October 15, 2008

Nelson Mullins Riley & Scarborough, LLP
Attn: Daniel Westbrook
Keenan Building, Third Floor
1330 Lady Street
Post Office Box 11070(29211)
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Re: South Carolina Department of Corrections
Lee Correctional Institution

Dear Mr. Westbrook

During September 15, 16, 2008 we site visited the Lee Correctional Institution (Lee CI) along with Steve Martin, Esq. We received a tour of general population housing units, programming areas (e.g. educational building, gym, dining area etc.), health services unit and the special management unit (which included a "supermax" section consisting of two wings (four cells per wing). We also had the opportunity to interview M.D.

During this site visit Jeffrey L. Metzner M.D. interviewed 12 inmates within the special management unit (SMU) as well as reviewing their mental health records contained in the automated medical records (also known as the CRT). Dr. Metzner also reviewed selected paper records of these inmates. Appendix I provides a summary of these inmate interviews and data that provided the basis for various findings summarized later in this report.

In addition, during this site visit, Raymond F. Patterson, M.D., interviewed and/or reviewed the records on an additional 25 inmates housed in general population or crisis cells. Appendix II provides a summary of Dr. Patterson's inmate interviews and record reviews.

Prior to this site visit we had the opportunity to review the deposition transcripts of the following persons:

1. (director of mental health services, SCDC),
2. (program manager for outpatient mental health services),
3. (clinical health director for the division of health services),
4. (healthcare authority),
5. (SMU administrator at Lee CI),
6. (clinical correctional counselor III),
7. (clinical correctional counselor III), and
8. (lead clinical correctional counselor III).

We also reviewed videotapes relevant to the use of force within the SMU.

Other documents reviewed included the following:

1. SCDC mental health services policy,
2. SCDC suicide policy,
3. SCDC crisis intervention policy,
4. SCDC use of force policy,
5. SCDC inmate classification policy,
6. SCDC disciplinary policy,
7. SCDC SMU policy,
8. organizational chart for Lee CI,
9. internal audits,
10. job description of Human Services Coordinator I,
11. a document listing the length of stays in the SMU for inmates at Lee CI and Leiber CI,
12. a January 31, 2007 report entitled " Mission Critical Funding Needs" from the Director of SCDC.
13. the 2006-2007 Agency Accountability Report (September 14, 2007).

Overview

Lee Correctional Institution, which is a level III prison, was opened during 1993. The total inmate count during our site visit was approximately 1740 inmates with 226 inmates receiving mental health services, which represented 13% of the total inmate population. Each of the general population housing units had a capacity of about 256 inmates. The Kershaw housing unit housed 35% of all mental health caseload inmates. The next largest concentration of caseload inmates was in the special management unit where 52 of the 248 inmates were on the mental health caseload. These 52 SMU inmates represented 23% of all caseload inmates and 21% of all SMU inmates.

During the morning of September 15, 2008, we received a brief tour of Lee CI. Accompanying us were mental health counselor Associate Warden Lt. and Captain

Special Management Unit

The count in the SMU was 248, which equaled its capacity. A variety of different inmate classifications was housed in the SMU which included protective custody, young offenders, prehearing detention, security detention, safe keepers and crisis intervention status inmates. There were four crisis intervention cells within the housing unit that were adjacent to other SMU cells. There were also eight supermax cells. These latter cells were filthy and inmates in these cells had severe privilege restrictions. Reference should be made to the report by Steve Martin, Esq. for a more detailed description.

We also observed the restraint chair that was located in a room near the correctional officer's office in the "rotunda." The correctional officer did not have an unobstructed view of persons restrained in the restraint chair.

Within the SMU were various office settings that could be used for meeting with caseload inmates.

During our exit from the SMU, we briefly talked with two nursing staff entering the SMU for the morning pill pass. They indicated that the morning pill pass usually occurs between 8:30 a.m.-10 a.m., the next pill pass between 2-3 p.m. and the last pill pass after 7:30 p.m.

Other Areas

We toured the health services unit which does house medically ill inmates on a 24-hour basis, but did not house inmates whose primary problems were mental health related. The health services building also contained offices for the mental health clinicians, which were used for meeting with caseload inmates.

We also toured the educational building, recreational building and the Kershaw housing unit. The Kershaw housing unit had a capacity of 256 inmates. Each side of this housing unit had 64 cells.

Kershaw Housing Unit

The Kershaw Housing Unit is called a "dormitory" as are the other housing units at Lee Correctional Institution but is comprised of two sides designated the North and South side with 64 cells on each side comprised of 32 cells on the lower tier and 32 cells on the upper tier. The majority of these cells housed two inmates; however, some of these cells housed only one inmate because of medical disabilities. Although it was reported there is no dormitory for mentally ill inmates, this dormitory has a higher number than any other that are on the mental health caseload. There are two dayrooms on each side, one on each tier, which contain a microwave and several tables and benches in which inmates may sit in small groups in addition to a large open area where inmates may watch four televisions that are tuned to radio stations that will permit the inmates to wear headphones and listen to particular programs. There were 69 mentally ill inmates housed in the Kershaw dormitory at the time of the site visit. Between the two units there is a lieutenant's office and a sergeant's office and Dr. Patterson was allowed to use the sergeant's office to conduct interviews of individual inmates in a confidential setting. In addition, Dr. Patterson selected a group of inmates from Kershaw to be interviewed and interviewed them in a larger room that had a conference table and chairs that appeared to be utilized more for storage than for any ongoing activities.

Chesterfield Housing Unit

The Chesterfield Housing Unit is on the East side of the campus and was toured as one of the housing units. This dormitory was also described as having two sides with 64 cells on each side with 32 on the upper tier and 32 on the lower tier. This dorm was doubled celled but had the designation of housing inmates who had been charged with sexual misconduct and found guilty of those offenses and required to wear pink/red jumpsuits. There were approximately 25 inmates housed in this dormitory who were of that designation and several were interviewed during the course of the site visit. Inmates in this dormitory also reported that the East side of the campus was a more chaotic environment in which they had to be very careful because there had been inmate on inmate and inmate on staff violence as well as thefts of property.

Interview with Janet Woolery, M.D.

During the morning of September 15, 2008 we interviewed Dr. has been working at Lee Correctional Institution since January 2008. She works eight hours on Mondays and four hours on Wednesdays. She reported that Dr. provides mental health services as needed, which apparently involved monthly visits to Lee CI. Dr. estimated that she sees 15-17 inmates during Mondays and 8-9 inmates during Wednesdays. Initial sessions generally require about 30 minutes. Follow-up sessions range from 15-30 minutes. She reported that frequency of her visits was as clinically indicated, although all visits were at least once every 90 days. Dr. thought that most visits were once every 90 days.

Dr. reported access to the automated medical records during her sessions with inmates. She did not access the paper medical records, which is the only source of the treatment team developed treatment plan, records from Gilliam Psychiatric Hospital and mental health providers in the community.

There were 4.0 FTE mental health counselors, one of whom was licensed according to Dr. . Bates 6875-D-0001 of the deposition exhibits summarizes the educational background of the mental health counselors.

Formulary medications do not include Zyprexa, or Abilify. SSRIs on the formulary include Prozac, Paxil, Celexa and Zoloft. Depakote and Celexa are also on the formulary. Benadryl has recently been taken off the formulary due to abuse.

Emergency involuntary medications were occasionally used. Non-emergency involuntary medications were not used.

Dr. reported that she does receive referrals relevant to medication noncompliance although she was not aware of the definition used for noncompliance. She indicated that medications at Lee CI periodically run out of stock.

In the SMU, Dr. sees inmates in an office with a door open with a correctional officer nearby, which does not provide for sound privacy. Although she thought this would have an impact on her interactions with the inmates, she has not discussed such an impact with them. Dr. has not been in the SMU housing units. She also had minimal involvement with the inmates in the crisis intervention cells within the SMU.

Informed consent forms are not used by Dr. She indicated that she does obtain verbal informed consent. She was not aware of any heat plan in place. In fact, Dr. was not familiar with any mental health policies and procedures at Lee CI.

It was estimated by Dr. that 80-90% of her caseload inmates meet criteria for a serious mental illness (SMI). She thought that 50-60% of these inmates were receiving antipsychotic medications and another 70-80% receiving mood stabilizing medications. Approximately 60% of these inmates have a coexisting intermittent explosive disorder. ADHD is generally treated with Wellbutrin and Strattera. Dr. estimated that 40 to 50% of the caseload inmates in the SMU were exhibiting psychotic symptoms.

Dr. indicated that the MARs are available when she assesses inmates. She was not familiar with any quality improvement process. Dr. was not involved with any management or policy making roles within the mental health system at Lee CI. She was not involved with either training of correctional officers or supervision of mental health counselors.

Dr. reported that she refers 0 to 1 inmate per month to the Gilliam Psychiatric Hospital. She generally does not make referrals to the intermediate care unit. She has visited GPH but not the ICS. She, at times, will make a referral to the cutters unit.

In general, Dr. indicated that her diagnoses correlated well with the diagnoses made by the various mental health counselors. Malingering was considered but was described as not a common diagnosis.

Dr. uses the SOAP documentation process in the CRT. She was not familiar with the use of any standardized mental health forms within the SCDC (including the treatment plan form) except for a suicide watch form that she co-signs, although she was not familiar with the purpose of this form. Dr. is not required to and does not see the inmates for which this form is used.

Dr. was not familiar with the process that newly arriving inmates to Lee CI, who are on the mental health caseload, are identified by the staff.

Dr. reported that the medication passes in the SMU occurred at 4 a.m., shortly after noon and from 5 pm to 6 pm.

Findings

Significant problems in the mental health system at Lee CI were apparent based on our site visit and review of relevant discovery documents. This report will provide a summary of these problems.

The psychiatrist staffing allocation is inadequate. Dr. provided 12 hours per week of psychiatrists' time which translates into a .3 FTE position. It was unclear how much time is provided by Dr. based on information received from Dr. . Assuming that Dr. provides eight hours of psychiatric services per month, the total FTE psychiatrist time would be increased by only 0.05 FTE to .35 FTE. A task force report by the American Psychiatric Association (American Psychiatric Association. Psychiatric Services in Jails and Prisons. 2nd edition. Washington, D.C.: American Psychiatric Association, 2000) recommends 1.0 FTE psychiatrist for every 150 inmates prescribed psychotropic medications. It is likely that at least 180 inmates at Lee CI were prescribed psychotropic medications. Unfortunately the exact number was not obtainable during our site visit related to the lack of an adequate management information system at Lee CI.

In addition, there are problems associated with the use of the psychiatrist, which may be related to the staffing allocation issue. These problems include the psychiatrist's lack of familiarity with relevant policies and procedures, lack of input into pertinent policy decisions, minimal involvement with the treatment planning process, lack of significant involvement with inmates on crisis intervention status and use of the automated medical records exclusively in contrast to supplementing its use with the paper medical record that includes relevant information from past providers including the Gilliam Psychiatric Hospital and various community mental health providers.

Special Management Unit

The psychiatrist's lack of presence in the housing units within the SMU, especially the supermax section, is very concerning from a clinical perspective. The supermax section of the SMU is not an appropriate housing unit for any inmate and is highly likely to exacerbate symptoms of mental illness in an inmate who has such an illness. This was confirmed by interview of inmates with mental illness who were housed in this section (refer to Appendix I). Conditions of confinement within the supermax section included lack of access to the recreational cages, limited access to shower (related, in part, to malfunctioning showers within the cells), very poor hygienic conditions within the cells (i.e., they were filthy and smelled badly) and significant social isolation related to the nature of the physical plant. Many of these cells had what had been known during the 1970s as "dog runs" that were both dehumanizing and resulted in increased isolation.

Mental health services provided by the counselors in the SMU were uniformly described by inmates as almost always being at the cellfront, short in duration (several minutes to 15 minutes), generally infrequent (i.e., ~1 contact/month), usually "welfare" checks and rarely including meaningful therapeutic counseling. The lack of sound privacy was a very limiting factor in such contacts being therapeutic.

Even when the office in the SMU was used for clinical contacts, as was almost always the case with Dr. , adequate sound privacy was absent due to the close proximity of the correctional officers with the door open, which clearly had a negative effect from the perspective of inmates being willing to discuss sensitive and/or confidential information with the psychiatrist. Such a concern was uniformly expressed by the inmates interviewed in the SMU.

There was an excessive use of force (e.g., pepper spray and the restraint chair) on inmates with mental illness in the SMU, which is summarized in the report by Steve Martin, Esq. The lack of a mental health policy and procedure relevant to the use of restraints for inmates with mental illness as well as the lack of interventions as clinically appropriate is below the standard of care for a correctional mental health system.

Crisis Intervention Cells

SCDC policy/procedure HS 19.01 (placement of inmates in crisis intervention status) (November 1, 2007) was reviewed, which included the following provisions:

> In order to provide for the safe and humane treatment and care of inmates, the SCDC will develop and implement procedures whereby inmates who appear to be suffering from a mental health disorder or problem may be separated from the general population and placed in Crisis Intervention (CI) status for evaluation or in appropriate inpatient facilities... .

The placement of crisis intervention cells in the special management unit is clinically inappropriate for several reasons. First, the special management unit is not a healthcare setting and is clearly a punitive setting. Thus, the message is implicit or explicit that inmates who are mentally ill and requiring placement in a crisis intervention cell are being punished. In fact, such inmates have property restrictions, which reportedly are clinically driven based on deposition testimony but, in fact, are clinically inappropriate. For example, it is not clinically appropriate, except in very limited circumstances, to not provide an inmate in a crisis cell with a mattress. Similarly, it is clinically inappropriate not to provide such inmates with a suicide gown or blanket and/or clothing (unless clinically contraindicated). Inmates routinely reported that the suicide blankets, when provided to them, were not clean.

In addition, the SCDC policy/procedure HS-19.01 entitled 'Placement of Inmates in Crisis Intervention Status' requires the MHP/Medical staff complete SCDC Supply M-

120 "Crisis Intervention" and the CI bed space is to be used for up to 7 days and "may not exceed 14 days except in extraordinary circumstances as determined by the Treatment Team and approved by the physician. CI status can only be discontinued by order of a physician or nurse practitioner." These provisions are apparently not being followed as the psychiatrist reports she occasionally signs forms, although she reported no knowledge of how these forms are used, policy requirements, or formal Treatment Team meetings with the counselors or inmates. The policy further requires inmates be placed in a suicide gown and given a suicide blanket; however, we were informed there is a subsequent policy that prohibits provision of paper gowns to inmates. Further, SCDC policy/procedure HS-19.03 entitled "Inmate Suicide Prevention and Intervention" requires inmates who are potentially suicidal "will be immediately referred to mental health staff..." This policy also states that when an inmate is determined as clearly a danger to him/herself, medical staff will initiate an inpatient admission and if no beds are available at the appropriate inpatient psychiatric facility, the inmate will be admitted to the designated Infirmary on crisis intervention status. The policy continues that if no beds are available at the inpatient psychiatric facility or the designated infirmary, the inmate will be transferred to an area designated for crisis intervention. This policy also requires provision of the paper gown to the inmate. Further, it provides that the type of suicide watch (continuous observation or 15-minute watch) will be determined at the discretion of the Clinical Correctional Counselor or professional healthcare staff. The requirements of these policies are not being met, and the designation of Clinical Correctional Counselor to determine types of suicide watch exceeds their training and credentials. Neither policy requires direct participation of the psychiatrist in these determinations.

Although mental health staff reportedly was required to see inmates on crisis intervention status on a daily basis, inmates reported that they were not seen daily Monday through Friday, which appeared to be confirmed by a review of various medical records of inmates on such status. Finally, the psychiatrist had little to no involvement with inmates placed on crisis intervention status.

Disciplinary Issues

There are a number of concerns regarding the disciplinary process and specifically the participation of mental health staff in this process. We reviewed over 560 Use of Force Reports and/or Incident Reports, from 2004 thru 2008 for the SCDC. Approximately 90% of these reports were generated at Lee Correctional Institution or Lieber Correctional Institution. In addition, we reviewed 93 Disciplinary Write-ups for Self-Injurious Behavior/Mutilation since January 2005. These Disciplinary Write-ups involved 30 inmates from various facilities, 9 of whom had between 4 and 11 such write-ups. The Use of Force/Incident Reports and Disciplinary Write-Ups included a number of incidents involving suicide attempts, threats of suicide, and/or self-injurious behaviors. The standard operating procedure for these incidents appears to consistently include use of chemical spray to the inmate by correctional officers and placement in the restraint

chair. The behavior may have been resolved, and, in some cases, the inmate had been sent to an outside hospital emergency room for treatment. Even so, the inmate is usually placed in the restraint chair for approximately four hours or more. Some Write-Ups include statements that the inmate was placed in the restraint chair for the "required" four hours. There is minimal evidence that the mental health staff has been contacted or have interviewed the inmate to determine the appropriateness of what appears to be a punitive practice without regard for the inmate's mental status at the time.

The Disciplinary Hearing Officer (DHO) responsible for reviewing the charges placed against inmates sometimes is provided with a mental health assessment of whether the inmate's mental state had any relevance to the charges and opinion as to whether or not the inmate should be held responsible for the behavior resulting in the charges. Based on discussion with staff and inmates, and review of the records, this practice appears to be inconsistent and the assessments provided by the counselors do not include a direct examination of the inmate pertaining to the specific charge. Several inmates who have received various charges were in active mental health treatment, including prescribed medications (which they may or may not have been receiving) at the time of the charge. Once again, the psychiatrist is not involved in this process.

An additional disciplinary practice is the requirement for inmates who have been found guilty of sexual misconduct to wear pink jumpsuits. There were approximately 25 inmates in this category at the time of the site visit. Discussion with staff and inmates and review of the records revealed that none of these inmates were formally assessed for the presence of a mental illness or disorder that may have contributed to their sexually inappropriate behaviors, and none have received specific treatment to address these behaviors.

Treatment Planning

General Population

The Lee Correctional Institution is a level three prison from the security standpoint but also has mentally ill inmates who have M2 or M3 classifications. The M3 classification refers to inmates who are outpatients and who may be receiving medications but seen less frequently than the M2 mentally ill inmates who have area mental health designations. The M3 inmates are required to be seen every 90 days by a counselor and every 90 days by a psychiatrist with treatment planning updates every six months. The M2 classification inmates are required to be seen every 90 days by a psychiatrist but every 30 or 60 days by a counselor with treatment plan updates every three months. All general population mentally ill inmates as well as other inmates who are receiving medications must obtain them from the pill line which is described elsewhere in this report. The determination of how inmates are placed on the mental health caseload is made by the counseling staff who receives information from classification when an inmate is admitted to the facility which includes a medical screening that is provided by the sending

institution. We were informed that the process is for the classification staff to notify the mental health counselors of inmates who are on the mental health caseload or taking psychotropic medications. Inmates then are seen by the counseling staff and the process involves the primary counselor and the supervisor and/or another counselor writing the treatment plan that includes the Axis I and Axis II diagnoses, medications and a format identifying the "problem", "objective", and "approaches". The psychiatrists do not sign the treatment plans that are developed for the inmate nor is there a treatment team meeting that includes the mental health counselor and psychiatrist meeting directly with the inmate together. There is also no format for participation of custody, medical, nursing or any other staff in a treatment team meeting which includes the inmate as these types of meetings simply are not done at Lee Correctional Institution. The other mechanism for access to care for general population inmates is through the staff request process in which a staff request form can be dropped into the staff request box which is a box that is located just outside of the cafeteria.

Treatment plans were reviewed, many of which appeared to have recently been developed and/or updated in anticipation of our site visit. Unfortunately, these treatment plans were not individualized and clinically were not very meaningful. The psychiatrist was not part of the team treatment planning meetings and was not even aware of the treatment planning form that was present in the paper medical record.

Diagnostic Issues

Contributing to the lack of meaningful treatment plans was inaccurate diagnoses and significant changes in diagnoses without adequate documentation, both of which appeared to be related to multiple causes that included the following:

1. lack of clinical expertise among the mental health staff,
2. the psychiatrist not reviewing relevant past psychiatric records from either Gilliam Psychiatric Hospital or past community records that were only available in the paper medical record in contrast to the automated medical record,
3. lack of meaningful clinical contacts in an appropriate out of cell setting that would facilitate establishment of a therapeutic alliance, clinical observation and gathering of relevant history,
4. the overuse and misuse of the intermittent explosive disorder (IED) diagnosis, and
5. lack of a quality assurance/improvement process.

The overuse of the intermittent explosive disorder (IED) diagnosis at Lee CI is very similar to the overuse of the "malingering" diagnosis present in many correctional settings that have been found to provide inadequate mental health services. In both circumstances, clinicians focus on these diagnoses to the exclusion of other symptoms exhibited by the inmate that are consistent with the presence of a serious disorder. It is

likely that the IED diagnosis is used (intentionally or not) to reflect the obvious anger demonstrated by many inmates in the SMU, which is related to their conditions of confinement that exacerbate their feelings of feelings of helplessness and hopelessness.

It was also significant that despite inmates being diagnosed with mental retardation (see Appendix I), their treatment plans did not list issues associated with this diagnosis on the problem list or formulate appropriate interventions.

Medication Management Issues

Inmates clearly reported, and review of medication administration records confirmed, the presence of medication management issues that included gaps in medication administration (i.e., days when they are not administered for reasons that we could not discern based on record review) and medication non-adherence not being addressed in a timely manner. In addition, despite Dr. 's perception that she has clinical contacts with mental health caseload inmates receiving psychotropic medications at least every 90 days, it was clear from review of records and inmate interviews that such was not the case. In other words, it was not difficult to identify inmates who were not receiving timely follow-up by the psychiatrist.

Quality Improvement

The lack of any quality improvement process at Lee CI is very concerning but, in part, explains some of the deficiencies in the mental health system. This problem is exacerbated by the absence of an adequate management information system as evidenced by the representation from Will Davidson, Esq that the Lee Correctional Institution was unable to produce a list in a timely manner of all caseload inmates sorted by housing location, let alone by diagnoses or psychotropic medication use. Without such a management tool, it becomes much more difficult to evaluate both mental health system processes and outcomes. It is not surprising that in two days we were able to identify significant mental health system issues that apparently were not recognized by staff based on deposition testimony and/or staff interviews.

Examples of such findings referenced above include the statement by Dr. that she sees all of her caseload inmates at least every 90 days or sooner if clinically indicated. Such was not the case as is documented in Appendix I. A similar issue is present relevant to medication management issues in the context of continuity problems and timing of the various medication administration times.

Please call us if we can answer any further questions.

Sincerely,

Jeffrey L. Metzner, M.D.

Raymond F. Patterson, M.D.

Appendix I

Appendix II

Special Management Unit

1. Inmate 1

This inmate reported that he is seen at the cellfront by his mental health counselor, whom he does not find to be helpful related to his background as a correctional officer prior to being a mental health counselor. He reported that he has been in the SMU for 2.5 years and in the supermax section for about the past three months. Inmate 1 stated that he does not have access to showers or recreational yard. He reported that he and another inmate were recently "cleaned up" by the correctional staff prior to our site visit.

The healthcare record of this inmate was briefly reviewed. Dr. last saw this inmate during May 21, 2008. Her note included the following: "I'm doing better with the meds. I would like my Tegretol back." Inmate 1 was noted to be in lockup related to sexual charges. His diagnosis was intermittent explosive disorder. Medications included thioridazine, Zoloft and Cogentin. He has not been seen by Dr. since May 2008. He has been seen on a monthly basis by mental health counselor His previous visit with a psychiatrist was August 29, 2006

A July 30, 2008 note by Mr. indicated that the session focused on medication compliance, expected behaviors and necessary changes. He was seen at the cellfront.

Inmate 1 had a history of prior treatment at the Gilliam Psychiatric Hospital.

He reported a history of physical altercations with correctional officers.

Diagnoses at GPH included schizoaffective disorder, bipolar type, alcohol abuse, cannabis abuse and moderate mental retardation. Inmate 1 reported being able to read and write. Past history included special education classes and completion of the eighth grade.

A September 3, 2002 discharge summary from Gilliam Psychiatric Hospital was reviewed, which was consistent with the above diagnoses.

The most recent treatment plan review was dated September 11, 2008. The only problem listed was compliance with medications and behaviors poor. The objectives essentially were to take medications as prescribed and refrain from self-injurious behaviors and develop appropriate coping skills. The approach was to refer to the psychiatrist, monitor medication compliance and provide individual and group counseling as needed. Diagnoses were intermittent explosive disorder and antisocial personality disorder.

Assessment: This inmate has not been seen in a timely manner by the psychiatrist. In addition, the documentation was inadequate regarding the significant changes made in diagnoses. The treatment plan was not adequate. His history was consistent with the presence of a serious mental disorder and mental retardation.

2. Inmate 2

Inmate 2 is a 40-year-old man who has been in the SMU since 2001. He has been in the supermax section due to assaultive behavior with other inmates since May 2008. Medications include Zoloft and Tegretol, which he reported taking due to hyperactivity and depression. He thought the medications were somewhat helpful. Inmate 2 estimated that he saw the psychiatrist about every 90 days in an office setting that did not allow for sound privacy. He meets with his mental health counselor at the cellfront for 10-15 minutes on about a monthly basis.

Inmate 2 reported infrequent access to the recreational yard. Access to showers reportedly ranged from weekly to three times per week depending on various factors.

Inmate 2 reported issues with medication continuity. He stated that about two months ago he was without Zoloft for one week because the institution ran out of this medication. He also indicated that periodically medications are not delivered related to various yard disturbances.

The healthcare record of this inmate was reviewed. An August 25, 2008 note by Dr. confirmed his history that he had refused to come to a scheduled appointment. He was rescheduled to see Dr. His previous appointment with Dr. was during March 3, 2008. Inmate 2 reported at that time that he was not receiving his medications on a consistent basis. He appeared disheveled in appearance and was very loud and aggressive in his presentation. Tegretol, Zoloft and Inderal were restarted. He was to be seen again in 90 days.

The last documented counseling session with his mental health counselor was dated August 19, 2008, when he was seen in the supermax area within SMU.

A CCC team review note dated July 29, 2008 indicated the diagnosis of intermittent explosive disorder.

Assessment: This inmate has not been seen in a timely fashion by the psychiatrist. In addition, it is very likely that his current conditions of confinement are exacerbating his mental health problems.

3. Inmate 3

Inmate 3 was readmitted to SCDC during March 2008. He has been in the SMU since April 2008. He reported being in the supermax section for three months until about one week ago. Inmate 3 stated that he did not have access to showers or yard while in supermax and continues to have very limited access to yard. He reported being in the SMU due to being a threat to staff and other inmates.

A history of prior treatment of the Gilliam Psychiatric Hospital was described by Inmate 3, with the longest stay being about 18 months. He reported that he has refused medications because he did not think that he had any mental health problems except for an anger problem.

The healthcare record of this inmate was reviewed. His last meeting with Dr. was during August 25, 2008, when he reported getting gassed due to outbursts of banging on the door. He was described as feeling agitated and was noted to be pacing. His presentation was reported to be consistent with an intermittent explosive disorder and a cognitive disorder NOS. His current medications were discontinued and he was started on a trial of Tegretol, Risperdal and Cogentin. A CBC and LFTs were ordered as was a Tegretol level. The plan was to see him again in 3-4 weeks.

The previous session with Dr. was during June 23, 2008. He reported having muscle spasms related to the medication. His Cogentin was increased and Geodon was started. Prolixin was to be decreased and he was to be seen again in four weeks.

Dr. met with Inmate 3 during June 11, 2008. He was described as a 30-year-old man who was in a crisis cell was after chewing a razor blade. He was not suicidal and did not appear psychotic. His presentation was consistent with an antisocial personality disorder and mental retardation. Prolixin was started.

A June 12, 2008 treatment plan included the following:

> Objective: inmate to become 100% compliant with taking his prescribed medication.
> Approach: daily medication administration by nursing staff
>
> Objective: inmate to refrain from assaultive behaviors
> Approach: 1:1 counseling and case management by CCC prn
>
> Objective: inmate to gain some insight into his behavior
> Approach: inmate to be dealt with in a matter of fact manner.

The treatment plan was updated during September 10, 2008 to include poor impulse control as a problem although the objectives and approaches were unchanged.

Inmate 3 reported times when in the crisis intervention cells that he was without clothes and without a suicide blanket, in addition to having limited or no access to toilet paper. Review of an August 29, 2008 progress note was consistent with being in the cell without clothes. Specifically, this note included the following: "CCC arrived to find that inmate was indeed naked in holding cell. He asked for a CI blanket … ."

There was a history of speech therapy and special education classes.

Inmate 3 reported his sessions with his mental health counselor were at the cellfront and not very helpful, in part, related to lack of adequate sound privacy.

Records from Gilliam Hospital were not present in his paper medical records.

Assessment: The diagnostic discrepancies between his diagnoses were not addressed in any progress notes in his medical record. His conditions of confinement have clearly resulted in periods of exacerbation of his mental health problems, especially when placed on crisis intervention status.

4. Inmate 4

Inmate 4 was a 29-year-old man who has been in prison for eight years and in the SMU for about 44 days following a fight at Kirkland CI in the ICS. He reported having received treatment in the ICS for about six months. Inmate 4 was being released back to the general population yard during the day of this interview. He was concerned that he would not be able to make it in the yard and wanted to go back to the ICS at Kirkland CI. However, Inmate 4 was told that he will not be able to return to the ICS.

Inmate 4 indicated that he has not had access to the recreational yard because he has either been asleep or too tired to stand during count time. He also has not been showering until very recently due to a reaction (i.e., itching) his body has to the available state soap. His lack of showering was consistent with a September 10, 2008 progress note.

The healthcare record of this inmate was reviewed. A March 21, 2008 counseling note indicated a diagnosis of schizophrenia, undifferentiated. Medication compliance was to be continuously monitored. Dr. renewed Risperdal 1 mg po hs during March 31, 2008. He attended a "living with schizophrenia" group during April 2, 2008.

During April 17, 2008 Inmate 4 complained of experiencing auditory hallucinations. He was placed in the crisis intervention unit. A Depakote level was obtained during April 21, 2008. Risperdal was discontinued by Dr. . Risperdal Consta 50 mg IM q 2 weeks was started that same day. Depakote 500 mg po bid was renewed.

Depakote was discontinued and Tegretol started during May 20, 2008. During May 21, 2008, he was noted to be in lockdown for 10 days due to fighting. During June 11, 2008 Inmate 4 was noted to be receiving benefit from the Tegretol. His assessment was consistent with an intermittent explosive disorder and psychosis NOS. Schizophrenia was noted to be in remission during July 11, 2008 by Jimmy Pacheco M.D.

A July 28, 2008 note indicated he was on lockdown due to pending assault charge. A treatment plan was reviewed during treatment team during July 29, 2008. Inmate 4 was being considered for discharge to area mental health status with a diagnosis of

schizophrenia in remission. During August 6, 2008 he pled guilty to charge of a fighting. He indicated that he wanted to get out of the ICS.

Inmate 4 was initially evaluated by Ms. upon his transfer to Lee CI during August 29, 2008. He reported taking medications at ICS with good results. He wanted to return the ICS but was advised that he was not likely to return due to the behavioral problems he had caused.

A September 9, 2008 note indicated that he was due for his Risperdal Consta shot but Kirkland CI had not sent his medication with him to Lee CI. This medication was renewed that same day. He eventually received this injection during September 12, 2008.

A September 11, 2008 treatment team review indicated the diagnosis of schizophrenia, undifferentiated, by history and intermittent explosive disorder by history.

Assessment: This inmate's history was consistent with a diagnosis of a chronic schizophrenia, which appeared to have responded reasonably well to treatment in an ICS environment. His current treatment plan was not adequate. Inmate 4 has experienced some medication continuity disruption following his transfer to Lee CI and has not yet met with a psychiatrist.

5. Inmate 5

Inmate 5 was a 39-year-old man who reported that he has been in the SMU for about 14 days. He cut himself today (September 15, 2008) because he was unsuccessful in his attempts to obtain a Bible. He reported that he has Hepatitis C but was not receiving treatment for Hepatitis C because his length of incarceration was reportedly too short to be eligible for such treatment.

The healthcare record of this inmate was reviewed. A July 11, 2008 note indicated that this inmate was assaulted by his roommate with a sock that had two bars of soap in it.

Inmate 5 was seen for crisis intervention follow-up during September 12, 2008. He initially had been placed in the crisis unit after being seriously assaulted by his roommate with a lock in a sock. The progress note included the following: "He stated his head still hurts and he really needed a mattress to rest his head on. Undersigned spoke with Lt. Jenkins about inmate in need of a mattress but she stated they had no mattress at this time but as soon as one became available she would give it to him... . Inmate was cooperative and talkative during assessment, who is willing to discuss his mental health history with ease. He reported he began receiving mental health treatment at the age of 17 when he began hearing voices. He admitted to an extensive substance-abuse history... ." Inmate 5 reported that he continues not to have a mattress.

A September 13, 2008 note indicated that a correctional officer observed this inmate having a seizure in his cell. Inmate 5 was subsequently taken to the medical infirmary for an assessment. He was subsequently sent back to the SMU after about 30 minutes.

The last progress note of a psychiatrist was dated June 23, 2008. Inmate 5's presentation was consistent with an intermittent explosive disorder. His medications were continued and doxepin added. However, BuSpar was ordered in contrast to doxepin.

Dr. met with Inmate 5 during March 24, 2008. His presentation was consistent with a borderline personality disorder, dependent personality disorder and history of polysubstance abuse. Seroquel 400 mg po qd was prescribed. He was to be seen again in 90 days by the psychiatrist.

Meds were refilled (Risperdal and Seroquel) by Dr. during December 28, 2007. Other meds prescribed during the past year have included Dilantin and Depakote. Liver function tests were ordered during January 29, 2008.

Inmate 5 also reported medication continuity problems. Specifically, he reported two days last week he did not receive this evening dosage of Seroquel, which was confirmed by review of the MAR.

He reported lack of access to yard or showers for the past 15 days.

Review of a May 9, 2001 discharge summary from Gilliam Psychiatric Hospital indicated discharge diagnoses of bipolar disorder not otherwise specified, alcohol dependence and antisocial personality disorder.

Assessment: Inmate 5's presentation was fairly confusing based on a review of his healthcare record although it appears to be consistent with a diagnosis of borderline personality disorder. He clearly has significant medical problems which are negatively impacted by his mental health issues.

6. Inmate 6

Inmate 6 was a 26-year-old Caucasian man who has been in prison for seven years and reported being in the SMU for the past six years. He stated that he did not want to be in the general population due to problems he was encountering with different gang members.

This inmate indicated that he declines going to the recreational cages on a daily basis although he does take advantage of access to showers on a three time per week basis. He had been receiving Remeron and Invega until he started refusing these medications about one month ago because he did not like them. He described experiencing auditory

hallucinations since the age of 15 related to the use of LSD. He described the voices as being the devil's voice and being distressing to him.

The healthcare record of this inmate was reviewed. Inmate 6 had been transferred from Gilliam Psychiatric Hospital to Lee CI during August 7, 2008. He initially was transferred to GPH during February 2008 after cutting his abdomen in an attempt to kill himself. The most recent mental health counseling note was dated September 11, 2008, which was a treatment team review. His diagnosis was psychotic disorder NOS due to ecstasy use. Medications prescribed included Remeron and Invega. The treatment plan, which was reviewed, was not specified in the CRT.

The most recent note by a psychiatrist was written by M.D. during August 12, 2008. The note indicated that he had stopped taking medications when he came to Lee CI. He reportedly had trouble dealing with his life sentence and could not sleep because he did not have a mattress. Auditory and visual hallucinations were present. He was encouraged to take his medications.

Review of the paper chart revealed the presence of a medical screening form upon admission that included questions relevant to suicide and medications. A September 10, 2008 treatment plan was reviewed that included the following:

> Objective: Inmate to be evaluated by the psychiatrist.
> Approach: Inmate to see psychiatrist prn
>
> Inmate to refrain from any drug use.
> Approach: 1:1 counseling and case management

A July 14, 2008 discharge summary from Gilliam Psychiatric Hospital was reviewed. His discharge summary included psychotic disorder due to ecstasy, malingering, antisocial personality disorder and narcissistic personality disorder. His self-mutilation was viewed as manipulation in order to be transferred to Columbia.

An August 13, 2007 discharge summary from GPH demonstrated a similar formulation.

Assessment: The treatment plan for this inmate was inadequate because it did not address relevant clinical issues. There does not appear to be a dispute that this inmate has symptoms of a serious mental disorder although he has been assessed also to be malingering symptoms based on his hospitalization at GPH. Symptoms of his serious mental disorder need to be addressed even if he was malingering. Inmate 6 reported feeling sad and bored since returning from GPH. This inmate should be considered for treatment in an ICS setting.

7. Inmate 7

Inmate 7 was a 22 year old man who has been in prison under the Youthful Offenders Act for four years and in the SMU for the past 3.5 years. He is serving a life sentence. He reported that he goes to the recreational cages about two hours per week and has access to showers on a three times per week basis.

This inmate was prescribed Tegretol for anger problems, which he thought was somewhat helpful. Inmate 7 reported seeing a psychiatrist in a private office setting about every 30 days but did not think he was seeing a mental health counselor.

The healthcare record of this inmate was reviewed. The most recent appointments with the psychiatrists were during April 21 and July 28, 2008. His presentation was consistent with an intermittent explosive disorder. Dr. prescribed carbamazepine. Results of a carbamazepine blood level were reported during July 28, 2008.

His last session with a mental health counselor was dated November 29, 2007.

Assessment: It is unclear why he has not been seen on a regular basis by mental health counselor. Inmate 7 reported that he is put in request to seek counsel without results.

8. Inmate 8

This inmate is a 33-year-old Caucasian man who has been incarcerated for the past 13 years and in the SMU for nine months. He initially was transferred to the SMU following a fist fight but his received more time related to problems with the correctional officers.

He has been prescribed Paxil since meeting for the first and only time with a psychiatrist during June 2008. He reported a family history of bipolar disorder and a past history of posttraumatic stress disorder.

The healthcare record of this inmate was reviewed. A June 30, 2008 progress note written by Dr. was reviewed. Inmate 8 had been treated for several months at Gilliam Psychiatric Hospital due to depression and suicidal thinking. He also had a history of mental health treatment prior to his incarceration. His presentation was consistent with posttraumatic stress disorder rule out and intermittent explosive disorder. The treatment plan included a trial of Paxil and return to clinic in six weeks.

Inmate 8 reported that he has not again been seen by the psychiatrist despite requests to see the psychiatrist via his mental health counselor, who sees him about every five weeks at the cellfront for about 10 minutes.

Inmate 8 reported that he experienced excessive sedation related to the Paxil and discontinued this medication about four weeks ago although it continues to be offered him on a daily basis. He also informed his counselor abound his discontinuation.

A July 24, 2008 progress note indicated that his case was staffed with the treatment team. Diagnoses were PTSD and rule out intermittent explosive disorder. The plan was "continue mental health services to monitor stability and for medication administration." He was placed at an outpatient mental health level of care.

An August 5, 2008 progress note was consistent with this inmate's report of discontinuing his medication. In addition to his diagnosis he was noted to be extremely antisocial. An August 19, 2008 note indicates that his August MAR was checked for compliance which indicated that he accepted all doses. Inmate 8 indicated that he was accepting the medications but not taking them. He stated that he eventually would throw these medications away.

A September 2, 2008 progress note included the following: "when asked about his refusal to see psych M.D. & if he was willing to continue mental health follow-up-he never gave a straight answer. CCC discussed at length his med compliance and compliance with treatment as well as behavioral problems. Inmate was receptive... ." The treatment plan included a psychiatric consultation as well as potential discharge for mental health services.

Assessment: It is unclear why he has not been seen by psychiatrist either per the June 2008 plan or related to his medication noncompliance. He has not been receiving timely follow-up by the psychiatrist.

9. Inmate 9

Inmate 9 was a 25-year-old man who has been in prison for two years and in the SMU for one year. He had been any supermax section for 3.5 months until July 2008. He has been receiving Seroquel for a sleep disturbance and agitation. Inmate 9 also reported that this medication helps decrease his tendency to "flip out real fast."

Inmate 9 reported that he received cellfront visits from his mental health counselor, which are not very effective due to lack of privacy. He does meet with the psychiatrist in a setting that allows for better privacy.

The healthcare record of this inmate was reviewed. He was first seen by psychiatrist at Kirkland CI during February 16, 2007. The progress note included the following:

> Has history of mental illness and has been followed at Pee Dee mental health. Came in on Seroquel, but has tapered off and is now on Haldol bid... . States he continues to hear little voice here and there, he claims they are getting worse. Denies command hallucinations... ." His presentation was consistent with schizophrenia. Haldol was increased.

History obtained during March 22, 2007 indicated a past history of treatment with the use of Ritalin, Depakote, Seroquel and Haldol. A treatment team note during March 23, 2007 indicated diagnosis of schizophrenia. He was on an area mental health level of care.

During March 29, 2007 Inmate 9 was placed in the SMU following a verbal confrontation with unit staff. He was described as being upset and crying during April 10, 2007, which appeared to be related to his lockup status. His diagnosis remained unchanged during April 16, 2007.

Psychological testing was scheduled during April 17, 2007. Haldol continued to be prescribed during April 24, 2007. He was scheduled to be released back to general population during April 26, 2007. At his request Haldol was being tapered during May 2007. Malingering was also considered at that time.

A note dated May 22, 2007 indicated that his Haldol had been discontinued. Malingering was now considered to be the likely diagnosis by M.D. However, there was no supportive documentation concerning such a diagnosis. Mild mental retardation was also diagnosed.

It appears that he was seen during June 20, 2007 in order to consider discharge from the behavioral mental health services. Psychological testing yielded an IQ range of 57-64. Additional charges were described during July 23, 2007. The diagnosis of intermittent explosive disorder was made and a trial of Tegretol was started.

Inmate 9 was placed back on the mental health caseload during August 2007. Information obtained from a DDSN caseworker indicated that he had been diagnosed as having schizophrenia at a community mental health center. However, an August 2, 2007 note indicated no evidence of symptoms consistent with this diagnosis during his current incarceration.

An August 17, 2007 treatment team note indicated a diagnosis of an intermittent explosive disorder with a treatment plan consisting of Tegretol. This inmate was pepper sprayed five times during August-September 2007 related to reported behavioral problems in the SMU.

Dr. again saw this inmate during November 27, 2007. During December 2, 2007 this inmate was found in his SMU cell non-conversant and slumped to one side. No crisis intervention cells were available nor were any paper gowns or suicide blankets available. A similar presentation occurred during January 19, 2008. He was evaluated in the medical clinic at that time.

Inmate 9, retrospectively, stated that the above issues were related to his mood swings.

A January 28, 2008 progress note described Inmate 9 as having an affect that was "a bit pressured and talkative." His diagnosis was unchanged. He was described as continuing to act impulsively and respond verbally to any perceived threats to his "respectability." His thinking was concrete and simplistic.

A March 31, 2008 note indicated that his constant behavioral problems resulted in transfer to the supermax section. He reported he had cups of urine, feces and milk threatening to throw on officers.

Dr. evaluated this inmate during April 12, 2008. She noted a history of psychosis and current diagnosis of intermittent explosive disorder. He was again seen by Dr. during July 7, 2008. Little change was noted. He was continued on Seroquel.

Pepper spray was again used during August 3, 2008. During August 12, 2008 he was no longer in the supermax section of the SMU. He had been disciplinary free for almost 5 months.

A CCC treatment team note, which was dated August 15, 2008, indicated that his diagnosis was intermittent explosive disorder. Seroquel continue to be prescribed. Inmate 9 was receiving an outpatient mental health level of care.

The treatment plan listed intermittent explosive disorder as his only problem with the clinical objective being discontinue sexually inappropriate behavior and the approach being psychiatric clinic p.r.n. and daily medication as given by nursing staff as well as 1:1 counseling and case management.

This inmate's paper medical record was reviewed, which included a June 2005 discharge summary from the Columbia Care Center, Just Care. Following a hospitalization of about six weeks, his discharge diagnoses included schizophrenia, differentiated type, mild mental retardation and antisocial traits.

Assessment: The diagnostic assessment and treatment plan is inadequate for this inmate. His mental retardation is not being adequately addressed and it is likely that his condition is consistent with a serious mental disorder.

10. Inmate 10

Inmate 10 was a 27-year-old African-American who has been incarcerated since January 2008 and in the SMU since June 2008. He reported that people in the yard had been trying to kill him, which has not been believed by custody staff. He reported that he has been charged with refusing to obey an order to go to the yard.

Inmate 10 reported that he has experienced auditory hallucinations since his early teens and continues to hear a voice telling him to protect himself. There was a history of receiving mental health treatment in the community, where he states that he was diagnosed as having paranoid schizophrenia and bipolar disorder. Medications in the past have included Depakote, Thorazine, lithium, Vistaril and Ritalin.

Inmate 10 reported that his cellfront meetings with his mental health counselor were not helpful due to lack of adequate privacy. He has better privacy, but still not adequate sound privacy, during his clinical contacts with the psychiatrist.

The healthcare record of this inmate was reviewed. A December 28, 2005 progress note indicated a history of bipolar I disorder and antisocial personality disorder. He was referred to the Seneca area mental health center. Inmate 10 was scheduled for release from SCDC during January 2006.

A January 10, 2008 progress note at Kirkland CI indicated a past history of anger issues and bipolar disorder. He had been treated in the past with Ritalin related to behavioral problems at school.

Seroquel was started during March 25, 2008 by M.D. who diagnosed borderline personality disorder, attention deficit hyperactivity disorder, and a history of marijuana abuse.

An intake assessment at Lee CI was performed during April 4, 2008. His past history with anger problems was noted. His diagnosis was unchanged. An April 11, 2008 initial treatment team note was consistent with the previous progress note. The treatment plan, contained in the paper medical record, included the following:

> Objective: inmate to remain 100% compliant with taking his prescribed psychotropic medication.
> Approach: follow by psychiatrist prn daily medication administration.
>
> Objective: inmate to refrain from any sexual inappropriate behaviors. Inmate to improve problem-solving and decision-making skills by 50%.
> Approach: 1:1 counseling and case management prn

Dr. evaluated this inmate during June 9, 2008. Paranoid thinking was described. Her assessment concluded bipolar disorder, ADHD as a child and history of marijuana use. The plan was to taper and discontinue Seroquel, start Navane and see Inmate 10 in 4-5 weeks.

During July 1, 2008 this inmate took an unknown number of pills in order to get away from correctional officers in his dormitory related to his paranoid thinking that they were doing something to his food. He was placed in a crisis intervention cell. Inmate 10 now

reports he took this overdose in an attempt to see a mental health counselor because his requests to the correctional officers to see a counselor were being ignored. He stated that he also had submitted three requests directly to his mental health counselor which did not result in any response.

Inmate 10 indicated he was in the crisis cells for two weeks but only seen by a mental health counselor on two occasions. Inmate 10 also reported that he was given no clothes or blankets or a mattress for the first two days in the crisis cell. However, a progress note in the CRT indicated that he was discharged from the crisis cell during July 2, 2008. Review of the paper medical record indicated that crisis intervention status was discontinued during July 3, 2008 and his personal belongings were to be returned.

Subsequent progress notes were consistent with Inmate 10 telling staff that he was concerned about his surroundings and that he again received a charge for refusing to obey an order.

During August 7, 2008 Inmate 10 requested to see the psychiatrist due to problems with his medications. He also requested transfer to the intermediate care services program but was told that he was too high functioning to be sent to this program. An appointment with the psychiatrist was to be scheduled.

M.D. evaluated Inmate 10 during August 12, 2008. His presentation was consistent with a mood disorder NOS. Navane was discontinued and Prolixin and Paxil started.

Laboratory studies were ordered but were refused by the Inmate 10. Inmate 10 stated he did not refuse to have his blood drawn.

Dr. again saw this inmate during September 16, 2008. Labs were reordered and his medications continued.

Assessment: This inmate's presentation was consistent with a serious mental disorder associated with psychotic symptoms. His follow-up by the psychiatrist was not timely based on the timeframe recommended by his treating psychiatrist not having been met.

Inmate 10's current conditions of confinement likely exacerbate his mental health symptoms. Treatment in an ICS level of care should be considered.

11. Inmate 11

Inmate 11 was a 22-year-old Caucasian male who has been in SCDC for the past four years and in the SMU since July 2008. He reported that he was in the ICS for about 14 months before being discharged related to "taking advantage of people-selling

cigarettes... ." He reported that this program was helpful to him. He also stated that he has been barred from returning to GPH for reasons that are unclear to him.

Inmate 11 reported a history of bipolar disorder and ADHD.

The healthcare record of this inmate was reviewed. An April 10, 2006 note described Inmate 11 as being nonverbal and uncooperative. He was found to be guilty but mentally ill and sentenced to 30 years. His differential diagnosis included schizophrenia.
, M.D. transferred him to the Gilliam Psychiatric Hospital.

He was discharged from GPH about one month later with the discharge diagnoses of psychotic disorder NOS, polysubstance dependence, ecstasy induced persisting dementia and antisocial personality disorder. The discharge summary referenced a confirmed suspicion of continued drug use.

Malingering was considered in the differential diagnosis during May 17, 2006. Risperdal was tapered at that time.

A June 16, 2008 progress note indicated that Dr. renewed Risperdal. Inmate 11 was placed in the crisis intervention related to suicidal thinking during July 9, 2008. Subsequent progress notes were dated July 11, 14, 15, 16, 17, 2008. His crisis intervention cell status was discontinued during July 17, 2008.

A July 29, 2000 eight initial treatment team report indicated the diagnosis of malingering, psychotic disorder NOS and polysubstance dependence.

Inmate 11 reported to his mental health counselor during August 7, 2008 that he would refuse to be placed on the yard at the Lee CI due to his concern that he would be in danger from other inmates.

A September 10, 2008 by M.D. was reviewed. This note included the following information: "Inmate is a 22-year-old white male who has been active in the mental health program. He had been an ICS for two years and then was barred from the program for selling contraband. Inmate currently is on Risperdal. He states that he does not need med anymore as he is no longer hearing voices. He is not depressed, appetite is improved, and he feels he is functioning well. Inmate wants me to discontinue hold so that he can move to another facility. Inmate history significant for long association in mental health in Greer County, although he states he never got medicine, he was there for behavior and drugs. He has been hospitalized to GPH four times, the last time this year for not eating. Not clear if this was a manipulative behavior."

The diagnoses were intermittent explosive disorder and polysubstance dependence. Medications discontinued at his request. He was changed to outpatient mental health status. The plan was to monitor for three months prior to taking out of mental health.

Assessment: The current treatment plan is not appropriate, with specific reference to discontinuing Inmate 11 from the caseload in three months if no significant clinical change, based on his past psychiatric history. He is at high risk of clinical deterioration if not followed closely, especially if not taking psychotropic medications.

12. Inmate 12

Inmate 12 was a 23-year-old African-American man who has been incarcerated in SCDC since 2002 and in the SMU since 2004. He reported that he has currently been in the supermax section four about 2.5 months.

This inmate has been pepper sprayed on numerous occasions as well as having been placed in a restraint chair on multiple occasions. Reference should be made to the report by Steven Martin, Esq. for a summary of such incidents. Inmate 12 reported chronic eye symptoms that included burning and visual problems. He reported that he has not been assessed by medical related to the symptoms despite requests to receive medical treatment.

Inmate 12 reported that his shower, similar to other showers in the supermax section, was nonfunctional. He indicated very limited access to showers, which generally occurred prior to visits with healthcare providers or other official visits. He indicated that he had no access to the outdoor recreational cages.

The healthcare record of this inmate was reviewed. An August 12, 2008 note by his M.D. indicated that Inmate 12 stopped taking medication when he returned to Lee CI. His behavioral problems were noted to be related to his Axis II diagnosis. He was also assessed have been a delusional disorder by history as well as an antisocial personality disorder.

Dr. renewed his medications during April 22, 2008 following his discharge from GPH. They included clonidine, Risperdal and albuterol inhaler.

An April 23, 2008 note indicated that Inmate 12 was in his room with only a piece of foam. The mental health counselor spoke with the captain about getting him a blanket, sheet, town, and rag. Inmate 12 was given a form to fill out relevant to requesting further property.

Dr. again evaluated this inmate during February 20, 2008. Diagnoses remained unchanged. His right eye was hearing from the use of pepper spray. He was reported to not be bathing. Tegretol and Risperdal were renewed.

A January 30, 2008 mental health counselor progress note indicated a diagnosis of intermittent explosive disorder and ADHD.

A January, 2008 medical progress note indicated that Inmate 12 was evaluated by an R.N. due to his complaints of burning in his eyes that has continued since he was sprayed with chemical munitions. The plan was to see him as needed.

During January 4, 2008 Inmate 12 drank some cleaning fluid. He stated that he drank this because he was feeling unsafe in the prison and wanted to be transferred to a hospital.

M.D. evaluated Inmate 12 during January 3, 2008 following his GPH admission. A trial of Tegretol was started and Risperdal was to be tapered. The diagnoses of intermittent explosive disorder and ADHD were made.

Review of his extensive medical record indicated repeated admissions to the crisis intervention unit and assessments by an LPN following use of pepper spray.

He was evaluated by , NP III during December 23 come 2007 due to a sty.

A December 21, 2007 treatment team initial note indicated diagnosis of delusional disorder, purse to retype. Medications included Risperdal and Benadryl.

A one year prescription for clonidine was written by , NP III during December 5, 2007.

Inmate 12 was admitted to GPH during September 26, 2007. He was subsequently discharged during November 26, 2007. Delusional symptoms were described. Risperdal was prescribed.

The April 29, 2008 discharge summary from Gilliam Psychiatric Hospital was reviewed. This summary included the following information:

> Inmate 12 was referred to GPH [due to] hostile and aggressive [behaviors] towards staff and inmates and was refusing to take his psychotropic medications. Mr. also reported Inmate 12 lacked insight into his mental illness and was fixated on his sentencing being incorrect. Inmate 12 was observed banging, flooding, and throwing feces out of his cell.
>
> Upon admission to GPH, Inmate 12 displayed normal affect, was cooperative in answering staff questions, and was oriented to person and place. Inmate 12 admitted noncompliance with medication while at the Lee CI and attributed this to want to attention from staff at Lee CI... .
>
> During his first week at GPH Inmate 12 was alert and oriented in all spheres and displayed fair personal hygiene. His affect was irritable. He described his mood as "not good" which he attributed to being treated

> unfairly by SCDC staff. He also voiced complaints about a number of lawyers and judges not treating him fairly... .
>
> Due to episodes of loud and disruptive behavior including yelling, banging on his door, and threatening staff; he was given injections of Prolixin and Benadryl for education on April 10, 16, and April 20, 2008. His behavior became calmer and more cooperative and the severity of his paranoid and persecutory ideation decreased after he received each injection. After receiving these injections Inmate 12 became more consistently compliant with oral medications.
>
> On April 18, 2008 writer pointed out to Inmate 12 that appears to have better control over his behavior and does not get in trouble as much when he takes his psychiatric medication as prescribed versus when he does not take his medication. Inmate 12 agreed and said his getting fewer disciplinary write-ups was the benefit of the taking medication. However, he complained that the medication makes him very sleepy... He voiced some paranoid ideation about staff being against him but the severity and frequency of his paranoid ideation had decreased... He described his mood as good but admitted he is quite anxious to be discharged from GPH so that he may return to Lee CI to resume working on his legal paperwork.

Discharge medications included Risperdal 3 mg po bid, clonidine 0.1 mg po bid, Cogentin, Prolixin 5 mg and Benadryl 50 mg IM q 8 hours p.r.n. agitation, Albuterol inhaler, Motrin and Keflex.

Discharge diagnoses include a delusional disorder, persecutory, alcohol dependence by history, cannabis dependence by history, antisocial personality disorder, and history of asthma and history of hypertension.

Assessment: It was unclear why Inmate 12 was not seen by psychiatrist until almost 4 months following his discharge from GPH to Lee CI. His conditions of confinement clearly exacerbate its mental health problems. His treatment plan is inadequate. He is in need of treatment in an inpatient psychiatric setting. He is also in need of medical consultation regarding his eye complaints. We informed staff about this latter need.

Appendix II

Lee Correctional Institution
Inmates Interviewed and/or Records Reviewed

13. This inmate was a 45-year-old male who reported that he had been in treatment for 8-10 years and possibly more because of an Anxiety Disorder. He reports that he had been housed in the Kershaw dorm for the past two years after his transfer from Perry State Prison. He reported that when he was initially transferred from Perry to Lee he was transferred to the lock-up unit and he had been receiving treatment for his mental health problem and asthma while at Perry. He reported that he did not see anyone from the mental health department for the first two months after his transfer from Perry to Lee and that he went from the lock-up unit (SMU) to Darlington dormitory. He also reported that prior to his incarceration at Lee he had been in the ICS program at Kirkland for approximately one year. He reported that he has a history of Anxiety Disorder and "sticking myself" with various objects including paper clips. He reported that he last inserted a paper clip into his stomach on 7/23/07. He reported that he wrote a letter to the Warden on 7/30/07 and got a response from the Warden on 8/10/07 which he displayed during the interview. In his handwritten letter to the Warden he requested that the paper clip be removed from his stomach because he was feeling pain and the response from the Warden indicated that this would be referred to the medical department. He reported that he was told by the medical department on 8/10/07 they would leave the paper clip in place to "teach you a lesson". He stated the physician in the medical department told him they would not remove the paper clip because he would only insert another paper clip.

    With regard to his current treatment at Lee, this inmate reported that Ms. is his counselor and that he sees her approximately every two to three months. He reports that he attends a stress management group but it was cancelled four of the eight times that it was scheduled. He also reported that Ms. has stated to him that the counselors are taking inmates off the caseload because there are "too many people". He reported that he is afraid to go to outpatient status as he currently is on area mental health status because in outpatient he would only be seen every six months.

    With regard to his medication management, this inmate reported that he is prescribed Klonopin because he has such severe anxiety that he "break out in sores". He displayed pictures of himself that had been taken by medical staff of the extensive sores on his body secondary to his Anxiety Disorder. He reported he gets his medication regularly except during lock downs when the officers do not take inmates to the pill lines. Review of the inmate's medical record MARs demonstrated he is prescribed Wellbutrin 150 mgs BID and Klonopin 1 mg AM and 2 mgs PM. For the month of August 2008 there were two blanks on the MAR indicating he had not received medications on those two days. For July 2008, there was one blank on the MAR indicating he did not receive medications on that day, and in June 2008, there were two blanks also indicating he did not receive his medications on those two days.

During the course of the interview, I did ask the inmate what he wanted to do in terms of the paper clip that remained in his abdomen and he stated that he did not want to have that reported by me or "cause any problems." He reported that a doctor at Kirkland had worked vigorously to have him placed on Klonopin as it is a non-formulary medication and after several efforts, attempts, and appeals, he was finally prescribed Klonopin. The inmate reported he is afraid that if he "causes any problems" his Klonopin will be discontinued and his Anxiety Disorder will become out of control resulting in his self-harming behaviors (sticking himself) and a return of the bruises and sores that he displayed on pictures in his property. Also, there is no documented evidence in the record that the inmate provided written informed consent to any of the medications that he is prescribed.

Assessment:
This inmate has been prescribed Klonopin for a clearly documented Anxiety Disorder which should be continued as well as Wellbutrin for his depression. He is extraordinarily frightened that should there be any further pursuit of removing the paper clip that remains in his stomach for over one year, there will be repercussions against him which would include taking his much needed medication away from him. There was not evidence in his record that there was participation by a psychiatrist or by medical staff in the treatment planning efforts to manage his overall mental and medical health.

14. This inmate reported that he had been housed at Lee for the past 15 months and recalled having met with me during a previous site visit when he was housed at Kirkland. The inmate reported he is currently receiving Navane 10 mgs and has been receiving mental health care since 1984. He also stated he has medical problems including hypertension for which he takes three pills and diabetes which he stated is "ok" although he reported weighing 320 pounds. He reported he has in addition to his other medical problems, sleep apnea, but stated "they don't treat it here". When asked what he meant he stated that he had been prescribed Ambien by a physician but the Ambien has not been given to him while at Lee and there are no provisions for any type of C-PAP or other breathing apparatus to address his sleep apnea.

He reported he has seen a psychiatrist and is scheduled to see her again in 30 days but has been told by the psychiatrist that sleep apnea is a medical problem and one that is not treated by mental health clinicians.

This inmate also reported his counselor is counselor and he attends depression group that meets once a week conducted by Ms. He reported there have been no treatment team meetings similar to the ones that he had been involved in at Kirkland and he has never had a meeting with his counselor, psychiatrist and medical staff at the same time. When asked whether he knew of any discussion of his medical problems including hypertension, diabetes and sleep apnea by medical staff with a psychiatrist for his schizophrenia, this inmate reported that he does not believe they have ever talked with each other and certainly not in his presence.

When asked about his medications, the inmate reported his medications "run out for three to five days at the end when there is no refill". When asked to elaborate, he described medication prescriptions that expire and when he then goes to the pill line, he is told by nursing staff that the medication has not been re-ordered and until it is re-ordered he will not receive it.

A review of his medical record demonstrates he is prescribed Trifluoperazine 20 mgs HS and received his medications appropriately for the month of August 2008. However in July and June 2008, there are multiple blanks on the MARs indicating he did not receive his medications as prescribed. Also, in the review of the record, there is no documented evidence the inmate provided written informed consent for any of the medications he is prescribed.

Assessment:
This inmate's care and treatment are inadequate and there is not an interface between mental health and medical staff to appropriately treat his schizophrenia, hypertension, obesity, diabetes and sleep apnea. Further, he weighs 320 pounds and a review of his record does not demonstrate any planned efforts to reduce his weight to potentially help with his medical conditions.

15. This inmate is a 36-year-old male who reported he was transferred from Lieber C.I. to Lee C.I. in April 2006. He reported he has been receiving mental health care since he was age 11 and has been receiving mental health care in the SCDC since 2001. The inmate reported he is currently prescribed Celexa which was ordered 2 ½ to four weeks prior to this interview but stated that he has yet to receive the Celexa that was ordered by the psychiatrist. He also reported he does receive Geodon 200 mgs each day for the past few years but that he has signed refusals and the medication has been changed. He reported that since his signing a refusal he has been charged for the medications but he is not supposed to be. He stated he is also a member of the IRC Board.

This inmate reported his counselor is Mr. and he has spoken with him about the medication issues and Mr. has stated that he would check with the nurses, however he continued to be charged. In terms of his treatment, this inmate reported he has attended multiple groups since his incarceration at Lee including Anger Management, Symptom Management, Medication Management, Thinking Toward Change, and a "couple of more". He reported the composition of the group typically begins with 8-16 inmates and by the time the group is finished, there may be 4, 5, or 7 inmates because there is a high dropout rate of 40-50% of inmates for the various groups. When asked why he thought this was so, this inmate stated there are multiple reasons including "personality/attitude of group leaders". He stated he does not believe the group leaders are "bad people" but they need more training. He sees various clinicians from the mental health program, less often than the policy requirement, that the counselor sees the inmate every 60 days as an inpatient and every 90 days as an outpatient and that he, himself, sees the psychiatrist approximately every six weeks. When asked if there were any treatment

team meetings including the counselor and psychiatrist, he reported there are no treatment team meetings at Lee.

In terms of medication management, this inmate reported the pill lines typically begin at 4:00 a.m. with a second pill line between 11:00 a.m. and 12 noon and a third pill line between 4:30 p.m. and 6:30 p.m. He reports that when there are lock downs, there is a problem with medication distribution because the nurses don't come to the dormitory initially so that medications are missed for the first one or two days. Also, in the review of the record, there is no documented evidence the inmate provided written informed consent to any of the medications that he is prescribed.

This inmate offered spontaneously "yesterday a man died". When asked what had occurred, the inmate gave the name of the inmate who he believes died because of complications of diabetes. He stated the inmate who died was diabetic and had blood sugars over 300 and the "pusher" (an inmate who pushes another inmate's wheelchair), found this inmate in his room faced down and clammy. He reported that prior to this, the inmate who died had been given a shot by medical and sent back to his unit and after lunch the inmate was found by the pusher and when custody staff responded the inmate had no pulse. This inmate reported that no nurse responded for approximately 20 minutes and a lieutenant was giving the inmate CPR while the nurse "was not in a hurry to get here". The inmate stated he had corresponded with the Nelson Mullins law firm in the past and they should expect a letter from him describing the problems that he believed were responsible for the other inmate's death.

When asked what he thought would improve the mental health problem, this inmate stated "training for COs and mental health" and a "core program" and "staff". When asked to elaborate on these items, the inmate stated the correctional officers are disrespectful to the mentally ill inmates and don't have a basic understanding of mental illness, there is no designated program for the treatment of inmates at Lee and he made references to programs he had encountered while incarcerated in the State of Georgia, and there are inadequate numbers of staff in the mental health program.

Assessment:
This inmate's care and treatment are inadequate specifically with regard to his assertion that he has been prescribed an anti-depressant 2 ½ to four weeks ago which has yet to have been administered to him. Further he reported there is a high dropout rate in the group therapies provided by the counseling staff for a variety of reasons. He also has major concerns with regard to the medical care provided to inmates in the facility and makes specific reference to an inmate he believed died from a condition that may have been preventable as well as inadequate emergency response by nursing.

16. This inmate was currently housed in the Kershaw dormitory and reported he had been transferred from Kirkland to Lee on 10/31/06. He reported that initially he had spent his first two months in the Darlington dorm and stated the "East Side is rough". He reported he was subsequently transferred to the Kershaw dorm and is prescribed Prozac and Vistaril.

The inmate reported he had been transferred to Kershaw because he had a cerebral vascular accident as well as heart operation and is currently transported in a wheelchair because he has "no balance". He stated he has a pacemaker as well as diabetes, hypertension, and gastroesophageal reflux disease (GERD). The inmate stated his medical problems, he believes are under reasonable control with the exception of his loss of balance requiring that he be in a wheelchair, but his major problem has to do with "claustrophobia". The inmate reported he has requested the psychiatrist transfer him to another unit or his door be left unlocked as it had been prior to a lawsuit filed by another inmate who had had some of his property stolen. This inmate reported, "security keeps locking my door" and he has filed a grievance. He reported the Warden stated all the doors have to be locked because of the lawsuit filed by another inmate. He reported further the "West Side is better, no robberies in Kershaw" and expressed his opinion that all of the dorms should not be penalized because of the occurrence of a robbery in one of the dorms that took place on the East Side of the facility.

I asked this inmate what he had done in addition to filing a grievance and he stated he had talked to his counselor Mr. . and he believes the counselor is trying to help him but to date there has been no change in his door being locked which causes him great anxiety as he is claustrophobic.

This inmate also offered, "guy died here yesterday". When asked what he meant, he stated the other inmate had been sent to medical and "they sent him right back", and the other inmate subsequently died in his cell.

I asked him specifically about his contacts with mental health staff and he reported he sees his counselor every month and a psychiatrist every two months.

The inmate then offered that his major problems are with custody staff because he stated custody staff "sometimes won't open the door to let us out". He continued that custody staff "let us out when they feel like they get enough officers". He stated that when the custody staff is understaffed, inmates are locked in their cells and the doors are not opened for them to circulate in the dayroom.

The inmate stated that medical staff has said he is not handicapped but he is in a wheelchair and has a single room. He reported he can't stay in the room for very long unless he takes Vistaril 100 mgs TID and Prozac 3 tablets in the morning. He stated he goes to the diabetic line in the morning and the evening as well as the pill line at noon. Also, in the review of the record, there is no documented evidence the inmate provided written informed consent to any of the medications that he is prescribed.

When asked what would make the mental health program better for him, the inmate stated "to get away from here – my problem is claustrophobia – any institution where they don't lock the doors will be better". He stated, "I'm a two but 24 hour medical" and at Kirkland he was only receiving Vistaril 50 mgs BID and that since he has been at Lee "it keeps going up". He stated his counselor wrote to Columbia for him regarding the

locking of the doors and concluded our interview by stating the management of the doors at Lee is not the same as it is in other facilities.

Assessment:
This inmate's care and treatment are inadequate largely because his treatment is not individualized and patient centered. There is no evidence from the interview with him there has been any collaboration between mental health, medical and in his case custody staff to address his issues of claustrophobia and his 24 hour medical status. He reported his anti-anxiety medication has been progressively increased since he has been at Lee because of his complaints of claustrophobia and there are certainly other interventions that could be operationalized for his specific management including management of the locked doors and/or transfer to another facility that could better address his mental health and medical needs.

17. This inmate reported he has been incarcerated at Lee since 2005 when he was admitted to the SCDC from a county facility. He reported he is classified at the M3 level of care and he is currently receiving Vistaril, Clonidine, Zoloft and two other medications that he could not recall. He reported he was initially on the East yard but was moved to the West yard and has resided in Kershaw since movement to the West yard. He reported with regard to his medications that he is being weaned from his Zoloft and he was very concerned because his previous prescription for Fluoxetine was not working. He stated Dr. is making these medication changes and during the course of his description became progressively more anxious and began crying.

This inmate currently works in an office and attends a horticulture program and believes these are helpful in maintaining his mental stability.

With regard to the mental health program he reported he has attended groups including Stress Management and Anger Management and in those groups there were 10-15 inmates. He reported there are new groups "every once in a while" and stated his opinion the groups are "not helpful". When asked to elaborate, he stated the groups are comprised of a large number of inmates, some of whom dominate the groups by talking all the time and others that don't get to say very much at all. He stated he has not seen his counselor except for groups and in his last group he "got mad and said I won't come back". When asked why he became angry the inmate stated it was the same as in other groups where there was very little chance for him to talk about his issues and other inmates dominate the groups. When asked about his contacts with the psychiatrist, this inmate reported that for "6-7 months didn't see a psychiatrist or a counselor except in group". He then became anxious as demonstrated by increased psychomotor activity and trembling and asked whether or not he would get in trouble for reporting this to me. I reassured him that we were interviewing inmates to get their viewpoints on the mental health system or any other concerns as well as to contribute to our assessment of how they were doing and how the mental health program was working. The inmate visibly relaxed and stated he just wanted to tell me that his cellmate is an inmate who was found guilty but mentally ill and had requested that one of us (doctors) meet with him.

A review of this inmate's record indicates he was transferred from the Kirkland R&E on 5/19/05 and his medications at that time were Clonidine, Tegretol, Vistaril and Fluoxetine. The medical screening of 5/19/05 indicated the inmate was on the above medications and also had a history of suicidal behaviors and currently, as well as a trauma history. The treatment plans of 5/31/05, 8/12/05, 11/18/05, 2/17/06, 5/19/06, 8/11/06, 11/17/06, 2/16/07, 8/24/07, 2/22/08 and 8/15/08 were all signed by a counselor and supervisor and indicated the inmate was receiving outpatient mental health services. His diagnoses were noted as Dysthymic Disorder, Generalized Anxiety Disorder, and Attention Deficit Hyperactivity Disorder. The staff's assessment of the "problem" was symptoms of paranoia, crying spells, OCD behavior and sporadic compliance with treatment with the "objectives" to be 100% compliance with medication and the use of depression management tools as well as for the inmate to vent/admit feelings of anger. The "approach" was for the counselor to see the inmate and provide case management services prn and to approach the psychiatrist prn, for each of these treatment plans. The most recent treatment plan was a six-month treatment plan update that identified essentially the same problems and objectives with the approaches for the psychiatrist clinic prn, one to one counseling and case management by CCC, group, and the nurse to administer medications. The MARs for August had blanks for Clonidine for four days, Zoloft for five days, Prozac refusals for two days and blanks for three others. In July the inmate was noted to have no showed for Zoloft on two days with a blank for administration of Zoloft on one morning. In July there were also two Zoloft orders, one for 100 mgs TID and a second for 200 mgs HS with the indication that the inmate would be getting 400 mgs a day however it appears that he may have gotten 500 mgs per day because the a.m. dosage had not been stopped. There were frequent no shows noted, for the noon dosages of Zoloft so that the inmate was getting 100 mgs at noon when he appeared and 300 mgs in the p.m. in July. In June 2008 both the inmate's Klonopin and Zoloft expired on 6/8/08 but he appears from the MARs to have continued receiving the Klonopin through 6/11 and the Zoloft through 6/17. However, after 6/9/08 the inmate did not appear (did not show), for Zoloft 15+ times and Clonidine 15+ times. In May 2008 the inmate did not show or there were blanks for all of his medications in the a.m. and multiple blanks in the MAR for his noon dosages of medication. Also, in the review of the record, there is no documented evidence that the inmate provided written informed consent to any of the medications that he is prescribed.

Assessment:
This inmate's care and treatment are inadequate and the statement by the inmate that his Prozac was not working and that he is being weaned from Zoloft do not appear to take into account the issues of non-compliance and non-administration of his medications from May through August 2008. Quite remarkably the treatment plans are silent on the issues of medication management and this inmate's non-compliance or non-administration by nursing staff of his medications for this continuing period of time. The inmate's statements that he did not see a psychiatrist for 6-7 months or counselor except in groups and that he ultimately stopped attending groups is also not reported in any of the treatment plans which are essentially unchanged or with minimal changes from May 2005 – August 2008. The treatment planning process and the integration of a

multidisciplinary treatment team for this inmate is of poor quality, well below standards, and reflective of an overall lack of adequate treatment planning for this inmate.

18-24. I had the opportunity to interview a group of seven inmates who are currently housed in the Kershaw dormitory and all are participants in the mental health program. I also had the opportunity to review medical records for several of these inmates which I will detail further below. On interview, the inmates reported they had all been in the facility for a range of two to six months with the exception of one inmate who had been in the facility for two years. When asked about their treatment from the mental health program, all of the inmates reported that their medications have expired for two to three days up to three to four weeks at the times when their medications are to be renewed. They reported when they approached the nurses on the pill lines, they are told the medications have not been reordered and that they cannot be dispensed until they are reordered. Several inmates, however, reported that they have observed nurses "borrowing" medications from another inmate's box when their specific medications have not been reordered. The inmates reported there are times when the custody staff "don't call pill line – lock down". They also reported that if an inmate is sleeping he may miss the pill line and that the times for the pill line varies widely such that the a.m. pill line can be any time from 4:00 a.m. to 7:00 a.m., the noon pill line begins at approximately 10:30 a.m. to 12 noon, and the p.m. pill line begins at 4:00 p.m. for diabetics and 5:00 p.m. to 6:30 p.m. for other inmates with an 8:00 p.m. to 9:00 p.m. pill line for some inmates although these inmates reported that none of them receive their medications that late. They reported that the problem with lockdowns is significant in that nurses don't come to the dormitories for the first or second day and that they will bring pills but not liquid medications that have been prescribed for the inmates when they do come to the dormitories. One of the inmates reported that he had been in lock up in the SMU and he did not get his medications until the next day or two after he had been placed in lock up.

I then asked the inmates about other components in the mental health program including group therapies as all of these inmates had been selected because they are listed as being in a group together. The inmates reported that there are "eight classes" that comprise a group therapy sequence with groups meeting two times per week for one hour each. They reported their groups tend to meet for the full eight sessions with one or two of the groups being cancelled during the course of an eight group sequence. These inmates reported however that the dropout rate is high for the groups that typically start with 15-17 inmates and by the time the group ends there are only 6-8 inmates attending. When asked what they thought the reasons for inmates dropping out of the groups, the inmates stated "(1) getting nothing out of it, (2) personal issues they didn't want to discuss, (3) hygiene, and (4) conflicts with schedules, like the gym". This particular group of inmates reported they tend to attend all of their groups but there are some inmates who dropout for the above stated reasons.

When asked how things are working with the mental health program, the inmates began talking about what they described as a "chaotic environment". They stated that they lose privileges and are locked down because something may have happened on the East yard even though all of these inmates are on the West yard in the Kershaw dormitory. They

stated that the response by custody is punitive because they don't understand mental illness and non-mentally ill inmates don't understand mental illness. They elaborated the custody staff are "not educated" and that "COs lock up instead of understanding people on medications – not functioning as well". They stated the officers are "quick to holler pill line – officers laughing at us – because we get medicine – talk to you real messed up – agitated us". They concluded by stating the officers "need training". When I asked the inmates how they communicate this information to their treatment staff and treatment teams, they reported there are "no treatment teams". They elaborated that maybe the mental health staff meets "amongst themselves" and one inmate stated he did have two mental health staff members talk to him at the same time when he was in lock up in 2006 at another facility. When asked about the accessibility of the mental health staff, the inmates all stated they "got to go through your counselor to get to your psychiatrist". I asked them about going to the counselor to the psychiatrist and they reported there are considerable delays in that they send a request to the counselor that takes "weeks to respond, then wait to see the psychiatrist". One of the inmates elaborated that if he submitted a request on the first day of the month he wouldn't see the counselor for a month and then another appointment with a psychiatrist after that which could take weeks to months. When asked about the staff request or sick call process the inmates stated there is a "mailbox by the cafeteria – put it in on Monday, they pick it up on Wednesday, may see you the next Monday, sometimes three to four weeks from now". Two of the inmates stated that if a specialist was required, it would be two to three and up to six months before they would be seen by a specialist.

On observation and interview, this group of seven inmates had a wide range of mental health functioning from low mental health functioning to moderately high mental health functioning, with some inmates having considerable difficulty in expressing themselves and others becoming annoyed with those inmates and overriding what they wanted to say, and the need for there to be redirection to hold their comments until the first inmate had finished making his statements.

I asked the inmates why they thought it took so long to see a counselor or psychiatrist and the responses from two inmates were "these people don't care" which was agreed by several other inmates, and from another inmate "I don't know".

I had the opportunity to review the records of several of these inmates including inmates' numbers 19, 20, 21, 22, 23, and 24.

19. I reviewed the MARs in the medical record for inmate number 19 and his prescription for Seroquel 400 mgs HS. In August 2008 there were blanks on the MAR indicating he did not receive the Seroquel on three dates. In July 2008 the MAR documented his receiving the Seroquel each day. In June 2008 his Seroquel was prescribed at 200 mgs BID and he was recorded as no showing 18 of 22 days in June with three blanks on the MAR for his a.m. dosages and three no shows and one blank for his p.m. dosage. In May 2008 the MAR recorded that he no showed for all of his a.m. Seroquel dosages of 200 mgs but received all of his p.m. dosages of 200 mgs.

20. I reviewed the MARs for inmate number 20 as referenced above for his Remeron 30 mgs HS and Perphenazine 12 mgs HS and for August 2008 there was one no show, July 2008 one blank, and June 2008 two blanks and one no show on the MARs.

21. I reviewed his MARs for a prescription of Wellbutrin 150 mgs Q AM. For the month of August 2008 the MAR recorded he was a no show every day except for two. For July 2008 he was a no show every day except for two and there was one blank on the MAR indicating the medication had not been given. For June 2008 he was a no show seven times for his Wellbutrin.

22. I reviewed his MARs and he was prescribed Vistaril 100 mgs TID. For August, July and June 2008 the inmate was a no show for all of his A.M. Vistaril but appeared for his noon and p.m. Vistaril prescriptions.

23. This inmate was prescribed Seroquel 200 mgs BID. For August 2008 the MAR recorded 12 no shows and five blanks through August 22 with eight additional no shows or blanks for August 23-31. For July 2008 the MAR recorded 20 no shows and for June 2008 the MAR recorded 15 no shows. The majority of the no shows for these three months were in the mornings.

24. I reviewed the MARs for his Perphenazine 8 mgs HS which was prescribed in August 2008 and indicated four blanks between August 7-31. For July 2008 he was prescribed Seroquel which the MAR recorded as his having received each time for the month of July however for June 2008 the MAR recorded one blank and 13 no shows for his Seroquel.

Assessment:
This group of inmates was selected because they had already been placed in a group therapy. Remarkably, the group that they had been placed in was a Medication Management Group and based on my interviews with the inmates as well as my review of several of their MARs in the medical records it appears that medication management is a significant failed component of the treatment process at Lee. All of the inmates reported consistent difficulties in receiving their medications particularly when they are about to expire, and my review of the MARs indicated that a substantial number of MARs recorded the inmates did not come for their medications or at various times they were not given their medications as indicated by blanks on the MARs. The apparent lack of involvement of the psychiatrist in the medication management and treatment planning process is clearly demonstrated based on the interviews of these inmates and reviews of their records. In addition, I did not find any written documentation of informed consent regarding the medications being prescribed by the psychiatrist for any of these inmates. Further there was no documented participation on the treatment plans by the psychiatrist and the treatment plan updates were remarkable for unchanging objectives and approaches to the inmate despite there being clear changes in the inmate's adherence to medication, provision of medication by nursing staff and in some cases dropping out from group therapies. The inmate's complaints regarding the access to mental health staff, the delays in such access particularly to the psychiatrist but also to the counselors, and what they described as a "chaotic environment" in which custody staff respond to

them in demeaning and/or punitive ways are also important contributents to the lack of an organized, developed and comprehensive mental health system.

25. I attempted to interview this inmate who was housed in the SMU in one of the crisis cells. The inmate refused when an officer approached his cell front to come out of the cell to speak with me. I therefore went to the cell to attempt to interview the inmate who looked at me and shook his head "no" that he did not want to speak with me. The officer also reported that he would not get up for them and although he did stand up and look at me, he shook his head and walked to the back of the cell. The inmate was dressed in a jumpsuit and had a suicide proof blanket and reportedly remained on crisis intervention status at the time of the attempted interview.

Assessment:
I could not assess this inmate based on his refusal to be interviewed.

26. I did interview this inmate who was housed in the SMU in a crisis intervention cell. I had to wait for a correctional officer to get a jumpsuit for the inmate as he did not have one provided to him as he was on crisis intervention status. When interviewed, the inmate was calm and cooperative and reported to me he had been incarcerated in the SCDC since 2006 and had been transferred to Lee in November 2007. I asked him about his being placed in the crisis cell and he reported this was the second time and that the first time had been a few weeks prior when he had cut both of his arms and he demonstrated multiple old cuts on both of his arms. He reported the second time was six days prior to this interview when he had been moved from a SMU cell to the crisis cell because he had threatened to harm himself. When I asked the inmate how long he had been engaged in self-injurious behavior or cutting himself, he said since age 15 or 16 and he is currently 19 years old. When asked why he does this, he reported he does it because "it relieves the stress". He elaborated he is stressed from not having heard from his family for a couple of months and has been unable to contact them. I asked the inmate if he had had mental health treatment in the past and reported he had been placed on Ritalin and Adderall when he was eight or nine years old but he wasn't sure how long he stayed on it. He reported that at some point his mother stopped giving it to him.

He reported he has been in the crisis cell and does not know when he may be released. He reported he has a thick blanket in his cell but no mattress and no paper gown. I asked if he had contact with mental health staff and he reported he sees a counselor who comes around once per day and that the counselor looks in his cell, asks him if he is alright and although he has asked to talk to the counselor the counselor walks off and doesn't return until the next day. This inmate reported to me that he had told staff at Reception that he took Ritalin and Adderall but he is currently not receiving any medications and is not on the mental health caseload. He reported his only contacts with the counseling staff had been at the cell front in a crisis cell. When I asked him if he had talked with a psychiatrist or requested to see the psychiatrist, he reported he doesn't know who the psychiatrist is and when he has asked to talk to the mental health counselor, the counselor walks away. I asked him if he had put in any staff requests or sick call and he says he has

trouble reading and writing but he would put in a sick call to the mental health staff and he would try to talk with the counselor again when he came to his cell and ask to see the psychiatrist about medications.

Assessment:
This inmate reported he informed staff at Reception that he had been prescribed medications as a child for what appears to have been ADHD. He also has a history of serious self-injurious behavior by cutting his arms which has been well documented and resulted in his being placed in the crisis cells twice since his transfer to Lee. His description of the counselor making rounds at the cell front but refusing to see him outside of the cell or talk with him and his lack of knowledge about how to attempt to access the psychiatrist are in my opinion reflections of the poor quality of the intake and assessment process specifically at Lee but quite possibly at Reception as well. This inmate has been placed in the crisis cells twice, has seen the counselor at cell front and yet has not been given a full evaluation to determine his mental health needs or the reasons for his self-injurious behavior. These are inexcusable failures to properly evaluate and quite possibly treat an individual who has a high likelihood of having a serious and persistent mental illness.

27. This inmate was interviewed as he was housed in the SMU in a crisis cell. The inmate reported he is on the mental health caseload and had multiple charges of sexual misconduct. The inmate reported he has been in the SMU for 14 months and has requested protective custody because another inmate had threatened to take his canteen. Since he has been at Lee, he reports he has been charged with sexual misconduct six or seven times and he has been given detention time of six months on each charge. He reported he has been in detention (SMU) for 14 months but has up to 36-42 months total detention time based on these charges. He stated the charges are based on his exposing his penis and masturbating in front of female correctional officers. He got his first two charges of sexual misconduct while he was on the yard and got his first six months lockup based on the second charge and has accumulated additional detention time since then.

This inmate reported his history of having been incarcerated in November 1999 and that he has been at MacDougall, Lieber, and finally Lee and was housed in the Kershaw dorm, prior to his having a work release which he violated and was returned to Lieber at the SMU and eventually to the Lee SMU.

The inmate reported he was in a crisis cell once in 2006 after his grandfather had passed away and that he was about to cut his wrists when seen by an officer who stopped him however he was charged with assaulting the officer. The inmate reported he was in the mental health program in 2004 at Lieber until approximately 2007 when he got off the mental health program. When asked why he asked to be removed from the mental health program, the inmate stated that he believed the staff "were experimenting on me with psychotropics – Risperdal, Zoloft (hurting my stomach), Thorazine, Vistaril, Benadryl, Tegretol". When I asked him if any of these medications had been helpful to him, he stated that he believed the Tegretol and Risperdal had helped him "with my

schizophrenia and sleeping pattern – up all night, pacing the floor". He reported further that the medications helped him not hear voices and helped him not believe that people were trying to hurt him.

He reported that currently he does not hear voices but he still believes that people are trying to get him but that its not occurring as often as it had been.

I asked the inmate about his continuing to get charges for sexual misconduct because of exposing himself and masturbating and he reported he does this because he is "trying to relieve my sexual tension – nocturnal emissions". When I asked him since he is single celled why the exposures and he stated "sometimes act without thinking – haven't had a charge in a year; still six months detention". He reported he plans to put something up on his window because he has nocturnal emissions but he is not actively exposing himself.

I asked the inmate how he would go about obtaining mental health treatment if he felt he needed it, and he stated that he would have to write a staff request to one of the counselors. He stated he will if he has to and he wants a medication "that will help me without changing up – switching".

Assessment:
This inmate reported he has accumulated years of SMU time based on charges of exposing his penis and masturbation in front of female correctional officers. He reported a history of using bad judgment but also acting without thinking that in my opinion strongly suggest he needs to be evaluated as possibly having a sexual paraphilia i.e., exhibitionism. When seen he was in a pink jumpsuit because inmates who have been found guilty of sexual misconduct are housed in pink jumpsuits for extended periods of time. The stigmatization of this practice and identification of inmates as having sexual misconduct is a system-wide practice. There is however no apparent effort at evaluating individuals who have repeated sexual misconduct charges such as this inmate for the possibility of a mental disorder that may indeed respond to treatment. Further this inmate has a history of what appear to be psychotic symptoms and treatment with anti-psychotic and mood stabilizing medications, none of which he is receiving currently. His aversion to mental health care is by his self-report based on his belief that staff were experimenting on him with psychotropic medications. He reported there were two medications that were helpful to him but he does not want to be in the mental health program where medications may be "switched". The practice of not obtaining written informed consent for inmates placed on psychotropic medications may very well contribute to inmates refusing medications and mental health treatment despite the need for such treatment. In my opinion this inmate's care and treatment are inadequate and he is in need of a re-evaluation to properly assess his mental status and the possibility of a Psychotic Disorder, Mood Disorder and/or Sexual Paraphilia. Confining him to a SMU for extended periods of time does not appear to be supportive of his mental health needs.

28. This inmate was seen in the SMU because he was housed in a crisis cell. The inmate reported he was placed in the crisis intervention cell on 9/10 or 9/11/08 with this interview being conducted on 9/16/08. He reported he was having problems with his

roommate and was told by a lieutenant that the lieutenant would move his roommate but when his roommate was not moved this inmate threatened to kill himself and had a razor blade in his hand. He reported he was taken initially to medical and to the crisis cell and has remained there for the last five or six days even though he was taken off of crisis intervention status the day after he was admitted to the cell.

The inmate reported he has been incarcerated for seven years and has never been in a mental health program and has never had any history of treatment. He reported he has never taken any medication but is concerned that he has no property in the crisis cell. He reported he does have a thick quilted blanket but no mattress and when on crisis intervention status no clothing, and no paper gown. He reported he sees a mental health counselor walk past the crisis cells once a week or more if there are other people in the cells. He reported he has seen the counselor walk past the crisis cells four times since he has been in the crisis cells for the past five or six days. This inmate reported he wrote to the psychiatrist but received no response. He also reported he was told by two counselors that he should sign up for sick call and he has, and when he was seen he was told that he was a drug addict and does not need any mental health services. He reported he has not filed a grievance even though he has not been placed on the mental health caseload and believes that he should be. He reported all of his contacts with the counselor staff have been cell front interviews and speaking with me in an interview room is the first time he has talked with a mental health practitioner outside of the cell.

Assessment:
This inmate is not currently on the mental health caseload although he has requested he be seen by the psychiatrist. He reported the counseling staff have told him that he does not need to be seen by the psychiatrist because he is drug seeking and does not need mental health services. In my opinion, this is an inappropriate judgment for the counseling staff to make and they have not properly evaluated this inmate for his mental health history and mental health needs since his incarceration. He has threatened to cut himself with a razor blade resulting in his being placed in the crisis cell where he has remained despite being taken off crisis status. The use of the crisis intervention cells is improper and the attendance by the mental health staff is inadequate. This inmate is in need of a proper mental health evaluation by a properly credentialed and trained mental health professional with regard to his mental health needs and the possibility of his needing psychotropic medication and/or other interventions. The standard operating procedure at Lee to have screenings done by the counseling staff of staff requests by inmates to be seen is inadequate and may very well result in inmates threatening to harm themselves and indeed harming themselves in efforts to be properly evaluated by a psychiatrist. This practice is unacceptable.

29. This inmate was interviewed in Chesterfield dorm. He reported he has been incarcerated for the past 28 years and began having mental health problems in 1994 or 1995. He reported he had been getting mental health treatment at Lieber prior to his transfer to Lee 16 months prior to this interview. He reported he has been at Gilliam Hospital multiple times because of his mental health problems. He reported he is currently on outpatient status and sees a counselor once every 90 days and a psychiatrist once every 90 days. He

reported he is prescribed Seroquel and he gets it each day except for when there are lockdowns, short staffing, or emergencies.

He reported he believes he has serious mental health problems although he has been told by a counselor at Lee "my mental stability doesn't affect my behavior". He reported that when he has experienced problems, particularly before 2002, he was a major disciplinary problem. He reported he has not been since except for one incident where he stabbed two people while at Lieber. He also reported "I had a major problem with cutting". He added that his counselor "isn't concerned about my mental health or stability – she just don't give a damn".

I asked him how often does he see his counselor and he stated he sees his counselor every 60 to 90 days but "the only thing she was interested in was me not bringing her any work – she said "well don't cut yourself because I would have to do a bunch of paperwork". He continued "when they do call me up to talk to me, the way I see it, they are going through the motions, to put the paperwork in" or to document that they have seen him. He added "the few people here are supposed to be helping don't care – if I could put a little bit of trust in the staff I think I would be doing better, feeling better."

I asked him if he participates in any of the groups or has had contact with the treatment team and he reported he attended Anger Management class and attended four of eight because four were cancelled because of lockdowns or they didn't have staff. With regard to the treatment team, he reported that at Gilliam Hospital he had met with treatment teams but "not here". He reported there are no treatment teams at Lee where mental health staff discuss with the inmate any treatment issues.

I had the opportunity to review this inmate's MARs and his medical record. He appears to have received his Seroquel XR 300 mgs once per day in August 2008 with one exception, in July 2008 with two exceptions and June 2008 with three exceptions. Five of the six times that he did not receive his medications, there were blanks on the MAR indicating they had not been given and the sixth time he was reported as not showing for his medications which occurred in June 2008.

Assessment:
This inmate's care and treatment does not appear to be adequate. He reported he has a long history of incarceration as well as mental health treatment and he has improved in the last six years or so. He acknowledges however that he has had one incident since that time in which he has stabbed two people. The inmate stated he is currently prescribed Seroquel and he gets it on a regular basis unless there are staffing shortages or lockdowns. He reported he doesn't trust the mental health staff and has essentially no confidence in their treatment efforts or in their assessment that his behavior is unrelated to his mental stability. This inmate also has a history of self-injurious behavior by cutting himself and therefore a multidisciplinary approach and relevant structured therapeutic activities including group therapy and possibly individual therapy would be important interventions for him to have.

30. This inmate was interviewed in Chesterfield dorm and reported he had been transferred from Perry to Lee on 5/5/08. He reported he has been in the mental health program and receiving services for the past 10 to 11 years since he has been locked up. He reported he had been at Gilliam Hospital in late 2001 as an inpatient.

The inmate reported that since being at Lee his understanding is that his counselor has to see him every 90 days because he is an outpatient on M2 status. He reported his counselor did see him in May but has not seen him since and 90 days would have occurred sometime in August 2008. He reported he did see the psychiatrist in May and for a second time the week prior to this interview. He reported he is currently prescribed Haldol, Cogentin and Celexa but stated he is "not getting meds right during lockdowns". When asked what happens he stated the nurses bring the noon and p.m. meds at the same time and give them to an officer and then the nurses go to the other side of the building. He reported the officers then give the inmates their medications cell to cell and that he is doubled celled. He reported this practice has been going on since May but it stopped five to six days prior to this interview. He reported the practice applied to any type of medication including psychotropics or "regular until 5-6 days ago". He reported the practice of not getting medications during lockdowns or getting two dosages given to the officers who then give them to the inmates resulting in at least one problem with another inmate who is a neighbor of his who had a fight with his cell mate because he hadn't been getting his medication and he was complaining. This inmate reported that his neighbor had two or three seizures and they wouldn't come and get him" and eventually the other inmate had to go to the hospital.

This inmate was wearing a pink jumpsuit and I asked him what this meant and he stated it "symbolizes sexual misconduct or masturbation – I'm wearing one because classification woman said I groped myself in front of her". He reported he was given a three year sentence by the Disciplinary Hearing Officer (DHO) to wear the pink jumpsuit but the Warden knocked it down to two years and put him in the Chesterfield dorm. He reported he had no charges for 18 months before this charge but he got the three years because in 2004 he had a sexual misconduct charge when he said something "lewd" to the officer. When I asked him what he said he stated he said to the officer "you got a fat ass".

I asked the inmate about the mental health program and his treatment. He stated the inmates are not getting adequate treatment "like get a charge – sent to mental health counselor – counselor doesn't talk to us about the charge – just fills out the paper". The inmate reported his opinion that the inmate should be seen by mental health staff before going to the DHO. He reported further when asked about the treatment team there is no treatment team at Lee like had at Gilliam Hospital. I asked him if he had had any past mental health treatment and he stated he used to go to mental health "on the street" and had diagnoses of Schizophrenia, depression and ADHD but that he, himself, thought that he might be "bipolar".

I had an opportunity to review this inmate's medical record and noted his transfer from Perry on 5/9/08 with a medical screening having been done at Perry on 5/1/08. A treatment plan of 5/13/08 was signed by a counselor and supervisor and noted he had a

history of auditory hallucinations, suicidal ideation and depression and his medications were Haldol, Desimpramine and Cogentin. Objectives on the treatment plan were for the inmate to take medications, to educate the inmate for the inmate's utilized coping skills, for the inmate to refrain himself from destructive behavior and for group therapy prn. The approach was for the counselor to monitor the inmate's medications, the psychiatric clinic and individual and group therapy prn. A review of the inmate's MARs indicated that he had blanks on his MARs in August for not receiving Haldol three times, Cogentin three times, and Celexa twice, blanks on the MARs in July 2008 for not receiving Desimpramine seven times and Haldol four times and Cogentin and Celexa four times, and in June 2007 the MARs indicated that his Haldol had been refused five times, blank once and all of his medications were blanks (missed) on June 14 and 15.

Assessment:
This inmate's care and treatment are inadequate. There have been deficiencies in his having his medications administered consistently, his treatment plans are essentially unchanged, and he has been placed in a pink jumpsuit for sexual misconduct for two years without any assessment or evaluation of whether or not this misconduct is in anyway related to mental illness or mental disorder.

31. This inmate was interviewed in Chesterfield dorm and reported he had been incarcerated for the past 18 years. He reported he had been admitted to Gilliam Psychiatric Hospital 12 or 13 times over the past 18 years most recently three months prior to his transfer to Lee and that admission had been for three months. The inmate reported he is currently prescribed Haldol, Cogentin and Prozac. The inmate also reported he had been in the ICS program at Lee in 1994 and 1999, and his diagnosis is Paranoid Schizophrenia.

This inmate reported there is no treatment team at Lee like the one at GPH and he believes he needs to have groups and better treatment.

He reported he is supposed to see his counselor once per month but he doesn't see him that often and at times the whole unit is on lockdown. He reported he gets his medications everyday except when they "run out" or during lockdowns. He reported he will miss three or four medications during the lockdown and eventually the nurse will come and give the officer his packet and the officer slides the packet under the door. The inmate reported "this is not a good place for me – lockdowns, two or three stabbings, and only one hot meal a day". He reported he sees his psychiatrist once every three months but that he believes he is in need of more intensive treatment.

Review of his record indicates he was transferred from RCI on 1/26/08 and a discharge summary from GPH of 3/26/08 documents his admission from 1/30 through 3/26/08 with a diagnosis of Schizoaffective Disorder Bipolar Type and Antisocial Personality Disorder. The treatment plan done at Lee on 4/25/08 was signed by two counselors and repeated the diagnoses and described his level of care as area mental health. The "problem" statement stated he has a history of depression, psychosis, returns from GPH secondary to non-compliance with medications and that he was prescribed Haldol and

Cogentin. The "objectives" were for him to take his medications to educate the inmate, for the inmate to develop coping skills, and group therapy prn. The "approach" was to refer the inmate to the psychiatric clinic, medication compliance, and one to one prn. The treatment plan update on 7/25/08 said essentially the same thing and that the inmate was stable and compliant with his medication. MARs were reviewed and the inmate was prescribed Haldol, Prozac and Cogentin and did not show on the mornings of August 10, 13, 28 and 31 for his a.m. medications, and there was no documentation he received his medication on the 21st. In July 2008 all of his medications were missed on July 3rd and 4th. The record did not have MARs for the months of April, May or June 2008.

Assessment:
This inmate's treatment plans and medication management are inadequate and should be reviewed for the appropriateness of his level of care.

32. This inmate was interviewed in Chesterfield dorm and reported he had been housed at Lee for just over one year since his admission to the SCDC. He reported he has a past mental health history and treatment for bipolar disorder, anxiety disorder for the past four years and that he has been prescribed Remeron and Vistaril currently. He had been prescribed Depakote but developed side effects so he asked to be taken off the medication approximately two to three months after he got to Lee. He reports that he has never been in a psychiatric hospital.

With regard to his medications, the inmate reported he doesn't get his Remeron and Vistaril "some times – don't let us go to the pill line, mainly lockdowns". When asked about the nurses coming to the dorm, the inmate stated they didn't use to come over to his previous dormitory and that dorm sent the inmates to the pill line even during a lockdown, however, he stated the nurses bring the medications to Chesterfield, give the medications to an officer and the officer then slides the medications under the door. This inmate reported his medications were "short three times for three days consistently".

I asked the inmate about his counselor and he reported he sees his counselor sometimes two times per month and sometimes not for a whole month at all. He reported he is in a medium custody dorm and they moved him and his roommate for "no reason" and he asked his counselor to find out why. He reported his current dorm is a "very dangerous dorm" and elaborated that inmates "here try to kill the police." He stated further he has not done anything to be placed in this dorm and his counselor doesn't seem to be able to help him with this.

With regard to the psychiatrist, this inmate reported he sees the psychiatrist once "every two months something like that". He elaborated that he had a problem with his medication, his counselor did put him in to see the psychiatrist and he saw her two weeks later. He reported he was prescribed Vistaril for anxiety and Remeron for anxiety and sleeping but "I stayed severely depressed but afraid to tell them cause they throw you in a crisis cell, butt naked – freeze to death". He reported he was taking Klonopin and Neurontin on the street and staff here would give an inmate Neurontin for muscle problems but not for mental problems. He reported he brought this up to the psychiatrist

and she told him that she doesn't prescribe Neurontin. The inmate concluded by saying "I really need a better medicine for my bipolar disorder and anxiety."

I had the opportunity to review this inmate's medical record which states he was transferred to Lee from Reception and Evaluation on 9/20/07. The treatment plan of 10/4/07 was signed by a counselor and supervisor who designated his level of care as area mental health. His diagnosis was deferred. His problems were identified as family problems, prison adjustment, legal correctional history. His objectives were to be evaluated by the psychiatrist and to adjust, and the approach was for the psychiatrist prn, to take his medications, one to one and case management prn. He had two treatment plan updates on 1/24/08 and 7/24/08 and his diagnosis on 1/24/08 was entered as ADHD with the same problems, objectives and approach and on 7/24/08 the diagnosis was changed to Major Depressive Disorder with essentially the same objectives and approach. MARs for August, July and June 2008 indicated he had six blanks for his medications and one no show.

Assessment:
This inmate's care and treatment appear to be inadequate and his diagnosis does not appear to have been consistent nor do the medications prescribed at the dosages they were prescribed appear to be adequate, particularly based on the inmate's complaints of his being depressed and in need of medication to treat his Bipolar Disorder and anxiety. There does not appear to be participation by the psychiatrist in the treatment planning process and certainly not in discussion directly with the inmate. His anxiety level is also increased by what he has reported as a "dangerous" environment and this does not appear to be addressed in his treatment plan which has nearly identical objectives and approaches regardless of his changes in environment and mental status.

33. This inmate was interviewed in Chesterfield dorm. He reported he was admitted to Lee in 2006 from home and he has a 20 year sentence. The inmate reported he had no past mental health treatment but was admitted to GPH from February through March 2007 because "couldn't handle my mental status here". He reported he is not getting his medications correctly and he doesn't know the names of the medications anymore. He said when he asks the nurses "they told me to take what they are giving". The inmate stated he attempted to hang himself twice and he was admitted to GPH but found the food trays inadequate. He stated while he was at GPH his medications were Prozac, Benadryl, Artane and Haldol and then recalled that currently he is on Paxil, Cogentin and Tegretol. He stated he has trouble sometimes managing his anger and that he has asked to see the psychiatrist but the "counselors control that – they say I didn't show but I had an appointment, orthopedic at Kirkland". He stated his counselor told him that his caseload was too high, so for two and one-half to three months he had no counselor. He reported that currently he is being seen every 90 days. I asked him about groups and the inmate stated he was in "Thinking For A Change" with a counselor but the group only met four of the eight sessions because the other four were cancelled. I asked him if he had ever met with a treatment team and he said he did at GPH but "never here".

This inmate was also wearing a pink jumpsuit and I asked him why and he stated that he had openly masturbated twice, the last time in May or June but he also stated he didn't masturbate in May or June but had a verbal conflict with a female staff member. He stated he has to wear the jumpsuit for a year and a female staff member can say "anything they want" about an inmate that can result in them having to wear the pink jumpsuit.

I asked this inmate what he thought could make the mental health program better at Lee and he stated "people – staff take time to listen, staff need to be observed and supervised." He added there are "no programs prior to release". The inmate also stated he had no history of treatment for sexual disorder.

This inmate's record was reviewed and indicated he had been admitted to SCDC on 8/7/06 and transferred to GPH from 3/7 to 3/15/07. A medical screening on 3/20/07 appears to have been done while he was at GPH. The discharge summary indicates the inmate was involuntarily admitted and had diagnoses of Malingering, Polysubstance Dependence by History, Antisocial Personality Disorder and Narcissistic, Histrionic and Borderline Personality Disorder. A treatment plan of 8/25/06 at Lee was signed by a counselor and supervisor and indicated a diagnosis of Malingering and Sexual Impulse Control Disorder. His level of care was area mental health and his problems were identified as sexual inappropriateness, SIB, suicidal threats/gestures, and Polysubstance abuse. He was noted to be taking Zoloft and Valproic Acid. The objectives were for him to take his medications, refrain from SIB and manipulative behaviors, and to be held accountable for his behaviors. The approach was substance abuse group, the counselors schedule a psychiatric clinic, one to one, and group prn. The treatment plan of 11/17/06 was essentially the same. The update on 2/12/07 changed the diagnoses to Intermittent Explosive Disorder and Impulse Control Disorder with the same objectives and approach. On 5/11/07 he was noted to have returned from GPH with suicide attempts/gestures and the same objectives and approach. On 8/24/07 his diagnosis was changed to Psychotic Disorder NOS and his medications included Valproic Acid, Paxil and Risperdal with the same objectives and approach. The update of 12/14/07 was essentially identical to that of 8/24/07 although the update of 6/13/08 returned the diagnosis of Intermittent Explosive Disorder and his medications were Tegretol, Depakote, Risperdal and Paxil. Review of his laboratory studies revealed he had Valproic Acid levels on 3/9/07, 3/20/08, and 6/18/08 that were all less than 10. He had Tegretol blood levels on 4/21/08 and 6/18/08 and on 4/21/08 it was less than two and on 6/18/08 it was just within the therapeutic range at 4.6.

Assessment:
This inmate's care and treatment are inadequate. His diagnosis has been changed multiple times and yet the objectives and approaches on his treatment plan remained essentially the same. He has had prescriptions for medications including two mood stabilizers that had been sub-therapeutic and not been repeated to assure that the laboratory testing results were accurate nor have there been adjustments or changes in his medication or any documented review by the psychiatrist that resulted in any change in his treatment plan. The treatment planning for this inmate is woefully inadequate and it appears he has been diagnosed with Intermittent Explosive Disorder with very little

clinical indication that he suffers such a disorder and again the treatment plan does not appear to have any relevance to the changes in his diagnoses which has ranged from Malingering, Psychosis, and Intermittent Explosive Disorder, to Sexual Impulse Control Disorder. This inmate's care and treatment are in need of review by a multidisciplinary treatment team that reviews his whole history particularly since it is anticipated that he will remain within the SCDC for an extended period of time.

34. This inmate was interviewed in Chesterfield dorm and reported he has been at Lee since March 2008. He reported he was incarcerated in 2005 and has had mental health treatment since 1997. He reported mental health treatment continued until July 2008. He also reported the mental health treatment included 4-5 admissions to GPH and the prescriptions of Geodon and Benadryl. When asked about his mental symptoms, the inmate reported he has "audio-visual hallucinations" and that "they never told me" a diagnosis but he had killed a man when he was 13 and he sees this man and hears him sometimes. He reported that caused him to attempt to overdose in January 2008 on pills that he got from other inmates at RCI. He reported this resulted in his going to GPH for 30 days and eventually to Lee. He stated he is very unhappy with being at Lee because he had been stabbed at Lee before and believes his life is in jeopardy. He stated he is supposed to be a level two but is area mental health and he believes he can only go to Perry or Lieber. He said he was also told he can't be transferred unless he is off the mental health caseload and then he would be able to go to a level two yard. He stated he has asked his counselor about going to Perry or Lieber and he doesn't know why he can't go but he had stopped taking his medications so he can be off the caseload.

When I asked him how he has been feeling since he stopped taking medications, he said he has been hearing the guy that he killed and he is "paranoid about getting stabbed". He stated he was told by his counselor that a transfer would be up to classification and believes he is still on the counselor's caseload as an outpatient. He stated he was told that any transfer would be up to classification after he had "been up for two days straight" and he knows he needs to be back on his medication, but he wants to be transferred.

This inmate was also wearing a pink jumpsuit and stated it was because of a sexual misconduct charge he got at Ridgeland when "lady officer said she looked through my window and saw me" and he was in his room "jackin." He reports he has to wear the jumpsuit for a year and is appealing that timeframe but it takes 60 days for the appeal to go through. When I asked him if this was the first time that he had ever been charged he said "no", he had been charged "a few times" since he was 17 and he is 33 now. When I asked him for more information about that and pressed him on the subject, he admitted he had been charged more than 20 times. He stated he has tried to talk to counselors about it but "they say its not a part of mental health." When I asked him why he continues to masturbate in front of female officers, he stated "I get urges – my lust – can't control it". He asked about whether this is something that staff could help him with but said "they don't care".

He stated further, "the counselors don't do nothing except asking if we thinking about killing ourselves". He stated then that inmates are stripped naked "till they say what the

counselor want" and "then back to the same condition no treatment just medication." He stated he believes this is like being a crack head who is detoxified and then sent back to the same environment. He reported the counselors see the inmates once every 60 days but in a crisis their whole thing is to strip naked in the cell with no change in the program, the same conditions." I asked him why he is talking to me today given how he feels about the mental health program and staff not caring and he said "I'm talking to you cause it seems like you care about it and us – people can tell."

I reviewed this inmate's record that indicates he was transferred from RCI on 3/27/08. The medical screening was done on 3/24/08 at RCI. The treatment plan at Lee was done on 4/25/08 and signed by two counselors and the inmate's level of care was noted as area mental health. His diagnosis was Psychosis NOS and his problems were noted as auditory hallucinations, suicide attempts/gestures, Polysubstance abuse and he was prescribed Geodon. The objectives were for him to take his medications, develop coping skills, refrain from SIB and drugs, attend group and the approach was for the counselor to refer him to the psychiatric clinic, monitor compliance with medication, and one to one and group prn. The update of 7/25/08 was essentially the same and indicated the next review would be 1/09. A review of the MARs revealed that the last MAR in his record was for May 2008 and he was prescribed Geodon 80 mgs BID. There were 25 no shows or blanks for the morning dose of Geodon in the month of May and five blanks and one no show for the p.m. dose for the month of May.

Assessment:
This inmate's care and treatment are inadequate. He has a substantial history of Psychotic Disorder and possible Mood Disorder. He also has a substantial history of at least 20 sexual misconduct charges for openly masturbating in front of female officers. This inmate has requested help with controlling his sexual urges from mental health staff and according to him has been told that "it is not a part of mental health." He has also requested a transfer to another institution because of his fears of being harmed at this institution and according to him been told that he can't go to another institution because of his mental health status so that he has stopped taking medications which he clearly needs. The inmate continues to report psychotic symptoms that also could be related to a post-traumatic stress disorder. His sexual behavior deserves evaluation for possible sexual paraphilia and treatment if indeed he does have a sexual paraphilia rather than continuing charges, stigmatization with the pink jumpsuit, and probable detention time based on continuing the same behaviors. This inmate's care and treatment as well as his custodial status and housing are in need of serious review and adjustment. His condition is not being improved and very likely worsened by the failure to provide comprehensive treatment and custodial management.

35. This inmate was interviewed in Kershaw dormitory based on his own request. The inmate reported he had requested speaking with one of the doctors conducting interviews because he has been found guilty but mentally ill and had been receiving treatment from the mental health program but has not in the last year and one-half to two years. He reported he stopped seeing the psychiatrist around a year and one-half to two years ago because the psychiatrist had changed his medications a couple of times and told him he

didn't have to stay on medications so the inmate stopped taking them. He reported he continued to see his counselor but stopped seeing her approximately a year ago. He reported he has seen his counselor on the grounds and told her that he would like to get back in the mental health program and has been told to send a staff request form. He stated he has sent a staff request form but has not heard anything since that time.

I reviewed this inmate's medical record which indicates he was transferred from Reception on 4/5/05. A treatment plan at Lee on 4/15/05 provides diagnoses of Major Depressive Disorder and Post Traumatic Stress Disorder. He was noted as an outpatient and GBMI. He also had a history of sexual assault, substance abuse, and was prescribed Vistaril and Prozac. The objectives were for him to take medications, develop coping skills and the approach was prn counseling and psychiatric clinic. He had an update on 7/29/05. He was noted to have poor compliance with his medications and group but the objectives and approach remained essentially the same. On 10/28/05 he was noted to have increased anxiety and depression and on 1/27/06 he was diagnosed with Dysthymic Disorder. My 7/28/06 his diagnosis had been changed to ADHD and he was prescribed Seroquel. On 1/5/07 his diagnosis remained ADHD however Generalized Anxiety Disorder was added. The last treatment plan was on 7/20/07 and he was diagnosed with ADHD, GAD and Avoidant Personality Disorder and the objectives and approach remained the same. The initial diagnosis of Major Depressive Disorder and PTSD on the treatment plan of 4/15/05 is consistent with the discharge summary from GPH of 2/23/05 which gave the diagnoses of Major Depressive Disorder Recurrent, Severe with Psychotic Features, PTSD, and Personality Disorder NOS. A review of his MARs noted that his last psychotropic medications were discontinued on 8/14/07 which consisted of Buspar 30 mgs TID.

Assessment:
This inmate has been determined legally to be guilty but mentally ill. He has been diagnosed with a Major Depressive Disorder with Psychotic Features and Post Traumatic Stress Disorder as well as Personality Disorder. Those diagnoses have been changed by different clinicians at Lee and the treatment plans have remained essentially the same with the exception of some changes in medication until August 2007. The inmate's history is remarkable for him having what are usually considered severe and persistent mental illnesses and which require treatment. The inmate appears to have adjusted to prison life and has a job at Lee however his request to be returned to the mental health caseload has run into the same process i.e. the counselors as gatekeepers when this is clearly a case that would require an evaluation by a psychiatrist. His complex history, his changing diagnoses and the use of multiple medications in the past as well as a legal determination of his having a mental illness should require that he be seen promptly by a psychiatrist to determine whether or not he is in need of resumption of mental health treatment. To allow that determination to be made by a counselor with no further review is harmful to this inmate's mental health and potentially harmful to others.

36. This inmate was seen in Kershaw dorm and reported he had been transferred from Trenton to Lee in March 2008. He reported he had been on Seroquel when he was on the street and had been prescribed Klonopin since his incarceration which was later changed

to Seroquel and Celexa. He reported he has had problems with pill lines and lockdowns and that for a month or two there were times when he did not get his medications for two days in a row because the pill lines were cancelled. He stated one of those was because of a bad electrical storm so he wouldn't have gone to the pill line anyway. He reported he gets his medications at 4:00 a.m. and he has seen the new psychiatrist and met with her every three months and believes that she's "terrific". He reported further he believes his mental health case worker has been helpful to him and anticipates going home in February 2009. He also reported he has been in an Anger Management class and completed all eight of the classes.

This inmate reported there are no treatment teams at Lee and was not sure of how that would work as he has never been in a treatment team meeting since he has been in prison. He reported he was receiving treatment prior to incarceration and plans to return to the community provider he had been treated by prior to his incarceration.

Assessment:
This inmate reported he is satisfied with the psychiatric and counseling services he has received at Lee since March 2008 and anticipates he will be discharged in February 2009. He reported he has not seen a treatment team since he has been incarcerated but has missed his medications on a few occasions when the pill lines were cancelled. He said he does not have any other complaints about the mental health services he has received.

37. This inmate's medical record was reviewed for the documentation of mental health services. The inmate was transferred from MCCI on 12/9/05 and was receiving Thorazine prior to his transfer. A treatment plan of 2/17/06 was signed by a counselor and supervisor and the diagnosis was Malingering Psychosis. The treatment plan had the usual objectives for an inmate to take medications, educate the inmate, the inmate to refrain from self-destructive behaviors, utilize coping skills, with the approach for the psychiatry clinic prn, individual and group prn and a counselor to monitor for medications.

On 8/11/06 the inmate's diagnoses was changed to Impulse Control Disorder and Exhibitionism and he was prescribed Zoloft with the same objectives and approach. The update of 2/2/07 had the same diagnoses and assigned the inmate to a Medication Management group but otherwise was the same. On 8/24/07 the treatment plan update was the same but assigned the inmate to Thinking for Change group. On 2/28/08 and 9/11/08 the inmate's objectives were changed to include no sexually inappropriate behavior and he was described as stable. The MARs indicate this inmate did receive his Zoloft 200 mgs HS for the months of May through August with only one blank on the MAR.

Assessment:
This inmate's treatment plan and diagnoses are in need of review. His diagnoses were changed from Malingering Psychosis to Impulse Control Disorder and Exhibitionism and

he has been prescribed Zoloft. There is nothing in the treatment plan to suggest there has been any attempt to treat his Exhibitionism with the possible exception of prescribing an anti-depressant. There is a need for more comprehensive review and development of other treatment interventions for the treatment of sexual paraphilia when it is diagnosed.

38. This inmate's medical record was reviewed specifically the MARs for medication management. The inmate was prescribed Risperdal 2 mgs BID and Prolixin Decanoate by injection 12.5 mgs every two weeks. For the months of June, July and August the inmate received Prolixin injections on June 10th and June 24th. He however did not receive it again until July 25th, four weeks after his last injection, and did not receive it again until 8/18/08, three and one-half weeks after the 7/25 injection even though it was ordered for every two weeks. With regard to his Risperdal, the inmate was noted as a no show on six of nine days in August for both of his dosages of Risperdal. In June and July 2008 he was noted as a no show for all of his dosages of Risperdal except for seven days in June and three days in July when the MARs were blank indicating that the medications were not offered.

Assessment:
This is a horrific example of poor medication management for an inmate who is on two antipsychotic medications, one of which is an injectable medication to be given every two weeks. The MARs indicate that not only was he not coming to take his oral medications and on some days was not offered his oral medications but he was inconsistently receiving his injectable medication and this occurred over a three month period. This is an example of very poor medication management and reflects not only poorly on the nursing service but also on the psychiatrists and counselors in the mental health program as a whole for not having detected these problems and formulating alternative interventions and/or more appropriate medication management.