides treatment planning, education, supervision, and oversight of therapeutic activities for inmates with a mental health classification.

Case Management refers to assisting inmates in meeting and maintaining mental health treatment goals and objectives through advocacy, ongoing assessment and evaluation, planning, communication, education, resource management, and service facilitation.

Continuity of Care refers to the process of ensuring care from the point of admission to discharge to transition into the community.

Crisis Intervention (CI)/Suicide Precaution (SP) refers to the process designed to address immediate acute distress and associated behaviors when an inmate is a danger to him/herself or others. If it is determined that the inmate requires CI or SP status, the

inmate may be transferred to a designated CI bed space. The usual length of stay in CI will be ten (10) days or less. The licensed Clinical Supervisor, psychiatrist, physician, physician's assistant, or nurse practitioner who ordered CI or SP will complete SCDC Form M-120, "Crisis Intervention Form."

Developmental Testing refers to administration, interpretation, and reporting of screening and assessment instruments for inmates to assist in the determination of developmental levels for the purpose of facilitating mental health services, placement and treatment planning.

Discharge Planning refers to preparation for program or institutional dismissal to assure continuity of care and effective aftercare planning prior to inmates expected release date.

Duty to Warn refers to the obligation to warn an identifiable individual, organization, or entity of a specific threat of harm.

Evidence-based Treatment refers to intervention with consistent scientific evidence demonstrating improved recipient outcomes.

Healthcare Setting refers to a clean, safe, therapeutic environment with a nursing station that is staffed 24/7.

Hunger Strike/Extended Fast refers to a situation in which an inmate communicates to an SCDC staff member that s/he is on a hunger strike/extended fast, or when an SCDC staff member observes the inmate not consuming an adequate amount of food or liquid for 72 hours or more.

Individual Treatment Plan (ITP) refers to a document that details a client's current mental health problems and outlines the goals and strategies that will assist the client in overcoming his or her mental health issues.

Initial Assessment refers to face-to-face interaction between a mental health staff member and inmate designed to gather information that enables the clinician to evaluate and assess for mental health services.

Inmate refers to a male or female convicted of an offense against the State of South Carolina, sentenced to imprisonment for more than three months and serving a criminal sentence under commitment to the State Department of Corrections, including persons serving sentences in local detention facilities designated under the provisions of applicable laws and regulations.

Inpatient Care refers to a voluntary or involuntary commitment to a psychiatric hospital.

Level of Care (LOC) refers to a hierarchical coding system that reflects an inmate's current medical and mental health classification, mental health service need(s) and the intensity of treatment an individual will receive. All inmates receive a Level of Care classification.

Medical Record, Automated (AMR) refers to a multidisciplinary, computerized network that links mental health professionals and medical professionals to information. The AMR tracking system helps to maintain continuity of care and allows for timely and efficient access to information.

Medical Record, Hard File refers to a paper-based system of recordkeeping that stores medical, mental health information, and other documents/information not stored in the AMR. Hard files are stored in the medical record area of the inmate's assigned institution. When an inmate transfers to a different institution, the hard file follows the inmate.

Mental Health Disciplinary Review Team (MHDRT): Established to review and provide case guidance of for inmates with a mental health classification and found guilty of a disciplinary offense.

Mental Health Screening consists of observation and structured inquiry into each inmate's mental health history and symptoms. Structured inquiry includes questions regarding suicide history, ideation, and potential, prior psychiatric hospitalizations and treatment, and current and past medications, both those prescribed and what is actually being taken.

Mental Health Technician refers to a staff member with at least a Bachelor's Degree and (2) years' experience in a mental related field or an Associate's Degree and (4) years of experience in a mental health related field who provide adjunct mental health services such to mentally ill inmates under the supervision of licensed clinical staff.

Mental Status Examination refers to a confidential, structured assessment of behavioral and cognitive functioning that describes the mental state of the individual receiving the evaluation. It includes both objected observations by the clinician and subjective descriptions given by the inmate.

Outpatient Care refers to the level of care intended for mentally ill inmates who are able to function satisfactorily in a general population setting for extended periods of

time. This includes two subsets of inmates: Higher Intensity Outpatients and Lower Intensity Outpatients.

P-SERC refers to a service delivery process involving psychiatric screening, evaluation, resolution and classification.

Potential Victim refers to an identifiable individual, organization, or entity who/which is the target of a specific threat of harm.

Psychiatric Assessment/Evaluation consists of a face-to-face interview of the inmate and review of all reasonably available healthcare and mental health records and collateral information. It includes a diagnostic formulation and, at least, an initial treatment plan.

Psychiatrist refers to an individual licensed to practice medicine in the State of South Carolina, who is (1) certified by the American Board of Psychiatry and Neurology or eligible for certification by that Board, or (2) certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by the Board.

Psychological Testing refers to psychological evaluation using standard assessment methods and instruments to assist in mental health assessments and treatment planning processes.

Clinical Supervisor refers to a Qualified Mental Health Professional (QMHP) as a Clinical Supervisor supervising/managing mental health professionals in a program and/or region ensuring quality clinical care.

Psychotropic Medication refers to any medication (i.e., anti-depressant, anti-anxiety, anti-psychotic or mood stabilizing) prescribed for treating various mental health symptoms.

Qualified Healthcare Practitioner (QHP) refers to a physician, physician's Assistant, or Nurse Practitioner.

Qualified Mental Health Professional (QMHP) refers to a mental health practitioner licensed by the State of South Carolina such as a Psychiatrist, Licensed Clinical Psychologist, Licensed Professional Counselor, Licensed Professional Counselor-Supervisor, Licensed Independent Social Worker, Licensed Marital and Family Therapy (LMFT) or Psychiatric Nurse Practitioner. It also, includes licensed a Master Social Worker and Licensed Professional Counselor-Intern and LMFT-Intern with appropriate supervision.

Referral (Mental Health) refers to a request for mental health services.

Residential Care is reserved for mentally ill inmates unable to function in a general population setting due to a mental disorder, but who typically do not meet the criteria for admission to a psychiatric hospitalization. Residential care options, situated in a therapeutic environment, are available to inmates who present with mental health issues likely to affect their ability to function effectively while incarcerated.

Sick Call refers to a system that allows an inmate to report health and mental health concerns and receive individualized and appropriate medical or mental health services for non-emergency illness or injury, to include non-emergency mental health complaints and requests to see counselors.

Specific Threat refers to a written or verbal declaration of intended harm toward an identified potential victim(s).

Suicide Precaution (SP) refers to intervention measures to reduce physical self-harm by an inmate identified as a risk for suicidal behavior. These measures include placement of the inmate into a safe cell under constant observation.

Tele-Psychiatry refers to a process that uses video conferencing to assist in providing psychiatric services to inmates residing in remote institutions.

Therapeutic Environment refers to mental health treatment provided in a setting that is conducive to the achievement of its goals. This includes the physical setting and the social-emotional setting, in which an atmosphere of empathy and respect for the dignity of the patient is maintained. Mental health services are conducted in private and carried out in a manner that encourages the inmate's subsequent use of services. A therapeutic environment implies the following conditions:

- a sanitary and humane environment;
- written procedures;
- adequate medical and mental health staffing;
- adequate allocation of resources for the prevention of suicide, self-injury, and assault;
- adequate observation, treatment, and supervision; and
- social interactions that foster recovery.

Treatment Team refers to a multidisciplinary group including, but not limited to, mental health staff (QHP's, QMPH's, medical personnel, and uniform staff) who discuss integrated therapeutic services, collaborate, and share appropriate information

based on the inmate's level of care, for the purpose of treatment of mentally ill inmates and continuity of care.

SIGNATURE ON FILE

s/Bryan P. Stirling, Director

Date of Signature

ORIGINAL SIGNED COPY MAINTAINED IN THE OFFICE OF POLICY DEVELOPMENT.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF HEALTH SERVICES

PHARMACY SERVICES

Number:	HS – 18.16
Referenced:	HSPs 800.1, 100.8, 800.4, 800.5
Date:	October 2006
Update:	June 1, 2016

PURPOSE AND SCOPE: To provide guidelines for a broad spectrum of operations in the Department of Corrections pharmacy program.

PROGRAM OBJECTIVES. The expected results of this program are: An inmate's access to quality, necessary, cost-effective pharmaceutical care will be provided.

HEALTH SERVICES POLICIES/PROCEDURES REFERENCED
800.1, 100.8, 800.4, 800.5

STANDARDS REFERENCED
1. South Carolina Pharmacy Practice Act
2. Federal statutes

DEFINITIONS:

Active TB Disease refers to a clinically active disease caused by organisms of the Mycobacterium tuberculosis complex, which are sometimes referred to as the tubercle bacillus.

Administration of Medication refers to an act in which a single dose of a prescribed drug or biological (e.g., vaccine) is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's/dentist's orders, giving the individual dose to the proper patient, and promptly recording the time and dose given. This will only be done by licensed medical staff (MD, DDS, DMD, PA, NP, RN, or LPN).

Chronic Medications refer to medications ordered on an on-going basis for a chronic disease process.

Controlled Medications refer to drugs identified by the DEA to have a high potential for abuse. They are classified as Schedule II, III, IV, and V.

Delivery/Distribution of Medication refers to the delivery of a drug, other than by administering or dispensing, to a patient. This may be done by licensed medical staff or a medically trained person.

Directly Observed Therapy (DOT) refers to directly observed administration of one (1) dose of medication at a time.

Dispensing of Medication refers to an act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a patient or for a service unit of the facility.

Doctor's Box Medications refer to pre-packaged and pre-labeled medication to be kept at a clinic and given under the direct order of a physician/dentist. A list of medications to be used as the clinic doctor's box medications will be approved by the Director of Medical Services for use in the clinics.

Dose-by-Dose Administration refers to administration of one (1) dose of medication at a time.

Health Trained Employee refers to an institutional staff member other than a physician, physician's assistant, or nurse, who has been trained by the medical staff to deliver medication to inmates.

Keep-on-Person (KOP) Medications refer to medications that the inmate is allowed to keep on his/her person for self-administration.

Latent TB Infection refers to a condition in which a relatively small number of living tubercle bacilli (i.e., M. Tuberculosis) are present in the body but are not multiplying or causing clinically active disease. Although infected persons usually have positive tuberculin skin-test reactions; they have no symptoms associated with the infection and are not infectious or contagious.

Psychotropic Medications refer to drugs that affect psychological function, behavior, or experience. For the purpose of this policy, this includes antidepressants, neuroleptics/ antipsychotics/anxiolytics, and mood stabilizers.

Pharmacy refers to a place where drugs are prepared and dispensed for proper utilization.

Pharmacy Outlet refers to a secured area where medications are held prior to licensed personnel administering those medications as ordered by medical staff. .

Standing Order Medications refer to pre-packaged and pre-labeled medication used to treat patients per SCDC Standing Medical Orders, as authorized by the Director of Medical Services.

Starter Pack Medication refers to pre-packaged and pre-filled medications that are kept in the clinics and given under the direct order of a physician, nurse practitioner, or dentist. These medications will be used to treat acute medical conditions that require medications immediately. Starter packs are limited to a supply of three (3).

Stock Medications refer to a quantity of prescription medications approved by the Director of Medical Services to be kept in infirmary/clinic areas to treat patients by direct order of a physician/dentist. Stock medications must be administered dose by dose.

Temporary Medications refer to medications ordered on a limited basis for an acute medical condition.

I. STAFFING

The South Carolina Department of Corrections' (SCDC) pharmacy services will be provided by a central pharmacy located in Kirkland Correctional Institution at 4344 Broad River Road, Columbia, SC 29210. The pharmacy will be maintained by professionally and legally qualified pharmacists and staffed with a sufficient number of personnel to meet the scope of medical needs of the institutions within the SCDOC.

II. STANDARDS OF OPERATION

A. Kirkland Correctional Institution will provide space, equipment and supplies for professional and administrative functions of the pharmacy to promote patient safety through proper storage, preparation and dispensing of pharmaceuticals.

B. Each institution will house a Non- dispensing drug outlet staffed by nurses. The institution will provide space, equipment, and supplies for professional and administrative functions of the Non-dispensing drug outlet to promote patient safety and proper administration of drugs.

C. The Pharmacy Director will maintain up to date reference materials (computer accessible or print), specifically:
   1. Drug information reference (e.g. Facts and Comparisons)
   2. Medispan (drug interactions)
   3. A copy of the SC Pharmacy Practice Act

D. Equipment in the pharmacy and Non-dispensing drug outlets will include at least:
   1. Adequate computer equipment
   2. A refrigerator dedicated to and appropriately labeled, for the storage of medications and biologicals
   3. Adequate lighting and ventilation
   4. A sink with running water
   5. A system to monitor temperature control that meets Department of Health and Environmental Control (DHEC) standards. Medications not kept a proper temperature must be discarded.

III. KEY CONTROL AND ACCOUNTABILITY

A. Kirkland Correctional Institution Pharmacy
   1. Only Pharmacists and the Warden of Kirkland Correctional Institution will have keys to the pharmacy.
   2. The warden's key will be kept in the warden's safe for emergency purposes only
   3. Only pharmacists have keys to the controlled substance cabinet

B. Non-dispensing Drug Outlet Permits
   1. Only one nursing staff member per shift will be assigned the key to the outlet and the room will remain locked at all times, even when occupied.
   2. Access will be limited to specifically designated personnel.
   3. Controlled substances in the outlets will be double locked and must be counted at the beginning and end of each shift

IV. PROCEDURES AND OPERATIONAL PRACTICES

The Pharmacy Director will develop and maintain written procedures and operational practices pertaining to pharmaceutical services, in concert with the medical staff, and as appropriate, with representatives of other disciplines.

A. **PHARMACY AND THERAPEUTICS COMMITTEE.** The Medical Director will establish a Pharmacy and Therapeutics (P&T) Committee that will meet at least quarterly. Members of the Committee will be:
   1. The Medical Director, who is chairman of the committee;
   2. Chief of Psychiatry
   3. The Pharmacy Director or designee, and;
   4. Director of Nursing
   5. Physicians, dentists, and other staff members as designated by the Chairman

   The P&T Committee will consider and approve/disapprove all proposed additions to the Formulary. Requests for changes to the formulary will be submitted to the Committee Chairman.

B. **FORMULARY**

1. All pharmaceuticals available for the treatment of inmate patients by professionals of SCDC or contracted Health Services will be listed in a Formulary which is published online and accessible through the SCDC intranet.

2. Authorization for the use of items not listed on the SCDC formulary may be requested using the Non-Formulary Drug Request form (internal form available from Health Services – see Page 12). The form along with a prescription must be submitted for approval to the Medical Director, Chief Psychiatrist or designee.

3. Upon approval from the medical director, Non-formulary drugs will be filled by Kirkland Correctional Institution Pharmacy.

C. **Training and Education.** Pharmacy personnel will participate in relevant education programs, including orientation of new employees, in-service and outside continuing education. Records of training will be maintained in the employee's personnel file.

All health care providers performing pill line operations will complete pharmacy orientation as part of the Health Services Orientation before administering medications in pill line. Pill line is for administration or distribution of medications not dispensing. Dispensing is a function of pharmacy personnel ONLY.

D. **Patient Safety.** The Pharmacy Director will ensure there are written procedures in place for patient safety and the control, accountability, and distribution of drugs. These procedures will be reviewed /revised annually, as necessary.

1. All drugs will be labeled according the guidelines outlined in the SC Pharmacy Practice Act and will include:

   a. Patient Name/location
   b. Prescriber
   c. Name/Strength of drug ordered
   d. Quantity dispensed
   e. Signature
   f. Manufacturer
   g. Address of Pharmacy
   h. Order Start Date
   i. Order Expiration Date
   j. Number of Refills remaining

2. Discontinued and outdated drugs and containers with worn, illegible, or missing labels will be returned to the pharmacy for proper disposition.

E. **Dispensing Medication Orders.** Before a medication order is dispensed, a pharmacist will review it prospectively for the following:

1. Drug/drug interactions
2. Drug/disease interactions
3. Drug/food interactions
4. Therapeutic duplications
5. Overuse/underuse
6. Allergies

7. Therapeutic appropriateness
8. Appropriate dose
9. Appropriate route of administration
10. Duration of therapy
11. Adverse drug reactions
12. Proper laboratory monitoring
13. Appropriate clinical outcomes and
14. Provide the final check of the medication order

F. **Transport/Receipt of Medication**

1. Medications will be transported from the central pharmacy to institutions using the SCDC bus transportation system, by designated employees, in security sealed, numbered totes. A delivery sheet specifying items in the tote will be included in each tote and the number of the security seal will be recorded on the delivery sheet.

2. All items transported form the pharmacy will be signed out in log books maintained for this purpose. Logbooks will be maintained for two years and sign out information will include:
   a. Location destination
   b. Person transporting
   c. Date and time leaving the pharmacy

3. The totes will be sealed by dispensing pharmacists and unsealed by the receiving nurse at the Non-dispensing drug outlet.

4. Medications will be received at the Non-dispensing drug outlets then checked in by nursing staff and reconciled with the delivery sheet included in the tote.

5. The pharmacy should be notified concerning any delivery sheet discrepancies daily.

6. Prescription medication for inmates being transferred from one institution to another will be transported in a secure container by SCDC transporting officers and delivered to the appropriate employee at the receiving institution.

G. **Administration of Medication from Non-dispensing drug outlets.** Items approved by the Board of Pharmacy to be located in the Non-dispensing drug outlets include:

1. Filled patient specific prescriptions (pre-packaged, pre-labeled);
2. Standing order drugs;
3. Starter packs and
4. Specially approved emergency drugs for direct administration (e.g. Epipen).

H. **Inspections.** Each Non-dispensing drug outlet will be inspected monthly by a consultant pharmacist per SC Board of Pharmacy Regulations. A record of these inspections will maintained in the central pharmacy for two years. A copy of the inspection will be kept in a file at each institution by the nursing supervisor.

I. **Drug Monitoring**. The Pharmacy Director will provide drug monitoring services keeping with each patient's needs, FDA and manufacturer recommendations, and practices recommended through drug information references.

DEA CONTROLLED SUBSTANCES

A. **Applicability of Federal Law.** Drug Enforcement Administration (DEA) controlled substances are drugs and drug products under jurisdiction of the Controlled Substances ACT of 1970 and are divided into five schedules (I, II, III, IV, and V).

1. For renewal of a DEA registration number the Pharmacy Director will renew online at deadiversion.gov FORM DEA-224
2. The Pharmacy Director will verify fee exemption status
3. "Registration Classification" on DEA-224 will be checked as "hospital/clinic." There will be only one official registration number for each SCDC institution
4. The DEA number will be used only for official federal business
5. The Pharmacy Director will complete and submit these forms

B. **Responsibility.** The Pharmacy Director will be the responsible authority for all DEA controlled substances. The main stock will be kept in the central pharmacy in a locked cabinet to which only pharmacists have the key.

At the Non-dispensing drug outlets controlled substances will be kept in a locked cabinet, drawer or box within the locked outlet room. Only nursing staff designated by the nursing supervisor of each institution will have the key to the controlled substance cabinet, drawer or box.

C. **PURCHASING/RECEIVING.** Purchase orders for controlled substances will be prepared by a designated employee in the pharmacy.

1. Controlled substances will be stocked in single dose packaging when available.
2. The Pharmacy Director will establish a proper system of security for their receipt

D. **RECORDS**

1. The Pharmacy Director will maintain proper records accounting for ordered/dispensed controlled substances.
2. An annual inventory of controlled substances will be taken at the close of business on April 30. The quantity on hand of controlled substances will be recorded. The inventory will maintained by the Pharmacy Director in the controlled substance file in Kirkland pharmacy.
3. Patient specific control registers (internal form) will be sent to the non-dispensing drug outlets at each institution with each controlled substance dispensed. Each dose given will be recorded on the sheet by nursing staff and a perpetual count will be kept. The completed registers will be kept in a file at each institution for three years.

E. **Security.** The DEA and SCDHEC require safeguarding and accounting for all controlled substances.

1. Controlled substances will be stored in locked cabinets, drawers or boxes at each institution.
2. When a controlled substance requires refrigeration, the medication must be secured in a locked refrigerator or in a locked drawer within the refrigerator.

F. **Disposal.** Expired/outdated controlled substances will be destroyed in accordance with HSP 800.1.

VI. **Prescription of Medication:** Pharmaceuticals will be provided for the treatment of inmates only, except as provided for by HSP. 100.18, "Use of Health Serviced Resources for SCDC Employees/Volunteers,"

SCDC physicians, dentists, physician assistants, and nurse practitioners will write prescription using the following guidelines:

A. Prescriptions must be legible and complete or must be properly transmitted to the pharmacy via the Automated Medical Record system; pharmacists will not fill prescriptions containing unclear or incomplete information, but will refer them to the prescribing practitioner for clarification/correction as required.

B. Prescriptions must be dated, have the number/amount of medication, and contain an expiration or "stop order" date or specific duration (no longer than one (1) year).

1. If the prescription is for dose by dose administration from a stock pack, the physician may write the prescription for chronic medications up to twelve months.
2. If the prescription is for KOP supply, the physician must write the prescription for the KOP amount and may include authorization for up to eleven months' worth of refills. (KOP amount will be one [1] month or less.)
   If the institutional physician, in cooperation with the nursing supervisor, has assessed the inmate and found him/her incapable of managing large supplies of medication, the physician must order the medication in reduced quantities to meet the inmate's needs. This reduced quantity must be indicated on the prescription so that the pharmacist may package it accordingly, i.e., daily or weekly packs, etc.

C. Physicians will re-evaluate the need for continuation of medication prior to renewal.

D. Telephone orders for prescription medication will be written in the sick call notes/AMR, and the physician will co-sign the order upon his/her return to the clinic.

E. **Controlled Substances:**

1. The prescription must have the physician's DEA registration number and be a phoned, faxed or paper prescription CIII-CV or paper prescription only for CII medications.
2. **Schedule II Drug Prescriptions:** Schedule II drugs will be limited to a ***seven (7) day*** supply (except in infirmaries or with previous approval by the medical director). The physician must write and sign the prescription (i.e., the nurse may not fill in the prescription for the physician's signature). Telephone orders for schedule II drugs must be called to the pharmacy by the medical doctor and will be filled by the pharmacy only in extreme emergencies, and the written prescription must be immediately forwarded to the pharmacy.

F. Special Considerations: If the inmate requires dose-by-dose medication administration, the Health Summary for Classification must be reviewed and updated by the institutional physician (if necessary) so the inmate may be transferred to an institution with coverage to meet that requirement. If an inmate loses his/her medication pack, the nursing supervisor or designee will consult with the physician in making the decision whether or not to reorder the medication.

VII. DISPENSING AND ADMINISTRATION

A. Definitions

1. Administration is defined as providing one dose of medication to be applied or consumed immediately.

2. Dispensing is defined as placing multiple doses in a properly labeled container for use over a period of time. Dispensing is the act of prospectively reviewing the order as described in 8.e. Only **pharmacists** may dispense medications.

Distribution is defined as physically handing a filled prescription or Over the Counter (OTC) product to an inmate. Any licensed medical professional who has completed Health Services training may distribute or administer medications.

B. **Dispensing.** Prescriptions, standing order medications, doctor's box/dentist's box medication, and stock medication will be dispensed by licensed pharmacists from SCDC/contract pharmacies to authorized SCDC employees (never inmates) for delivery/administration directly to inmates. The following will apply:

1. The pharmacist must receive a legible SCDC Supply M-11, "Medical Prescription," or other legal prescription; SCDC Supply M-34, "Physician's Order;" or SCDC Supply M-35 "Medical/Laboratory Supply Order," electronic order via the Automated Medical Record system; or a telephone order before the prescription/order can be filled.
2. All written orders must be signed by SCDC physician, dentist, physician's assistant, or nurse practitioner.
3. Pharmacists will ensure that Pharmacy Drug Orders are not in conflict with the limitations outlined in this policy/procedure and that prescription medications are formulary or approved as an exception by the Director of Medical Services or designee.
4. Pharmacists will ensure that dispensed prescriptions are correctly labeled
5. Dose by dose (DXD) medications may be dispensed in a stock pack from which the nurses may administer the medication. Stock packs may contain up to three months' supply of medication.
6. Chronic Keep on Person (KOP) medications will be packaged in no more than a one (1) month supply.
7. For medications whose potency can be altered due to temperature and moisture extremes, the pharmacist will provide appropriate packaging to prevent medication deterioration, or arrangements must be made for appropriate storage.
8. The nurse or health trained employee must distribute the medication to the inmate in the same pack prepared by the pharmacy. The medication may not be re-packaged by non-pharmacy personnel for delivery to inmates.
9. Refills for current medications treating chronic conditions including mental health diagnoses will be automatically generated through CIPS pharmacy program and processed daily by pharmacy staff.
10. All other refills will be requested using the inmate's name, prescription number, and type of medication sent to the pharmacy ***on a refill request sheet.***

C. **Transferring.** When an inmate transfers from one (1) institution to another, the sending institution must transfer all the inmate's medication and MARs along with the medical record. At the receiving institutions:

1. The medical staff will write the name of the new institution on the current pill packs/containers.

D. **Distribution/Administration.**

1. **Institutional Medication Guidelines:** Medications will be given to inmates either as dose-by-dose administration or in KOP packs. (Refer to HSP 800.4 "Medication Administration/Delivery," for further details.) The following will apply:

a. The decision as to which medications should be administered by each method (KOP or dose-by-dose) will be determined by the Pharmacy and Therapeutics Committee, taking into account the security level of the institution as well as the hours of nursing coverage and other medical management issues. This status can also be considered on an individual basis by medical staff at an institution as well.

b. A list of dose-by-dose medications will be issued by the Pharmacy and Therapeutics Committee
c. For most non-controlled chronic medication, a 30-day supply will be issued to the inmate.
d. At all institutions controlled medications will be *dose by dose.*

2. TB Medications: (Refer to SCDC HSP- 800.4, "Medication Administration/Delivery," for more details.)

   a. TB medications for treatment of active tuberculosis will always be given as directly observed therapy (DOT).
   b. TB preventive treatment medications will be administered as dose-by-dose DOT.
   c. ***SCDC will provide TB preventive therapy for an inmate on Work Release. The covering institutional*** Medical staff will continue to provide and document the inmate's TB medications.

3. Doctor's Box Medications: The Pharmacy and Therapeutics Committee will provide a list of pharmaceuticals approved for the doctor's box for institutions with outpatient clinics. SCDC Supply M-77, "Control Register," will be used to ensure accountability for these medications.

4. Standing Order medications may be administered by a nurse in strict compliance with procedure for the use of Standing Medical Orders.
   a. Standing Medical Order drugs will be ordered from the pharmacy using SCDC Supply M-35, "Medical/Laboratory Supply Order." The physician must sign SCDC Supply M-35.

   b. The Standing Order medications will be prepackaged and pre-labeled by the pharmacy as required by law, leaving space for the date of issue and the inmate's name.

   c. Audits will be conducted monthly by a pharmacist to ensure proper documentation and counts of Standing Order drugs. This will be documented on an audit checklist, "Pharmacy Monthly Audit," developed and maintained by the Director of Pharmacy Services. The completed audit checklists will be maintained in the pharmacy for two (2) years.

5. Stock Medications: Kirkland Correctional Institutional pharmacists will be responsible for stocking infirmaries with infirmary approved medication in adequate levels to meet the needs of the infirmary.

VIII. Documentation

A. In medical clinics and infirmaries, medication administration will be documented by medical staff on the AMR, SCDC Supply M-10, "Daily Medication Administration Record," or SCDC Supply M-36, "Inpatient Medication Administration Record," and SCDC Supply M-99, "Tuberculosis Preventive Treatment Record," as outlined in the Agency's Documentation Standards Guidelines. Administration/delivery of standing order medication will be documented on the Sick Call Clinic Notes/AMR.

B. KOP and over the counter (i.e., can be obtained without a prescription) medications delivered to inmates by non-Health Services personnel will be documented on SCDC Supply M-105, "Medication Log," which will be kept on file in the institution for three (3) years. "Medication Logs" will include date, name of the medication, and the inmate's name, SCDC number, and signature.

C. In Pre-Release or Work Release Centers where there is no full-time medical staff, SCDC Supply M-105, "Medication Log," will be reviewed bi-annually by medical staff of the covering institution. The completed "Medication Logs" will be maintained by the medical staff for three (3) years.

D. Inmates who are on medications will have their prescriptions reviewed. This will be documented on SCDC Supply M-30, "Medical Information for Released Inmates." (See HSP 800.5, "Medications for Inmates Being Released from SCDC," for further details.)

IX. MENTAL HEALTH MEDICATION MANAGEMENT: *In addition to items 1-12, the following accommodations are made for mentally ill offenders:*

A. Reception and Evaluation

1. Inmates currently prescribed psychotropic medication:

   a. If inmates arrive to SCDC with psychotropic medication currently prescribed, nursing staff will obtain relevant information from the inmate, through available records and through consultation with the detention center.

   b. The R&E medical practitioner will be notified by nursing staff and will evaluate the records and write an order to continue, discontinue or substitute the medication. The R&E medical practitioner will perform a physical exam as part of the R&E process.

   c. Mental Health staff will be notified by nursing staff of the arrival of inmates taking psychotropic medication. The inmates will be seen per existing R&E procedures unless the situation warrants immediate attention.

   d. The inmate will be scheduled for evaluation by Psychiatry.

2. Inmates who exhibit symptoms of mental illness and are not taking medication

   a. Inmates will be evaluated by psychiatry and medication will be prescribed if indicated

   b. The prescribing psychiatrist will discuss potential side effects of the medication when it is prescribed.

3. Inmates taking psychotropic medication will be evaluated by the R&E psychiatrist at least every 30 days or more often, if clinically indicated, until transfer to another institution or program.

4. Follow up procedures for care of inmates on medications who are transferred to another institution or program will be initiated consistent with institutional/program mental health services.

5. If psychotropic mental health medication is discontinued, the prescriber will assure appropriate reassessment and monitoring for return of symptoms and any possible withdrawal side effects.

B. Specialized mental health programs

1. Inmates will be regularly evaluated by the psychiatrist or a psychiatric nurse practitioner/physician assistant practicing under the supervision of a psychiatrist. The evaluation will include assessment of effectiveness and the development of potential side effects.

2. The following is the maximum allowed period of time between assessments. Inmates will be seen more frequently if necessary. Ultimately, the frequency of follow up will be determined by the acuity of the mental illness.

   a. Gilliam Psychiatric Hospital—at least weekly for 4 weeks and at least monthly after that.

b. Intermediate Care Services/Behavioral Management Unit—at least monthly

c. Others—at least every 90 days

3. All practitioner medication management encounters will be documented in the automated medical record.

C. General prescribing guidelines

1. Every effort should be made to use medications on formulary.

2. If a non-formulary medication is ordered, it must be ordered per the non-formulary process with detailed rationale for the need to use a non-formulary medication.

3. Medications which require laboratory monitoring must have pertinent labs ordered by the prescribing practitioner.

4. Polypharmacy (using more than two drugs from the same class or more than four medications to treat the same condition) should be avoided when possible and rationale for use of multiple medications in the same class or for the same purpose should be clearly explained in the inmate/patient record.

5. Inmates receiving antipsychotics, lithium, tricyclic antidepressants, or any medication identified by the Pharmacy and Therapeutics Committee as associated with poor heat tolerance or interference with temperature regulation should be assigned to dorms with air conditioning. CREATE A HEAT MED LIST

6. Psychotropic medication for inmates who are on a stable psychotropic medication regimen of a chronic / long term illness may be ordered for a maximum of 180 days at a time to limit the likelihood of lapse in medication regimens due to prescription processing but the inmate must be evaluated at least every 90 days by a psychiatrist or psychiatric nurse practitioner and documentation of that evaluation and the current medication treatment plan must be entered into the inmate's medical record.

D. Informed consent

1. Practitioners will provide information about the proposed treatment and explain the expected benefit and potential side effects of psychotropic medications before initiating therapy. This information will be documented in the Automatic Medical Record.

2. If an inmate is mentally ill and an imminent danger to self or others, an emergency dose of medication may be ordered to be administered against the inmate's will.

3. Inmates housed at GPH who are committed on an emergency basis or have been committed involuntarily may be given forced medication if they have been evaluated by 3 physicians who concur that they pose a significant risk to themselves, others or property if not medicated.

4. Inmates who have been court ordered to participate in treatment to include taking medication may be given medication against their will.

E. Noncompliance

1. When 3 consecutive doses of mental health medications are missed, or an inmate misses 50% of their medication or demonstrates a clinically significant pattern of missing medication within a week, the nurse will notify the prescribing physician and the Qualified Mental Health Professional. Nursing staff will review MARs on a weekly basis to detect medication compliance issues and report their findings to the prescribing physician or nurse practitioner.

2. The MD/NP/PA or psychiatrist will be notified and the inmate will be seen or scheduled to be seen at the next available psychiatric clinic or more often if clinically indicated. An inmate wishing to discontinue medication will be encouraged to discuss this with their psychiatrist or the psychiatrist on call prior to stopping any medication. The need to taper any medication if abrupt withdrawal is contraindicated will be discussed with the inmate.

3. For an inmate with an acute need for the medication, the nurse or MH clinician will work with the practitioner to identify a solution (e.g., change to daily dosing, move to a higher level of care.).

4. If an inmate who has discontinued medication wishes to resume the medication, he/she will be scheduled to see the psychiatrist.

F. Mental Health KOP Medication

1. It is recognized that some mental health patients are able to manage their own medication administration when they are eligible for work release programs or SHOCK incarceration. SCDC Mental Health Services will evaluate inmates anticipating transfer to Campbell, Goodman, Manning, Walden and Wateree (Shock Incarceration) Correctional Institutions work release programs with less than daily nursing coverage and or no evening pill line (7pm or later).

2. Determination will be made by - agreement from counselor, nursing staff and the assigned psychiatrist, deciding if – he/she meets criteria for self-administering mental health medication. The criteria includes: the assessment of treatment/medication compliance, ability to name prescribed medications, demonstrated responsibility by attending pill line regularly and understanding the side effects of medications.

3. Mental health reserves the right to cap the number of mentally ill inmates at institutions with less than daily nursing coverage or no evening pill line.

4. The Division of Mental Health Services will maintain a list of medications that will be approved for KOP in this program. At present the list includes:

   ANTIDEPRESSANTS:
   - Celexa
   - Effexor
   - Paxil
   - Prozac/fluoxetine
   - Remeron
   - Zoloft

5. No more than a 30 day supply of medication will be dispensed at a time.

6. The approved medications will be self-administered keep on person (KOP). All other medication will be administered (DXD).

7. Inmates at these institutions will also be allowed to self-administer their non-mental health medication as appropriate.

8. Patients who take medications which alter the body's ability to maintain consistent body temperature will not be transferred to an institution which is not air-conditioned.

9. Mental health staff will provide counseling/education regarding self-administration of medication to the inmates chosen --for this procedure before being approved for self-administration of mental health medications.

10. Those inmates who are allowed to self-administer psychiatric medications will sign a letter of understanding, which will include:

    - Must take medications as ordered by the doctor.
    - No sharing, selling, or hoarding of mediations.
    - Must keep medications locked up at all times (must have lock on locker).
    - Report any side effects to medical staff.

11. The medical staff will monitor the inmates' self-administration of psychiatric medications weekly, using the "Keep on Person" (KOP) Psychiatric Medication Program Weekly Monitoring Sheet," for at least one month; then monthly until he is released or transferred.

12. Inmates who remain non-compliant after being counseled will be put back on DXD medication by the nursing staff and the prescribing physician will be notified by medical to see if appropriate to remain at current institution.

    a. Nurses will notify the psychiatrist when an inmate's medications are changed to DXD.

    b. Any other problems will be referred to the psychiatrist and treatment team as appropriate.

LOCATION: _____ **DATE:** _____

Rx

Another brand, equal in quality, of the same basic drug may be dispensed UNLESS checked:

_____**MD** _____**MD**

Dispense as Written **Substitution Permitted**

DEA#_____ **Rx. Expires**_____

MAXOUT DATE: _____

Specific Symptoms to be controlled by non-formulary medications:

_____

_____

_____

Medications on formulary previously tried to control symptoms:

NAME OF MEDICATION	MAXIMUM DOSAGE	RESULT

Approved: _____ **Disapproved**_____ **Additional Information:** _____

COMMENTS:_____

_____

_____

SIGNED: _____ **DATE:** _____

Approving MD

ATTACHMENTS

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
HEALTH SERVICES PROCEDURES

Accountability of Controlled Substances Administered in Outpatient Clinics

Number:	800.1
Related SCDC Policy:	ADM-16.08, HS-18.16
Date:	November 24, 2014

PROCEDURE: To provide guidelines for the accountability of controlled substances administered in outpatient areas.

PROCEDURAL GUIDELINES

Patients in outpatient clinics may be prescribed controlled substance medication. These controlled substances require strict accountability. The following procedures are to be used to ensure proper accounting of controlled substance medications.

I. Controlled drugs must be stored double locked in the pharmacy or pharmacy outlet (pill room).

II. Upon receipt of any controlled substance, the nursing staff will confirm the amount received.

   A. Two licensed medical employees will verify the count.

   B. Any discrepancy in the amount received and the amount indicated on the prescription will immediately be reported to the dispensing pharmacy.

III. Initiate the form Patient Specific Control Register or Perpetual Control Register for each prescription or stock order.

   A. The appropriate control register is to be used to sign out the medication each time it is administered.

   B. This form is not to be used in place of the Medication Administration Record (MAR). The MAR must also be used for these medications.

IV. Controlled drugs will be counted at the beginning and end of each shift by a nurse leaving duty and a nurse coming on duty.

   A. SCDC Supply M-95, Validation that the Control Drug/Item Count is Correct will be used.

   B. Any discrepancy in the count will be reported immediately to the nurse supervisor /regional clinical director.

      1. All shift nursing personnel will stay on duty to investigate usage of the missing drugs.

      2. If the immediate investigation does not reconcile the count, SCDC Form 19-29, Incident Report, will be completed and a copy forwarded to the regional clinical director.

V. If the patient is transferred to another institution, the balance of the inmate's patient-specific controlled medication must also be transferred via the transporting officer.

A. The sending institution must:

1. Verify the medication count and account for any discrepancy prior to sending.
2. Send the Patient Specific Control Register and the MAR along with the medication in an inter-office envelope, stapled shut.
3. If available, have transporting officer print and sign his/her name on the next line available of the control register that s/he received the medication, or the nurse may write on the control register to whom the medication is given for transport.
4. The sending institution should keep a copy of the Patient Specific Control Register.
5. It may be helpful to also document in the AMR the amount of the controlled medication being sent.

B. The receiving institution must:

1. Verify the amount of medication received. (Contact the sending institution if there is any discrepancy.)
2. Continue to document medication administration on the Control Drug Register and the MAR.

VI. Disposal of Discontinued Controlled Medications

A. Controlled medications can be returned to the pharmacy **ONLY** if

- the pharmacy fills an order incorrectly,
- there is a recall of the medication.

1. Record the amount returned on the control register, which is returned to the pharmacy with the medication. (The control register must be signed by both licensed medical employees.)
2. A copy of the Control Drug Register is kept for the clinic records.

B. Any other termination of the controlled medication order requires destruction and disposal of the medication at the institution. This is a DEA mandate.

C. Destruction must be done in the presence of two licensed medical employees.

D. Method of destruction:

1. Patches: flush down toilet. First, peel the patch from the backing and attach toilet paper before flushing.
2. Pills/Capsules/Injectables: Dissolve/dilute in 50/50 solution of bleach and water and throw away.

- **Bleach is NOT to be stored in the pill room or medication/food refrigerator. BLEACH SOLUTIONS MUST BE CLEARLY LABELED.**
- See SCDC Policy ADM-16.08 and the SCDC Safety Manual, regarding caustic/toxic substance accountability.

- A small amount of 50/50 bleach/water solution should be made up for each incident and then discarded.
- 50/50 bleach solution should be poured over the crushed medication (or over the poured out injectable medication) on a paper towel and then the paper towel with the diluted/dissolved medication discarded in the trash. **DO NOT FLUSH OR POUR DOWN THE DRAIN.**

E. The destruction must be recorded (date and time, # pills, amount of injectable solution, etc) on the MAR, the appropriate control register, and the Controlled Substance Destruction Record. Two licensed medical employees must sign the forms.

VII. Completed control registers, Validation that the Control Drug/Item Count is Correct, and Controlled Substance Destruction Records are to be maintained in the clinic for a period of three years and then discarded. They are not to be filed in the medical record.

Original: 7/1/2010
Revised: 1/10/2012
Revised: 3/1/2012
Revised: 4/1/2014
Revised: 11/24/2014

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
HEALTH SERVICES PROCEDURES

Use of Health Services Resources for SCDC Employees, Volunteers, and Visitors

Number:	100.18
Related SCDC Policy:	ADM-16.15, HS-18.01
Date:	April 1, 2012

PURPOSE: To provide guidelines SCDC medical staff in what resources can be used for SCDC employees and volunteers.

PROCEDURAL GUIDELINES

I. Appropriate medical assistance will be provided to any departmental or contract employee or any volunteer who sustains an injury or becomes acutely ill while in SCDC facilities. Health Services resources will be made available for employee health as required by OSHA mandates and will be used to promote employee wellness when resources allow.

II. Employees or volunteers who are injured or become ill in the agency work environment will be afforded medical screening, first aid treatment or emergency medical treatment by agency medical personnel as defined in SCDC Policy ADM-16.15, Worker's Compensation, procedural guideline 3 (when appropriate), and compatible written first aid protocols.

III. Standing orders approved for inmate emergency care may be used for employees, volunteers, and visitors in emergency situations.

IV. SCDC Health Services' resources will be used to comply with current OSHA mandates and state law in regard to employee and volunteer health.

A. **Employees** are currently afforded the following services:

1. Hepatitis B immunization
2. TB screening: skin testing or verbal interview (for empoloyees with previously positive skin tests).
3. Flu vaccine as resources allow.
4. Reading TB skin tests after the employment physical at designated facilities.
5. Upon special request from Human Resources, the medical director may be asked:

a. To clear an employee to return to work after an extended illness.

b. To evaluate an employee prior to approval for the use of the sick leave pool.

6. "For-cause" drug testing.

7. Evaluation of injury

   a. Prior to a Workers Compensation Referral (See HSP 100.7, Guidelines for Screening and First Aid Treatment of Occupational Injuries and Illnesses)

   b. Post exposure to bloodborne pathogens. (See HSP 600.9, Management of Occupational Exposure to Bloodborne Diseases or Other Potentially Infectious Material.)

8. Employee Health Fairs when staffing allows.

9. Urine screening tests for bus driver physicals.

10. Other situations as determined by the Director for Health Services.

B. **Volunteers** are currently afforded the following services:

1. TB screening: skin testing or verbal interview (for empoloyees with previously positive skin tests).

2. Evaluation and first aid treatment after an injury. (Volunteers are not covered for Workers' Compensation but medical staff may provide initial treatment for emergencies and refer the volunteer to a community care giver or call EMS).

3. Post-exposure evaluation. (See HSP 600.9)

V. Any other non-inmate personnel (visitors, vendors, etc.) who are injured or become ill while on SCDC property will be afforded necessary first aid and emergency care, and if further attention is required, the appropriate EMS will be called.

Original 7/1/2010
Revised 4/1/2012

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
Division of Medical and Professional Health Services
MEDICAL PRESCRIPTION

FOR: _____ SER. NO.: _____

LOCATION: _____ DATE: _____

R_X

Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked. ☐
Label with medication NAME, STRENGTH, and QUANTITY UNLESS checked ☐

_____ M.D. _____ M.D.
Dispense as written Substitution Permitted

DEA # _____ RX. Expires _____

SCDC M-11 (Rev. 2/2009)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
Division of Health Services
Physician's Orders

SCDC M-34 (June 1995)

White: Chart
Canary: Pharmacy

A Generically Equivalent Drug May Be Administered Unless Checked Here.

✓	Check (✓) Off Each Order As Transcribed	START HERE →	DATE		MILITARY TIME	PLEASE USE BALL POINT PEN

Telephone Order By Doctor	Nurse	Physician's Signature Within 24 Hrs.	Date	Time	I.D.

✓	Check (✓) Off Each Order As Transcribed	START HERE →	DATE		MILITARY TIME	PLEASE USE BALL POINT PEN

Telephone Order By Doctor	Nurse	Physician's Signature Within 24 Hrs	Date	Time	I.D.

✓	Check (✓) Off Each Order As Transcribed	START HERE →	DATE		MILITARY TIME	PLEASE USE BALL POINT PEN

Telephone Order By Doctor	Nurse	Physician's Signature Within 24 Hrs.	Date	Time	I.D.

Physician's Orders

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
Division of Health Services
Medical/Laboratory Supply Order

Page _____ of _____ Pages

Ordering Institution			Date	
Amount Ordered	Description	Unit	Amount Issued	Cost
Ordered By		Filled By		
Approved By		Received By		

SCDC M-35 (Rev. September, 1988)

OUTH CAROLINA DEPARTMENT OF CORRECTIONS
HEALTH SERVICES PROCEDURES

Medication Administration/Delivery

Number:	800.4
Related SCDC Policy:	HS-18.16
Date:	February 5, 2015

PURPOSE: To provide guidelines for the administration or delivery of medication to inmates in SCDC.

PROCEDURAL GUIDELINES

I. General administration guidelines:

A. Nursing staff will identify each patient by asking the patient to state his/her name and SCDC number. In addition, available identifiers (e.g., medication labels, Medication Administration Records (MAR), SCDC identification cards, patient ID bands, or other approved photographic IDs) will be used to ensure the medication is administered in accordance with the rights of medication administration:

- The right person (name and inmate #).
- The right medication.
- The right time.
- The right route.
- The right dosage.
- The right documentation.
- The right reason.
- The right response.

B. Administering medication in a non-medical area (e.g., SMU, RHU or SHU):

1. Prescribed medication will be administered/delivered to the individual inmates in all segregation units by the nursing staff.
2. Nurses passing medications in a lockup unit must be alert to the healthcare needs of the population as to ensure unimpeded access to medical care. In addition to daily cell checks, sick call access must be consistent with the general population of that facility.
3. Nurses preparing medication for administration in a non-medical area of the institution may pour one dose of medication(s) into an envelope for dose-by-dose (DXD) administration. The nurse will label that envelope with the inmate's name and SCDC #, medication name(s), dose, and time of administration for that one dose only.
4. Narcotics will be signed out on the Control Drug Register prior to that dose being taken to the administration area. The nurse can write in the time administered when s/he returns to the medical area. If the inmate refuses the medication, it will be destroyed in accordance with HSP 800.1 VI. Part C, D & E.

5. Inmates at pill line or in a general population dorms must show their ID cards in order to receive medications.
6. MARs will be signed when the nurse returns to the medical area.
7. During the medication rounds, the nurse will be on the alert for the health care needs of the unit's population and collect the sick call requests from inmates on designated days.

II. Nurses will not borrow one inmate's medications to share with another inmate.

III. If the keep-on-person (KOP) medication has not been picked up by the inmate within three days of him/her being made aware that the medicine has arrived, the nurse will:

A. Ensure s/he is aware that the medication is available.

B. Return it to the pharmacy, making note that the inmate failed to retrieve the medicine on the MAR.

IV. Documentation:

A. Documentation of administration/delivery of medications is to be completed at the time the medication is given unless given outside of medical area as noted above.

B. Medication administration/delivery will be documented in the appropriate area:

- In the AMR (SO medications, injections, etc...)
- On SCDC Supply M-10, "Daily Medication Administration Record,"
- On SCDC Supply M-36, "Inpatient Medication Administration Record,"
- On SCDC Supply M-99, "Tuberculosis Preventive Treatment Record,"
- On SCDC Supply M-77, "Control Drug Register."

C. In non-medical areas:

- Over the counter (i.e., can be obtained without a prescription) medications delivered to inmates by non-Health Services personnel will be documented on SCDC Supply M-105, "Medication Log," which will be kept on file in the institution for three (3) years. "Medication Logs" will include date, name of the medication, and the inmate's name, SCDC number, and signature.
- In pre-release or work release centers where there is no full-time medical staff, SCDC Supply M-105, "Medication Log," will be reviewed bi-annually by medical staff of the covering institution. The completed "Medication Logs" will be maintained by the medical staff for three (3) years.

V. Institutional Medication Guidelines

A. For institutions with 24 hour or daily nursing coverage, the following medications/circumstances will require DXD administration as directly-observed-therapy (DOT):

1. Specific medications identified by Health Services to be given dose by dose (e.g. psych meds, controlled meds, narcotics, and frequently abused meds).
2. TB treatment or preventive treatment medication.

3. Inability of the inmate to manage his/her own medications.
4. Physician/practitioner's order.
5. Non-compliance (as determined by the physician) of the inmate in taking prescribed medications.
6. Medications given in an infirmary setting.
7. Medications ordered for the treatment of HIV, HCV, and MRSA, unless ordered otherwise by the physician.
8. Other special category medications as specified by the nursing supervisor, practitioner, or Health Services central office.

B. For institutions with Monday through Friday nursing coverage, the following medications will require DOT administration:

1. Controlled medications that do not require weekend dosing. If the controlled medication is ordered for a prolonged time period, the physician will update Health Summary for Classification for transfer to an appropriate institution.
2. Medications ordered for the treatment of HIV, HCV, and MRSA, unless ordered otherwise by the physician.
3. Injections that do not require weekend administration.
4. Refer to HSP 700.6, Mental Health KOP Medication, for guidelines about administering KOP psychiatric medications.

C. For institutions with part time or off-site nursing coverage (i.e., pre-release and work-release centers), the physician will write the prescriptions to be dispensed so that the entire prescription, up to a 30 day supply, of all medications will be delivered to the inmate. Controlled or injectable medications will be addressed case-by-case.

VI. Procedures for TB treatment medication and TB preventive treatment medication:

A. TB treatment medications (for the treatment of active TB disease):

1. All inmates being treated for active TB will be housed in an inpatient infirmary. When no longer contagious, they will be housed at institutions with at least daily nursing coverage. The Health Summary for Classification may need to be updated to reflect this.
2. TB treatment medications will always be administered dose-by-dose as DOT. This will be documented on the "Medication Administration Record," SCDC form #M-10.

B. Preventive treatment medication (for the treatment of latent TB infection) is administered as DOT. Inmates prescribed latent TB medication while at a work-release institution will have weekly DOT medication administered by the covering institutions' nurse. Preventive treatment medication administration is documented on SCDC Form M-99, "Tuberculosis Preventive Treatment Record."

VII. Standing order (SO) medications may be administered by a nurse in outpatient settings after the assessment of an inmate. The medication must be given to the inmate exactly as prescribed in the SO.

A. SO medications will be ordered from the pharmacy using the standing order stock supply sheet.

B. The SO medications will be prepackaged and pre-labeled by the pharmacy as required by law, leaving space for the date of issue and the inmate's name.

C. Monthly audits will be conducted as needed by a pharmacist to ensure proper documentation and counts of SO drugs. The completed audit checklists will be maintained in the pill room for three (3) years.

VIII. Doctor's box medications:

A. Are ordered from the pharmacy at the discretion of the institutional physician.

B. Are used in outpatient clinics only to keep on hand in small quantities for use until a regular prescription can be written for the patient.

C. Are filled in packs of one week or less.

D. Only one strength of each drug will be filled for a doctor's box.

E. The entire pack is given to the patient upon the order of the physician, or the medication may be administered dose-by-dose.

Original 11/1/2010
Revised 10/22/2012
Revised 2/5/2015

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF MEDICAL & PROFESSIONAL HEALTH SERVICES
Control Register

Location: _____ Article: _____ Unit: _____

Date	Time	Dr. Name	Name of Patient or Usage Reason	Rx. #	Amount Rec'd	Amount Adm'd	Balance	Initial

SCDC M-77 (July, 1994)

SOUTH CAROLINA DEPPARTMENT OF CORRECTIONS
Division of Health Services

All Entries Must Be Printed

Inpatient Medication Administration Record

Diagnosis ______________________________

____

Allergic To ______________________________
(Record in Red)

Word No.

Or Date Initials	Exp. Date Time	Medication-Dosage-Frequency-Rt. of Adm.	HR	DATES GIVEN													

SINGLE ORDERS – PRE-OPERATIVES

Or Date Initials	Medication-Dosage-Rt. Of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	Or Date Initials	Medication-Dosage-Rt. Of Adm.	To Be Given Date	To Be Given Time	Nurse Initial

(PRN ORDERS – SEE REVERSE SIDE)

SCDC# ________________ Name ______________________________

SCDC M-36 (Rev. June. 1995)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
Division of Medical and Professional Health Services

Tuberculosis Preventive Treatment Record

Date of Birth: _____ Tuberculin Skin Test: Date: _____ Results: _____ mm

Chest X Ray: Date: _____ Results: _____

HIV Results: _____

SGOT: Date _____ Results _____
Date _____ Results _____
Date _____ Results _____
Date _____ Results _____
Date _____ Results _____

Physician's Orders for Preventive Treatment

Date _____ Dr _____

MEDICATION SIDE EFFECTS YES — NO (If yes, explain in progress notes)

Monthly Review Date												
Dark Urine												
Jaundice												
GI Distress Symptoms												
Rash/ Purpura												
Tingling												
DIZZINESS												
Nurse's Initial												

DATE	TIME	PROGRESS NOTES

Nurse's Signature & Initials for Medication Administered

_____ _____ _____
_____ _____ _____
_____ _____ _____

SCDC #: _____ NAME: _____

SCDC M-99 (Rev. September, 1993)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
Division of Health Services

MEDICATION LOG

Date	Inmate Name & SCDC #	Medication/Item	Inmate Signature	Officer Staff Initials

SCDC Supply M-105 (Revised April 2000)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
HEALTH SERVICES PROCEDURES

Medication for Inmates being Released

Number:	800.5
Related SCDC Policy:	HS-18.16
Date:	November 1, 2010

PROCEDURE: To provide guidelines for providing "max-out" medications for inmates being released from SCDC.

PROCEDURAL GUIDELINES

I. Discharge planning is vital to ensure appropriate continuity of care upon an inmate's release.

A. The MD/NP/PA will write a new prescription so that up to a 5-day's supply of medication will be available when an inmate is released.

B. SCDC Supply M-30, "Medical Information for Released Inmate", should be completed when possible, especially on inmates with significant illness. The form is given to each inmate being released to promote continuity of care with his/her local physician. A copy should be placed in the medical record.

II. Max-out medication prescriptions:

A. Max-out medication prescriptions will be for 5 days only.

B. Only medications currently ordered for the inmate will be filled.

C. Max-out medication prescriptions will be filled in childproof containers with appropriate auxiliary labels.

1. If the inmate has a stock supply of KOP medications already issued to him, he may return it to Medical in exchange for his max-out medication in the child-proof vial.

2. If the inmate wishes to take his KOP or stock medications home rather than the 5-day supply of max-out-medication:

a. The nurse should not request that the pharmacy fill the max-out medication prescription.

b. The nurse will ask the inmate to sign the form, "Max-out Medications—Release of Liability" releasing SCDC from liability for problems that may occur due to the inmate's taking medication home in a non-child-proof container.

c. If the inmate indicates that there are children in the home where s/he is going, the nurse should give the inmate an unlabeled, childproof vial that is large enough to place his entire medication bag inside.

D. All the above should be documented in the AMR. Document also if the inmate does not report to Medical to get the max-out medications or to sign the form in lieu of the max-out prescription.

Max-out Medications—Release of Liability

I, _____, SCDC # _____, wish to
Print Name
take my keep-on-person or stock supply of medication with me upon my release. I do not want the special 5-day supply of max-out medications to be filled for me in childproof containers. I realize that my current supply of medication(s) is not packaged by SCDC's pharmacy in childproof containers with appropriate auxiliary labels. I release SCDC from any liability for any problems that occur due to these medications being in non-childproof containers and not having auxiliary labels.

____ There are children in the home where I will be residing.

____ There are no children in the home where I will be residing.

____ Nurse, initial here if an unlabeled, childproof vial(s) was provided for the inmate to place his pack(s) of medication inside.

Name of Medication	Dose	Route	Date Filled	Comments

If more room is needed, list other medications on the back of this sheet.

Signed _____ Date: _____

Witness: _____ (Print name) _____

(Added graphics)

Completed Internet Form - NOT FOR SUBMISSION
DEA/Control Number - AK6756588
Submission Date: 11-24-2014

APPLICATION FOR REGISTRATION
UNDER CONTROLLED SUBSTANCES ACT OF 1970

Form DEA 224A - Completed Internet Receipt. NOT FOR SUBMISSION

Application Complete. Internet confirmation no.: 4791068
Fee Paid: $0.00

THE DEBT COLLECTION IMPROVEMENT ACT OF 1996 (PL 104-134) REQUIRES THAT YOU FURNISH YOUR FEDERAL TAXPAYER IDENTIFYING NUMBER TO DEA. THIS NUMBER IS REQUIRED FOR DEBT COLLECTION PROCEDURES SHOULD YOUR FEE BECOME UNCOLLECTABLE. IF YOU DO NOT HAVE A FEDERAL TAXPAYER IDENTIFYING NUMBER, USE YOUR SOCIAL SECURITY NUMBER.

NAME, APPLICANT OR BUSINESS (LAST)
KIRKLAND CORRECTIONAL INSTITUTION

(First, MI)

TAX IDENTIFYING NUMBER AND/OR
576007591

SOCIAL SECURITY NUMBER

PROPOSED BUSINESS ADDRESS (WHEN ENTERING A P.O. BOX, YOU ARE REQUIRED TO ENTER A STREET ADDRESS)
ATTN: PHARMACY
4344 BROAD RIVER ROAD
LIMITED TO OFFICIAL DUTIES ONLY AT

CITY
COLUMBIA

STATE ZIP CODE
SC 29210 0000

APPLICANT'S BUSINESS PHONE NUMBER
803 896 2048

APPLICANT'S FAX NUMBER
803 896 1275

REGISTRATION CLASSIFICATION

1. BUSINESS ACTIVITY: HOSPITAL/CLINIC

2. INDICATE HERE IF YOU REQUIRE ORDER FORM BOOKS. ☐

3. Drug Schedules. (Fill in all circles that apply)

☑ Schedule IINarcotic ☑ Schedule IINon Narcotic ☑ Schedule IIINarcotic ☑ Schedule IIINon Narcotic ☑ Schedule IV ☑ Schedule V

4. All Applicants must answer the following:

Are you currently authorized to prescribe, distribute, dispense, conduct research, or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the state or jurisdiction in which you are operating or propose to operate?

State License No. 2238 State: SCExpire Date: 06-30-2015

State Controlled Substance Lic. No. 70-02238 Expire Date: 04-01-2015

1. Has the applicant ever been convicted of a crime in connection with controlled substance(s) under state or federal law, or been excluded or directed to be excluded from participation in a medicare or state health care program, or any such action pending?	N	4. If the applicant is a corporation (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy, has any officer, partner, stockholder or proprietor been convicted of a crime in connection with controlled substance(s) under state or federal law, or ever surrendered or had a federal controlled substance registration revoked, suspended, restricted or denied, or ever had a state professional license or controlled substance registration revoked, suspended, denied, restricted, or placed on probation, or is any such action pending?N
2. Has the applicant ever surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied, or is any such action pending?	N	
3. Has the applicant ever surrendered (for cause) or had a state professional license or controlled substance registration revoked, suspended, denied, restricted, or placed on probation, or is any such action pending?	N	

6. Payment Method: N/A

7. Certification for Fee Exemption
Certifying Official's Name: Wendy Knox
Certifying Official's Title: Pharmacy Director
Certifying Official's Phone: 803- 896- 2052

Application Certification:

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than $250,000, or both.

By typing my full name in the space below, I hereby certify that the foregoing information furnished on these application/DEA forms pages is true and correct and understand that this constitutes an electronic signature for purposes of these applications/DEA forms only.

*** Name of Applicant (For individual registrants, the registrant themselves MUST complete this E-Signature) or name of Officer of the Corporation/Company**

e-Signature: Wendy M Knox

This electronic application/DEA form must be certified by the applicant/registrant, if an individual; by a partner of the applicant, if a partnership; or by an officer of the applicant, if a corporation, corporate division, association, trust, or other entity. See 21 C.F.R § 1301.13(i) for more information on who can certify this application

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF BEHAVIORAL/MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

RECEPTION and EVALUATION: MENTAL HEALTH SCREENING, EVALUATION, CLASSIFICATION POLICY

Number: HS - 19.11
Date: July 19, 2011
Revised: June 1, 2016

PURPOSE: The South Carolina Department of Corrections (SCDC) has established guidelines for inmates to access mental health services through its Reception and Evaluation process. This process considers behavior and other objective factors when assessing an inmate's institutional placement in relation to the inmate's mental health needs and ongoing mental health care.

POLICY STATEMENT: The SCDC ensures all inmates receive a mental health screening upon entry and as needed anytime thereafter in order to identify mild, moderate and serious mental illness and/or crisis intervention needs that may be associated with psychiatric and psychological problems. The SCDC ensures the administration of appropriate therapeutic mental health care for its mentally ill inmates prior to institutional assignment and throughout the term of adjudicatory confinement.

SCDC Reception and Evaluation Centers:

Male Inmates: Kirkland Correctional Institution
Male Inmates (Death Row Only): Lieber Correctional Institution
Female Inmates: Camille Griffin Graham Correctional Institution

DEFINITIONS:

Sick Call: Allows inmates to report and receive individualized and appropriate health services for non-emergency illness or injury, to include non-emergency mental health complaints and requests to see counselors.

Request to Staff: Provides inmates with the opportunity to make written requests to a staff member. All inmates have the freedom to address questions, requests, or concerns to a Behavioral/Mental Health and Substance Abuse Services staff member.

Mental Health Classification Code: An alphabetical or numeric code assigned to an inmate that reflects the inmate's current mental health status and mental health services needs.

Level of Care (LOC) Classification: Hierarchical mental health coding system ranging from representing inmates who are able to function with limited assistance from mental health staff, to (1) representing hospitalization and the greatest need for mental health care, L5 identifies inmates without current need for mental health services. LC identifies inmates in the SIB program.

Qualified Healthcare Practitioner (QHP): Physician, Physician's Assistant, Nurse Practitioner

Qualified Mental Health Professional (QMHP): Psychiatrist, Licensed Psychologist, Licensed Professional Counselor, Licensed Professional Counselor-Supervisor, Licensed Independent Social Worker, Licensed Marital and Family Therapist (LMFT), and Psychiatric Nurse Practitioner. Also includes Licensed Master Social Worker, LMFT/Intern, and Licensed Professional Counselor-Intern with appropriate supervision.

APPLICABILITY:

Unless otherwise noted, R&E procedures are applicable to both male and female inmates.

I. GENERAL PROVISIONS:

A. Upon arrival at Reception and Evaluation (R&E), inmates participate in an intake process that includes agency and program specific orientations as well as assessments that encompass individual and group screening from several different administrative areas include mental health. Inmates presenting with a psychiatric or psychological problem during any one of the screening processes are referred for additional mental health services.

B. In addition to the various intake screening assessments offered during intake, inmates can self-request mental health services by reporting to "Sick Call" and/or completing a "Request to Staff". Emergency situations involving threats or attempts of self-harm and/or homicide demand the need for uniform, medical and mental health staff to follow Crisis Intervention (CI)/Suicide Precaution (SP) procedures as required.

C. Request or referrals for mental health evaluations from SCDC staff members, inmate family members, various legal entities and agencies are accepted verbally and/or in writing at any time during the intake process or thereafter.

D. Inmates who require specialized mental health services due to mitigating circumstances involving Prison Rape Elimination Act (PREA); Infirmary Care; Special Management Unit (SMU); Gay, Lesbian, Transgender, Bi-Sexual, or Questioning (GLTBQ) sexual orientation; Shock Incarceration; and Guilty But Mentally Ill (GBMI) will have services based on agency guidelines and clinical needs identified in their individual treatment plans.

E. Inmates with a mental health concern receive a detailed mental health evaluation that may include but is not limited to: assignment of a special classification status evaluation, a clinical evaluation by a psychiatrist or psychologist, establishment of a provisional diagnosis/diagnoses, a level of functioning analysis and recommended level of care placement to include Suicide Precaution and/or Crisis Intervention.

F. Inmates classified as mentally ill and permanently assigned to R&E due to a short-term commitment status receive mental health services based on their assigned mental health level of care and discharge planning prior to release.

G. Inmates who are prescribed psychotropic medication for mental illness are monitored by medical and mental health staff.

H. Mental health R&E services including initial screening, evaluation, and classification are completed within 30 days of an inmate's arrival to ensure timely processing for permanent placement at a receiving institution.

II. GUIDELINES:

A) Screening

1) P-SERC (required for all inmates) is initiated on the first day of the inmate's arrival at SCDC and continues until a formal classification is made:

(a) Intake Assessment Interview: Conducted upon admission to SCDC, by an assessment classification caseworker in an effort to obtain the following information: presence of or history of suicidal ideation and/or attempts; current psychiatric treatments (including medications); general medications; marital/family social history (to include last known address and emergency contact information); education/vocational/employment history; juvenile history; substance abuse history; pertinent medical/dental/mental health history; needs assessment; adult criminal record/legal aspects of the case; sexual misconduct data; court ordered recommendations; staff recommendations. (See Attachment A). Results of this assessment dictate urgency of additional mental health and/or medical assessment.

(b) Medical Intake Screening: Conducted by medical personnel (RN/ LPN), within 8 hours or earlier if dictated by results of Intake Assessment Interview of otherwise clinically indicated, in an effort to (1) screen for presence of suicidal and/or homicidal ideation, (2) identify medical conditions/medication prescriptions that need current attention, (3) address other medical needs. (See Attachment B) The medical intake screener is responsible for reviewing the data collected and entered into the inmate's record by the intake screener and will document doing this on the medical intake screening form.

(c) Mental Health Screening: Initial mental health screen (Form III) is completed by the inmate within 3 business days or earlier if it is identified through intake or medical screening that an urgent or emergency evaluation is warranted. The completed form is reviewed immediately following administration by a Qualified Mental Health Professional (QMHP), to help detect signs and symptoms of psychiatric problems and disorders such as: suicidal ideation; schizophrenia; depression; PTSD;

phobias; intermittent explosive disorder; delusional disorder; sex/gender/identity disorder; eating disorder; manic/panic disorder; obsessive-compulsiveness; learning and developmental disabilities, etc. (See Attachment C). Results of the screen are used to identify which inmates need further mental health evaluation and whether the second level evaluation needs to be completed on an emergent (within 4 hours), urgent (within 24 hours) or routine (within 14 days) basis.

2) Mental Health Orientation is routinely completed in a group setting with inmates on the third day of the inmate's intake processing, in conjunction with routine mental health screening. If an inmate's is identified as being in need of emergency or urgent mental health screening, the orientation will be conducted on an individual basis at the time of their screening.

   (a) QMHP's conduct the mental health orientation involving a brief overview of mental health services including referral procedures, classification, case management, sick call procedures, treatment and medication compliance information and a primary mental health screen (See Attachment C).

   (b) QMHP's instruct each inmate to complete the Mental Health Screening Form-III (MHSF-III).

   (c) The MHSF-III is self-administered and must be completed by all inmates.

   (d) The QMHP will explain the purpose of the screening process, read each questions aloud and assist the group in understanding and accurately completing the screening instrument.

   Inmates who are unable to speak or understand English will be provided appropriate interpretative services as needed.

   Inmates who are hearing impaired, visually impaired or require other special accommodations will receive services in accordance with ADA compliance standards.

   Inmates who have a reading impairment and/or are unable to read will have the MHSF-III read to them.

3) Mental Health Screening may result in determination for additional evaluation on an emergent, urgent or routine schedule. Any inmate who enters SCDC who is on psychotropic medication or claims to be on psychotropic medication will be triaged during medical intake screening for urgency of referral to mental health. Current prescriptions, after verification, may be continued by order of a physician or mid-level practitioner for a fourteen day period until face to face review by a psychiatrist or mid-level psychiatric practitioner occurs. If verification is not available, and /or no bridge order is in effect then the inmate claiming to be on psychotropic medication will be scheduled to be seen by a psychiatrist or psychiatric nurse practitioner within seven business days or sooner as clinically indicated..

4) **Prison Rape Elimination Act (PREA):** Inmates are individually screened by a classification caseworker for risk for sexual victimization or sexual perpetration within 72 hours of arrival at SCDC and again at each subsequent institutional transfer.

5) **Education Assessment Testing**: In a group setting, all newly received inmates and those who have not been evaluated in the past three (3) years will be administered reading portion of the Wide Range Achievement Test (WRAT).
6) **Drug Dependence Screen (DDS):** Conducted in a group setting to determine if an inmate qualifies for residential substance abuse treatment (See Attachment D). This is completed within 3 business days.

7) **Shock Incarceration Program (SIP) Evaluation:** Physical and psychological examination used to aid in determining eligibility for participation in the SIP program, completed pursuant court order.

8) **Suicide Risk** Assessments: An assessment completed by the QMHP or other mental health staff member when the Intake Assessment Interview identifies a current of past history of suicidal ideations or attempts. The Columbia Suicide Severity Rating Scale (C-SSRS) and C-SSRS Risk Assessment form are administered to assess modifiable or treatable acute, high-risk suicide factors, and available protective factors to inform inmate's suicide risk management, treatment and safety management requirements.

9) **General Observation:** Daily observations of appearance, behavior, evidence of abuse or trauma and symptoms of psychosis, depression, anxiety or aggression.

10) **Emergent Evaluation**: Inmates are referred for a secondary evaluation by a QMHP and Psychiatric follow-up care within 4 hours. The inmate will be kept under direct observation until the full evaluation is completed and an individualized treatment plan is initiated

11) **Urgent Evaluation**: Inmates receive a secondary mental health evaluation by a QMHP within 24 hours and are seen by a psychiatrist within 3 days or earlier if clinically indicated.

12) **Routine Evaluation:** Inmates receive secondary mental health evaluation by QMHP within 7 days and are seen for psychiatric evaluation within 14 days or earlier if clinically indicated.

13) Upon receipt of a determination requiring no additional mental health services, the inmate's health summary for classification/assignment is updated by mental health staff within 2 business days.

B) Evaluation

1) Secondary Mental Health Evaluation

(a) The DSM Cross Cutting Symptom Measure, Psychosocial Assessment, Clinical/Suicide Risk Assessment – brief questionnaire and the Columbia Suicide Severity Rating Scale (C-SSRS) together compose the secondary mental health evaluation conducted by the QMHP. The DSM Cross Cutting Symptom Measure is an optional instrument to be used by the QMHP during the secondary evaluation phase.

(b) All inmates referred for an emergency, urgent or routine evaluation are administered the Psychosocial Assessment by a QMHP.

(c) DSM Cross Cutting Symptom Measure (Optional): Assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. In addition, the measure may be used to track changes in the individual's symptom presentation over time.

(d) Psychosocial Assessment: Evaluation of an inmate's presenting problem, and mental, social, and functional capacity; including but not limited to: review for presence of physical/psychiatric illness and its impact, results derived from psychological tests, legal status, descriptions of other problem(s), review of existing assets and resources, identifying a prediction of outcome, and development of a treatment.

(e) Suicide Risk Assessments are conducted to assess risk/protective factors and assist in gathering of other information pertaining to suicide risk.

- Columbia Suicide Severity Rating Scale (C-SSRS) - is a suicidal ideation rating scale created by researchers at Columbia University to evaluate suicidality in persons ages 12 and up. The C-SSRS identifies behaviors which may be indicative of an individual's intent to commit suicide. Versions of the C-SSRS utilized by R&E include the Lifetime/Recent form, the C-SSRS Risk Assessment form, and the C-SSRS Daily/Shift Screener form

- The Columbia Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent form and the C-SSRS Risk Assessment form are completed when suicidal risk factors are identified during the R&E intake process.

- The Columbia Suicide Severity Rating Scale (C-SSRS) Daily/Shift Screener form is completed daily while the inmate is on Crisis Intervention and continuing to be assessed by the QMHP at R&E.

2) Psychiatric Evaluation

(a) Psychiatric Evaluations are completed by a Psychiatrist and consists of a clinical interviews and detailed evaluation of available information.

(b) All inmates requiring an urgent or routine evaluation will be assessed using both the DSM Cross Cutting Symptom Measure and Psychosocial Assessment prior to being examined by a Psychiatrist.

(c) Inmates placed on CI or SP status automatically receive both the DSM Cross Cutting Symptom Measure and Psychosocial Assessment with assistance and follow-up care provided by a Psychologist or Psychiatrist within 24 hours.

(d) Inmates presenting as psychologically symptomatic during the intake process, but who do not require being placed on CI or SP status, will receive a second evaluation to determine the need for an urgent or routine evaluation. If an urgent referral is not required, the offender will be placed on a Psychiatric Clinic list to meet with a Psychiatrist within 14 business days.

(e) The Psychiatrist will document all findings, diagnostic impressions, level of care, program and treatment recommendations as a Description Assessment Plan (DAP) note or Subjective/Objective Assessment Plan (SOAP) note in the AMR.

3) Evaluation Processes

A) Emergent Evaluation

1) Inmates requiring an emergency evaluation during the intake process are immediately referred for a second evaluation by a QMHP within 4 hours. Inmates identified as needing emergent care will receive direct observation until an emergency evaluation is completed by a Psychiatrist.

2) Referrals for emergent mental health evaluations will be made for (but not limited to) inmates who:
   a) Appear to be in acute psychotic distress (hallucinations, delusions, etc.);
   b) Show signs of significantly impaired cognitive functioning;
   c) Display suicidal and/or homicidal behavior or intention;
   d) Render responses to the MHSF-III that identify need for emergent assessment.

3) Inmates referred for emergent evaluation may or may not require crisis care. The QMHP will determine the need for crisis intervention or suicide precaution based on the information gained from the initial assessment, DSM Cross Cutting Symptom Measure, Psychosocial Assessment, and/or professional clinical observation and/or opinion.

4) A Psychiatrist will complete a psychiatric evaluation and provide recommendations for the inmate's treatment and level of care within 4 hours.

5) A mental health staff member will update the inmate's mental health classification and provide therapeutic services as needed/required until the inmate is transitioned from R&E to a receiving institution.

B) Urgent Evaluation

1) When inmates require an urgent evaluation, a QMHP will complete an updated initial mental health screen and secondary mental health evaluation within 24 hours. Referrals for urgent mental health evaluations will be made; but not limited to inmates who:

   a) Appear to have active symptoms of serious mental illness;
   b) Demonstrate some disorganized or confused thinking;
   c) Appear unstable and demonstrate inappropriate emotions;
   d) Display unusual behavior or some overt impairment in judgment; or

2) Inmates referred for urgent evaluation may or may not require crisis care or referral for psychiatric evaluation. The QMHP will determine the need for Crisis Intervention, Suicide Precaution or Psychiatric referral based on the information gained from the initial assessment, DSM Cross Cutting Symptom Measure, Psychosocial Assessment and/or professional clinical observation and/or opinion.

3) A Psychiatrist will complete a psychiatric evaluation and provide recommendations for the inmate's treatment and level of care within 3 days or earlier if clinically indicated on any urgent referral.

4) A mental health staff member will update the inmate's mental health classification and provide therapeutic services as needed/required until the offender is transitioned from R&E to a receiving institutions.

C) Routine Evaluation

1) Inmates referred for routine evaluation may or may not receive a psychiatric referral. The QMHP will make a determination for a psychiatric referral based on the information gained from the secondary evaluation and professional, clinical observation and/or opinion. Routine evaluations may be generated as a result of any of the following situations or for other reasons:

a) An SCDC staff member may request that an offender be evaluated by completing SCDC Supply M-122, "Referral/Action Taken Form" detailing the concern or incident precipitating the request, and forwarding it to a medical staff member,
b) Inmates are identified as having "special needs" related to a mental disorder,
c) Inmates demonstrate positive but non-critical signs of potential mental problems,
d) Inmates, not requiring an emergent or urgent evaluation, requests mental health services by reporting to "Sick Call" and/or by submitting a "Request to Staff Member" to medical.
e) A physician, nurse or nurse practitioner evaluating inmates may also refer any inmate for a routine evaluation is one has not already been recommended during the screening process.
f) Inmates previously identified as having received mental health services at SCDC, another correctional/jail facility or community mental health agency.
g) If the QMHP determines further evaluation is necessary, the QMHP will add the inmate to the Psychiatry Clinic list and the inmate will be evaluated by a Psychiatrist within 14 days or earlier if clinically indicated. In the event the inmate's status changes and they require an emergency or urgent evaluation, the inmate can be placed on CI/SP status and receive a more rapid evaluation initiated by a QMHP with assistance and follow-up care provided by a Psychologist or Psychiatrist as outlined above.

D) Comprehensive Medical Evaluation: Conducted by medical personnel (physician/mid-level practitioner), within 7 business days or earlier if clinically indicated, to review medical history, complete physical examination and appropriate laboratory studies and develop medical treatment plan.

III. RESOLUTIONS

Based on initial, secondary and/or psychiatric evaluation, mental health personnel will resolve to identify a program or services, provided by the SCDC Division of Mental Health, suitable for mentally ill inmates' individual mental health care needs. Available Options include:

1) Psychiatric Hospitalization: If recommended after evaluation or after an inmate has returned from a community hospital or other emergency medical treatment facility, a SCDC Physician must examine the inmate and declare the inmate medically stable prior to being admitted. The physician must document in the medical record that the inmate is physically and medically cleared for admission to Gilliam Psychiatric Hospital (males) or a contract hospital facility (females).

Should hospital placement occur during R&E processing, the inmate will need to complete other R&E processing requirements prior to transfer to another institution or mental health classification.

2). Crisis Unit- See policy (include Policy number)

3). Residential Care

A) Intermediate Care Services (ICS) (See Policy Statement # 19.05)

1) Provided for mentally ill inmates with serious, persistent mental illness needing frequent or ongoing mental health services including those who require close monitoring for medication management, and any inmate whose MI whose condition or circumstances may require more extensive monitoring, treatment or case management without hospitalization.

2) Inmates meeting specific program admission criteria for ICS may be referred during R&E process by a QMHP, Treatment Team, Psychologist or Psychiatrist and a mental health services referral packet is submitted to the Program Supervisor/Manager for approval.

3) If the inmate is accepted into the program, the h/she will be transferred from R&E directly into ICS.

4) The inmate's Health Summary must be updated by a physician, psychiatrist or nurse practitioner to reflect the appropriate assignment, along with the most recent diagnosis.

5) The designated QMHP will notify the Division of Classification and Inmate Records of approval and the inmate assigned or re-assigned for program admittance/transfer.

B) Habilitation Programming Unit (Hab.) (See Policy Statement # 19.06)

1) The Habilitation Program (Hab) provides appropriate social, vocational, and academic skills programming for inmates with Intellectual Disability or other developmental disabilities.

2) A Psychiatrist/Psychologist completes an evaluation and performs program specific testing for entry into the Hab. Program.

3) QMHP's complete a referral package for review by the Hab. Program Manager for approval. Decision is made on a case-by-case basis.

C) Self-Injurious Behavior (SIB) (See Policy Statement # 19.07)

1) Inmates who display chronic self-injurious behavior receive ongoing specialized medical and clinical mental health services including but not limited to participation in special programs, crisis intervention services and inpatient.

2) Male Inmates

a) Male inmates may be placed in the Self-Injurious Behavior program. SIB program participants are first assessed by a Psychiatrist/Psychologist, and then a referral package is completed for review by the SIB Program Manager. Decisions are made on a case-by-case basis.

b) Repeat inmates and/or first time inmates entering R&E who have a documented history of acute self-injurious behavior, may qualify for entry into the SIB Program. Decisions are made on a case-by-case basis.

3) Female Inmates

a) Female inmates who display chronic self-injurious behavior receive ongoing medical and clinical mental health services, including crisis intervention services as needed/required.

b) Female inmates identified by a Psychiatrist/Psychologist as needing more intensive mental health treatment for self-injurious behavior will be referred to a contract facility for inpatient services or will be managed through an individualized treatment plan.

D) Substance Abuse Treatment (See Policy Statement # HS-20.02)

1) Provides substance abuse treatment focused on short-term prevention, intervention, and treatment services to inmates dually diagnosed with mental illness and substance abuse challenges.

2) Inmates must be documented to be sufficiently psychologically and medically stable to receive substance abuse services.

3) Potential participants must meet eligibility and custody level requirements for the purpose of institutional custody and security requirements.

4) An inmate classified as Mentally Ill must be evaluated by a QMHP before admission to a residential Addictions Treatment Unit can be finalized.

5) All such referrals will be submitted in writing to the Division Director for review and approval.

6) Referral requirements include but are not limited to review of: mental health history; current mental health condition and classification; current and/or past prescribed treatments; mental health treatment plan; and assessment summary.

E) Behavior Management Services (See Policy Statement # 19.08)

1) Provides additional assessment and treatment to mentally ill inmates who display or have displayed serious, on-going behavioral problems and/or have a significant amount of lock-down time due to disciplinary infractions.

2) Inmates identified by a Psychiatrist/Psychologist as needing placement in the BMU have a referral package completed for review by the BMU Program Manager. Decisions for admission are made on a case-by-case basis.

4). Outpatient

A. Intensive Outpatient Mental Health Services – (IOP)

1) Provides for inmates
   a. Presenting with moderate symptoms needing frequent or ongoing mental health care.
   b. Prescribed psychotropic medication that can have serious side effects, or require close monitoring.
   c. Whose condition or circumstances require a higher level of evaluation, treatment, and/or case management without the need for hospitalization or residential care programs.

2) When a Psychiatrist indicates IOP Services are needed, a QMHP will update the inmate's medical classification information in the AMR to reflect the current mental health status.

3) Inmates requiring IOP care are assigned to an institution with full-time mental health staff.

B. Outpatient Mental Health

a) Inmates classified as "Outpatient" present with a minimal level of psychiatric symptoms and are able to function with limited supervision from mental health staff.

b) When a Psychiatrist indicates that outpatient mental health services are needed, a QMHP will update the inmate's medical classification information in the AMR to reflect the current mental health status.

c) Inmates requiring outpatient care are assigned to an institution with full-time mental health staff.

5). No mental health service needs identified.

IV. CLASSIFICATION (Refer to General Provisions policy – 19.02)- Major heading

A. An inmate routinely followed by mental health services must receive a mental health level of care classification code.

B. Once the mental health and medical classifications have been entered and the inmate is classified as a candidate to receive mental health services, classification staff determines what institution is suitable for the inmate.

C. An inmate classified as mentally ill is NOT automatically limited to/guaranteed placement in a specific institution. Placement decisions are made on an individual basis and inmates are transferred to an institution capable of providing the most appropriate medical and mental health care while allowing participation in other SCDC programs (i.e., pre-release, work, etc.).

D. Inmate placements are processed by Classification staff on a priority basis to ensure timely transfer to an appropriate treatment setting and foster a plan of care designed to minimize symptoms and adverse effects of mental illness, maximize wellness, and promote recovery.

E. Mental Health professionals utilize both a paper-based (hard file medical record) system and automated medical record (AMR) system of documentation and record keeping to track mentally ill inmates and maintain accurate and complete medical records.

F. Automated documentation such as SOAP notes, DAP notes, medical appointments, classification, program and housing information are maintained in the AMR and links mental health professionals, medical professionals, uniform and essential non-uniform staff to pertinent information involving mentally ill inmates.

G. Paper records such as treatment plans, psychosocial assessments and screening tolls are maintained hard file medical record that is stored in the medical area of the inmates' assigned institution. When an inmate is transferred to a different institution, the hard copy medical record is transferred to the inmate's receiving institution.

H. All mental health documentation is stored in the AMR or hard file medical records.

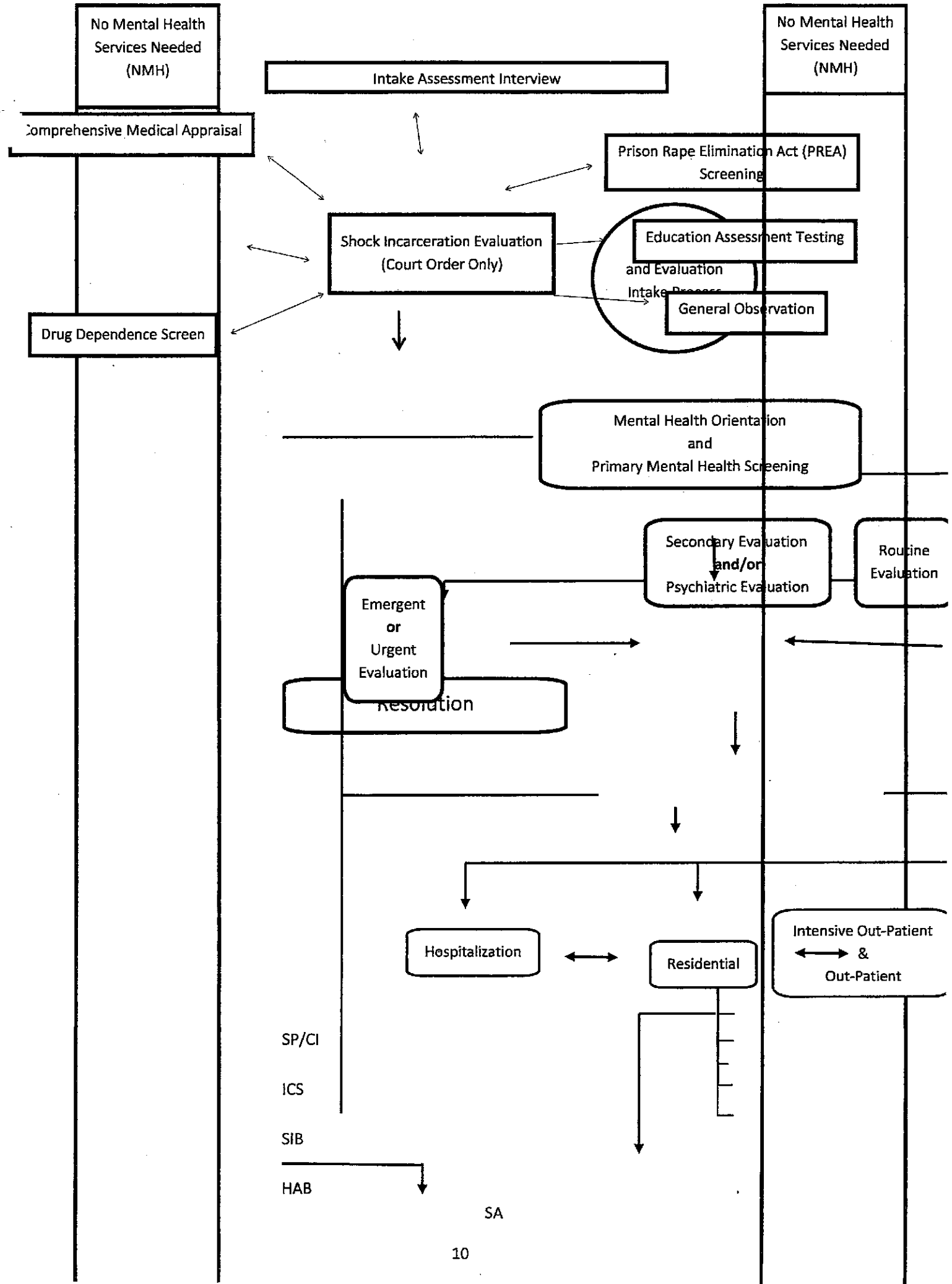
I. Non-referrals are completed and entered into the AMR by a mental health staff member within 5 business days if:

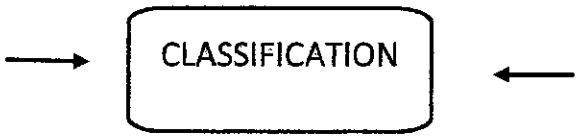
1) After completing the Correctional Mental Health Screen, the inmate does not require mental health additional services;

2) After the second mental health evaluation, the Clinician does not recommend additional services;

3) After a psychological evaluation, the Psychiatrist/Psychologist determines no additional mental health services are required.

4) The Inmate signs a refusal for mental health services.


No Mental Health Services Needed (NMH)
Intake Assessment Interview
No Mental Health Services Needed (NMH)
Comprehensive Medical Appraisal
Prison Rape Elimination Act (PREA) Screening
Shock Incarceration Evaluation (Court Order Only)
Education Assessment Testing
and Evaluation
Intake Process
General Observation
Drug Dependence Screen
Mental Health Orientation
and
Primary Mental Health Screening
Secondary Evaluation
and/or
Psychiatric Evaluation
Routine Evaluation
Emergent
or
Urgent
Evaluation
Resolution
Hospitalization
Residential
Intensive Out-Patient
&
Out-Patient
SP/CI
ICS
SIB
HAB
SA


CLASSIFICATION

Attachment A: Reception and Evaluation Intake Process Screening Tool

Attachment B: Medical Screening Tool

Attachment C: Mental Health Screening Form III

Attachment D: Substance Abuse Screen

Attachment E: Psychosocial Assessment

Attachment F. DSM Cross Cutting-Cutting Symptom Measure

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
INMATE IDENTIFICATION

SCDC#: 0000000 **LOC:**

SSN#. . . . . >	- -	**SSN CARD INDICATOR>**	_____
BIRTH STATE. . . . >	_____	**BIRTH COUNTY. . . . >**	_____
BIRTH COUNTRY. >	_____	**BIRTH DATE. . . . . .>**	00/00/00
FBI NUMBER. . . . . >	_____	**SID NUMBER. . . . . >**	_____
RACE. . . . . >	_____	**SEX. . . . . >**	_____
EYE COLOR. . . . . >	_____	**HAIR COLOR. . . . . >**	_____
SKIN TONE. . . . . >	_____	**BODY BUILD. . . . . >**	_____
HEIGHT. . . . . >	____ FT ____ IN	**WEIGHT. . . . . >**	000 LBS.
ETHNIC ORIGIN. . >	_____	**CITIZENSHIP. . . . . >**	_____
MARITAL STATUS.>	_____	**RELIGIOUS PREF. . . . >**	_____
NUM OF CHILDREN>	_____	**MILITARY BRANCH. . . >**	_____
MILITARY STAT. . .>	_____	**PRIMARY LANGUAGE >**	_____
CONSULAR NOTIFICATION. >	_____	**SECONDARY LANG. 1.>**	_____
INTERNATIONAL NOTIFICATION. >	_____	**SECONDARY LANG. 2.>**	_____
		SECONDARY LANG. 3.>	_____

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
LAST ADDRESS/EMERGENCY CONTACT

SCDC#: _____ **LOC:**

LAST ADDRESS:
STREET. .> _____
CITY. . . . > _____ **COUNTY .>** _____
STATE. . .> _____ **ZIP. . . . . >** _____
FIRST NAME. .> _____
LAST NAME . .> _____
RELATIONSHIP> _____

EMERGENCY CONTACT:
FIRST NAME. .> _____
LAST NAME . .> _____
RELATIONSHIP> _____

EMERGENCY ADDRESS:
STREET. .> _____ **PHONE-1>** 000 000-0000
CITY. . . . > _____ **PHONE-2>** 000 000-0000
STATE. . .> _____ **ZIP. . . . . >** _____
COUNTY > _____

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
EDUCATION/EMPLOYMENT

SCDC#: _____ **LOC:**

EDUCATION

HIGHEST GRADE COMPLETED IN SCHOOL . . . . . > 00
REASON DID NOT FINISH HIGH SCHOOL . . . . . >
WERE YOU EVER IN SPECIAL ED/RESOURCE CLASSES? . . . . . >
HIGHEST DEGREE RECEIVED . . . . . >
VOCATIONAL TRAINING> ____ **AREA>** ___ **RECEIVED CERTIFICATE?>** _____

EMPLOYMENT

EMPLOYER . . . . . > _____
CITY. . . . . > _____ **STATE>** _____
POSITION HELD . . . > _____
WHAT KIND OF WORK DO YOU USUALLY DO?
MAJOR OCCUPATION . . > _____
SECOND OCCUPATION . > _____
EVER EMPLOYED BY LAW ENFORCEMENT? . . . >
WHERE AND WHAT POSITION? . . . . . >

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
JUVENILE

SCDC#: _____ **LOC:**

1. **WERE YOU EVER ARRESTED BEFORE YOU TURNED 17 YEARS OLD?>** _____

2. **NUMBER OF JUVENILE ARRESTS . . . . . >** 00

3. **AGE AT FIRST ARREST . . . . . >** 00

4. **DID YOU EVER SERVE TIME AS A JUVENILE? . . >** _____ **NUMBER OF TIMES>** 00
   WHAT FOR, WHEN, HOW LONG?>

   _____

5. **EVER ON PROBATION AS A JUVENILE? . . . . . >** _____ **NUMBER OF TIMES>** 00
   WHAT FOR, WHEN, HOW LONG?>

   _____

6. **EVER RUN AWAY FROM HOME AS A JUVENILE? . .>**
   EVER ESCAPE FROM A JUVENILE DETENTION CENTER/FACILITY?> _____

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
ALIAS/ACCOMPLICE NAME SUMMARY

SCDC#: _____ **LOC:**

TYPE	NAME

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
MARKS/SCARS/STG

SCDC#: _____ **LOC:**

BEGIN. . . . >

< . . . END

STG:

ARE YOU A MEMBER OF A GANG? . . . . . >

SCDC OFFENDER MANAGEMENT SYSTEM
INTAKE ASSESSMENT INTERVIEW SYSTEM
ALCOHOL AND DRUGS

SCDC#: _____ **LOC:**

WERE YOU UNDER THE INFLUENCE OF ALCOHOL/DRUGS AT THE TIME OF THE CRIME> ____
ALCOHOL _____ **DRUGS** _____ **BOTH** _____

ARE ALCOHOL/DRUGS RELATED TO CRIME? (SELECT UP TO 3 CHOICES):

_____ **ALCOHOL USE**

_____ **DRUG USE**

_____ **DUI**

_____ **PROFIT/FINANCIAL GAIN**

_____ **MONEY TO BUY/USE DRUGS**

_____ **POSSESSION AT CRIME**

_____ **NOT APPLICABLE**

_____ **DO YOU CURRENTLY USE ANY TOBACCO PRODUCT?**
(CIGARETTES, CIGARS, CHEWING TOBACCO, DIP, SNUFF, ETC.)

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
INMATE STATEMENT

SCDC#: _____ **LOC:**

BEGIN. . . . >

<. . . END

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
TEST DATA

SCDC#: _____ **LOC:**

DATE TESTED . . . .> 00/00/00

ESTIMATED IQ (NON VERBAL GROUP) . . . > 000

WRAT READING . . > .0 **SASSI. . :**
WRAT MATH . . . . . > .0 **BECK . . >** _____
TCUDDS:

MEETS YOA BOOT CAMP CRITERIA? . . > _____ **(IF NO, PROVIDE REASON BELOW)**
REASON> _____

MEETS SHOCK REQUIREMENTS? . . . . . > _____ **(IF NO, PROVIDE REASON BELOW)**
REASON> _____

REFER TO R&E CLINICIAN . . . . . >

SCDC OFFENDER MANAGEMENT SYSTEM
RECEPTION AND EVALUATION INTAKE PROCESS
MENTAL HEALTH

SCDC #: _____

1. Were you ever hospitalized for Mental Health treatment or an evaluation? If yes, when?

2. Have you ever had outpatient treatment for a mental health problem? If yes, when?

3. Are you taking medication for mental health reasons?

4. Have you ever tried to hurt yourself? If yes, when?

5. Are you thinking about hurting yourself now? **If answer is yes, constitutes an emergent referral to mental health.**

6. Do you hear voices or sounds that others don't hear or see things that are frightening /unusual that others don't see or hear?

7. Have you suffered any significant trauma?

8. Were you ever physically or sexually abused?

9. Does your present charge involve sexual misconduct?

10. Have you ever been accused of the sexual assault of another inmate in a federal, state, juvenile, county or local facility? Explain when, where and who?

11. Have you ever been the victim of a sexual assault by an employee or inmate in a federal, state, juvenile, county or local facility, or while on any form of Community Supervision? Explain when, where and who?

Scoring Key

- Positive responses to question #5 is an emergent referral
- Positive responses to four or more questions is an urgent referral
- Positive responses to any questions is a routine referral.

*** Screener has the right to override the above based on professional judgment if inmate needs to be seen earlier by a Mental Health Professional.

Scoring Disposition

No indication of Mental Health issues _____

Emergent Referral _____

Urgent Referral _____

Routine Referral _____

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF HEALTH SERVICES
MEDICAL SCREEN

This questionnaire should be completed by a medical staff who interviews the inmate when he/she is received at the institution who also has reviewed the information from the mental health classification screen.

GENERAL INFORMATION:

Inmate Name: _____ SCDC#: _____ Institution: _____
Sex: _____ DOB: _____ Age: _____ Race: _____
Current Vitals: B/P:_____ Temp: _____ Weight _____ H/R_____
SAT: _____
Primary Care Physician/Primary Health Care Provider Prior to Incarceration: _____
Approximate Date of Last Medical Examination/OBGYN Exam:_____
Are you currently pregnant: Yes ____ No ____ History of problems during pregnancy: Yes ____ No ____

MEDICAL HISTORY:

1. Current Medical or Dental Problems:

Medical/Dental Problem	Yes	No	Describe
High Blood Pressure			
Diabetes			
Heart Disease			
Allergies			
Epilepsy/Seizures			
Ulcer			
Special Diet			
Ulcer			
Communicable Illness			
Serious Infection			
Other			

2. Past Medical Problems (check all that apply):

Heart Attack		Pneumonia	
Arthritis		Asthma	
Dizziness		Thyroid Problems	
Fainting Spells		Lung Disease	
Stroke		Back, arms, legs or other joint injury	
Cancer		Epilepsy/Seizures	
Nervous/Emotional Problems		High Cholesterol	
Anemia		Other, Specify:	

3. List any prescription medications, non-prescription/self prescribed medications, dietary supplements and/or vitamins you are currently taking:

Name of Medication	Why?	Amount Used	Frequency Used	Mode of Usage	Date/Time of Last Dose

4. History of any problems as result of stopping usage: Yes ____ No ____ If Yes, Which Medication:_____
Describe symptoms:_____

5. Have you even been in treatment or hospitalized for psychiatric/mental health problems? If yes, describe?

6. Have your ever tried to hurt yourself or commit suicide? If yes, describe? _____
7. Are you presently thinking about killing yourself? Yes_____ No_____ **If yes, emergent referral.**
8. Does the inmate report or appear to be (check all that apply):

Indication	Yes	No	If Yes, Describe:
Depressed			
Anxious			
Aggressive			
Hearing Voices			
Having Visions			
Hopeless			
Suffering from substance withdrawal			

9. Drug Abuse History:

	YES	NO
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
Are you experiencing withdrawal symptoms (feel sick) now? **If yes, emergent referral.**		

OBSERVATIONS:

Physical Features	**Yes**	**No**	**If No for general appearance and/or Yes to any others, please Describe:**
Genera Appearance WNL			
Physical Deformities			
Skin (jaundice, rash, etc.)			
Needle Marks			
Evidence of Trauma (abrasions, bruises, etc.)			
Behavior	**Yes**	**No**	**If Yes, Describe:**
Appearance			
Cooperative			
Tremors			
Sweating			
Alert to person, place, time?			

DISPOSITION OF INMATE/PLACMENT RECOMMENDATION (Check One):

General Population, No Referral for Services		Comments:
General Population w/referral for Health Care		
General Population with referral for Mental Health (check		
1. **Emergent** (positive response to # 7)		
2. **Urgent** (Yes response to being prescribed a Psychiatric medication and/or more than 3 positive responses to questions 4-7.)		
3. **Routine** (Positive response to any mental health question)		
Referral for emergency care?		

Did you receive Medical and Mental Health Orientation? Yes ☐ No ☐
Do you want/wish to see a mental health counselor? Yes ☐ No ☐
Inmate Signature_____ **Date**_____

Medical Professional Use Only

Signature of Person completing form: _____ **Date:** _____

Intake Form Reviewed? Yes_____ No_____ Comments: _____

SCDC M-14 (Rev. July 2004) cc: Inmate Health Record and Inmate Institutional Record

NAME:	SCDC#	DATE:

In this program, we help people with all of their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you deal with any emotional problems you may have, but we can do this only if we are aware of the problem. Any information you provide to use on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note each item refers to your entire life history, not just your current situation. This is why each question begins, "Have you ever..."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	Yes	No
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help?	Yes	No
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	Yes	No
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	Yes	No
5. Have you ever heard voices no one else could hear or seen objects which others could not see?	Yes	No
6a. Have you ever been depressed for weeks at a time, lost interest in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	Yes	No
6b. Did you ever attempt to kill yourself?	Yes	No
7. Have you ever had nightmares or flashbacks as a result of being involved in a traumatic/terrible event?	Yes	No
8. Have you ever experienced any strong fears? For example, heights, insects, animals, dirt, attending social events, etc?	Yes	No
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property	Yes	No
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors?	Yes	No
11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	Yes	No
12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating?	Yes	No
13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	Yes	No
14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly,	Yes	No
15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations?	Yes	No

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?	Yes	No
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?	Yes	No

THIS SECTION FOR SCDC USE ONLY	
Inmate Name:	Date:
Name of Completing QMHP:	
QMHP Comments:	
Total Score	_____ (each yes = 1pt.) x

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
TCU DRUG SCREEN II

NAME:	SCDC #:	DATE:

During the last 12 months (before being locked up, if applicable)

	Yes	No
1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	o	o
2. Did you try to cut down on your drug use but were unable to do it?	o	o
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	o	o
4. Did you get so high or sick from drugs that it –		
a. kept you from doing work, going to school, or caring for children?	o	o
b. caused an accident or put you or others in danger	o	o
5. Did you spend less time at work, school, or with friends so that you could use drugs?	o	o
6. Did your drug use cause -		
a. emotional or psychological problems	o	o
b. problems with family, friends, work, or police?	o	o
c. physical health or medical problems?	o	o
7. Did you increase the amount of a drug you were taking so that you could get the same effects as before?	o	o
8. Did you ever keep taking a drug to avoid withdrawal symptoms or keep from getting sick?	o	o
9. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	o	o

10. Which drug caused the most serious problem? [CHOOSE ONE]
    - o *None*
    - o *Alcohol*
    - o *Marijuana/Hashish*
    - o *Hallucinogens/LSD/PCP/Psychedelics/Mushrooms*
    - o *Inhalants*
    - o *Crack/Freebase*
    - o *Heroin and Cocaine (missed together as Speedball)*
    - o *Cocaine (by itself)*
    - o *Heroin (by itself)*
    - o *Street Methadone (non-prescription)*
    - o *Other Opiates/Opium/Morphine/Demerol*
    - o *Methamphetamines*
    - o *Amphetamines (other uppers)*
    - o *Tranquilizers/Barbiturates/Sedatives (downers)*
    - o *Bath Salts*

o *Other (specify)*

ATTACHMENT D: Substance Abuse Screen

11. How often did you use each type of drug during the last 12 months?

	DRUG USE IN LAST 12 MONTHS				
	NEVER	ONLY A FEW TIMES	1-3 TIMES A MONTH	1-5 TIMES A WEEK	ABOUT EVERY DAY
a. Alcohol	o	o	o	o	o
b. Marijuana/Hashish	o	o	o	o	o
c. Hallucinogens/LSD/PCP/ Psychedelics/Mushrooms	o	o	o	o	o
d. Inhalants	o	o	o	o	o
e. Crack/Freebase	o	o	o	o	o
f. Heroin and Cocaine (mixed together as Speedball)	o	o	o	o	o
g. Cocaine (by itself)	o	o	o	o	o
h. Heroin (by itself)	o	o	o	o	o
i. Street Methadone (non prescription)	o	o	o	o	o
j. Other Opiates/Opium/Morphine/Demerol	o	o	o	o	o
k. Methamphetamines	o	o	o	o	o
l. Amphetamines (other uppers)	o	o	o	o	o
m. Tranquilizers/Barbiturates/Sedatives (Downers)	o	o	o	o	o
n. Bath Salts	o	o	o	o	o
o. Other (specify)	o	o	o	o	o

12. During the last 12 months how often did you inject drugs with a needle?
o *Never* o *Only a few times* o *1 – 3 times per month* o *1 – 5 times a week* o *Daily*

13. How serious do you think your drug problems are?
o *Not at all* o *Slightly* o *Moderately* o *Considerably* o *Extremely*

14. How many times before now have you ever been in a drug treatment program? [DO NOT INCLUDE AA/NA/CA MEETINGS]
o *Not at all* o *Slightly* o *Moderately* o *Considerably* o *Extremely*

15. How important is it for you to get drug treatment now?
o *Never* o *Only a few times* o *1 – 3 times per month* o *1 – 5 times a week* o *Daily*

ATTACHMENT D: Substance Abuse Screen

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

CLINICAL ASSESSMENT

Evaluation Date: _____

NAME:	**SCDC#:**

I. **IDENTIFYING INFORMATION**:

DOB: _____ Age: _____Race: _____ Sex: _____

Marital Status: _____ Place of Residence: _____

Current Sentence: _____ Projected Max Out Date: _____

Crime: _____

Referring Institution: _____ Admission Status: _____

II. **REASON FOR REFERRAL**: _____

_____

Client's Conception of Problem: _____

_____

III. **MENTAL HEALTH HISTORY**:

HISTORY	**Yes**	**No**	**Explain**
Alcohol and Illicit Drug Use			
Hospitalization for Psychiatric Problems			
Currently Suicidal			
Currently Homicidal			
History of Assaultive or Suicidal Behavior			
Treatment for Substance Abuse			When: Where:
Risk for Violence of Self Harm			High Moderate Low
Prescribed Medication			Present: Past:
Efficacy/Compliance:			
Sleep Difficulties			
Appetite Problems			

IV. SOCIAL HISTORY

Mental Health History of Family: _____

_____

_____

Criminal History of Family: _____

_____

_____

Family Support: None ___ Minimal ___ Moderate ___ Very Supportive ___
(Name/Address/Telephone Number of Next-of-Kin): _____

_____

_____

Education: 1 2 3 4 5 6 7 8 9 10 11 12 GED 13 14 15 16

Special Education: Yes _____ No _____

Employment History: _____

_____

_____

_____

Marital History: _____

_____

_____

Physical Abuse/Neglect and/or Sexual Abuse History: _____

_____

_____

Juvenile Incarcerations: _____

_____

_____

V. ALCOHOL/DRUG HISTORY

	ALCOHOL	DRUG(S)	OTHER
Age at first use			
Type first used?			
Drink of choice			
Date last used?			

Describe your frequency and pattern of use: _____

_____

From: _____ To: _____
From: _____ To: _____
From: _____ To: _____

Why? _____

_____

STATEMENT	Yes	No
Drugs/Alcohol use has affected my personal and family relationships.		
My judgment has been impaired while using drugs/alcohol.		
Family members have expressed concern about my using/drinking.		
I feel that I would be a better person if I did not use/drink.		
I have used drugs/alcohol in spite of efforts or promises not to.		
I have experienced a preference to use/drink rather than do what is expected of me.		
I have been arrested or convicted of an offence that was drug or alcohol related.		
I have continued using drugs/alcohol in spite of serious harmful consequences.		
I have been abusive to others when using/drinking.		
I have taken more drugs/alcohol to feel its effects more quickly.		
I have had problems on the job because of my drug/alcohol use.		
I have used drugs:		
to calm down		
to relieve physical pain		
to forget		
when feeling lonely		
when depressed		
to gain social acceptance		

VI. **MENTAL STATUS EXAM**: *(Circle all that apply):*

Orientation:	Person	Place	Time	Location
Ability to Concentrate:	Good	Fair	Poor	Unable to Assess
Recent Memory:	Good	Fair	Poor	Unable to Assess
Remote Memory:	Good	Fair	Poor	Unable to Assess
Judgment:	Good	Fair	Poor	Unable to Assess
Insight:	Good	Fair	Poor	Unable to Assess
Abstract Reasoning:	Good	Fair	Poor	Unable to Assess
Suicidal Ideations:	Denies	Suicidal	Homicidal	
Sleeping:	2-4 hours	4-6 hours	6-8 hours	8 or more
Appetite:	Meals Eaten: 1 2 3	Increased	Decreased	
	Weight Gain/Loss	Binge	Purge	

Perceptual Disturbances: *(Circle all that apply):*

Thought Content:	Appropriate	Confused	Ideas of Reference	Hopeless		
Thought Process:	Appropriate	Illogical	Loose Associations	Circumstantial		
	Tangential	Flight of Ideas				
Hallucinations:	Auditory	Visual	Tactile	Gustatory	Olfactory	Denies
Delusions:	Persecutory	Phobic	Paranoid	Religiosity	Denies	

Other Impressions: *(Choose one)*

Attitude:	Guarded	Hostile	Open _____
Affect:	Elated	Flat	Depressed _____
Speech:	Pressured	Relaxed	Rapid Slow Within Normal Limits
Eye Contact:	Good	Adequate	Poor
Psycho-motor Activity:	Excessive	Impaired	Within Normal Limits

Additional Observations: _____

_____

_____

VII. DSM-5 SELF RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE – ADULT

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____

In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicine **ON YOUR OWN,** that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	0	1	2	3	4	

DSM-5 SELF RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE – ADULT - continued:

Instructions to Clinicians – This is a self- or informant-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. In addition, the measure may be used to track changes in the individual's symptom presentation over time.

This version of the measure consists of 23 questions that assess 13 psychiatric domains, including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance use. Each item inquires about how much (or how often) the individual has been bothered by the specific symptom during the past 2 weeks. If the individual is of impaired capacity and unable to complete the form (e.g., an individual with dementia), a knowledgeable adult informant may complete the measure. The measure was found to be clinically useful and to have good test-retest reliability in the DSM-5 Field Trials that were conducted in adult clinical samples across the United States and in Canada.

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the "Highest Domain Score" column. A rating of mild (i.e., 2) or greater on any item within a domain (except for substance use, suicidal ideation, and psychosis) may serve as a guide for additional inquiry and follow up to determine if a more detailed assessment for that domain is necessary. For substance use, suicidal ideation, and psychosis, a rating of slight (i.e., 1) or greater on any item within the domain may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is needed. The DSM-5 Level 2 Cross-Cutting Symptom Measures may be used to provide more detailed information on the symptoms associated with some of the Level 1 domains (see Table 1 below).

Frequency of Use

To track change in the individual's symptom presentation over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. For individuals with impaired capacity, it is preferable that the same knowledgeable informant completes the measures at follow-up appointments.

Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

Table I: Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: domains, thresholds for further inquiry and

associated Level 2 measures for adults 18 and over

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Depression	Mild or greater	LEVEL 2 – Depression – Adult (PROMIS Emotional Distress – Depression – Short Form)[1]
II.	Anger	Mild or greater	LEVEL 2 – Anger – Adult (PROMIS Emotional Distress – Anger – Short Form)[1]
III.	Mania	Mild or greater	LEVEL 2 – Mania – Adult (Altman Self-Rating Mania Scale)
IV.	Anxiety	Mild or greater	LEVEL 2 – Anxiety – Adult (PROMIS Emotional Distress – Anxiety – Short Form)[1]
V.	Somatic Symptoms	Mild or greater	LEVEL 2 – Somatic Symptom – Adult (Patient Health Questionnaire 15 Somatic Symptom Severity [PHQ015])
VI.	Suicidal Ideation	Slight or greater	None
VII.	Psychosis	Slight or greater	None
VIII.	Sleep Problems	Mild or greater	LEVEL 2 – Sleep Disturbance – Adult (PROMIS Sleep Disturbance - Short Form)[1]
IX.	Memory	Mild or greater	None
X.	Repetitive Thoughts and Behaviors	Mild or greater	LEVEL 2 – Repetitive Thoughts and Behaviors – Adult (adapted from the Florida Obsessive-Compulsive Inventory (FOCI) Severity Scale [Part B])
XI.	Dissociation	Mild or greater	None
XII.	Personality Functioning	Mild or greater	None
XIII.	Substance Abuse	Slight or greater	LEVEL 2 – Substance Use – Adult (adapted from the NIDA-modified ASSIST)

[1]The PROMIS Short Forms have not been validated as an informant report scale by the PROMIS group

VIII. SUICIDAL/SELF-INJURIOUS HISTORY:

Have you ever cut yourself, burned yourself, etc. for some reason other than trying to commit suicide? If so, elaborate?

IX. **COUNSELOR'S SUMMARY AND IMPRESSIONS**: _____

Assessed by: _____
(Name) (Job Title)

Date: _____

COLUMBIA-SUICIDE SEVERITY

RATING SCALE

(C-SSRS)

Lifetime Recent - Clinical

Version 1/14/09

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.	Most Severe	Most Severe
Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*) Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)		
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____

Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better,*** ***get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**	Yes ☐ No ☐ Total # of Attempts _____ Yes ☐ No ☐	Yes ☐ No ☐ Total # of Attempts _____ Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts _____	Yes ☐ No ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime	Clinical Status (Recent)
☐	Actual suicide attempt ☐ Lifetime	☐	☐ Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	☐ Major depressive episode
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐	☐ Mixed affective episode (e.g. Bipolar)
☐	Other preparatory acts to kill self ☐ Lifetime	☐	☐ Command hallucinations to hurt self
☐	Self-injurious behavior ***without*** suicidal intent	☐	☐ Highly impulsive behavior
Suicidal Ideation **Check Most Severe in Past Month**			☐ Substance abuse or dependence
☐	Wish to be dead		☐ Agitation or severe anxiety
☐	Suicidal thoughts		☐ Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)		☐ Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)		☐ Homicidal ideation
☐	Suicidal intent with specific plan		☐ Aggressive behavior towards others
Activating Events (Recent)			☐ Method for suicide available (gun, pills, etc.)
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)		☐ Refuses or feels unable to agree to safety plan

Describe:		☐	Sexual abuse (lifetime)
		☐	Family history of suicide (lifetime)
☐	Pending incarceration or homelessness	**Protective Factors (Recent)**	
☐	Current or pending isolation or feeling alone	☐	Identifies reasons for living
Treatment History		☐	Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments	☐	Supportive social network or family
☐	Hopeless or dissatisfied with treatment	☐	Fear of death or dying due to pain and suffering
☐	Non-compliant with treatment	☐	Belief that suicide is immoral; high spirituality
☐	Not receiving treatment	☐	Engaged in work or school
Other Risk Factors		**Other Protective Factors**	
☐		☐	
☐		☐	
☐		☐	
Describe any suicidal, self-injurious or aggressive behavior (include dates)			

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF BEHAVIORAL/MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

INMATE SUICIDE PREVENTION AND CRISIS INTERVENTION

Number: HS - 19.03
Date: January 1, 2015
Revised: November 11, 2015

PURPOSE: To establish guidelines for identifying and recognizing potentially suicidal inmates and for preventing the likelihood of inmate suicide and to provide guidance for the management of inmates identified to be in crisis in the South Carolina Department of Corrections (SCDC).

POLICY STATEMENT: SCDC will develop and implement procedures for the management and care of inmates who present with suicidal behaviors or crisis situations and intervene appropriately. The suicide prevention and crisis intervention program will be inclusive of the following components: training, identification, referral, evaluation, treatment, housing, monitoring, communication, intervention, notification, reporting, review, and debriefing. Each Warden or his/her designee and the SCDC Director of Mental Health and/or his/her designee will ensure that this suicide prevention and crisis intervention program is implemented consistent with this policy.

GOAL: SCDC operates a suicide prevention and crisis intervention program to assist staff in identifying and managing potentially suicidal inmates and inmates who are experiencing a crisis. The policy will provide a continuum of comprehensive suicide prevention and crisis intervention services aimed at the collaborative identification, continued assessment, and safe management of inmates at risk of self-harm or harm to others.

The purpose of the policy is to:

1. Establish standards of intervention and care.
2. Establish ongoing education and training for clinical, custodial, and administrative staff.
3. Provide instructions and guidance for establishment and maintenance of the Agency and Local Suicide Prevention Review Committees.
4. Support review of suicide deaths regarding systems issues, clinical care issues, and custody response.
5. Ensure that quality improvement (also known as corrective action) plans are drafted and implemented, when indicated, to reduce the incidence of preventable suicides, improve the delivery of quality care, improve the involvement of non-healthcare staff, and contribute to ongoing education and training.

DEFINITIONS:

Agency Suicide Prevention Committee (ASPC) – The purpose of the Agency Suicide Prevention Committee is to:

1) Provide oversight and guidance for each Local Suicide Prevention Committee (LSPC) regarding time sensitive due dates.
2) Monitor implementation and compliance with all SCDC policies and procedures relating to suicide prevention and response.
3) Provide for the planning, development, and implementation of statewide training, in collaboration with the SCDC Division of Health Services Training staff regarding the issue of suicide prevention and response.
4) Monitor and track all suicides and suicide attempts statewide.
5) Provide for the selection and dispatch of a mental health suicide reviewer (MHSR) after a suicide occurs.
6) Provide oversight, assistance, coordination and supervision of MHSR activities and reports.
7) Track and analyze demographic and clinical information received from the SCDC Division of Health Services for improving suicide prevention and response.
8) Conduct a root cause analysis with the advice and participation of counsel and in anticipation of litigation.
9) Ensure that all information, notes, reviews, analysis, recommendations, reports and debriefings created or gathered by the LSPC, MHSR, ASPC, and debriefing staff as a result of a suicide or attempted suicide are confidential, attorney-client documents of General Counsel for the purpose of advice of Counsel and/or in anticipation of litigation.

The ASPC is co-chaired by the SCDC Chief of Psychology and the SCDC General Counsel and will be comprised of:

The Co-Chairs: or Designees;

- Warden of the institution where the suicide occurred;
- A Representative from the Division of Operations;
- An attorney from the Office of General Counsel;
- Division Director of Mental Health Services;
- Director of Psychiatry;
  Medical Director;
- Deputy Director of Health Services;
- Director of Nursing; and
  Quality Management Director

NOTE: The Chairperson may add additional personnel.

AMR - Automated Medical Records.

CSU (Crisis Stabilization Unit) – a treatment unit consisting of crisis beds in a Healthcare Setting.

CSU Level of Care – Inmates requiring close observation in a Healthcare Setting for diagnostic/assessment and/or treatment purposes. The usual length of stay is 10 days or less. All CSU cells meet the definition of a safe cell provided below.

CSU Treatment Team – Chief Psychologist (Team Leader), Psychiatrist, Nursing staff, Custody Staff, QMHPs, Physician, Physician's Assistant or Nurse Practitioner, and Recreation Therapist.

Cell Check Log - Form to record general observed behaviors during 15-minute intervals when inmate is on constant watch.

Close Observation - Observation for the inmate who after evaluation by a QMHP is determined to not be actively suicidal (either threatening or engaging in suicidal behavior) but expresses non-specific suicidal ideation such as expressing a wish to die without a specific threat or plan, or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide but demonstrates other, concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury should be placed under close observation. Staff should observe such an inmate at staggered intervals of not more than 15 minutes (e.g., 5, 10, 7 minutes, etc.).

Constant Observation - Observation for the inmate who is actively suicidal (either threatening or engaging in suicidal behavior). Staff or supervised inmate observers should observe such an inmate on a continuous, uninterrupted basis. Other aids (e.g., closed-circuit television, inmate companions or watchers) can be used as a supplement to, but never as a substitute for, these observation levels. Finally, mental health staff should assess and interact with (not just observe) suicidal inmates on a daily basis.

Crisis Intervention (CI/SP) – Emergency mental healthcare designed to assist individuals in a crisis situation for whom the criteria for suicide precautions are met. CI/SP is utilized to restore inmates to their baseline biopsychosocial functioning and to minimize the potential for emotional/physical harm to themselves or others. Intervention measures to reduce physical self-harm risk while evaluating an inmate for self-injurious or suicide risk potential may include placement in a safe cell in a Healthcare Setting.

Healthcare Setting - A therapeutic environment with a nursing station on the unit that is staffed 24/7.

Inmate Observers - Inmates who are trained as observers of other inmates who are on constant watch due to suicide precautions.

Columbia Suicide Severity Rating Scale (C-SSRS) - is a suicidal ideation rating scale created by researchers at Columbia University to evaluate suicidality in persons ages 12 and up. The C-SSRS identifies behaviors which may

be indicative of an individual's intent to commit suicide. Versions of the C-SSRS utilized by SCDC include the Lifetime/Recent form, and the Daily/Shift Screener form.

LOC – Level of care

Local Suicide Prevention Committee (LSPC) – Each institution will have a LSPC consisting of the Warden or designee, the Regional Clinical Supervisor or designee, the Chief Psychologist or designee, a Psychiatrist, a Physician, and a Registered Nurse.

Mental Health Screening Form-III (MHSF-III) - a self-administered screening tool given to inmates that helps to detect general signs and symptoms of psychiatric disorders such as: suicidal ideation; schizophrenia; depression; PTSD; phobias; intermittent explosive, delusional, sex/gender/identity, eating, manic, panic, obsessive-compulsive, and gambling disorders; learning and developmental disabilities (See attachments).

P-SERC – Service delivery process involving psychiatric screening, evaluation, resolution, classification.

Qualified Healthcare Practitioner (QHP) - Physician, Physician's Assistant, Nurse Practitioner.

Qualified Mental Health Professional (QMHP) - Licensed Psychiatrist, Licensed Psychologist, Licensed Professional Counselor, Licensed Professional Counselor-Supervisor, Licensed Independent Social Worker, Licensed Martial and Family Therapist (LMFT), Psychiatric Nurse Practitioner. Also, includes Licensed Master Social Worker, LMFT-Intern and Licensed Professional Counselor-Intern with appropriate supervision.

Regional Clinical Supervisor - Licensed Professional Counselor-Supervisor (LPC-S), Licensed Independent Social Worker, and Licensed Professional Counselor-Supervisor-In-Process.

SCDC Certified Staff - Staff who has graduated from the SCDC Correctional Officer Certification Course.

Safe Cell – A safe cell is a suicide resistant cell free of all obvious protrusions. These cells should contain tamper-proof light fixtures and air vents, and surfaces that are protrusion-free and not conducive to hanging. Each cell door should contain a heavy-gauge Lexan (or equivalent grade) glass panel that is large enough to allow staff a full and unobstructed view of the cell interior. Cells housing suicidal inmates should not contain any electrical switches or outlets, bunks with open bottoms, towel racks on desks and sinks, radiator vents, uncovered bars, or any other object that provides an easy anchoring device for hanging.

Special Observation: This status may be initiated by QMHPs to allow for further evaluation of inmates needing separation from general population and/or protection for mental health reasons but for whom the criteria for suicide precautions are not met. Intervention measures to reduce physical self-harm risk while evaluating an inmate for self-injurious or suicide risk potential may include placement in a safe cell.

Staff Observers - SCDC Security staff who provide observation of inmates on CI/SP or Special Observation status.

Step-Down for Inmates with High-Risk Factors form: Document used to initiate, track, and discontinue a step-down protocol for monitoring inmates who present with high-risk factors that warrant periodic reassessment after coming off CI/SP or Special Observation status.

Step-Down Protocol- Precautionary monitoring and counseling measures applied to inmates who no longer evidence the need for suicide precaution status, but who would benefit from a course of ongoing monitoring to assess for acute relapse of self-harm and/or suicidal ideations.

Suicide Precautions - intervention measures to reduce physical self-harm by an inmate identified as a risk for suicidal behavior. These measures include placement of the inmate into a safe cell under constant observation.

Suicide Risk Factors - characteristics that are known to be associated with individuals who have attempted suicide, or die by suicide.

Therapeutic Environment - A setting that is conducive to the achievement of mental health treatment goals. This includes the physical setting and the social-emotional setting, in which an atmosphere of empathy and respect for the dignity of the patient is maintained. Mental health services are conducted in private and carried out in a manner that encourages the patient's subsequent use of services. A therapeutic environment implies the following conditions:
A sanitary and humane environment
Written procedures
Adequate medical and mental health staffing
Adequate allocation of resources for the prevention of suicide, self-injury, and assault
Adequate observation, treatment, and supervision
Social interactions that foster recovery

1. TRAINING

1.1. Staff Training: The Agency Suicide Prevention Committee will develop prevention and intervention plans in accordance with SCDC Policy/Procedure ADM-17.03, "Administration of Agency Training Programs."

1.2. Suicide Intervention and Prevention training will focus on:

- Identifying suicide risk factors/protective factors;
- Typical inmate profiles of completed suicides;
- Recognition of potentially suicidal behavior;
- Appropriate information associated with identifying and referring suicidal inmates;
- Responding to a suicide emergency (e.g., a suicide in progress), including location and proper use of suicide cut down tool, and;
- CPR and First Aid

1.3. All staff with the responsibility for inmate supervision will initially receive 8 hours of training in mental health related content to include suicide prevention and intervention. New employees will receive the training during institutional orientation and/or during the Correctional Officer Certification Course.

1.4. In addition to the training requirements set forth in section 1.3, all staff with direct inmate contact/supervision is required to attend 4 hours of annual training in suicide intervention and prevention as well as the supervision of suicide-prone inmates. An instructor assigned by the Chief Psychologist to the Division of Training or a Mental Health Professional will conduct the training.

1.5. SCDC certified Correctional Officers and all medical and mental health staff (SCDC and contract) are required to maintain CPR certification every two years. All other employees with direct inmate contact/supervision are strongly encouraged to become certified.

1.6. First aid training will be mandatory for SCDC certified staff, and all medical and mental health staff, once every two (2) years. All other employees with direct inmate contact/supervision are strongly encouraged to complete this training every two years.

2. IDENTIFICATION

2.1. The P-SERC process is required for all inmates and is initiated on the first day of the inmate's arrival at SCDC

2.2. Classification- Intake Assessment Interviews are conducted by an assessment classification caseworker in an effort to obtain information about an inmate's suicidal ideation history, substance abuse history, and mental health history. If an inmate reports a suicidal attempt or ideation within the last year, they will be referred for urgent evaluation. If they verbalize current suicidal ideation they will be referred for emergent evaluation.

2.3. Medical - An Intake Medical Screening is conducted by medical personnel, within 8 hours of inmate's arrival at SCDC. This screening will assist in identifying potentially suicidal inmates and will be documented on SCDC Supply M-14, "Medical Screen." (See attachments) If an inmate reports suicidal attempt within the last year they will be referred for urgent evaluation. If they verbalize current suicidal ideations, they will be referred for emergent evaluation.

2.4. Mental Health- Mental Health Screening Form-III (MHSF-III): The MHSF-III is self-administered and must be completed by all inmates. QMHPs instruct each inmate to complete the Mental Health Screening Form-III (MHSF-III) during orientation, which is completed by the third day of the inmate's arrival. This screening helps to detect general signs and symptoms of psychiatric disorders such as: suicidal ideation; schizophrenia; depression; PTSD; phobias; intermittent explosive, delusional, sex/gender/identity, eating, manic, panic, obsessive-compulsive, and gambling disorders; learning and developmental disabilities (See attachments).

2.5. Upon completion of the MHSF-III, if the inmate indicates past or present suicidal ideations, a QMHP will determine whether an inmate receives an emergent evaluation, or an urgent evaluation.

2.5.1. Emergent Evaluation: These inmates have indicated they are actively suicidal and/ or psychotic. If the inmate is actively suicidal, he/she will be placed on Crisis Intervention/Suicide Precaution (CI/SP) Special Observation status and kept under constant watch. Within (4) hours, inmates are seen for an evaluation and Psychiatric follow up is arranged. The management of these inmates and the results of individual evaluations will be documented within the Automated Medical Record (AMR).

2.5.2. Urgent Evaluation: These inmates have indicated a history of suicide ideations and/ or attempts within the last year. Within (24) hours, inmates receive a mental health evaluation that includes a suicide risk assessment. The evaluation is performed by a QMHP.

2.5.3. **Suicide Risk Assessment: All inmates scoring a positive result for suicidality on the MHSF-III and receiving an emergent or urgent** evaluation are administered the Columbia Suicide Severity Rating Scale (C-SSRS)-Lifetime/Recent form (Attachment #1) by a QMHP to identify modifiable or treatable acute, high-risk suicide factors, and available protective factors that inform of inmate's treatment and safety management requirements.

2.6. After the assessment, a QMHP will make one of four recommendations. If the QMHP is not a licensed psychologist, psychiatrist or psychiatric nurse practitioner they will coordinate obtaining any necessary orders from such practitioner:

2.6.1. **No In-Patient Treatment, Crisis Intervention, or Suicide Precautions status necessary:** If it is determined that the inmate does not require in-patient treatment, CI/SP, or Special Observation status, appropriate referral for necessary mental healthcare (Outpatient Care) will be completed.

2.6.2. **In-Patient Treatment Necessary:** If it is determined that the inmate needs in-patient treatment, a referral will be made for admission to a hospital setting (GPH for males or outside hospital for females), and upon acceptance a SCDC physician will complete the admission orders and the inmate will be transferred to the Gilliam Psychiatric Hospital (for males) or contract care facility (for females) pursuant to SCDC Policy/ Procedure HS – 18.13, "Health Screening and Exams." Direct observation will occur until the inmate is transferred.

2.6.3. **Crisis Intervention/Suicide Precautions (CI/SP):** Within 60 hours of determining that the inmate requires CI/SP, the inmate will be transferred to CSU for a period of up to ten (10) days. The QMHP who ordered CI/SP will complete SCDC Form M-120, "Crisis Intervention Form." By ten (10) days, the CSU Treatment Team shall determine whether the inmate needs in-patient treatment, an ICS level of care, further observation on CI/SP, a returned to general population, or R&E housing. CI/SP may be renewed for an additional five (5) days, but may not exceed fifteen (15) days except in extraordinary circumstances as determined by the CSU Treatment Team and approved by the CSU assigned licensed psychologist, psychiatrist, or psychiatric nurse practitioner.

2.6.4. **Special Observation:** A QMHP places inmates on Special Observation status to allow for further evaluation of inmates needing separation from general population and/or protection for mental health reasons but for whom the criteria for suicide precautions are not met. A QMHP may initiate Special Observation. A licensed psychologist, psychiatrist, physician, physician's assistant, or nurse practitioner is then informed of the Special Observation status and the inmate may be admitted to the CSU for up to ten (10) days. By ten (10) days, the CSU Treatment Team shall determine whether the inmate needs in-patient treatment, Crisis Intervention/Suicide Precautions status, ICS level of care, a returned to general population, or R&E housing. If further observation is needed, a psychiatrist or the CSU-assigned licensed psychologist will write an additional order, Special Observation status may be renewed for an

additional five (5) days. Special Observation status may not exceed fifteen (15) days except in extraordinary circumstances as determined by the CSU Treatment Team and approved by the CSU assigned licensed psychologist, psychiatrist, or psychiatric nurse practitioner.

3. REFERRAL

3.1. Wardens will ensure when an inmate is observed by staff to be possibly experiencing a mental health problem, a referral will be immediately made through the Senior Shift Officer on duty to medical staff who will refer to the QMHP, if necessary. Confidential assessments will be conducted by the QMHP, psychiatric nurse practitioner, or physician prior to an inmate's removal from the general population. (NOTE: The only exception will be in emergency situations when an inmate displays irrational and/or uncontrolled emotional behavior that could become, dangerous and/or result in injury to him/herself or others. In these instances, security will take necessary precautions to separate the inmate from other inmates until such time that the inmate is assessed).

3.2. Any SCDC staff member, on becoming aware that an inmate may have a mental health problem, presenting at a crisis level, will contact the onsite nursing staff, on-call medical staff, or the on-site or on-call designated QMHP, and request an assessment and will immediately notify his/her supervisor. The inmate will be kept under continuous observation until assessed by mental health or medical staff.

3.3. When a crisis determination is made by a QMHP, they will also complete SCDC Supply M-120, "Crisis Intervention Form" and SCDC Form M-135 "Crisis Intervention Log." The SCDC Form M-135 "Crisis Intervention Log" will be maintained in a designated place (See attachments).

3.4. Upon referral, during normal working hours, the QMHP assigned to the institution will provide a confidential, face-to-face evaluation the same working day and the C-SSRS Lifetime/Recent form will be utilized. This evaluation will be documented in the Automated Medical Record (AMR). During off duty hours, the on-call Mental Health Professional will provide a telephone consultation within 30 minutes of being paged by Medical or Correctional staff. Continuous observation (face-to face, in person) will be provided while awaiting an assessment by a QMHP.

4. EVALUATION

4.1. A confidential evaluation, conducted by a QMHP determines the appropriate intervention status:

- No Crisis Intervention or Suicide Precautions necessary;
- Recommendation for transfer to an inpatient mental health facility or program;
- Crisis Intervention/Suicide Precautions, or
- Special Observation status

Inmates on CI/SP or Special Observation status are re-assessed at a minimum every 24 hours to identify changes in condition that indicate a need for a change in supervision level and placement. The C-SSRS Daily/Shift Screener form (Attachment #2) is completed as a part of the re-assessment.

4.2. While on CI/SP or Special Observation status, the assigned QMHP will assess the inmate each day in consultation with the psychiatrist or licensed psychologist. Unless safety concerns or behavioral factors make it prohibitive, the assessments will take place out of cell each day while the inmate is on CI/SP or Special Observation status to ensure confidentiality, and the C-SSRS Daily/Shift Screener form is completed daily. The QMHP will document observation(s) in the Automated Medical Record. The documentation will include a mental status evaluation, and an assessment of risk and harm to self or others.

4.3. At a minimum, the Suicide Risk/Crisis Intervention Assessment will include identification and documentation of:

4.3.1. reason for/ source of referral;

4.3.2. risk factors assessed (relevant history, environmental factors, lethality of suicide plan);

4.3.3. risk assessment findings (determination of level of suicide risk, level of supervision needed);

4.3.4. diagnosis; and

4.3.5. follow-up recommendations.

4.4. Prior to an inmate's removal from CI, the inmate must be re-evaluated either face-to-face or via telepsychiatry technology by a licensed psychologist or psychiatrist. The reason for removal shall be documented in the AMR.

4.5. In all cases a crisis follow-up assessment will be conducted by the QMHP and documented the next day after an inmate is removed from crisis. The C-SSRS Daily/Shift Screener will be completed as part of the follow-up assessment.

4.6 **Step Down for Inmates with High-Risk Factors:** Inmates with known history of serious self-harm, frequent needs for CI/SP or Special Observation status, severe mood disorders, non-compliance with treatment, SIB history, traumatic brain injury or intellectual disability, will be assessed by a QMHP for possible placement on a step-down protocol.

4.6.1 Inmates are appropriate for step-down monitoring after discontinuance of CI/SP or Special Observation status when high-risk factors are a continued concern. Any mental health professional may recommend initiation of the step-down protocol, but approval is signified by the signature of the Regional Clinical Supervisor on the form entitles "Step-Down for Inmates with High-Risk Factors".

4.6.2 Licensed psychologists and psychiatrist may also instruct the Regional Clinical Supervisor to place inmates on the step-down protocol.

4.6.3 Inmates on the step-down protocol may return to CI status at any time deemed appropriate by clinical staff.

4.6.4 The high-risk protocol involves step-down monitoring and requires reassessment of suicidal risk at a minimum of, every other day for at least a week, then weekly for 1 month, and then monthly for 4 months.

4.6.5 Each reassessment session is documented in the AMR

4.6.6 A licensed psychiatrist or licensed psychologist may discontinue the high-risk monitoring protocol at any time when a face-to–face, or tele-psychiatry facilitated assessment leads to a clinical opinion that high-risk monitoring is no longer necessary. The discontinuation order is documented in the AMR and the Step Down for Inmates with High-Risk Factors form is completed and signed.

5. INTERVENTION

5.1. When an inmate is referred to CI on an urgent or emergent basis, he or she is to be placed in a safe cell under constant observation until he/she is evaluated by a QMHP. Only inmates already in a segregation cell may be placed in a safe cell within a segregation unit. Whoever makes the urgent or emergent referral will ensure the initiation of constant observation. A QMHP will evaluate the inmate within 24 hours of the initial referral to CI. If the evaluating QMHP believes that CSU level of care is appropriate, the QMHP consults with the CSU Team Leader (licensed psychologist), or designee regarding admission. Inmates needing CSU level of care will be transferred to the CSU at Graham (females) or Broad River (males) within 60 hours of the initial referral. If the QMHP determines a CSU level of care is not needed, or is undecided, the QMHP will consult with a psychiatrist or licensed psychologist within 48 hours of the initial referral regarding disposition. This consultation may include an evaluation by the psychiatrist or licensed psychologist. If the psychiatrist or licensed psychologist agrees that a CSU level of care is not warranted, the inmate will then be returned to his/her prior location. If the psychiatrist or licensed psychologist determines a CSU level of care is warranted, or if it is unclear, the inmate will then be transferred to the appropriate CSU within 60 hours of the initiation of intervention measures. When an inmate arrives at the CSU, he/she will be evaluated by the psychiatrist or licensed psychologist within 24 hours. A preliminary treatment plan will be developed by a QMHP after conducting a clinical assessment.

5.2 The Columbia Suicide Severity Rating Scale (C-SSRS) - Lifetime/Recent form will be administered within 24 hours to any inmate for whom an urgent or emergent referral is made.

5.3. A QMHP will conduct daily rounds assessing and interviewing inmates currently on CI/SP or Special Observation status. Completion of the C-SSRS Daily/Shift Screener is part of the daily assessment procedure. A treatment plan will be developed with the intent of addressing why the inmate is currently on CI/SP or Special Observation status.

5.4. A basic treatment plan will be developed by the CSU Treatment Team for every CSU inmate. This treatment plan will address factors listed on SCDC Form M-120, and information gathered via an clinical assessment to include environmental, historical, and psychological factors that contribute to the detainee's suicidal ideation or CI status including . The treatment plan should include strategies and interventions to be completed by staff and the inmate if suicidal ideation or CI status persists.

5.5. If the inmate was placed on CI/SP or Special Observation status due at least in part to a reaction to a custody related issue, the QMHP will address the issue with the appropriate custody staff. Strategies and services to address the underlying reasons for the inmate's CI/SP or Special Observation status will be assessed and adjustments to the inmate's treatment plan will be made and documented.

5.6. Every inmate in the CSU is reviewed by the CSU Treatment Team on at least a two-times-per-week basis for the determination of what other services/programs may be needed to facilitate resolution of the inmate's CI/SP or Special Observation status.

5.7 Prior to the suicide precautions being discontinued, the C-SSRS Discharge Screener form (Attachment #4) is administered and results analyzed as part of the discharge assessment.

5.8. The average length of stay in the CSU is 10 days or less. If more than 10 days are needed, consideration of a higher level of care is warranted.

6. RESPONSE TO ATTEMPTED SUICIDE.

6.1. Equipment: Each SMU, MSU, Safe Keeper, and Death Row unit will have the following equipment immediately available to the Officers on duty to be used in responding to a suicide or suicide attempt. (NOTE: This equipment will be kept in a locked area accessible to the Officers. It should be labeled "For Suicide Emergency Only," and SCDC Correctional staff should ensure that the equipment is in place and in working order on a daily basis.):

1. An airway protection device;
2. Medical exam gloves;
3. Compression bandage (for excessive bleeding);
4. Cut down knife;
5. Large shears; and
6. Pocket mask.

6.2. Response to a suicide. The staff member identifying the situation will immediately call for help and follow SCDC security protocol in accessing the inmate if in a segregated area. Certified staff will initiate appropriate first aid/CPR. Medical staff on duty will be contacted immediately and will respond to the site with a crash cart. If possible, the inmate will then be transported to the medical area. If no medical staff is on site, and the inmate has life-threatening injuries, persons responding will call EMS (911 or the local emergency phone number) and then the medical staff at the covering institution. If no medical staff is on duty and the inmate's injuries are minor and not life threatening, persons responding to the situation will call the medical staff at the covering institution for further instructions.

6.3. Response if an Inmate is found hanging: Staff members arriving at the scene must cut the inmate down immediately. After that, if possible, the knot in the rope should be loosened, and the rope should be cut at some point away from the knot so that the knot remains intact. When cutting an inmate down from a hanging, insure to protect the head by supporting the head, neck and back; and gently place the inmate on the floor face up to protect the airway and check for signs of life and initiate appropriate action as described above. The scene should be secured and the steps outlined in SCDC Policy/Procedure HS-18.04, "Inmate Death," should be followed.

6.4. If death has been determined by a physician or outside emergency response team at the site of the event, the body will not be moved from the scene. It is a violation of state law for the body to be moved without the authorization of the coroner. However, if the inmate is found hanging, he/she should be immediately cut down. (See Procedure 6.3, above.) If medical staff is on duty, they will be notified and the area secured. The medical staff will come to the scene, and the procedures outlined in SCDC Policy/Procedure HS-18.04, "Inmate Death," will be followed. If no medical staff is on duty, the persons discovering the body will secure the area. The procedures outlined in SCDC Policy/Procedure HS-18.04, "Inmate Death," will be followed, and the medical staff at the covering institution will be notified.

7. HOUSING

7.1. When clinically indicated, an inmate on CI/SP or Special Observation status shall be placed on close observation or constant observation in a safe cell. All inmates on close or constant observation shall have a note on their progress recorded daily by a QMHP in the AMR.

7.2. The primary goal in designating a safe cell for suicide watch must be the ability to observe, protect, and maintain adequate control of the inmate. Before an inmate occupies a safe cell, the correctional officer must document that the cell has been cleaned and checked for objects with which the inmate could harm himself. All safe cells must be kept clean and temperatures regularly monitored and documented to assure they are in an appropriate range.

7.3. The inmate will be stripped before being placed in a safe cell, but will be given a clean suicide-resistant mattress, a clean suicide-resistant smock, and a clean suicide-resistant blanket, (an all-in-one Anti-Suicide bed may take the place of a blanket). An inmate in a safe cell may be deprived of any item or activity for security and/or safety reasons, although deprivation of a suicide-resistant smock, suicide – resistant blanket, or suicide-resistant mattress should rarely occur and only by the order of a psychiatrist or licensed psychologist. Reasons for denial will be made on the M-120 and posted on outside of the cell door and the Cell Check Log by the officer in charge. Restoration of clothing and other personal belongings will occur based on clinical assessments.

7.4 An inmate placed in a safe cell will be initially prohibited from having any personal belongings while on precautions that could be used for self-harming purposes. The psychiatrist may order the inmate to be allowed the following: books, therapeutic reading materials (handouts), crayons and paper, playing cards, and/ or puzzles. It is recognized that the availability of these items may serve a therapeutic purpose. Access to these items will generally be authorized by the ordering clinician unless it is determined that doing so for an individual inmate will pose a risk of harm to self or others. The inmate may be provided suicide-resistant eating utensils during meal times. Each time the inmate transits to and from the cell (showers, out-of-cell assessments, etc.), the inmate and the room will be searched for items considered contraband for persons on CI/SP status.

7.5 RHU inmates in CSU will be allowed daily showers if security staffing presence permits. Otherwise, RHU inmates with be allowed to shower a minimum of 3 times a week. Non-RHU inmates will be allowed to shower daily, unless restricted by a psychiatrist or licensed psychologist for clinical reasons. Inmates at the CSU will only be provided basic personal hygiene items when showering. Security staff will carefully monitor all issued items. The inmate will be allowed 15-30 minutes to use these items and then will be required to return them to security staff. Any items posing a potential risk of harm will be used only while under direct observation of staff. On an individualized basis, the QMHP will determine if an item should be added or removed from the list of permitted hygiene items. This information will be documented on the M-120. The medical staff or QMHP will document any item restrictions in the inmate medical records and on SCDC Form 19-29, "Incident Report". The Form 19-29 will be forwarded to the Senior Shift

Officer. The Senior Shift Officer will ensure that this information is noted on the inmate's SCDC Form 19-7, "Cell Check Log", so that officers are aware of such restrictions.

7.6 Custody status of CSU inmates will remain unchanged from the inmate's status at the sending institution. CSU inmates are not treated as RHU inmates unless that was their status at the sending institution.

7.7 All non-RHU CSU inmates, unless clinically contraindicated, shall have access to out-of-cell time for 10 hours of structured and 10 hours of unstructured activity in a seven day period. This includes access to the dayroom and outdoor recreation.

7.8 When an inmate is under constant observation, one observer may be responsible for two inmates when he/she is able to maintain line of sight on both inmates. Video monitors shall never be the sole means of observation for an inmate on close or constant observation.

7.9 Custody and/or health care staff assigned to provide continuous observation during suicide watch shall document observed behaviors every 15 minutes on SCDC Form 19-7.

7.10 Inmates who were on CI/SP or Special Observation status watch in the CSU shall be returned to their sending institution only after the CSU Treatment Team determines the inmate is not at significant risk of suicide. A step-down or transitional placement for additional monitoring and intervention may be considered before return to the sending institution.

8. MONITORING

8.1. **Staff Observers:** The suicide watch may be conducted using staff observers. Staff assigned to a suicide watch must have received the suicide prevention and intervention training.

8.2. **Inmate Observers:** Suicide watch may be conducted using trained Inmate Observers. The Inmate Observers must have successfully completed the Inmate Observer training course and have been granted approval by the CSU Director and Program Coordinator before being utilized as an Inmate Observer.

8.3. **Placement on Crisis Intervention or Suicide Precaution status:** If it is determined that an inmate is a danger to himself and/or others, the inmate will be placed under continuous watch until the inmate can be evaluated by a licensed psychologist, psychiatrist, or psychiatric nurse practitioner to determine the appropriate level of care needed. When an inmate is ordered to Crisis Intervention status without suicidal precautions, observation checks may reduce to every 15-minutes.

8.4 **Continuous Watch:** Any inmate placed on suicide watch will be kept under constant observation. Security will perform checks based on the outcome of the mental health evaluation documented on form M-120. Inmates determined to be suicidal will be kept under continuous in person observation.

8.5 **Cell Check Log:** Security will document observed behaviors at irregular intervals, at least every fifteen minutes/continual. Security will document checks on SCDC Form 19-7, "Cell Check Log."

8.6 **Log Books:** Staff and inmate observers will document on separate cell check logs which will be maintained as secure documents.

8.7. **Observer Location:** The observer and the suicidal inmate will not be in the same room/cell and will have a locked door between them.

8.8. **Summoning Help:** The observer performing the suicide watch must have a means to summon help immediately if the inmate under observation displays any suicidal or unusual behavior. Should security staff note inappropriate or detrimental behavior, a mental health professional (or, if not on duty, medical staff) will be contacted to ensure the safe and secure status of the inmate.

8.9 MONITORING USING THE INMATE OBSERVERS PROGRAM:

8.9.1. **Selection of Inmate Observer Candidates-** Because of the very sensitive nature of such assignments, the selection of inmate observers requires considerable care. To provide round-the-clock observation of potentially suicidal inmates, a sufficient number of observers should be trained, and alternate candidates should be available.

8.9.2. Observers will be selected based upon their ability to perform the specific task but also for their reputation within the institution. In the CSU Director's and Program Coordinator's judgment, they must be mature, reliable individuals who have credibility with both staff and inmates.

8.9.3. Observers must be able, in the CSU Director's and Program Coordinator's judgment, to protect the suicidal inmate's privacy from other inmates, while being accepted in the role by staff.

8.9.4. In the CSU Director's and Program Coordinator's judgment, they must be able to perform their duties with minimal need for direct supervision.

8.9.5. Any inmate who is selected as an Inmate Observer must be without disciplinary violations for the past three years.

8.10 **Inmate Observers Utilization.** Inmate Observers are used to provide constant watch only when SCDC staff are present with line of sight monitoring of the Inmate Observer.

8.11. **Inmate Observer Shifts.** Inmate Observers ordinarily will work a four-hour shift. Except under unusual circumstances, Inmate Observers will not work longer than one five-hour shift in any 24-hour period. Inmate observers will receive performance pay for time on watch.

8.12 **Training of Inmate Observers.** Inmate Observers will receive at least four hours of initial training before being **considered** eligible for suicide watch duty. Additionally, each observer will also receive at least four hours of training semiannually.

8.13. Each training session will review policy requirements and instruct the inmates on their duties and responsibilities during a suicide watch, including:

8.13.1 the location of suicide watch areas;
8.13.2 summoning staff during all shifts;
8.13.3 recognizing behavioral signs of stress or agitation; and
8.13.4 recording observations in the suicide watch log.

8.14. **Meetings with CSU Director and Program Coordinator.** Inmate Observers will meet at least quarterly with the CSU Director, Program Coordinator or designee to review procedures, discuss issues, and supplement training.

8.15. **Removal of Inmate Observer from the Program.** The CSU Director, Program Coordinator or designee may remove any Inmate Observer from the program at his/her discretion. Removal of an Inmate Observer should be documented in the records kept by the Program Coordinator.

8.16. **Records** - The Program Coordinator will maintain a file containing:

8.16.1. An agreement of understanding and expectations signed by each Inmate Observer;

8.16.2. Documentation of attendance and topics discussed at training meetings;

8.16.3. Lists of inmates available to serve as observers, which will be available to Correctional Services personnel during non-regular working hours; and

8.16.4. Verification of pay for those who have performed watches.

8.17. **Mandatory Supervision of Inmate Observer during a Suicide Watch.** Although inmate observers will be selected based on their emotional stability, maturity, and responsibility, they still require security officer supervision while performing a suicide watch.

8.17.1. Inmate Observer supervision will be provided by security officers who are in the immediate area of the suicide watch room or who have continuous video observation of the Inmate Observer.

8.17.2. In all cases, when an Inmate Observer alerts staff to an emergency, staff must immediately respond to the suicide watch room and attend to the emergency.

8.17.3. In no case will an inmate observer be assigned to a watch without adequate provisions for staff supervision or without the ability to obtain immediate staff assistance.

8.17.4. Supervision must consist of at least 60-minute staff checks of the suicidal inmate, conducted in-person. Staff will initial the chronological log upon conducting checks.

9. COMMUNICATION

9.1. Communication is necessary to ensure continuity of care while the inmate is on CI/SP or Special Observation status.

9.2. When an inmate is placed on CI/SP or Special Observation status the documentation is placed on the M-120 form. Copies of the form are then forwarded to Medical, Classification and designated Security.

9.3. The QMHPs of each institution are responsible for forwarding the names of the inmates on CI/SP or Special Observation status to the designated mental health staff member daily.

9.4. If an inmate is transferred to another institution while on Crisis, a CRT message or email is sent to the QMHP at the receiving institution to notify them of the inmate's arrival.

9.4.1. The QMHP (or, if not on duty, medical staff) must ensure that transportation staff and the receiving institution staff, are aware of the suicidal inmate's serious psychological management problems and that continuity of care is fostered.

9.5. Once the inmate is removed from CSU status, the M-120 form will be filed in the mental health portion of the medical record. The M-135 log will be retained by mental health staff and submitted monthly to Division headquarters.

10. NOTIFICATION

10.1. In the event of an attempted suicide, the Division Director will be notified by the Regional/ Program Manager. He/she will then make all other appropriate notifications within the Department of Corrections.

10.2. Institutional Chaplains will notify family members of the medical emergencies of inmates. Procedures state when correctional administrators, outside authorities, and family members are notified of potential, attempted, or completed suicides.

10.3. In the event of a completed suicide the following notification will be made:

10.3.1 Staff discovering the inmate will be responsible for immediately securing the area where the body has been found and informing the security supervisor in charge of that area.

10.4. The Supervisor will be responsible for:

10.4.1. Notifying the Emergency Action Center (EAC) (for more information, *see* SCDC Policy/Procedure OP-22.22, "Emergency Action Center (EAC)");

10.4.2. Notifying Medical or, if during non-duty hours, the medical staff that provides coverage for after hours, weekends, and holidays;

10.4.3. Notifying the Warden or Duty Warden; and

10.4.4. Notifying the Division of Investigations. (If the death is from natural causes, notification can be made on the next working day.)

10.5. The Nurse will be responsible for:

10.5.1. Notifying the institutional physician or, during non-duty hours, the on-call physician;

10.5.2. Notifying the appropriate Health Care Authority (HCA);

10.5.3. Notifying the appropriate county coroner;

10.5.4. Notifying the designated funeral home to transport the body;

10.5.5. Notifying the designated pathologist;

10.5.6. Notifying Health Information Resources at 896-8556 from 8 a.m. - 4 p.m. weekdays. At all other times (e.g., after hours, weekends, and holidays), the nurse will notify Kirkland Infirmary at (803)-896-8567 and send a CRT message to the Director of Health Information Resources or designee. The following information will always be provided:

1. inmate name and SCDC number;

2. assigned institution and place of death;

3. time of death; and

4. circumstances of death.

10.5.7. Notifying the Division Director of Health Services and the Director of Nursing (via CRT message unless there are unusual circumstances); and

10.5.8. Completing DHEC Form #676, "Burial-Removal-Transit Permit," (if death occurred in an institution) and providing a copy of the form to the coroner. (The top white copy of Form #676 remains with the funeral home representative. The pink and yellow copies must be hand carried to HIR immediately so that they can be forwarded to DHEC within 48 hours. (NOTE: In institutions, nursing personnel usually complete this form and provide it to the coroner. At other locations, this permit is often provided and completed by the coroner. The Office of Vital Statistics of the County Health Department controls the forms. Because these forms are numbered, a form completed in error must not be thrown away; rather, it must be returned to the Office of Vital Statistics.)

10.6. The Warden/Duty Warden will be responsible for:

10.6.1. Ensuring that the EAC is notified so that the staff there can contact other appropriate personnel;

10.6.2. Notifying the institutional Chaplain or on-call Chaplain;

10.6.3. Ensuring that a MIN (Management Information Note) is automated as required and disseminated;

10.6.4. Completing SCDC Form 8-2, "Death of Any Inmate in Jail or Prison"; (In accordance with South Carolina statutes, this form must be submitted within 72 hours of the inmate's death to the Division Director of Compliance, Standards and Inspections);

10.6.5. Notifying the Division of Victim Services if there is a registered victim; and,

10.6.6. Securing the inmate's medical record to provide to the investigators.

10.7. The Chaplain will be responsible for notifying the inmate's next of kin as outlined in SCDC Policy/Procedure PS-10.05, "Inmate Religion." Upon notification, the Chaplain will prepare SCDC Form 26-8, "Medical Emergency/Death of an Inmate." The original form will be placed in the inmate's institutional record and a copy will be forwarded to the Inmate Central Records Office. NOTE: The Chaplain will notify the Warden/Duty Warden if the next of kin claims the body and provides the name of the responsible funeral home.

11. REPORTING

11.1. All assessments will be documented in the AMR daily for inmates on CSU status.

11.1.1. Any attempted or completed suicide will be documented on SCDC Form 19-29, "Incident Report" by the all staff reporting to the scene.

11.2. Medical will document in the AMR any treatment resulting from an attempt or completed suicide.

11.3. Any attempted or completed suicide will be reported by on-duty medical personnel to their immediate supervisor who will then notify the Division Director.

12. REVIEW

12.1. The Chief Psychologist who coordinates the suicide prevention program, and the Chief Psychiatrist will coordinate a clinical case review of any suicide resulting in death, and may convene a similar review of any suicide attempts. These reviews will be conducted for the purpose of completing an in depth clinical review and supporting continuous quality improvement.

12.2. The Agency Suicide Prevention Committee will be responsible for conducting an administrative review following a suicide. The Agency Suicide Prevention Committee will be a resource for assisting with evaluating risk management issues, as a mechanism for SCDC General Counsel to obtain information on potential liability issues, to provide legal advice to Agency personnel, and to evaluate overall communication among all Agency disciplines concerning suicide awareness, prevention and intervention.

12.3. The Co-Chairpersons of the Agency Suicide Prevention Committee will schedule a meeting with members of the Agency Suicide Prevention Committee to meet within twenty (20) working days after a suicide occurs, to conduct an administrative review. The administrative period may be extended for additional thirty-day periods at the discretion of the Committee Chairperson. Appropriate SCDC staff may be invited to attend the meeting, at the discretion of the Committee Chairperson.

12.4 Within 24 hours of the inmate suicide, a member of the Local Suicide Prevention Committee shall complete a preliminary suicide report containing the following information(Inmate name, SCDC number, age, date and time of discovery of the death, institution, housing, mental health level of care (if applicable). This report shall be immediately forwarded to the Agency Suicide Prevention Committee, which will then schedule discussion of the report.

12.5 Within 60 days from the date of death, the ASPC shall review the clinical record, complete its review of the preliminary suicide report, review the corrective action plan on the preliminary suicide report, and complete its final report.

12.6 All discussions, notes, materials, reviews, and reports of the MHSR, LSPC, ASPC, and debriefing staff are confidential and treated as attorney/client privileged work product for the purpose of advice of counsel and/or in due in anticipation of litigation resulting from inmate suicide or attempted suicide.

13. DEBRIEFING

13.1. There will be an internal briefing on the divisional level and custody staff will be invited. The debriefing will occur no more than 72 hours after a suicide. Staff will be given an opportunity to express their thoughts and feeling about an incident, develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms. The debriefing will be documented.

13.2. Assigned mental health professionals will also conduct a debriefing with the inmates who have been identified as likely to be affected by the suicide. These debriefings will be documented in inmate's automated medical record.

COLUMBIA-SUICIDE SEVERITY

RATING SCALE

(C-SSRS)

Lifetime Recent - Clinical

Version 1/14/09

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice, *pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

	Most Severe	Most Severe
Lifetime - ***Most Severe Ideation:*** ___ *Type # (1-5)* ___ *Description of Ideation*		
Recent - ***Most Severe Ideation:*** ___ *Type # (1-5)* ___ *Description of Ideation*		
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	___	___
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	___	___
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	___	___
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	___	___
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	___	___

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SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	Lifetime	Past 3 months
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	Yes ☐ No ☐ Total # of Attempts _____	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts _____	Yes ☐ No ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Daily/Shift Screen

Ask questions that are bold and underlined	**Since Last Asked**	
Ask Question 2*	**YES**	**NO**
2) Suicidal Thoughts: ***Since you were last asked, have you actually had thoughts about killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. ***If YES, what did you do?*** _____ _____		

*** Note – for frequent assessment purposes, Question 1 has been omitted**

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF HEALTH SERVICES
_____ CORRECTIONAL INSTITUTION

CRISIS INTERVENTION

SCDC#:	Inmate Name:			Date:
	Last	First	MI	Time:

Name of Staff Placing Inmate on Crisis Intervention: _____

Reason for Placement on Crisis Intervention (Include description of behavior, incident, intervention, etc.)

Treatment Plan (Include instructions for observation, precautions and property allowed):

Name of Mental Health Counselor Consulted: _____

Name of Medical Staff Notified: _____

REMINDERS: Document Medical Record Distribute Form Complete CI Log

Staff Signature/Title/Date:

MENTAL HEALTH SERVICES

Date Removal from CI Status Recommended: _____ Date Physician Approved: _____

Disposition (Circle one and explain):

- Extended on CI
- Return to prior status
- Admit to inpatient care
- Transfer
- Other

Mental Health Professional/Title/Date:

White: Medical Record
Canary: Mental Health Supervisor

Distributions: Shift Captains Major Operations

SCDC M-120 (Revised September, 2007)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

INCIDENT REPORT

Page of

Institution/Center:	Date of Report:
Reporting Official (Full Name):	Time of Report:
Employee ID #:	Date of Incident:
Location of Incident:	Time of Incident:
Inmate(s)/Resident: SCDC # Age: Sex: Race:	Employee(s)/Witnesses Involved:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

On the above date and approximate time:

Signature: Title:

Evidence:

Disposition of Evidence:

Supervisor's Comments:

Printed Name:

Signature: Title: Date/Time:

Major/Responsible Authority:

Printed Name:

Signature: Title: Date/Time:

STG Related - Refer to STG Committee

☐ Yes ☐ No ☐ Unknown

This incident is DRUG related

☐ Yes ☐ No ☐ Unknown

Responsible Authority

Action Taken

☐ Informal Resolution

☐ Administrative Resolution

☐ Refer to Disciplinary Hearing

SCDC Form 19-29A (Rev. January 2005)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

Cell Check Log

INSTITUTION: ______________________

Inmate Name SCDC # Cell # Week Of:

MON. / /			*TUE. / /*			*WED. / /*			*THU. / /*			*FRI. / /*			*SAT. / /*			*SUN. / /*		
C	Init.	Time	C	Init.	Time	C	Init.	Time	C	Init.	Time	C	Init.	Time	C	Init.	Time	C	Init.	Time

ACTIVITY CODE: *1. Lying Down 2. Sitting 3. Standing 4. Out of Cell 5. Eating*

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF HEALTH SERVICES
MENTAL HEALTH SERVICES

CRISIS INTERVENTION LOG

Inmate Name and Number	Nature of Crisis	Date and Time Treatment Plan Completed	Date Removed from CI Status	*Disposition of Inmate

Disposition: * Admitted – Inpatient Status * Return to General Population * Other (Specify)

SCDC M-135 (Revised September, 2007)

NAME:	SCDC#	DATE:

In this program, we help people with all of their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you deal with any emotional problems you may have, but we can do this only if we are aware of the problem. Any information you provide to use on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note each item refers to your entire life history, not just your current situation. This is why each question begins, "Have you ever..."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	Yes	No
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help?	Yes	No
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	Yes	No
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	Yes	No
5. Have you ever heard voices no one else could hear or seen objects which others could not see?	Yes	No
6a. Have you ever been depressed for weeks at a time, lost interest in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	Yes	No
6b. Did you ever attempt to kill yourself?	Yes	No
7. Have you ever had nightmares or flashbacks as a result of being involved in a traumatic/terrible event?	Yes	No
8. Have you ever experienced any strong fears? For example, heights, insects, animals, dirt, attending social events, etc?	Yes	No
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property	Yes	No
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors?	Yes	No
11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	Yes	No
12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating?	Yes	No
13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	Yes	No
14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly,	Yes	No
15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations?	Yes	No

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?	Yes	No
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?	Yes	No

THIS SECTION FOR SCDC USE ONLY	
Inmate Name:	Date:
Clinical Correctional Counselor Administering Screen:	
Counselor Comments:	
Total Score	_____(each yes = 1pt.) x

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

Medical Emergency or Death of an Inmate

I. Inmate Information

, Date Occurred: / / Time Occurred: Institution:

INMATE'S NAME:	SCDC#:
Medical Emergency Information:	
Information Regarding Death:	

II. Family Information.

Date Family Was Notified: / /	Time: ☐ ☐
Name of Person Notified:	
Address:	
Relationship to Inmate:	Phone #- ( )

Family Members

NAME	RELATIONSHIP	ADDRESS	PHONE #
			( )
			( )
			( )
			( )

III. Burial Information
(Check the Appropriate Box Below)

☐

☐

☐ Family not located. SCDC provides burial.

SCDC 26.8 (May 1°2)

III.Burial Information
(Continued from front)

Funeral Home:		
Address:		Phone #- ( )
Day of Funeral:	Date: / /	Time: AM ☐ ☐
Funeral Location:		
Burial Location:		

IV. Inmate's Possessions

Relationship To Inmate:	Phone #- ( )

V. Report Information

Medical Emergency or Death Reported By:

/ /

Report Completed By:

/ /

VI. Comments

Page 2

SCDC 2&S (March, 1°2)

Mental Health Training

The South Carolina Department of Corrections and the Division of Behavioral/Mental Health & Substance Abuse Services are committed to the enhancement of the skills of our employees in working with special populations, which include those inmates living with mental illness within the Department. Different training levels are required based on the employment position.

I. Required Mental Health Training - Uniformed and Non-Uniformed Staff:

The Department requires employees to attend both a New Employee Orientation Training and a Correctional Officer Certification Training (BASIC). During these required trainings, Mental Health training is provided as follows:

A. New Employee Orientation Training consists of an introduction to mental health services. Objectives of the training are to increase staff knowledge about the mentally ill in our prisons, to review staff characteristics needed for working with the mentally ill, to review Behavioral/Mental Health & Substance Abuse services and programs, and to review crisis intervention procedures.

B. Correctional Officer Certification Training (BASIC) consists of mental health-recognition and reporting, pre-crisis communication skills, and suicide intervention/prevention. The training objectives are to familiarize employees with the content and scope of Mental Health Services provided to inmates by SCDC and to give a basic understanding of skills needed to handle and de-escalate potential crises in the prison system.

C. Initial mental health training will consist of agency orientation as well as BASIC training which consist of at a minimum eight hours.

D. Re-occurring training will consist of an annual suicide prevention/intervention course **of a minimum of four hours**, First Aid (year one) and CPR (year two). The initial CPR and First Aid is received during employee's BASIC training. Crisis Intervention Team (CIT) Training: - (Voluntary, Specialized training).

E. All Officers assigned to specialized mental health programs (GPH, SIB, ICS, and Intensive Outpatient Mental Health), will receive an additional **ten** hours of documented training addressing specific issues and trends relevant to those programs.

II. The Department, in conjunction with the National Institute of Corrections (NIC) has developed a CIT program for the purpose of increasing facility safety and reducing use of force incidents involving offenders in crisis. CIT is based on a partnership between corrections, mental health providers, and mental health advocates, both during and after the 40 hour training. This partnership creates a foundation for addressing underlying issues and practices that lead to deeper criminal justice involvement, including high rates of segregation and release violations, for people who live with mental illness. (See CIT policy OP-22.37 for further details.)

III. Required Mental Health Training- Qualified Mental Health Professionals:

A. Education and Training

1. Mandated, comprehensive, ongoing mental health training is provided both on-site and off-site for a positive, proactive and preventative approach to ensuring legal and ethical compliance based on state, federal and licensing mandates.

2. Written agency, institutional and divisional compliance standards are provided for all employees governing compliance related activities. Compliance training, based on the Mental Health Training Checklist, is provided at the start of service, annually and as needed to all employees.

3. Orientation to Mental Health Services and on-the-job training is provided to each new mental health clinician, and will be completed within 90 calendar days of start date **for a minimum of 40 hours.**

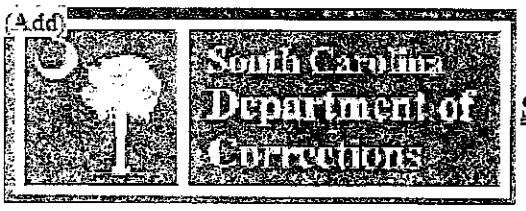
The purpose of the Mental Health Services Policy Training is to ensure the following:

a. The clinician is familiar with Mental Health Services policies, particularly those relating to provision of services and treatment to inmates.
b. The clinician is able to identify proper forms relating to each type of service.
c. The clinician is able to document contacts and services provided to inmates in accordance with agency, institution and divisional policies and procedures.
d. The clinician understands the Mental Health Services chain of command and how to report any concerns.
e. The clinician understands the SCDC Code of Ethics.
f. The clinician understands how to report non-spurious allegations of abuse conveyed by offenders.
g. Training is also provided as needed to:
    1. Correct identified erroneous practices and operations.
    2. Respond to training requests from staff or management.
    3. Comply with new mandated training requirements.
    4. Instruct on critical changes including divisional and institutional modifications; new or revised policies and procedures; and regulatory changes.

Core Competencies for Mental Health/Training Checklist- New QMHP's are trained by their perspective Regional Managers/Clinical Supervisors using the Training Checklist. The training consists of all Mental Health procedures including Suicide Prevention/Crisis Intervention, Confidentiality of Medical Information & Patient Safety, Identification of Suspected Abuse, Medication Monitoring, Clinical Documentation, Request to Staff, Treatment Plans, etc. (See checklist for specific core competencies.)

QMHP's will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure every two years.

In an effort to support the agency's licensed staff, the Division will offer ongoing opportunities to obtain further training in the areas of core competencies, such as suicide prevention, clinical documentation, treatment planning, etc. In addition, the Division will offer a yearly Behavioral Health Professional Conference for staff to obtain Continuing Education hours.



SCDC POLICY

NUMBER: HS-19.05

TITLE: MENTAL HEALTH SERVICES - TREATMENT PLANS AND TREATMENT TEAM MEETINGS

ISSUE DATE: ***DRAFT***

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

OPERATIONS MANUAL: HEALTH SERVICES

SUPERSEDES: SCDC POLICY: HS-19.02 (dated July 1, 2008) - NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES: 4-7, 19-11, 19-29, 19-45, 21-6, M-53, M-122, M-123, M-131, M-132, M-140 Attachments A, B, and C

ACA/CAC STANDARDS: 4-ACRS-5A-08, 4-ACRS-6A-11, 4-ACRS-7D-07, 4-4095, 4-4098, 4-4099, 4-4256, 4-4277, 4-4285, 4-4286, 4-4305, 3-4330, 334336, 3-4344, 3-4350, 3-4355, 3-4367, 3-4369, 3-4377, 4-4428, 4-4429, 4-4430, 4-4431, 4-4433, 4-4434, 4-4435, 4-4436, 4-4438, 4-4439, 4-4440, 4-4441, 4-4442, 4-4446

STATE/FEDERAL STATUTES: None

PURPOSE: To ensure procedures are in compliance with policy as it relates to Treatment Plans, Treatment Team meetings, and the Treatment Team Log. Additionally, the procedure will promote consistency and accuracy of clinical documentation in the Automated Medical Record (AMR) throughout the Division.

POLICY STATEMENT: The development of Treatment Plans and Treatment Team meetings will be used to help ensure consistency in the continuous therapeutic care and treatment of all inmates who are classified as mentally ill. Additionally, the process and documentation will be used to assist inmates in their recovery and provide ongoing continuity of care while ensuring inmates' mental health needs are

met. ***Unless otherwise noted, policy information is applicable to both male and female inmates.***

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SPECIFIC PROCEDURES:

1. FUNDAMENTALS OF TREATMENT PLANNING:

1.1 Mental health services are provided according to treatment plans that:

- are based on an inmate's mental health assessment and tailored to address the inmate's individual needs;
- identify mental health services recommended for patient/inmate participation; for example, counseling, individual/group therapy, substance abuse treatment or other services;
- contain statements of short and long term goals;
- outline methods by which goals are pursued and accomplished; and
- document a process that is reviewed and updated as necessary, based upon the inmate's progress, changes in circumstances, the effectiveness of services, or other appropriate considerations.

1.2 Mental health treatment plans are individualized, multidisciplinary, and include, at a minimum:

- problems identified;
- frequency of follow-up for evaluation and adjustment of treatment modalities;
- adjustment of psychotropic medications, if indicated;
- referrals for psychological testing, and/or medical testing/evaluation, including blood levels for medication monitoring as required.;
- when appropriate, instructions about diet, exercise, personal hygiene issues, and adaptation to the correctional environment,; and

- documentation of identified problems, treatment goals, and notation of clinical status progress.

1.3 Treatment Teams help to formulate treatment plans and provide clinical support by (1) allowing clinicians to gather and discuss relevant information with professionals also providing mental health care,; (2) helping the inmate and clinician identify problems and agree to goals, objectives, and interventions; and (3) providing information used in documenting the need for continued services.

GUIDELINES:

2. INDIVIDUAL TREATMENT PLANS:

2.1 SCDC Form 4-7, "Individualized Treatment Plan (ITP)" is used to create the Initial Treatment Plan (ITP), document treatment plan reviews/updates, and monitor continuous treatment services relating to presenting mental health problems, treatment goals and objectives, for all inmates classified as L2, L3, L4, and L5. Gilliam Psychiatric Center will use the "Gilliam Psychiatric Center Treatment Plan" form for all inmates classified as L1.

2.2 ITPs are reviewed/updated to address treatment goals and objectives outlined by the Treatment Team and the inmate.

2.3 The ITP is generated in accordance with clinical standards using the S.M.A.R.T. model. S.M.A.R.T. is an acronym for "Specific, Measureable, Attainable, Result Oriented, Timely." This serves to guide the development of the ITP as follows:

- **Specific** - Target a specific area for improvement. Be concrete. Use action verbs;
- **Measurable** - Quantify or at least suggest an indicator of progress - may be numeric, or descriptive, a quantity, or a quality;
- **Attainable/Achievable** - Capable of being done; feasible;
- **Results-Oriented** - Measures outputs or results; includes accomplishments; and
- **Timely** - Identifies target dates for achievement; includes interim steps to monitor progress.

2.4 The ITP is a running document reviewed as new information is obtained. Reviews include observing changes in the presenting problem, a change in frequency/type of service and/or when new goals and objectives are needed as treatment warrants.

2.5 A new ITP is initiated at each change in level of care, based on the inmate's needs at that level of care, including when a client is readmitted to a service.

2.6 An ITP, based on the mental health needs of the inmate, is developed by the treatment team in conjunction with the inmate, then signed and dated by the Treatment Team members and the inmate. The ITP is initiated following the initial clinical assessment, and a comprehensive treatment plan is completed and/or updated as follows:

2.6.1 Comprehensive Treatment Plan: Completed within ten (10) working days after the initial assessment and psychological evaluation. It is applicable to all new referrals and re-admits.

2.6.2 Treatment Plan Updates/Reviews:

- Treatment Plans for inmates admitted to Gilliam Psychiatric Hospital (GPH) are reviewed and/or updated weekly for the first month of admission, then monthly or more often if clinically indicated.;

- Treatment Plans for inmates in the Intermediate Care Services (ICS) program and the Habilitation program (Hab.) are reviewed and updated every **three (3) months** or more often if clinically indicated;

- Treatment Plans for inmates in the Self Injurious Behavior (SIB) program are reviewed and updated monthly or more often if clinically indicated;

- Treatment Plans for inmates classified as Intensive Outpatient Mental Health inmates are reviewed and updated every **three (3) months** or more often if clinically indicated; and

- Treatment Plans for inmates classified as Mid/Moderate Out-patient Mental Health, are reviewed and updated every **six (6) months** or more often if clinically indicated.

- Treatment Plan for inmates placed in the Crisis Stabilization Unit ("CSU") should be updated, or developed if one does not exist, within 72 hours of placement in CSU and reviewed weekly until the inmate is released from CSU

2.6.3 ITP reviews and updates will include, but are not limited to, the status of the problem(s) and whether the problem(s) ongoing, no improvement, improved or resolved.

2.6.4 Each type of mental illness or symptom presentation may dictate consideration of unique services to address their specific need. The Division of Behavioral/Mental Health and Substance Abuse Services strives to provide a wide variety of services at all levels for SCDC inmates.

2.6.5 Treatment plans are reviewed for the purpose of updating and monitoring progress and identifying new goals and objectives for the inmate.

2.6.6 ITP reviews and updates includes, but are not limited to, identifying the status of problem(s). This is addressed by indicating if the issue is ongoing, has shown no improvement, has improved or is resolved.

2.6.7 Treatment plans are filed in the "Mental Health" section of the medical record, and an Incidental/Non-Contact Note is entered in the AMR documenting the treatment plan has been reviewed/completed.

2.6.8 The diagnoses noted on the Treatment Plan must be consistent with the diagnoses given by the Psychiatrist in the AMR. Should the Psychiatrist change the diagnoses, the existing Treatment Plan must be revised to be consistent with the diagnoses.

3. TREATMENT TEAM:

3.1 Mental health multidisciplinary treatment teams provide integrated treatment in which team members work collaboratively, sharing responsibility for the individuals served. Treatment Plans result from a collaborative effort between team members and the inmate.

3.2 Treatment Team meetings will be scheduled by the assigned QMHP on a frequency based on the level of care being provided or more often as clinically indicated. Inmates will be asked to attend the initial ITP Treatment Team staffing and each ITP Treatment Team staffing review. They will be asked to document their involvement where appropriate by signing their name. Refusals to attend a meeting or

to sign a plan will be documented in the inmate's AMR and on the Treatment Plan form.

3.3 Treatment Team notes and/or documentation include, at a minimum the following:

- inmate's name;
- inmate's SCDC #;
- mental health classification;
- reason for staffing;
- diagnoses;
- current medications;
- progress of treatment;
- recommendations;
- Treatment Team decisions.

3.4 In the event medical staff, uniform staff, Psychiatrist or Psychologist, or other team member cannot attend the scheduled Treatment Team meeting, the presenting clinical staff member will attempt to gather relevant inmate information from the absent team member(s) prior to the Treatment Team meeting.

3.5 If a Treatment Team meeting needs to be changed, all team members and the inmate(s) on the docket are notified, and the meeting will be rescheduled.

4. TREATMENT TEAM LOG:

4.1 The Treatment Team Log minutes will be maintained by the Inmate's assigned QMHP or designee indicating the following:

- the date of the meetings;
- the inmates' name(s) and SCDC number(s); and
- a signature of all staff members present for the staffing.

4.2 A brief summary will be documented on the treatment team log and in the AMR and will includes the following information:

- current medication(s);
- level of care and level of care changes (if clinically indicated);
- current diagnosis
- recommendations and Treatment Team decision(s).
- next review date

4.3 A Treatment Team Log entry is completed for each Inmate.

5. TREATMENT TEAM MEETINGS:

5.1 Treatment Team Meetings have two (2) primary purposes: (1) the first purpose is the gathering of clinical and custody staff for the discussion of pertinent information that may be relevant to mental health programming. Staff may choose this platform to conduct in-services or discuss general program issues; and (2) The second function of Treatment Team Meetings is the staffing of individual treatment cases discussing clinical needs of inmates. Cases will be presented at Treatment Team Meetings to address the following:

- new assessment/intake (within fourteen [14] days of arriving at institution);
- admission to caseload (recommended or transferred MI/MR - within fourteen [14] days);
- recommendation to discharge from MI status;
- development of discharge plans;
- recommendations for changes in treatment plans;
- recommendations for referrals (psychiatry, ICS, Outpatient Mental Health centers);
- initial treatment/service plan;
- discussion/reviews;
- reviews on treatment/service plans;
- refusal of services; and
- placement on Crisis Intervention Status, Suicide Precaution Status or any significant change in diagnosis, treatment/service plan, and behavior management plans. (**NOTE**: At the Treatment Team's request, an inmate may be invited to any Treatment Team Meeting).

6. DEFINITION(S):

Action Step/Activity refers to what is going to be done and how it is going to be done in order to accomplish the objective. Are the actions steps presented sufficient to accomplish the objective(s)?

Date Service Ordered refers to the date initial treatment began; when the action step is to start/initiated.

Date Service Completed refers to the date treatment will end; when the action step is to be completed/terminated.

Diagnosis refers to the identification of a mental illness as defined by the latest edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders.

Expected Date of Achievement refers to the anticipated date the goal, objective, and/or activity will be achieved.

Goal refers to a broad statement of intent which addresses the clinical success factor and closes the gap between how things are today and how you want them in the future..

Individual Treatment Plan (ITP) refers to a document that details a client's current mental health problems and outlines the goals and strategies that will assist the client in overcoming his or her mental health issues.

Intervention refers to an action and/or influence that is utilized to affect the actions of an inmate, with regard to their mental health, in order to modify a behavior.

Justification for Treatment refers to the reason, fact, circumstance, or explanation that supports or defends the inmate's need for mental health treatment.

Lead/Responsible Person refers to who will accomplish the action step or coordinate others to accomplish the action step. This person will be responsible for reporting on achievements or progress regarding the action step.

Mental Health Treatment Team refers to a multidisciplinary group including, but not limited to, mental health staff (Psychiatry, Psychology, or other licensed QMHP medical personnel (including nursing), and uniform staff, who discuss integrated therapeutic services, collaborate and share appropriate information on a regular basis, and as clinically indicated in any inmate's case, for the purpose of treatment of mentally ill inmates and continuity of care. The composition of the team may vary in different settings and at different levels of care, and will be identified on the treatment plan form; but all disciplines remain available for consultation as clinically indicated. The prescribing clinician will be a part of the treatment team for any inmate who is prescribed psychotropic medications.

Objective refers to specific measurable statement of what should be accomplished. This is a subset of a goal, and all the stated objectives should promote achievement of the goal.

Outcome refers to the measure of success over the action-planning period (to include the month and year, as well as intervals for progress).

Problem refers to an identified issue that warrants mental health treatment or attention.

Qualified Healthcare Practitioner (QHP) refers to a Physician, Physician's Assistant, or Nurse Practitioner.

Qualified Mental Health Professional (QMHP) refers to a licensed Psychologist, licensed Professional Counselor, licensed Professional Counselor-Supervisor, licensed Independent Social Worker, and Psychiatric Nurse Practitioner. It also includes a licensed Master Social Worker and licensed Professional Counselor-Intern with appropriate supervision.

Regional Clinical Supervisors refers to a licensed mental professional (LPC, LPCS, Ph.D., LISW) with a minimum of five (5) years clinical experience.

Resources refers to what is needed to accomplish and objective.

Target refers to what will be achieved or expected to happen once a step is completed.

Treatment Team Meeting refers to members of the Mental Health Treatment Team who come together to discuss information about the inmate in an effort to identify issues, suggest problem resolution strategies, and recommend mental health care services options. Inmates are encouraged to attend Treatment Team Meetings that focus on their individual treatment plan, and are encouraged to provide input into the planning process.

SIGNATURE ON FILE

s/Bryan P. Stirling, Director

Date of Signature

ORIGINAL SIGNED COPY MAINTAINED IN THE OFFICE OF POLICY DEVELOPMENT.

Exhibit H
Release

FOR AND IN CONSIDERATION of the execution of the Settlement Agreement, the sufficiency and receipt of which is hereby acknowledged, T.R. on behalf of himself and others similarly situated and Protection and Advocacy for People with Disabilities, Inc., together with each of their respective heirs, devisees, executors, personal representatives, successors and assigns (collectively the "Plaintiffs") do hereby fully release and forever discharge the State of South Carolina, the Governor of South Carolina, the South Carolina Department of Corrections; William R. Byars, Jr., and Bryan Stirling and their past, present and future officers, directors, attorneys, agents, servants, contractors, representatives, heirs, devisees, executors, personal representatives, successors, assigns and insurers and all other persons, firms, corporations, state entities and political subdivisions (the "Released Parties"), from any and all past, present and future actions, suits, claims or demands for equitable or injunctive relief, together with all expenses, costs, attorneys' fees now existing or which may hereafter arise in any way related to any act or omission related to any care and/or treatment for any mental health disease, condition or disorder in violation of the South Carolina Constitution, any matter addressed in the Orders of the Honorable J. Michael Baxley, dated October 6, 2010 and January 8, 2014, or for any claim, cause of action, factual allegation or matter which was or could have been alleged in the case captioned T.R. on behalf of himself and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc. v. South Carolina Department of Corrections; and William R. Byars, Jr., as Agency Director of the South Carolina Department of Corrections (the "Released Claims").

The Plaintiffs further agree:

1. That this settlement is the compromise of a disputed claim and is not to be construed as an admission of liability on the part of any of the Released Parties, by whom liability is expressly denied. Nothing in this Release or the Settlement Agreement (to include all Policies or any other aspect of the Implementation Plan, each as defined in the Settlement Agreement) shall be used as evidence in any suit or otherwise in any deposition or other proceeding, including, but not limited to, establishing any standard of care or constitutional standard;

2. No other person or entity has, or had, any interest in the Released Claims, demands, obligations, or causes of action referred to in this Release, that Plaintiffs have the sole right and exclusive authority to execute this Release; and that the Plaintiffs have not sold, assigned, transferred, conveyed or otherwise disposed of any of the Released Claims.

IN WITNESS WHEREOF, the undersigned has hereunto executed this Release as of this the 31st day of May, 2016.

T.R. on behalf of himself and others similarly situated

By: Joy C Jay

Name: Joy C Jay

Title: Guardian Ad Litem

Protection and Advocacy for People with Disabilities, Inc.

By: Gloria M Prevost

Name: Gloria M Prevost

Title: Executive Director

Nelson Mullins Riley& Scarborough LLP
Attorneys for the Plaintiffs

By:

Name: Jan Westbrook