December 30, 2010

Nelson Mullins Riley & Scarborough, LLP
Attn: Daniel Westbrook
Keenan Building, Third Floor
1330 Lady Street
Post Office Box 11070(29211)
Columbia South Carolina 29201

Re: South Carolina Department of Corrections
Camille Graham Correctional Institution

Dear Mr. Westbrook

During August 23, 24, 2010, we site visited the Camille Graham Correctional Institution along with Steve Martin, Esq., Alan Pogue, and Steve Carter. We received a tour of general population housing units, programming areas (e.g. educational building, gym, dining area etc.), medical unit and the Special Management Unit (SMU).

The total inmate count during August 23, 2010 was 562 inmates, which included 124 Reception and Evaluation (R&E) inmates, 41 Special Management Unit inmates and 76 inmates in the Blue Ridge housing units.

During the morning of August 23, 2010, we toured the physical plant of the Camille Graham Correctional Institution. We visited the following units:

1. administration building,
2. medical building,
3. library/gymnasium,
4. Whitney housing units (A&B),
5. Blue Ridge housing units (C&D),
6. R&E/SMU,
7. educational building,
8. welding shop, and
9. apparel workshop.

The medical building had 2 "medical" cells but no 24-hour housing cells for mental health purposes. There were two large rooms that could be converted to crisis cells with appropriate renovations.

The Whitney housing units were dormitories with 48 individual cubicles per unit. Each unit also had 1 cell that was used for "holding" purposes (not for overnight stays). The unit was staffed by one correctional officer for both sides. Whitney B only housed women with HIV+ status (count was 22). The HIV+ women reportedly were segregated only for housing purposes in contrast to programming or dining purposes. There was one HIV counselor, Ms. , assigned to the

unit. It was reported that she was a staff member of Program Services and not a mental health counselor. There were three other housing units with similar configurations.

Blue Ridge D consisted of 48 celled housing with a count of 35 inmates. Some cells had bunked beds but all appeared to be single celled. There were eight camera cells located in Blue Ridge D. Blue Ridge C was a dormitory with 48 single cubicles. The count was 42.

Seventy-five (75) inmates were enrolled in programs within the educational building (primarily word processing/ computer skills). The Apparel workshop currently employed 65 inmates (non-paying jobs) and had a capacity of 79 inmates. Inmates worked four 10-hour days per week. The welding program has a capacity of 15 inmates and we were informed that the shop has had 11 to 15 inmates for the past eight months.

R&E inmates went to the dining hall three times per day and had access to the gym on a 5-day per week basis and had access to showers on a 3 times per week basis. There were 2 tiers with 24 cells on each side of the housing unit for a total of 96 cells. It was common for many of these double bunked designed cells to be triple bunked with one inmate on the floor. It generally took 7 days for R&E inmates to receive a PIN number for telephone purposes. They did not have access to a radio or TV.

There were 4 crisis cells for overflow purposes located in the R&E. SMU overflow inmates were also housed on the lower tier of R&E. A correctional officer and a supervisor staffed the R&E unit along with one CO in the control booth, who also staffed the SMU portion of the building. The average length of stay in the R&E unit was reported by Major to be between 30-45 days.

The SMU side of the building was also two tiers with a total of 96 cells. Four of these cells were also camera cells that were used for crisis intervention purposes. Two COs and one supervisor staffed this unit along with the previously referenced CO in the control booth. Inmates did not have access to either a radio or TV on this unit. Access to the recreational area was 5 times per week for one hour with a maximum of 10 inmates in the recreational yard at the same time.

In addition we were able to interview two groups of outpatients including nine that were previously classified at the L-2 level of care. They had multiple complaints of seeing their counselors infrequently. They also reported medication changes by Dr. without meeting directly with her. The inmates reported further that there are inmates housed on Blue Ridge D that are not mentally ill and others that are on the mental health caseload. They reported concerns that they did not know if Blue Ridge D was an ICS unit however many had ICS classifications by their self-report. The inmates with no mental illness were described as "bullies, troublemakers." They also reported limited access to their counselors stating that when they have exacerbations in their symptoms and request to see a counselor, they are routinely told that the counselor had already seen them for that month and therefore would not see them until the next monthly appointment. They also reported there are no mental health staff available to see inmates on weekends or holidays no matter what their conditions. They also reported that

medications have frequently run out and it takes 3-7 days for medications to be renewed. They reported they are stripped naked when placed in a crisis cell and that only makes their problems more intense. Several inmates reported they had been in lockup, and when released they are put on six-month program restriction and that all their therapeutic activities including faith-based programs are taken away. They also have no visitation, no telephone access, and no canteen except for personal items. Eight or nine of these inmates reported they had previous or current diagnoses of PTSD, however none have had a group focused on the treatment and management of PTSD.

Another group interview was conducted with five women from the Shock Boot Camp. This Boot Camp was described as a 90-day to 10-month program for young women between the ages of 17 to 27 as a Youth Offender program. These women reported that they have clinical counselors who may talk with them one time per month. They all reported they felt a need to have a mental health counselor as all five were on the mental health caseload and were prescribed medication by Dr. These inmates reported diagnoses of schizoaffective disorder, bipolar, schizophrenic, PTSD, post-partum depression, and depression. They reported they are in no mental health groups. They also reported they have treatment plans that include their getting their GEDs and participating in NA or AA groups. These treatment plans were signed by the inmates. They report there are no treatment team meetings where they are able to discuss their treatment plans with staff prior to or after their development. They also reported there is a lack of confidentiality as officers tell each other about the comments or issues that are raised by these women in the Shock Boot Camp program.

Psychiatric coverage has been provided by M.D. She is on site for eight hours every Thursday and an additional two days (12 hours per day) per month for a total of 56 hours of psychiatric coverage (i.e., 0.35 FTE) per month. The mental health caseload was over 200 inmates at Graham CI and did not include caseload inmates treated by Dr. at Graham CI who are from Leath CI.

Appendix I provides statistics relevant to the percentage of inmates in the Special Management Units who are on the mental health caseload.

Appendix II summarizes our interviews with inmates and review of healthcare records.

Summary and Opinion

System issues within the mental health system at Camille Graham Correctional Institution included the following:

1. Inadequate psychiatrist allocations,
2. Crisis cells placed in the SMU in contrast to a healthcare setting,
3. Inadequate treatment in the SMU (e.g., cellfront interventions), and
4. Apparent overemphasis on Axis I disorders.

There is a .35 FTE psychiatrist position at Graham CI for a mental health caseload of over 200 inmates at Graham CI, which does not include caseload inmates treated by Dr. at Graham CI who are from Leath CI. It is likely the following problems are directly related to this either allocation or vacancy issue:

1. lack of participation by the psychiatrist in the treatment team meetings,
2. lack of routine participation by the psychiatrist in crisis cell management of inmates,
3. access problems to the psychiatrist by inmates, and
4. lack of timely follow-up clinical contacts by the psychiatrist.

The use of crisis cells in the SMU and R & E housing units are very problematic and directly contribute to the following issues:

1. lack of a therapeutic milieu in the crisis cells,
2. lack of meaningful crisis interventions (i.e., therapy/counseling), and
3. creation of a punitive environment in response to inmates experiencing a mental health crisis.
4. The custody officer staffing in the SMU and R&E appears to be inadequate. A correctional officer and supervisor staff the R&E unit along with one CO in the control booth who also staff the SMU portion of the building. There are cameras utilized for observation in the CI cells which are monitored by a single correctional officer in the control booth. This is inadequate monitoring.

These problems are exacerbated by the following:

1. excessive property restrictions (e.g., lack of a mattress),
2. clinical "interventions" performed at the cell front resulting in lack of confidentiality,
3. the punitive atmosphere inherent in the SMU setting, and
4. absence of a treatment team concept.

The services for outpatients including those in general population as well as the Shock Boot Camp are also problematic, as follows:

1. inadequate numbers of therapeutic activities including group therapies and an absence of mental health groups for the young women in the Youth Offender program, i.e., Shock Boot Camp.
2. clinical counselors in the Boot Camp as well as the HIV counselor did not report to the lead counselor for the mental health program and their work is not integrated into the mental health programmatic activities or treatment plans.
3. lack of treatment planning and inmates are not participants in the treatment planning process
4. access to the psychiatrist by inmates
5. lack of medication consent forms, and

6. inmates without mental illness housed with mentally ill inmates.

There is inadequate treatment in the SMU for inmates with a mental illness, which includes those inmates with a severe personality disorder that is associated with significant functional impairments. The treatment available is essentially limited to medication management and "monitoring" by a mental health clinician at the cellfront. Many of the mental health caseload inmates have significant social skill deficits, anger management issues and cognitive distortions that require a very structured psychosocial rehabilitation approach for effective management, which is not accomplished via cellfront monitoring. It is not very surprising that some of these inmates have had extended stays in the SMU despite initially having short sentences in the SMU related to these deficits and the punitive milieu of the SMU.

The treatment plans were very generic in nature and did not appear to have been individualized or modified based on the inmate's clinical presentation. The paucity of positive reinforcements and abundance of negative reinforcements have contributed to a very poor treatment milieu within the SMU. In addition, there appeared to be very little coordination and communication between the psychiatrists and the other mental health clinicians as evidenced by the following testimony given by M.D.:

> Q. Do you provide individual therapy to your patients?
> A. I would say that I do provide supportive therapy for some of my patients, yes.
> Q. All right. And how is that different from their individual therapy provided by counselors?
> A. I don't know. I don't know exactly what they do.

In addition, there appears to be an overemphasis by the clinical staff on focusing solely on an inmate's personality disorder in contrast to recognizing other Axis I issues such as posttraumatic stress disorder, affective disorders and psychotic disorders. Some initial Axis I disorders appeared to have been "dropped" by the psychiatrist without adequate documentation re: the rationale for such a change.

Medication management issues appeared to be present as evidenced by lack of timely referrals to the psychiatrist related to medication noncompliance and reports by inmates regarding several days elapsing before receiving medications initially prescribed by the psychiatrist.

We were also made aware of a "new" level system for mental health services just prior to the site visit. The pre-existing mental health classification utilized designations from M-1 through M-6 for various levels of care. The "new" level system now emphasizes L-1 through L-5 and "MH". L-1 designates inpatient, L-2 designates ICS, L-3 designates area mental health, L-4 designates outpatient mental health, and L-5 designates MI stable. "MH" designates "no mental health." In interviews of inmates in the SMU as well as in outpatient housing units, they appear to be unaware of this new classification and could not tell us their current classification. They referred to the prior M-1 through 6 classifications to specify their level of care.

Please contact us if you have questions re: this report.

Sincerely,

Jeffrey L. Metzner, M.D.

Raymond F. Patterson, M.D.

Appendix I

Appendix II

Percentage of MI IMs in General Population and in Segregation at Graham 2007-2009[1]						
Date	*Total IMs*	*MI Ims*	***% MI of Total***	*Total IMs in Seg*	*MI IMs in Seg*	***% MI of Total in Seg***
12/31/06	580	259	**45%**	22	9	**41%**
06/30/07	600	286	**48%**	18	8	**44%**
12/31/07	614	258	**42%**	15	9	**60%**
06/30/08	662	302	**46%**	23	13	**56%**
07/31/08	645	289	**45%**	31	16	**52%**
08/31/08	604	270	**45%**	28	18	**64%**
09/30/08	670	282	**42%**	19	11	**58%**
10/28/08	647	272	**42%**	21	11	**52%**
11/30/08	647	284	**44%**	31	17	**55%**
12/31/08	598	266	**44%**	16	6	**37%**
01/31/09	605	282	**47%**	37	23	**62%**
02/28/09	590	275	**47%**	39	21	**54%**
03/31/09	599	275	**46%**	32	15	**47%**
04/30/09	577	276	**48%**	23	11	**48%**
05/31/09	607	259	**43%**	29	15	**52%**
06/30/09	595	271	**45%**	27	13	**48%**
07/31/09	564	258	**46%**	28	15	**54%**
08/31/09	567	262	**46%**	39	21	**54%**
09/30/09	576	253	**44%**	40	23	**57%**
10/31/09	567	236	**42%**	48	25	**52%**
Average	606	271	**45%**	28	15	**54%**

[1] The total number of inmates in population and the number of MI in total population were taken from 6875-OOO-009 thru 028. The total number of inmates in segregation and the number of MI in segregation were taken from 6875-OOO-167.

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Appendix II

Camille Graham Correctional Institution
Inmate Interviews

1. **Inmate 1**

Inmate 1 was a 20-year-old woman who has been incarcerated in SCDC for about one year related to a homicide conviction (her 6 month old daughter). She was diagnosed by Dr. as having a postpartum depression.

This was her second placement in the SMU. Her first placement was for an alleged assault which resulted in a 30 day stay. After being released for three days she was transferred back to SMU for 10 days due to having a new tattoo.

Inmate 1 indicated that she has seen Dr. on about three or four occasions for medication management. She has been prescribed lithium for about 2.5 months following unsuccessful trials of Zoloft, Celexa and BuSpar. She reported having blood drawn for the first three weeks following initiation of lithium. Inmate 1 stated that none of these medications have helped her mood swings. Periodically feeling very good with racing thoughts was described although other manic symptoms did not appear to be present.

This inmate indicated that she has an assigned counselor but has only met with the counselor on one occasion during her time in the SMU. Her first counselor no longer works at Graham CI.

This inmate will return to Blue Ridge C following discharge from the SMU. She stated that a variety of different group therapies were available within that unit. She has participated in the past in dream group.

There was not a history of mental health treatment prior to her arrest except for a brief period during the age of 13 related to apparent ADHD.

Officers have provided information to inmates re: heat risks and require inmates on psychotropic medications to always have water with them when they are outside and the outdoor temperature is high (~ 90°).

The AMR of this inmate was reviewed. This inmate was initially admitted to Graham R & E during April 23, 2009. HSC I evaluated this inmate during May 4, 2009. N.P. evaluated this inmate during May 9, 2009. Her presentation was consistent with a postpartum depression, major depressive disorder, recurrent, alcohol dependence in remission, and marijuana dependence in remission. Remeron was prescribed.

Another mental health evaluation was dated June 17, 2009. Her presentation was consistent with postpartum depression, major depressive disorder recurrent, and alcohol and marijuana

dependence. She has stopped the Remeron due to side effects. She was referred to Dr.
for further assessment.
Dr. initially evaluated this inmate during August 30, 2009. She was diagnosed as having a depressive disorder NOS and rule out personality disorder NOS. Zoloft was started.

During September 23, 2009 a mental health counselor noted that she was medication noncompliant. The plan was to see her in 90 days or as needed. Inmate 1 was again seen by Dr. during November 1, 2009. Zoloft was discontinued and BuSpar started.

A treatment team summary note was written during December 11, 2009. The psychiatrist did not attend this meeting.

Dr. again saw this inmate during December 31, 2009. A trial of Celexa was started and BuSpar apparently discontinued.

During February 22, 2010 this inmate was placed on crisis intervention status related to suicidal thinking. She was noncompliant with medications. During February 25, 2010, while still on crisis cell status, she was referred to the psychiatrist.

Dr. evaluated this inmate two days later. Celexa was discontinued. She was recommended for release from crisis intervention by CCC IV, during March 1, 2010.

During March 11, 2010 Dr. indicated that this inmate's diagnosis was personality disorder NOS with borderline features.

This inmate asked to be removed from the mental health roster during June 7, 2010. A referral to the psychiatrist was made at that time.

A trial of lithium was initiated during June 10, 2010.

A treatment team meeting occurred during June 11, 2010. The psychiatrist was not present.

The hard copy of the medical record was reviewed. Three treatment plans (6/17/09, 6/10/10, 12/9/10) were reviewed which were identical. Of significance, neither her postpartum depression and nor her medication noncompliance issues were either described or addressed.

Past mental health records from other providers were not present in the healthcare record.

Assessment: This inmate has not received consistently timely assessments by the psychiatrist. The lack of documentation relevant to the dropping of her postpartum depression diagnosis is a concern as well. Counseling has not adequately addressed issues relevant to the death of her daughter.

It is of concern that the psychiatrist does not participate in either treatment planning meetings or treatment of this inmate on a regular basis when she was in a crisis cell. The treatment plans were very generic in nature and did not appear to have been individualized or modified based on the inmate's clinical presentation.

2. Inmate 2

Inmate 2 is a 29-year-old separated African American woman who has been incarcerated for the third time in SCDC for the past three years. She spent her first two years of incarceration at Leath CI and has been at Graham CI for the past nine months related to, according to this inmate, a separation petition from a correctional officer who had been assaulted by this inmate via spitting.

This inmate's five-year sentence for breach of trust will be maxed out during July 1, 2011. She reported that she has SMU time through 2012. Related to her SMU time, she has lost canteen, visitation and telephone privileges through 2020. Inmate 2 will be living with her mother and four children (ages five, six, 10, 14 years) upon her release. It was unclear to her the current status of her relationship with her husband, who is a father of two of her children.

Mental health treatment was reported by Inmate 2 to have primarily consisted of medication management for "panic attacks, problems sleeping [and] nightmares." Medication trials of Triavil, Wellbutrin, Vistaril, Remeron, and Seroquel were reported by Inmate 2. She stated that Remeron had been helpful but was discontinued after she was found to be hoarding pills. Inmate 2 is currently prescribed Haldol, which was described as not being helpful.

This inmate received an additional one year sentence in SMU related to a hoarding charge as well as loss of visitation and telephone privileges as previously described. She stated that the warden from Leath CI told the warden at Graham CI not to suspend any of her SMU sentence. Inmate 2 reports being told by Dr. that she will only receive medications that are available in liquid form. Inmate 2 complained that other inmates with similar hoarding charges receive medications via crushed meds.

This inmate was seen by Dr. . about every three months in a lieutenant's office, which did not allow for adequate sound privacy because correctional officers frequently were in the office doing other tasks. She reported poor access to Dr. other than during her scheduled three-month appointments.

Ms. her mental health counselor, sees this inmate on a cellfront basis about once every 2 to 3 weeks.

The hard copy of her medical record indicated that she was transferred from Leath CI to Graham CI during November 10, 2009.

MARs indicated that she had been refusing her Haldol, lithium and Depakote during most of May 2010, which resulted in lithium and Depakote being discontinued.

Review of an October 2010 treatment plan indicated the diagnosis of depressive disorder NOS and anxiety disorder as well as a personality disorder NOS with antisocial and borderline features. The interventions described were generic in nature.

The AMR of this inmate was reviewed, which provided a different history than obtained from her. An October 16, 2009 progress note indicated that this inmate made it very clear that she wanted to be transferred from Leath CI due to her difficulties with Sgt. The mental health counselor thought she would function better at Graham CI. Following transfer to Graham CI, she requested a mental health counselor be assigned to her during November 16, 2009. She was initially seen by HSC I during November 23, 2009. Her presentation was consistent with a depressive disorder NOS and an anxiety disorder NOS.

Dr. initially evaluated this inmate during December 3, 2009. She was diagnosed as having a personality disorder NOS with antisocial and borderline features (severe) and a depressive disorder NOS. Medications prescribed included Remeron, BuSpar and Triavil.

A January 11, 2010 SMU review note indicated that this inmate was excited that she had been able to call her mother and children on Christmas day, which was the first time she had talked with them in 2.5 years.

During January 14, 2010 Inmate 2 was found to be hoarding medications. The registered nurse indicated that all her medications would be discontinued. Five days later this inmate was requesting to be placed back on psychotropic medications. She was subsequently referred to the psychiatrist by Ms. during January 20, 2010. She was again referred to the psychiatrist for similar reasons during February 1, 2010.

This inmate was evaluated by Dr. during February 18, 2010. Dr. told her that it was SCDC policy not to provide medications for sleeping purposes. Her presentation was reported to be consistent with a personality disorder NOS with antisocial and borderline features. Lithium was prescribed apparently related to her irritable mood and affect. Haldol was also was prescribed.

Her lithium level during March 2, 2010 with 0.83. She was again referred to the psychiatrist by Ms. during April 1, 2010 at her request.

She was again seen by Dr. during May 29, 2010. Diagnosis included a personality disorder NOS with borderline and antisocial features, severe. She had been noncompliant with medications that included Depakote and lithium. In an attempt to manage her irritability and impulsivity, her Haldol concentrate was increased, lithium continued and a trial of valproate was started.

During June 17, 2010 she was again noted to be medication noncompliant. She also refused to have her blood drawn as requested by the psychiatrist. A referral to the psychiatrist was not initiated.
During August 17, 2010 and she was noted to be medication compliant by her mental health counselor

Her report that security would not allow reduction of her disciplinary time was accurate.

Assessment: There were several problematic aspects of the treatment provided to this inmate which included the following:

1. a generic treatment plan,
2. lack of attendance by the psychiatrist at the treatment team meeting,
3. untimely responses to referrals to the psychiatrist,
4. lack of timely psychiatric follow-up,
5. apparent discontinuation of medication by a nurse without an physician order, and
6. lack of referral to the psychiatrist related to medication noncompliance.

It is very concerning that this inmate is scheduled to be discharged from the SMU back to the streets and that her phone calls and visitation privileges have been lost. The impact on her relationship with her children appears to be of little concern to relevant decision makers in this context. It is concerning that the treatment plan does not include the potential for regaining such privileges based on her behavior.

3. Inmate 3

Inmate 3 is a 23-year-old single African-American woman who has been incarcerated since 2008 and is currently serving a 30 year sentence. She has been in the SMU for 11 months with her SMU sentence ending during September 3, 2010. Her initial sentence to SMU was for 90 days related to striking an inmate. She has received subsequent SMU time related to threatening an officer and disruptive conduct.

A past history of mental health treatment was reported, which included psychiatric hospitalizations prior to her current incarceration. A chronic history of auditory hallucinations was described, which reportedly were not responsive to the use of psychotropic medications. Current medications included oral Prolixin 5 mg po qd and Remeron. Inmate 3 stated that these medications were not very helpful.

Dr. was reported to meet with this inmate every 90 days in an office setting. She was seen by her mental health counselor at the cellfront every 30 days.

Inmate 3 reported that newly ordered medications can take up to 3-4 days to actually be administered. Subsequent continuity of medication issues were not present.

Diagnosis was listed as antisocial personality disorder with borderline features, severe.

Inmate 3 thought that the mental health services could be improved if group therapies were offered, especially following acting out behaviors.

Inmate 3 has had at least 2-3 crisis intervention placements during the past six months. She indicated that she does not receive a mattress when housed in a crisis intervention cell.

The hard copy of this inmate's health care record was reviewed. It appears that she was admitted to Graham CI during March 26, 2008.

Treatment plans (6/15/09, 12/03/09, 6/09/10) were identical. For example, the approaches related to her symptoms of PTSD (which was not diagnosed) indicated the following: "counseling monthly, quarterly or as needed, quarterly psych evaluations or as needed, medication, if needed, monitoring of medication record, attending Anger Management Group and Impulse Control, Social Skills (West) once released from lockup.

The above approach was for the following problem: "inmate reports experiencing nightmares, flashbacks and the voice of the victim related to her crime, recurring thoughts and anger about childhood sexual abuse."

Records from Palmetto Health Richland were present in the chart. Diagnoses during 1999 included substance-abuse, adjustment disorder with disturbance of mood and conduct and rule out conduct disorder. Similar diagnoses were made during 2002.

The AMR of this inmate was reviewed. N.P. evaluated this inmate during April 12, 2008. She was prescribed Thorazine for psychosis and Celexa for depression. Her differential diagnosis included chronic PTSD and psychosis NOS versus schizophrenia. She was noted by the mental health counselor four days later to be noncompliant with medications.

During April 29, 2008 Inmate 3 was evaluated by HSC I, who diagnosed PTSD, major depressive disorder, cocaine dependence in remission and cannabis disorder in remission. , CCC IV diagnosed malingering the following day. She was transferred from R & E to Blue Ridge C during May 15, 2008.

Dr. evaluated this inmate during May 22, 2008. Her presentation was consistent with the diagnosis of rule out personality disorder NOS with antisocial features. She indicated that records from four previous health providers needed to be obtained. Ms. reported during June 3, 2008 that the plan was to obtain such records. Release of information forms were faxed to those institutions the following day.

Dr. reviewed records from Columbia Area Mental Health Center during June 5, 2008, which were relevant to treatment provided to this inmate when she was 11 years old. By 2005

this inmate's diagnoses were noted to be depressive disorder NOS, dysthymic disorder and PTSD.

A referral to Dr. was initiated by Ms. Brown during June 18, 2008. Dr. reported during June 29, 2008 that her record review confirmed the presence of a personality disorder. Ms. again referred this inmate to Dr. during July 23, 2008 for medication review at the patient's request.

She was seen by Dr. during Janet July 26, 2008. She reported the presence of auditory and visual hallucinations. She was diagnosed as having a severe personality disorder and malingering psychotic symptoms. Low-dose psychotropic medications were prescribed for anger control purposes.

Dr. again saw this inmate during October 12, 2008. Her diagnosis was unchanged. She increased Navane to 4 mg po t.i.d.

This inmate was being followed on a fairly regular basis by her mental health clinician. During March 2, 2009 she was referred to the psychiatrist.

She was placed on crisis cell status during April 2, 2009.

She was reminded by , HSC I during May 18, 2009 that "the psychiatrist wants her to be seen by the psychologist prior to writing another prescription."

During July 12, 2009 she was placed on crisis cell status. She remained on this status for at least four days.

Ms. again initiated a psychiatric evaluation during October 2009 related to symptoms described by this inmate. She was finally seen by Dr. during October 21, 2009. A trial of Trilafon was initiated. During November 16, 2009 this inmate refused her medications. As in the past, she complained of hearing voices. This inmate was placed on crisis cell status during November 18, 2009. She was seen by Dr. the following day. Her Trilafon was increased. Diagnoses were antisocial personality disorder, severe, with borderline personality features and history of malingering psychosis. This inmate was removed from crisis cell status during November 23, 2009.

A January 15, 2010 and progress note indicated that her medications had been discontinued due to noncompliance. She was again seen by Dr. during January 23, 2010. A trial of lithium was initiated.

By April 16, 2010 she was again noted by her mental health clinician to be noncompliant with medications. She reportedly took an overdose of medications one week later.

This inmate was evaluated by Dr. during April 25, 2010. Her behavioral problems were assessed to not be due to a psychotic illness but due to a severe personality disorder. Prolixin and Remeron were started by Dr. during May 27, 2010.

Inmate 3 has been seen on regular basis by several different mental health clinicians since May 2010. During August 17, 2010 she again was requesting to see Dr.

Assessment: There are various problems associated with the treatment of this inmate that included an inadequate treatment plan, lack of a structured treatment program for an inmate with an apparent severe personality disorder, untimely assessments by the psychiatrist and lack of adequate input into the treatment plan by the psychiatrist.

4. Inmate 4

Inmate 4 was a 28 year old, single Caucasian woman, whose current incarceration in SCDC has been since 2006 although she has had prior incarceration since 1998. She is currently serving three life sentences without the chance of parole.

Inmate 4 has been in the SMU since June 15, 2010 related to striking an inmate and threatening a public employee. She has a five-month sentence in the SMU.

A long history of mental health treatment related to poor impulse control and significant anger was described by this inmate. She also reported having "suicidal and homicidal tendencies" with many crisis intervention placements. Crisis placements in the SMU were characterized by having no mattress, a smock that did not fit and daily contact with the mental health counselor.

A past history of psychiatric hospitalizations was described, which has included multiple placements at Just Care.

Inmate 4 reported that she has been diagnosed as having a bipolar personality disorder. She sees Dr. every 90 days in a private setting. She reported that Dr. has told her she no longer trusts her related to a history of hoarding and passing medications. She started refusing her Prolixin decanoate and Depakote about six weeks ago because they were no longer working. However, she stated she wants to have her medications resumed at the present time.

Her mental health counselor meets her at the cellfront with her about once every 30 days.

The AMR of this inmate was reviewed. A note written during August 6, 2010 indicated that a correctional officer called nursing staff "after another inmate was gassed, this inmate is complaining of inability to breathe and does not have a current order for inhaler. Officer stated it does appear to her that inmate is unable to catch her breath. Informed officer she needs to sign up for sick call for new and inhaler order as her order expired in 2008. No treatment is needed if she is not in acute respiratory distress. Instructed officer [to] have inmate pour cold water on her head." [LPN] I did not find any further follow-up regarding this issue.

A July 25, 2010 note indicated that this inmate had a severe personality disorder (i.e. borderline personality disorder) and had been receiving involuntary medication via an outpatient commitment order which has now expired. Her medications were subsequently discontinued because she was refusing medications and was assessed to not meet the criteria for forced medications at that time. This inmate was also refusing to meet with Dr. at that time.

Inmate 4 indicated that she does not like Dr. because "she treats me like a dog."

She was working on a cleaning detail in the dorm prior to her SMU placement.

Assessment: The lack of a structured therapeutic program for this inmate was very problematic, as was the absence of the psychiatrist in treatment planning meetings and lack of the psychiatrist's participation in the crisis cell management of this inmate.

5. Inmate 5

Inmate 5 was a 27-year-old single Caucasian woman who has been incarcerated for the past nine years. Her current SMU placement has recently ended after 45 days related to fighting with another inmate.

She had been housed in Blue Ridge C for about one year prior to her current SMU placement. She indicated that she was very comfortable in Blue Ridge because she was able to isolate herself, which is much more difficult in other housing units. However, she will not be transferred back to Blue Ridge due to a shortage of beds.

Current medications include BuSpar, Zoloft and Tegretol for a long-standing seizure disorder. She indicated that Dr. had discontinued her Tegretol about 12 months ago due to reported abuse of this medication by other inmates but not specific to Inmate 5.

This inmate reported being seen by Dr. about every four months. She is seen by her mental health counselor, Ms. about every six months and she reported this counselor to be very good.

This inmate described symptoms consistent with the diagnosis of posttraumatic stress disorder related to a car accident that resulted in her current incarceration. Her symptoms included recurrent nightmares, which have been referenced in the AMR. This inmate also described purging behaviors related to her perception that she was obese.

The AMR of this inmate was reviewed. Ms. referred this inmate to Dr. during August 3, 2010, although she has not yet been seen by Dr. Diagnosis per Dr. included depressive disorder NOS and personality disorder with antisocial features, severe.

Her last three appointments with Dr. were June 15, May 29, 2010 and December 12, 2009.

Ms. indicated that counseling sessions would occur quarterly and as needed. The differential diagnosis of PTSD was not included in any of the notes reviewed.

Assessment: The lack of a structured therapeutic program for this inmate was problematic as was the apparent lack of consideration re: PTSD. Also problematic was this inmate's poor acces to the psychiatrist.

6. Inmate 6

Inmate 6 was a 25-year-old single African-American woman who has been incarcerated since 2006. She was serving a 14 year sentence. She has been in the SMU for 18 months. Inmate 6 reported that her disciplinary time was accumulated at Leath Correctional Institution.

Medications include BuSpar, Trilafon and Remeron. She reported that she receives these medications for treatment of a bipolar disorder. Inmate 6 described a past history of psychiatric hospitalizations.

She sees her counselor at the cellfront on a weekly basis and has been unable to meet with her in a private setting.

This inmate reported a history of periodically experiencing auditory hallucinations.

This inmate's AMR was briefly reviewed. An August 2, 2010 progress note indicated a diagnosis of personality disorder with antisocial features (severe).

The most recent appointment with Dr. was dated June 17, 2010. Medications at that time included Remeron, perphenazine and BuSpar. Tegretol had been stopped related to a low white blood cell count. She had been previously evaluated by Dr. during May 27, 2010.

This inmate has been assessed to need a cysto hydrodilatation of her bladder but has been told that she will not have this procedure until October 2000 when her SMU time has been served.

Assessment: The reported lack of responsiveness to a recommended medical procedure is very concerning. This issue was brought to the attention of Mr. Davidson.

7. Inmate 7

Inmate 7 was a 22-year-old single Caucasian woman who has been incarcerated in SCDC for about 15 months. She has just completed 30 days in the SMU related to an assault charge. She

will be transferred back to the SIU (i.e., Shock program). Her SMU stay has been difficult due to the lockdown status of this unit.

Medications include Haldol, Trilafon, Triavil, Prozac, and Geodon. She reported that she sees Dr. about every other month. Inmate 7 stated that she does not meet with a mental health counselor.

There was a history of multiple psychiatric hospitalizations in the past. Tactile hallucinations since the age of 16 were reported by this inmate.

The AMR of this inmate was reviewed. An August 6, 2009 social health services system note indicated diagnoses of bipolar disorder by history, antisocial personality disorder, anxiety, and panic attacks. A variety of psychotropic medications taken by this inmate was identified by nursing staff during August 10, 2009. She was seen for mental health assessment two days later. Diagnostic impression was manic depression NOS by history, anxiety disorder NOS by history and antisocial personality disorder by history. She was referred for psychiatric assessment by HSC I.

Ms. August 16, 2009 assessment included bipolar disorder, anxiety disorder NOS, PTSD, chronic and alcohol dependence in remission. Appropriate laboratory studies were ordered. Prescribed medications included nortriptyline, sertraline and Geodon.

A November 4, 2009 mental health clinician's note indicated that per Dr. ' there was no Axis I diagnosis. Axis II diagnosis was personality disorder NOS with borderline features (severe).

A November 6, 2009 staffing note indicated that this inmate was a YOA and would be transitioning back to the YOIP, which meant that she would not be receiving any mental health services at Graham CI.

During January 17, 2010 this inmate was very upset due to the suicide of her brother.

The next note in the chart was dated January 21, 2010 by Dr. Personality disorder NOS with borderline features was diagnosed. Paxil was discontinued and Prozac started. She reported being upset about her brother's suicide in jail.

At her request, Inmate 7 was placed back in the crisis cell during January 24, 2010 in order to help process issues related to the death of her brother. She stated she remained in a crisis cell for seven days. She reports not having received counseling relevant to his suicide following discharge from the crisis cell. She reported having no clothes while in the crisis cell although she did have a blanket to cover herself. She did not have a mattress. She reported only being seen by the chaplain during this period of time. However, there was one note by Marian Downing, HSC I in the AMR that was dated January 25, 2010, which recommended return to the YFOIP.

A March 19, 2010 note indicated that this inmate was very depressed and was referred to see Dr. by the mental health counselor. She was seen by Dr. during March 27, 2010 after being placed in lockup due to fighting with another inmate.

This inmate was participating in a parenting group during April 2010.

Inmate 7 was again seen by Dr. during June 17, 2010. Possible delusional thinking was noted at the time.

Assessment: The documentation by Dr. relevant to the change in her diagnosis of bipolar disorder to personality disorder with antisocial features was lacking. There was a discrepancy in the history reported by this inmate as compared to the history in the AMR relevant to the length of stay in the crisis cell. The nature of the treatment received in the crisis cell was of significant concern as was the apparent lack of treatment related to her brother's suicide following her crisis cell placement.

8. Inmate 8

Inmate 8 was a 26 year old single Caucasian woman who has been in SCDC for about eight years. She was serving a 20 year sentence. She has been in the SMU since August 11, 2010 related to a 90 day sentence due to tattoo paraphernalia and a drug charge related to Tegretol.

Mental health treatment has consisted of BuSpar for anxiety and infrequent meetings with her counselor.

The AMR of this inmate was reviewed. This inmate was first seen by Dr. during March 11, 2007. The differential diagnosis was mood disorder NOS and personality disorder NOS. Risperdal was started, BuSpar continued and Seroquel discontinued.

Initial assessment by her HSC I was completed during March 19, 2007. The differential diagnoses included PTSD, OCD, antisocial personality traits, amphetamine dependence and alcohol dependence.

Inmate 8 was again seen by Dr. during March 25, April 15, May 30, August 30 and December 13 2007. Sessions with her mental health also occurred during this period of time.

The three most recent appointments with Dr. occurred during June 27, February 25, 2010 and July 26, 2008. Medications were discontinued during July 26, 2008 and restarted during February 25, 2010.

Assessment: This inmate appeared to be receiving an appropriate level of mental health care.

9. Inmate 9

Inmate 9 was a 20-year-old single Caucasian woman who has been incarcerated since February 12, 2010 on a probation violation. She was initially sentenced to seven days in the SMU related to hitting a locker and apparently threatening a public employee. She reported that she subsequently had further charges in the SMU and has been in the SMU for five months. Inmate 9 reported having another 30-90 days left in the SMU.

This inmate previously had been in the SIU program. She is awaiting a psychological evaluation for potential transfer to the Blue Ridge housing unit.

Medications included lithium and Trilafon for a reported bipolar disorder. Inmate 9 stated that she infrequently sees her mental health counselor in the SMU and only sees her at the cellfront.

There was a past history of prior psychiatric hospitalizations.

The AMR of this inmate was reviewed. She was initially referred by , HSC I for psychiatric examination during March 2, 2010 after becoming out of control during an initial mental health assessment. She was again seen by Ms. during March 4, 2010 with another psychiatrist referral initiated.

Risperdal and lithium were started during the evening of March 10, 2010.

Dr. initially evaluated this inmate during March 11, 2010. She was assessed to have a borderline personality disorder (severe) and adjustment disorder.

This inmate was pepper sprayed during March 13, 2010 after attempting to jump off of the top bunk. She subsequently was placed on crisis intervention status during March 15, 2010 for attempting to harm herself.

Dr. again evaluated this inmate during April 24, 2010. Risperdal was discontinued and Trilafon started. A lithium level was ordered.

A March 7, 2010 note by , HSC I indicated that this inmate did not want to speak with her at that time. The plan was to have individual sessions every 30 days or as needed.

Her lithium level during April 28, 2000 was 0.4.

Dr. reported during June 26, 2010 that this inmate wanted to move to the Blue Ridge D program in contrast to the Y program.

Assessment: There were discrepancies in the history provided by Inmate 9 as compared to information in the AMR in the context of frequency of visits with her mental health counselor, although this inmate complained that mental health counseling visits were at the cellfront which was consistent with information obtained from other inmates concerning such visits in the SMU.

This inmate also provided similar information relevant to property restrictions and the nature of the treatment (or lack thereof) provided in the crisis cells.

It is very likely that this inmate would not do well in a shock treatment program and could benefit from a structured residential level of care program.

10. Inmate 10

Inmate 10 was a 34-year-old divorced, Caucasian woman who has been incarcerated for the third time since July 2, 2010. She was in her 30th day of a 45-day SMU sentence related to threatening an inmate. She remains on R&E status.

This inmate recently was started on Paxil. She stated that it took about three weeks for her to be seen despite repeated sick call requests.

The AMR of this inmate was reviewed. This inmate received an initial mental health assessment during July 19, 2010. Initial diagnostic impression was depressive disorder NOS and polysubstance dependence. A referral to the psychiatrist was initiated.

Dr. initially evaluated this inmate during July 24, 2010. Dr. diagnostic impression was consistent with the July 19, 2010 assessment. Paxil was restarted.

This inmate has had no further mental health contacts.

Assessment: There appeared to be access problems for mental health services based on information provided by this inmate. This inmate also reported that it took several days to receive her first dose of Paxil after it was initially ordered by Dr.

11. Inmate 11

This 21-year-old single, African-American woman was transferred from Leath CI during July 2010 following a sexual misconduct charge. She has been in the SMU for 60 days with another 120 days to serve. Inmate 11 reported that she had had been receiving trazodone and Abilify before her incarceration but was told that these medications were not available at SCDC. Inmate 11 indicated that Dr. wanted to start Prozac but she did not want to take this medication based on past experiences when she became irritable and hyper after being prescribed Prozac.

Inmate 11 indicated that she has not received counseling despite repeated sick call requests for such treatment.

The AMR of this inmate was reviewed. This inmate was initially evaluated by Dr. during January 23, 2010. Her presentation was consistent with a depressive disorder NOS and

rule out personality disorder NOS with dependent features. Celexa and Vistaril were started. These medications were later discontinued during April 22, 2010 by Dr. and BuSpar started. Inmate 11 was house at Leath CI during this period of time.

This inmate was seen at the cellfront by her mental health counselor for a 30 day SMU (at Leath) review during June 22, 2010. The plan was to see her as needed.

She was again seen by Dr. during July 7, 2010. A trial of Prozac was initiated.

Assessment: Access issues re: mental health counseling appeared to be present as well as issues re: the quality of the services being provided.

12. Inmate 12

Inmate 12 is an 18-year-old single African-American woman who has been incarcerated for the past one year. She originally was sentenced to SMU for three months after threatening an officer but has subsequently picked up several other charges with one charge pending. She was going on her fourth month in the SMU and reports that she is not doing well.

Medications include Remeron and BuSpar, which were reported by Inmate 12 to not be working. She stated that she is not prescribed a medication for ADHD because it was reportedly a drug of abuse within the correctional system. She also reported that she only sees her mental health counselor when in a crisis cell because she was told that she "is not mental health." Inmate 12 stated that her mental health counselor also refused to refer her to the psychiatrist for similar reasons.

The AMR of this inmate was reviewed. This inmate was placed in a crisis cell during August 10, 2010 after trying to hang herself. She reported being seen by a mental health clinician during two of the six days that she was in a crisis cell. She indicated she was very cold in the cell related to the restricted property.

The last appointment with Dr. was dated May 20, 2010. Her presentation was consistent with the depressive disorder NOS, personality disorder NOS and PTSD. Remeron was increased. Her previous appointment with Dr. was dated April 22, 2010.

Assessment: Access issues to the psychiatrist were clearly present. Lack of a structured treatment program for this inmate is also very problematic as evidenced by her inability to successfully complete her SMU sentence.

13. Inmate 13

Inmate 13 was a 24-year-old single African-American woman who has been incarcerated since July 26, 2010 due to a probation violation. She has been in the SMU since August 13 related to a sexual misconduct charge. Her hearing is scheduled for August 25, 2010.

Medications prior to her incarceration included Depakote and Seroquel for an apparent bipolar disorder. She reported that she has not received any mental health counseling since her incarceration.

Her AMR was reviewed. An August 2, 2010 mental health assessment by , HSC I was reviewed. Her presentation was consistent with the differential diagnosis of the depressive disorder NOS and a bipolar disorder NOS. She was referred to the psychiatrist. Inmate 13 has not yet been seen by the psychiatrist. She was currently not receiving any medications.

Assessment: This inmate has not received a timely evaluation by the psychiatrist and currently was not receiving an appropriate level of mental health care.

14.Inmate 14

Inmate 14 is a 46-year-old female that has been incarcerated at Graham since July 2010. She reported she has been diagnosed as having schizophrenia and has been prescribed Thorazine for the past 10 years which was changed to Haldol and Cogentin for the past six months. The inmate reported that she has seen her counselor, Ms. twice since her incarceration including one to two weeks prior to the interview on 8/23/10 and on 8/23/10. She reported she has seen Dr. one week after she was incarcerated but has not seen her since. She reported she is currently prescribed Haldol but does not know the dosage. She does not know her level of care. She reports she is not engaged in any groups but has been told she will be placed in a discharged planning group on 8/24/10. She reported that she has sent in a sick slip for discharge planning as she expects to be released from prison "soon". She described the mental health services as "real good".

This inmate was housed in the ICS Building but again could not state her level of care.

Assessment: This inmate has not received consistent mental health contacts from the mental health counselor. Further her medication was changed in the County Jail and she reports that she has seen the psychiatrist once since her admission and provides her opinion that her mental health services are "real good". This inmate's level of care is reported as L-3 which under the new classification is area mental health. She is not receiving services in keeping with the policies for area mental health inmates.

15.Inmate 15

Inmate 15 is a 54-year-old woman who is housed in the Blue Ridge D Unit. She reported she is "M-1 Area Mental Health". A review of her record indicates that she is classified as L-4, outpatient mental health under the new classification system. This inmate reports she has been incarcerated at Graham for 24 years after having been incarcerated at age 30 and receiving a life sentence for killing her four children. The inmate reports she has been incarcerated at Graham with the exception of an approximate six-month stay in the 1990s in the Cooper Building

because of mental illness. The inmate reported that she sees her counselor, Ms. each month to 45 days. She reports she sees Dr. every 90 days. If she needs to see Dr. before that time, she would write to Ms. and if Ms. deems it necessary for her to see Dr. that she will get to see her in a "reasonable" period of time. She reported that it "didn't use to be that way – was 90 days, indicating a q three month appointment with the psychiatrist, however the inmate stated "it changed in the last year". She added that unless the patient is put on crises status and stripped out "butt naked". I asked her if that had ever occurred to her and she reported that the last time she was placed in a crises bed was in the 1990s for approximately six months. She stated she then went to the SMU and from there to the Cooper Building because she has medical problems but was also suicidal and paranoid.

She reported she has been taking Risperdal Consta 37.5 mg every two weeks, Invega 9 mg every morning, Effexor ER 25 mg every morning, and Buspar 15 mg bid. She also reported that she takes Amantadine twice a day and Wellbutrin 200 mg twice a day. The inmate states that this combination is working "pretty good" for her and that her Risperdal Consta was decreased from 50 mg to 37.5 mg because of her "neck pulling to the right", and Invega was added.

When asked how she has been adjusting, this inmate reported "they take care of me because they know I can be a problem". She stated she was a LPN prior to her life sentence and that at the time of her killing her children, she had told her primary care doctor that she intended to kill herself and her kids. The inmate added "I'm a little bit paranoid about rattling their cage – don't want to be sent to Leath." The inmate added that she trusted Dr. now but didn't at first before she was receiving injections of medication. She reported she would go five or six days past when she should get the injection and "all hell would break loose".

The inmate added "we have no PRN meds around here – people in Blue Ridge need them but don't get them so some of us live in fear." She continued that the morning meds are given between 6:30 – 7:00, there's a 12 o'clock pill line for inmates who are on medication three times per day, and a 4:30 pill line in the afternoon for p.m. medications.

When I asked the inmate whether or not she had had any meetings with the treatment team or a treatment plan, she reported she had when she was in the Cooper Building in 1997. She elaborated "here there is no treatment team – no doctors involved – they (counselors) make all the decisions, and even override the psychiatrists."

She added that if an inmate does not have any money for crafts then there is no program other than medication and even though they are needed the staff let the medications run out. She concluded with "if you can hold on you go to the crises or lockup."

I reviewed this inmate's medical record and it indicated that she had been admitted to the SCDC 24 years ago but a medical screening on 6/27/01 did not identify any mental health issues. I reviewed treatment plans of 9/10/09, 3/11/10 and 7/9/10. Treatment plans reported her diagnosis as schizophrenia but the treatment plans were essentially very similar or identical with regard to the staff assessment of the problem, objectives and approaches. The staff assessment of the

problem varied from her being stable but also having some feelings of being "overwhelmed", episodes of depression, and emotionally stable while simultaneously recording depression/sadness, thoughts of the past/sickness at the time of the crime. The objectives were consistently for her to take her medications and discuss unresolved issues and she was on a waiting list for a depression group. During this same time period, her medications were changed because she appeared to have been having some difficulties however there is no indication that the medication changes were discussed by a multidisciplinary treatment team.

Assessment: This inmate's care and treatment are inadequate as she has been a long-term resident in the SCDC that continues to struggle with a number of issues related to her instant offense. Further she has had periods of depression and crises, and reports that she is fearful of reporting these feelings to staff because she expects the response to be to place her in a crises cell rather than to have her evaluated by the mental health staff.

Further, despite there being changes in the inmate's psychotropic medications by the psychiatrist, there does not appear to be any meaningful collaboration between the psychiatrist and the counseling staff with the inmate to develop an appropriate treatment plan given her long-term incarceration and ongoing mental health problems.

16. Inmate 16

Inmate 16 is a 23-year-old woman who reports she has been housed at Graham for two years and one month. She is currently in the Blue Ridge, C Side Dormitory. When asked about her mental health care she reported "I was area but I took myself off medications, now outpatient". When asked about her level of care regarding the L system, she replied she didn't know what I was talking about. She went on to state she believes her counselor "whose an idiot," and went on to state that "these counselors are "pay check" counselors, continuing "all they're here for."

She reported her diagnosis as "borderline schizophrenia". She stated that she has been Depakote for the past two months because that is the only medication that helps her. She further stated that she met with Dr. and opined "she's actually not that bad. I tell her how these counselors treat us and she seems baffled." The inmate stated that the only time she has seen a team is in psychiatric hospitals and wilderness camps that she's been in.

When asked about other services and she replied there are no groups and that she has asked for groups but she still has not received any. She stated she got herself into the Karos religious group through the chaplain and that she went on a four day spiritual walk.

The inmate then offered that there had been "four deaths since I've been here". She elaborated that one woman died after medical staff said she was faking seizures and elaborated "they let her die – medical, officers laughed at her between 5:30 count and 7:00 a.m. and she died from asphyxiation from a seizure." The inmate went on to state that there were other inmates that had died because of staff neglect, including one inmate who had been incarcerated for 26 years and was in a camera room when she died of a stroke.

I reviewed the inmate's medical record which indicated she was admitted on 5/23/08. The medical screening on 7/10/08 noted her history of attempted suicide as well as self-mutilation. I reviewed her treatment plans from 6/13/08, 2/27/09, 6/5/09, and 6/11/10. Initially she was diagnosed with borderline personality disorder and bipolar disorder by history. The staff's assessment of the problem indicated childhood issues, depressive thoughts and symptoms with objectives being for her to verbally identify sources of her depressed mood, developed cognitive patterns in three months with the approaches being one-to-one counseling per SCDC policies and monitoring medications weekly by the counselor. She was also noted to have a history of serious injurious behavior (SIB) and drug addiction with an objective to continue to resolve childhood/family issues, and refer to the Positive Thinking group with a counselor to meet with her. There was a handwritten line on 2/27/09 indicating "treatment plan update, continue as written". This was the only statement regarding her treatment planning being reviewed at that time. On 6/5/09 the bipolar disorder by history was dropped from the diagnosis and she was considered to have borderline personality disorder only. Despite the change, the objectives and the approaches were identical and remain such for the treatment plan of 6/11/10.

Assessment: This inmate's care and treatment are inadequate. Her treatment plans do not include the psychiatrist meeting with the counselors or providing any documented input regarding the treatment plan objectives. The inmate's diagnosis was changed and the objectives and staff approaches remained the same even when the inmate had some difficulties in maintaining her mental health stability. The treatment plans are generic and do not reflect any considerations of the inmate's changing psychodynamics and conditions.

17-21. Inmates 17-21

These inmates were interviewed as a group as they all are participants in the Youth Offender Program (Shock Boot Camp) and housed in the Shock Dormitory. I interviewed them as a group and reviewed their records individually.

As a group, these inmates reported that they all have been diagnosed with serious mental illnesses ranging from schizoaffective disorder, bipolar disorder, schizophrenia, PTSD, post-partum depression, ADHD, and depression. They reported that three of the five had been incarcerated for more than six months at Graham.

The inmates reported further they have counselors that they may get to talk to once per month but they do not have any mental health counselors. They identified three counselors by name but none of those counselors were listed as part of the mental health staff. The inmates stated collectively "we feel we should have a mental health counselor."

When asked how often they do see the counselor they said the clinical counselor sees them approximately once per month and if they put in a request the counselor has up to 30 days to respond to the request.

Four of the five women in this group reported they have 90-days to 10-months sentences however the fifth inmate reported she has a four year sentence. However the fifth inmate who is identified as having a four-year sentence stated she was horrified to find out from the counselor that she would not be released within 10 months if she successfully completed the program.

All five women reported that they have been prescribed medications by Dr.   and they see Dr.   approximately once every three months. These inmates reported they have no mental health groups. They also reported they have treatment plans and the treatment plans are provided to them by their counselors. There are no treatment team meetings with Dr.   and the counselors simultaneously.

Four of the five inmates reported they have never signed any consent for medications although all five inmates are prescribed medications by Dr.

The inmates reported as part of their program they work part-time and also attend school unless they already have their GED. They reported however that outside of those activities, there is "nothing to do".

When I asked them about other programmatic activities or assistance from the counselors, the inmates replied "no help from the counselors". They reported they don't feel they can talk to the officers and that they simply talk with each other and other inmates because there is no confidentiality in what they may say to the officers.

I reviewed the medical records of all five of these inmates and will describe them below.

17. Inmate 17

This 26-year-old inmate received a medical screening on 2/19/10. It was noted on the screening that she had been prescribed Haldol, had a suicide attempt two years prior to admission, was hearing voices in her head currently, and was pregnant. There was no treatment plan provided in the medical record nor was there any documentation in the Automated Medical Record (AMR) of treatment team meetings. The medical record included medication administration records (MARs) indicating prescriptions of Celexa, Haldol and Vistaril for six months periods, in excess of the 90-day limit on medication prescriptions.

The inmate was diagnosed with depressive disorder NOS and borderline personality disorder. The inmate signed a refusal form for Haldol and Cogentin on 7/15/10 however staff continued to offer it to her until she was seen by Dr.   who discontinued it on 7/26/10. The inmate had begun taking Haldol on 6/17/10 and subsequently stopped taking it on 7/5/10 and also signed a refusal form because of side effects.

The inmate is also being treated for hypertension and although the AMR provides notes by both medical and the psychiatrist, there does not appear to be any evidence of multidisciplinary treatment planning to manage her pregnancy and her mental health symptoms which were characterized by her reporting hearing voices and being concerned that something bad would

happen to her daughter, as well as depression. The inmate reported on admission that she had been diagnosed in the past with schizoaffective disorder and reportedly was addicted to crack cocaine. The inmate also reported she had been prescribed Haldol during her pregnancy and that after the birth of her child on 3/20/10 she was having increasing depression. She also reported to have been prescribed Zoloft prior to her pregnancy and had a history of suicidal ideation as well as self-mutilation.

The inmate was seen in the mental health clinic on 4/15/10 and prescribed Celexa based on diagnoses of depressive disorder NOS and borderline personality disorder. The medication was prescribed for a 180-day period by Dr. Although the inmate had been admitted to the Shock Dormitory Youth Offender program on 2/19/10, her first encounter with mental health staff was as noted above, almost two months after her admission.

Assessment: This inmate's care and treatment were inadequate. It was almost two months after admission before she was evaluated by the psychiatrist despite her history of depression, suicidal ideation, self-injurious behavior and crack cocaine addiction. Further, neither the AMR nor the medical record indicates any treatment plan being developed for this inmate and certainly not collaboration between the psychiatrist, clinical counseling staff and medical with regard to managing her pregnancy, hypertension, post-partum adjustment and mental health issues. Despite her very significant to serious co-morbidity, she was diagnosed with schizoaffective disorder by history, pregnancy and her stressors were considered "incarceration" with a GAF of 75 and a recommendation for outpatient mental health.

18. Inmate 18

This inmate was a 19-year-old woman whose medical record was reviewed. A medical screening on 10/29/10 indicated that she was pregnant and reported no mental health history or mental health problems. The MAR however indicates that she was prescribed Remeron 15 q day from 4/29/10 – 10/25/10 and there were multiple missed dosages or refusals documented on the MARs. She was also prescribed Tegretol 200 mg bid from 7/25/10 – 1/21/11.

There was no treatment plan in the medical record for this inmate describing her mental health diagnoses or the reason for prescriptions of these medications.

Assessment: This inmate's care and treatment are inadequate as she is reported in the record as being pregnant and also having been prescribed psychotropic medications for unclear reasons. There does not appear to be a treatment plan in the record and certainly no documented collaboration of a multidisciplinary treatment team including psychiatry, mental health counselors and medical.

19. Inmate 19

This inmate is a 19-year-old woman who had a medical screening on 6/25/09 that indicated she was receiving Celexa, Vistaril, and Trazodone for depression. There are medication orders for

Remeron 15 mg from 2/4 – 5/4/10, Celexa 20 mg from 11/5/09 – 2/2/10, and Vistaril 15 mg for that same time period which was discontinued as was the Celexa on 2/4/10.

There was no treatment plan in the medical record for this inmate. The inmate was seen on 7/6/09 for a mental health assessment based on a medical referral. She was described as an 18-year-old single female on her first incarceration, suffering from depression and taking the medications as reported above. She reported she had been taking medications for five months, denying suicidal or homicidal ideation and auditory and visual hallucinations. The diagnostic impression was depression with Axis II deferred, Axis IV stressor of incarceration and a GAF on Axis V of 72. The inmate was seen by Dr. on 9/24/09 who noted the inmate was depressed and having difficulty sleeping. Her insight and judgment were described as fair and she was diagnosed with depressive disorder NOS and her Celexa and Vistaril were restarted. This occurred approximately three months after admission.

Assessment: This inmate's care and treatment were inadequate in that it took an inordinately long period of time for her to be evaluated by the psychiatrist, despite her presenting complains of a history of depression and treatment with anti-depressant medications.

20. Inmate 20

This inmate was a 27-year-old woman whose medical screening on 5/27/10 indicated PTSD, bipolar disorder, asthma and she was prescribed Seroquel. She also was noted to have a history of suicide attempts. On 5/27/10 Seroquel XL 400 mg hs was ordered as well as Celexa 20 mg hs with no expiration dates for either medication. There was no treatment plan documented in the medical record of this inmate.

The inmate had a history and physical conducted on 9/21/07 and was noted to have medical conditions of COPD/emphysema/asthma, and substance abuse. She was prescribed Albuterol inhaler for asthma. On 5/27/10 the inmate had another history and physical and was noted to have a mental health history as having suicide attempts as well as a history of alcohol abuse, asthma, STD and being a smoker. The inmate also reported she had a history of PTSD and bipolar disorder and stated she was depressed and appeared depressed when returned to custody on 5/27/10. She was seen by mental health staff on 6/14/10 as she had been returned to prison because she had violated her YOA sentence. Upon her return she had Celexa and Seroquel with her and reported a past history of physical abuse as well as her mother having died in the recent past. She reported a suicide attempt at the age of 13 and again at age 23 after her father's death. Diagnostic impressions were rule out bipolar disorder, polysubstance dependence with the Axis IV stressors incarceration and Axis V a GAF of 70. The counselor recommended a psychiatric assessment on 6/14/10.

She was seen on 6/26/10 by Dr. who assessed that she had a mood disorder NOS, rule out primary personality disorder and polysubstance dependence. Dr. discontinued the Seroquel and began a trial of Trilafon. On 7/25/10 Dr. discontinued her Trilafon and tapered her Celexa with a plan to begin a trial of Remeron. On 8/26/10 based on the inmate's

continuing difficulties including depression and hearing voices at times, Dr. assessed mood disorder NOS, increased her Remeron and began a trial of Navane, an anti-psychotic.

Assessment: This inmate's care and treatment are inadequate in that although the psychiatrist appears to have been attempting to adjustment medications to treat her symptoms, no documentation in the record beyond the initial assessment and referral by a mental health counselor that counselors were following this inmate and providing any form of treatment. There was also no treatment plan in the record reviewed.

21. Inmate 21

This inmate was a 26-year-old woman who was also a participant in the Youth Offender program. A medical screening of 5/21/10 indicated that she was diagnosed with bipolar disorder and receiving Trazodone. There was no treatment plan in the record.

Her medications at the time of this review included Buspar, Navane, and Remeron with orders for Buspar and Remeron for a six-month period.

Assessment: This inmate's care and treatment are inadequate. There is no evidence in the medical records reviewed that she had a treatment plan or any collaborative efforts for treatment planning by the psychiatrist and counseling staff. Further her medication orders far exceeded the three-month limitations as dictated by policy.

22. Inmate 22

This inmate was a participant in the Youth Offender program however was not interviewed during the course of the site visit. Her medical record was reviewed and a medical screening of 2/12/10 identified diagnoses of ADHD, bipolar disorder, depression and "Terrets" which I interpreted to being Tourettes Syndrome. She was also reported to have been receiving Risperdal, Lithium, Concerta, Albuterol and other medications, and had a past psychiatric hospitalization. She was noted not to have any suicidal ideation.

A treatment plan of 5/13/10 indicated a diagnosis of opiate dependence and borderline personality disorder (severe).

She was placed in a crises cell from 3/13 – 3/16/10 after she had been discovered on the top bunk threatening to jump and harm herself by a counselor. On 3/16/10 she was returned to the SMU without any transition planning to indicate follow-up by mental health staff.

On 3/7/10 Lithium Carbonate 300 mg bid was ordered and she received her first dose of that as well as her first dose of Risperdal 0.5 mg bid on 3/8/10. Her Lithium was continued however the Risperdal was changed to Perphenazine on 4/24 and both were ordered to continue through 12/23/10 (six months).

Assessment: This inmate's care and treatment are inadequate in that she had been diagnosed with opioid dependence and borderline personality disorder but had a history of bipolar disorder and depression as well as possibly Tourettes Syndrome. On the medical screening, she was listed as having antipsychotic, mood stabilizing, attention deficit hyperactivity disorder medications as well as medications for asthma but did not receive a prescription for mood stabilizing medication (Lithium) or an antipsychotic (Risperdal) until three weeks after she was admitted. Shortly after the prescription of these medications, she required crises intervention for approximately four days. Subsequently, medications were ordered for a six-month period in violation of standard policies and procedures.

23. Inmate 23

This inmate was a 49-year-old woman who was requested to attend a group interview however she refused. Her medical record was subsequently reviewed and a medical screening of 9/18/99 reported a diagnosis of manic depression. She was classified at the M-2 area mental health level of care in 1999.

A review of her most recent treatment plan of 11/12/09 indicated the staff assessment of the problem was that she was "doing better" and that she was compliant with medication and treatment. The objectives were for her to take her medications for the next 180 days and verbalize her feelings. The approaches were for the counselor to review the MARs and to provide one-to-one counseling. Her diagnosis on Axis I at that time was "N/A", and diagnosis on Axis II was personality disorder, borderline. Axis IV stressor was a life sentence and no family and the Axis V global assessment of functioning was 70.

Despite the above diagnoses, she was prescribed Risperdal, Buspar and Celexa as well as medications for hypertension and diabetes. Her psychotropic medications were to be administered at hs, i.e. hour of sleep; however they appear to have been administered at 5 p.m. I was unable to locate any consent forms for these medications in her medical record.

Assessment: This inmate's care and treatment appear to be inadequate. There was an absence of consent forms in the medical record for the various medications she was prescribed and the diagnoses that she was given did not have appropriate relevance to the medications that she was prescribed. Also, the medications prescribed at hs, meaning hour of sleep, were actually given at 5 p.m. which is an unfortunate and unreasonable way to manage and prescribe medications.

24. Inmate 24

I had requested this inmate be interviewed as part of a group, however she refused to participate. I reviewed her record which indicated she had been admitted on 7/27/07. The treatment plan dated 10/4/07 indicated a diagnosis of schizoaffective disorder and the staff approach to the problem identified auditory and visual hallucinations. The objective was to reduce hallucinations and for her to take medications and one-to-one monthly meetings with the counselor. Treatment plan updates were done on 3/28/09, 7/16/09, 10/28/09, and 1/13/10. The

treatment plans were essentially the same throughout this time period identifying the same auditory and visual hallucinations as the staff's approach to the problem. She had been admitted to mental health observation on 7/3/09 because she stated that she wanted to kill herself. She was returned to population on 7/8/09. Despite this admission, her treatment plans did not make reference to her suicide history or make any substantive changes in the approaches which included one-to-one monthly meetings with the counselor, several groups and medication. Her global adaptive functioning remained at 67 prior to and after her admission to the mental health observation unit. Her last treatment plan in the record was 1/13/10 and she was therefore missing two treatment plans based on her level of care.

Assessment: This inmate's care and treatment were inadequate. This inmate's care and treatment do not appear to be based on her changing symptoms and particularly her having been admitted to mental health observation because of suicidal ideation.

25. Inmate 25

This inmate was a 46-year-old woman who had a medical screening on 7/23/08 which revealed a history of depression. I requested an interview with her however she was out on a medical run and therefore could not be interviewed. The medical screening also indicated she was taking Zyprexa and Vistaril and identified her as having depressed and anxious symptoms. Review of her record indicated a treatment plan dated 5/13/10 with diagnoses of obsessive compulsive disorder (OCD), pyromania, and borderline personality disorder. Her global adaptive functioning was 70. The staff approach to the problem (SAP) essentially restated the criteria for a diagnosis of OCD and pyromania. The objective was to decrease those symptoms and for the inmate to attend appointments. The approach was for one-to-one counseling, medication and for the inmate to identify conflicts, have medication compliance and provide feedback to control her actions. This plan was signed by the supervisor only and not by the inmate. A previous treatment plan from 1/19/10 was essentially identical to the treatment plan of 5/13/10 with the exception of the approach including her referral to an impulse control group. There was no indication that the inmate had received that group in the medical record or in the treatment plan on 5/13/10. On 9/30/10 there was a handwritten contract for safety which was signed by the HCS1 as well as the inmate. Her medications included Buspar and Prozac although the MARs indicated that in March 2010 she only took a prn on 3/30/10 and in June and July 2010 she only took her Buspar in the mornings even though it was to be given twice a day. She was also prescribed in July 2010 Prozac 80 mg, Wellbutrin 150 mg, (two antidepressants) without adequate clinical justification for the use of polypharmacy. Orders were written for Buspar to cover a six-month period from April through October 2010.

Assessment: This inmate's care and treatment appear to be inadequate. It is unclear from the record as to the clinical justifications for the medications that were prescribed for her. The treatment plans did not appear to reflect her changing symptoms and did not address treatment for her borderline personality disorder or pyromania.

26. Inmate 26
This inmate was a 40-year-old woman who I had requested attend a group interview however she refused. I reviewed her record which indicated that she had been diagnosed on 12/17/04 with schizophrenia as per medical screening. The screening also however indicated that she did not have any mental health problems. Treatment plans of 9/30/09, 1/13/10, and 5/13/10 were reviewed and indicated a diagnosis of schizophrenia undifferentiated type and antisocial personality disorder. The SAP, objectives and approaches were essentially the same for these treatment plans and indicated a GAF of 70. However, there was some difference noted in the treatment plan of 5/13/10 which indicated that the inmate had been given forced medications and no GAF score was recorded. It was noted she had auditory and visual hallucinations and that she was assaultive. The inmate's medications included Invega, Citalopram, Haldol and Amantadine.

Assessment: Based on the review of the record, it is unclear as to this inmate's overall functioning. Although she was given a GAF of 70 indicating that she had mild or inconsistent symptoms of mental illness, it was noted that she was being given forced medications because of auditory and visual hallucinations as well as being assaultive. The symptoms seemed inconsistent with her overall assigned global assessment of functioning.

27. Inmate 27
This inmate was a 47-year-old woman who was interviewed. She reported that she had been at Leath for five years prior to her transfer to Graham nearly four years ago. She reported she was transferred because there had been a chaplain at Leath who was reportedly "molesting girls". She reported that she has been receiving mental health treatment since she was 14 years old and that currently her medications include Paxil 60 mg per day. She reported that she sees Dr. every three months but that she has never signed a consent form for Paxil.

When I asked about her symptoms she stated she had "mood swings – from the change in life" and stated that because SCDC medical staff do not prescribe Premarin, Dr. prescribed Paxil for her. She added however "I'm not depressed".

This inmate reported that she sees her counselor "whenever she calls me in – every three months". She identified that she is in the outpatient mental health level of care but was not aware of a new classification including the L1 through L5 classification that we were apprised of during the course of the site visit. The inmate reported that she had never been to any treatment team meeting with the exception of once approximately four years ago when she saw Dr. and Ms. her counselor and was first diagnosed with depression.

The inmate continued that she has "problems with medical" and went on to describe that two years ago she was supposed to get a PAP smear but the physician did not do a swab as part of the examination. She said that when she asked why not, she was told this was something new to not do a swab. She reported she was concerned because other inmates have gone to medical and they have misdiagnosed cancer and she is concerned that she may have a serious medical

problem. She elaborated that she has "a knot in my stomach, while I'm scared to go to medical, and cancer is in my family." She reported two sisters, her mother, and her aunt had cancer.

When I asked her about the mental health program she reported that she was in a group that was a phase I substance abuse group that "just finished". When I asked about her experience she stated it was "really a joke" and that the group leader essentially talked all about herself and did not provide any handouts or homework for the inmates to work on.

I reviewed this inmate's records which indicated a medical screening dated 7/24/02 at Leath where she was admitted and was reported as a "cutter" with scars on her arms but that under the general appearance section of the medical screening no evidence of trauma was noted. Treatment plans of 9/12/08, 5/1/09, 11/2/09, and 5/19/10 were reviewed. The diagnosis recorded was depressive disorder NOS. The treatment plan of 9/12/08 was signed by the supervisor only but not the counselor or the inmate. She was also diagnosed with personality disorder NOS with borderline features. Her GAF was noted as 75. The staff approach to the problem identified depressive symptoms, incarceration, unresolved grief and self-mutilating behavior as well as a history of drug and alcohol abuse. The objectives were for the inmate to recognize and cope with depression in six months, take her medications and decrease her desire to use drugs. The approaches were one-to-one counseling every three months, and taking medication. The counselor was to monitor her medication on a weekly basis. Treatment plan updates of 5/1/09 and 11/2/09 indicated little to no depression and on 5/19/10 no depression but also indicated the inmate wanted to open up to her counselor about her past. Despite these notations, there was no change in the treatment plan, no increase in individual sessions with the counselor, and antidepressant medications continued.

Assessment: This inmate's care and treatment are inadequate. She reports that she has significant medical problems and concerns however they have not been addressed in a multidisciplinary treatment plan including mental health and medical staff. Her symptoms of depression according to the record have essentially resolved however her request to the counselor to be able to talk about her past and problems that she has experienced did not result in any change in the staff approach to the problem or to the actual approaches, i.e. therapeutic interactions or interventions by staff.

28. Inmate 28

Inmate 28 was interviewed and reported that she is a 47-year-old woman who has been incarcerated at Graham for the past six and one-half years. She reported that she believes that she is at the outpatient level of care but did not have any knowledge of the L level system of classification. The inmate reported that she spent 19 months in the County Jail prior to her prison incarceration and was receiving Elavil. She also reported that she had been hospitalized in a mental health facility for two weeks when she was a child. She stated her current diagnoses are seasonal affective disorder and bipolar disorder.

The inmate reported that she had been placed in crises intervention at Camille Graham and been prescribed Prozac which made her feel homicidal. She has subsequently been treated with Wellbutrin and Buspar but reports these medications sometimes expire and she may go from two days to one week without receiving her medications. She reports she has seen Dr. twice during calendar year 2010, approximately once every three months, however she believes this may have been changed to every six months and that her medication is now ordered for a six-month period. She reports she has never signed a consent form for medications.

The inmate reported that her counselor is Ms. and she reported that she was "great for me". The inmate reported that she has never had a treatment team meeting that included the psychiatrist and counselor with her at anytime during her incarceration at Graham. She reported that she has had "classes" in anger management and positive thinking and has seen a number of videos during these classes and then added "but nothing done to help you deal with your own issues." When I asked what she meant by that she stated that the classes are not tailored to discuss any of the inmate's individual issues and that the counselor don't appear to be able to help them with their individual problems. The inmate stated that she works out and that helps her because she has seasonal affective disorder and in the winter time there is "nothing they do for you."

The inmate reported she is in no groups currently and there are no groups there specific for her problems. The inmate added that she has had serious problems with medical services and reported that in 2005 she had an accident where she fell on the sidewalk, injuring her face, had trouble walking after that, and had multiple bumps and bruises. She stated she went to medical to clean herself up and actually had a medical appointment the following day but there were no x-rays or any other diagnostic tests. She reported that she would not make any appointments away from the institution including such things as mammograms because she's afraid that she would fall again. She implied that such appointments had been attempted for her but that she had not kept them because she is afraid that she would fall and not receive medical services.

Assessment: This inmate's mental health care is inadequate in that it is not individualized, does not reflect multidisciplinary treatment planning, and the "classes" that she has been assigned do not address her specific treatment needs. She also reports that she has had difficulties receiving medical services and is fearful of leaving the campus of the institution because of a traumatic accident she suffered in 2005 and fears that this could happen again.

29. Inmate 29

This inmate was a 51-year-old woman who was admitted to Graham in 2008. She reported that she had been living in California prior to that time. The inmate reports a history of having been treated for mental illness since age 14 and having multiple hospitalizations in Kansas and California because of past suicide attempts. She states her diagnoses have been social anxiety disorder and post-traumatic stress disorder secondary to being abused as a child. She also reported that she is a "self-mutilator" and that she has "pretty bad depression". The inmate

stated that she has refused most medications with the exception of Paxil because of health problems including carcinoma, a right radical neuropathy in 2001, hepatitis C and fatigue.

The inmate reported that she currently works in the sewing plant. I noted that she has repetitive movements in both hands that could be representative of tardive dyskinesia or anxiety.

The inmate reported that she has taken Geodon, Tramadol, Zoloft, Trileptal, Risperdal and Ativan in the past and that she has been taking Paxil as prescribed by Dr. whom she sees every three months. She reports the Paxil is helpful and she gets "zaps" in her head if she misses her Paxil.

The inmate reported that she sees her counselor every two to three months unless she goes to her office and peeks in. She stated she went to see her counselor after she had cut herself really badly as self-mutilation and was in a crises cell for 11 days. She reports she didn't see the counselor at all during that 11 day period and added they don't treat self-mutilation here." She then stated she has "lots of scars" and displayed scars on both arms as well as carvings on her legs saying "loser" and "hated". She reported that she had told Dr. about her scars and Dr. told her that the staff "look at it like tattoos here – they don't treat me for it and sometimes I get frustrated and I cut too deep."

When I asked the inmate if she had ever seen a treatment team since being at SCDC, she reported 'no' but she is very familiar with treatment teams from California. She added she has never had one at SCDC. She also reported that she had been in a crises intervention cell for cutting herself two months ago, was discharged she was discharged to a dormitory setting even though she has a diagnosis of social anxiety disorder. She reported that in the past she has attempted to hang herself as well as taking overdoses and is currently anxious that she may attempt to harm herself further at some point in the future. She reported that she asked her counselor about possible halfway houses that she could be discharged to four months ago and that her counselor has not given her any information. She did state that she was able to get some information from the chaplain.

I reviewed this inmate's medical record. The medical screening of 12/12/08 gave diagnoses of "bipolar, asocial, auditory hallucinations, and PTSD." She was noted to be taking Seroquel, Celexa, Vistaril and Tramadol at that time. A consent form was in the record and was signed for Geodon on 12/10/09. No other consent forms or notes were found in the record. The inmate was in a crises intervention cell on 8/31/09 for planning to hang herself and again on 12/16/09 when she had carved "loser" on her thigh with a razor. She remained there until 12/21/09 and was releaseded by the counselor. A treatment plan of 5/11/10 gave no Axis I diagnoses, and the Axis II diagnosis was personality disorder with borderline features. The treatment plan did not indicate depression or mood swings and the objectives were for the inmate to take her medications and remain stable. The approach was one-to-one counseling and to continue with group referrals as well as with counselor to monitor the MAR. The previous treatment plan of 2/22/10 was identical to the plan of 5/11/10.

Assessment: This inmate's care and treatment are grossly inadequate. The quality of the treatment plans are poor and ignore the past history of depression as well as fail to address the inmate's PTSD secondary to child abuse, seasonal affective disorder, and her self-mutilating behaviors. There is no documented multidisciplinary treatment plan or treatment team meeting for this inmate with very serious mental illness.

30. Inmate 30

Inmate 30 was a 33-year-old woman who reports she has been at Graham since 2004 having spent two and one-half years at Leath prior to transfer. The inmate reported she was first treated for mental illness at age 10 for depression. The inmate stated that she believes she is "area mental health" but did not have any knowledge of the L system level of classification. The inmate reported she is currently prescribed Remeron 45 mg each evening and that there have been approximately four times since January 2010 that the staff have not had her medication. She reported that this generally lasted four to five days before she received the medication after the staff has run out.

The inmate reported that she sees her counselor approximately two times per month or whenever she is called. She reported that she has been trying to get into an anger management group as well as group about medications and some others but that she has not been able to. She stated that she had had an anger management group before and it was helpful to her.

The inmate stated that she did have a treatment team meeting "one time" with the counselor and other counselors but she could not remember if Dr. attended that meeting. She stated that she was told by the counselors that if she went off her medications she'd go back to lockup and they "argued me down saying it does help when I keep telling them it doesn't help." She stated she has been in lockup more than 20 times and when I asked her why she said it's because the staff say that she has threatened them and added "I don't", as well as for disrespect and being out of place. She stated that she is always put in a crises cell but never because of threats to hurt herself. She stated that she did try to hang herself once, approximately one year ago, and she also told the sergeant that she was going to cut her wrist a couple of months ago.

The inmate stated that she is supposed to go home in December 2010 but that she has street charges because the officers said that she wrote threatening letters which she believes is based on racial issues. The inmate added that she has "water on the brain since eight months old" and displayed her neck to show where she had a shunt in place. She reports that mental health staff have not been checking her shunt and that she talked to Dr. about the shunt who sent her out to an outside doctor. She stated that she saw a doctor at Graham because medical won't send her out to an outside doctor.

The psychiatrist also opined that it appeared that the inmate's psychiatric conditions are organic in nature, most likely due to early brain trauma and the best diagnoses may be impulse control disorder NOS and cognitive disorder NOS. The notes by the counselors however do not appear to recognize or appreciate these diagnoses and there is no documentation that treatment planning

is directed at assisting her cognitive impairment and impulse control. The psychiatrist also opined that the inmate may be in need of long-term hospitalization once she is released from prison. There does not appear however to be any evidence of discharge planning to assist in possible hospital admission after discharge. In addition to the above diagnoses, she was also diagnosed with psychotic disorder NOS.

Assessment: This inmate's mental health care appears to be inadequate. Despite her reports of depression and suicidal ideation, as well as her having been in lockup multiple times for extended periods of time, she has not had multidisciplinary treatment planning and the treatment has not been focused on helping her reduce her impulse control problems, improve her depression, and assist her with controlling her anger which appears to be a major contributant to her disciplinary infractions.

31. Inmate 31

This inmate was a 22-year-old woman who reported she had been incarcerated at Graham for the past five years. This inmate reported she first received mental health treatment at age 13 for depression and then manic depression. She reported she has been prescribed Zoloft and Depakote and subsequently Seroquel. She reported that she stopped taking Depakote and subsequently stopped taking Seroquel approximately two months ago because the Seroquel was being crushed. She reported that she has been taking Tegretol for approximately one year. The inmate stated that she has not signed any consent forms for these medications.

I asked the inmate if she was attending any groups and she reported no mental health groups because "I don't like them." When I asked why she reported that she doesn't go to groups because the staff don't really talk to inmates about their medicines and how they are supposed to work and the staff do not try to help them. She reported they should have treatment teams here like she had at home prior to incarceration.

She elaborated that she has never had a treatment plan since incarceration and stated "this ain't no real mental health facility – I look up medicines in the library because they won't tell you." She states her diagnoses have been bipolar disorder and "something schizoid".

The inmate continued "another thing that crises intervention they put us on they strip you down, the steel bunk and when you are on your cycle you get one pad and no panties." She reported this is unsanitary and on crises intervention you are locked behind a door and "that's not treatment." The inmate added that she just needed to talk to someone when she is stressing or going through something. She stated she has not been in a crises cell for approximately two years "because it will make you loose your mind." She stated that before that she used to go to the crises cell nearly every week. The inmate concluded by stated that the inmates "that really are crazy – wigging out – get no treatment, loose hope, just sedated."

Assessment: This inmate's care and treatment appear to be inadequate and she reports that she has not had any multidisciplinary treatment planning. She also reports she did not sign any

consent forms for medications and is forced to look up information about her medications at the library because the staff will not discuss them. The inmate provides her opinion that there is no mental health treatment available at Graham particular for inmates who are severely mentally ill.

32. Inmate 32

Inmate 32 was a 50-year-old woman who reported that she has been in Graham since November 2008. She reported she first went to a mental health clinic in 1991 or 1992 because of anxiety and depression. She reported further that she has been treated with Abilify, Depakote, Klonopin, and Vistaril but that she currently is not taking any medications. She reported that her last medications six months ago consisted of Depakote and Vistaril.

When I asked about groups she reported she currently has no groups and had been placed on group restriction for six months because she made a three-way phone call. She reported that she had been placed previously in a substance abuse class even though she has no substance abuse problems.

When I asked about the three-way phone call the inmate stated that another inmate had appendicitis and medical did nothing so that she called the other inmate's mother and set up an illegal three-way phone call, which resulted in her restriction.

I asked the inmate about any treatment team meetings and she stated "absolutely not – they don't do that here." I then asked her about her opinions regarding the mental health program and she stated it is "very very poor". She stated she has never been in crises intervention and never been in lockup and reported that she has had no suicidal ideation since she has been at Graham.

I reviewed the inmate's records and they indicate she was in a depression group until they concluded in May 2010. She reported that she had received her certificate for good participation in the group. Additional notes in the record indicate that she was begun on Buspar by an internist however the psychiatrist discontinued the Buspar, writing that there was no indication for it and the patient stated that she did not want to take it. A note by the counselor made reference to the inmate having made a three-way phone call to inform another inmate's mother about her daughter's health. The counselor indicated that the inmate had fair insight and judgment and despite the diagnosis of anxiety disorder NOS in remission the counselor noted that she would make recommendations for the inmate's classification to change to "NMH" indicating no mental health. A treatment team summary note two weeks prior to the counselor's note indicated the treatment team consisted of counselors, noted the plan was reviewed but did not make any reference to removing the inmate from the mental health service. The records indicates the inmate has had a number of medical problems including dizziness, nausea and vomiting which she has attributed in part to problems with her medications, causing her to refuse medications. The inmate also reported continuing problems with anxiety. The inmate also had been enrolled in the understanding depression and addiction group but did miss some of the sessions. She also was enrolled in a parenting group but missed some sessions of that group.

The counselors noted that reasons are unknown for the inmate missing those groups and did not subsequently indicate that the attendance had been discussed with the inmate.

The records also indicates the inmate reported that she had "lupus" but that medical was having trouble substantiating that she indeed suffered from this medical illness.

Assessment: This inmate's mental health treatment appear to be inadequate. The record demonstrates that she has suffered from symptoms of anxiety and depression prior to and since her incarceration. There is a clear lack of multidisciplinary treatment planning as the inmate was started on an anxiolytic medication, Buspar, by a non-psychiatrist which was subsequently discontinued by the psychiatrist with the psychiatrist noting no indication for the medication. There is nothing in the record to indicate that there was any collaboration between the mental health and medical staffs about this inmate's overall treatment needs despite her having reported "lupus", dizziness, nausea, vomiting and other symptoms. At one point she was given a wheelchair because of her reported symptoms and yet there was again no documentation of collaboration via multidisciplinary treatment planning to assist this inmate in her overall treatment needs.

33-41. Inmates 33-41

A group of nine inmates were interviewed to obtain information about their care and treatment at Graham. These inmates were selected from a roster which indicated they were all at the L-2 (ICS) level of care.

The inmates reported they didn't have any knowledge of the new classification system and gave their levels of care as ICS, area of mental health or outpatient. Six of the nine inmates had been at Graham for more than one year and the other three had been at Graham for five, six and ten months respectively. The inmates asked a question was Blue Ridge D an ICS program to which I could not answer. When I asked those who believed they were on the ICS level of care what that meant, they reported they see a counselor once per month but there were no other differences they could identify. The inmates reported that they are housed on Blue Ridge D but there are a number of other inmates who are on Blue Ridge D that are not mentally ill and that they are bullies and troublemakers. They question how staff decides what inmate should be placed on Blue Ridge D because of this mixture of inmates.

The inmates reported that they have had significant problems with medication changes and that Seroquel and Tramadol have been sold by other inmates and therefore they are no longer on the formulary. They reported their medications have been changed without discussion with the psychiatrist and that they have not signed consent forms. One of the inmates reported that she had been assisted by Dr. because she had been taking Tegretol and suffering from trouble walking, very likely ataxia. She reported that Dr. changed her medication to Zyprexa and then Geodon and that has been helpful to her. She added however that she has been having trouble with medical with regard to hepatitis C because she was told three years ago that

she did not quality to take Interferon and has been asking since that time what she would need to do to be able to be placed on Interferon.

Several of the inmates reported that when they are having active symptoms i.e., "stressed" and are having interactions with other inmates, they wondered why they could not go outside for a time out or into their cells to get away from the environment. They suggested they would even be willing to go into a holding cell to calm down but that staff would not allow that to happen and the alternative is to place them in C.I. The inmates reported that when they have been in crises and asked to see a counselor they have been told that the counselor couldn't see them particularly if it was on a weekend. Another inmate reported that she told her counselor that she needed to talk to Dr. because her medications had been changed and they were not working for her, so she started refusing medications, and this inmate reported that she was told by the counselor that they would just "put me down, that's just wanting to get high to get medication". The inmate reported that she finally saw Dr. after several weeks and that her medications were changed again.

Another inmate reported that she had a crisis and essentially broke down and asked an officer if she would call a counselor and the counselor told the officer to ask this inmate what was wrong and did not see the inmate herself for two weeks. By contrast another inmate reported that her counselor would see her if she needed to as long as it was not on a weekend or holiday because there is no mental health staff present in the facility at that time.

All the inmates reported they see the psychiatrist every three months however five of nine reported that their medications had run out and that it usually takes from three to seven days and up to two weeks to actually have the medication restored.

Three of the inmates reported their beliefs that the officers need training because when the officers see the inmates laughing or socializing with each other they send them to their rooms rather than allow them to have that kind of interaction. When I asked about group therapies, three of the nine inmates reported they were in groups currently and six of the nine reported they had been in groups in the past six months. Six of the nine inmates reported they enjoyed the groups and that they believe they are helpful. I asked the inmates how they spend the rest of their time and they reported that most of the time they are in their cells. The inmates stated that the morning of this site visit, the staff woke them up and said "company coming". They were then told to wax the floors, clean up the unit "real good for y'all". They added that if you don't have the money to buy a radio you can't listen to the TV because the TV's are keyed into earphones. The inmates added "there is nothing for us to do."

Two of the nine inmates reported they had been to lockup in the last six months and four of the nine reported they had been to lockup in the last 12 months. The inmates reported that after they are placed in lockup, they are put on six months program restrictions. They reported that these restrictions include no visitations, no telephone, no canteen except for personal items and no participation in programs including their faith-based programs which are conducted by volunteers from outside of the prison. These inmates reported that this makes their lives even

more difficult because they had been on lockup and that after the lockup time is over, they have these restrictions and are unable to see their families or communicate with their families particularly their children.

These inmates reported that they have not had any multidisciplinary treatment planning but are told by the counselors what the "treatment team" has decided about them. I reviewed the medical records of inmates 33, 34, 35, 36 and the records were consistent with other records described in this report for the lack of multidisciplinary treatment planning, mental health counselor contacts that do not appear to focus on the diagnoses or the symptoms reported by the patients. It was also no evidence in the records that consent forms were signed for medications that were prescribed for these women. Lastly, the references to group therapy and largely to do with whether or not inmates attended groups did not give specific information about how the groups were helpful in addressing the mental illnesses that these inmates presented with.

Assessment: These inmate's care and treatment appear to be inadequate particularly if they are considered to be at the ICS level of care. Discussion with the inmates as well as review of their records does not indicate there is any significant difference in the treatment services provided to them at the ICS level of care as compared with inmates in area of mental health level of care, the L-2 for ICS versus L-3 for area mental health or L-4 for outpatient were unknown to these inmates and the services described by the inmates and the documentation in the records do not indicate any significant increases or enhances in treatment.

Of great concern is the practice of imposing restrictions on inmates who have been in lockup after their lockup time has been concluded as described by these and other inmates during the course of this site visit. It is clinically contraindicated and potentially extremely detrimental to have such restrictions placed on women with or without mental illness that prohibit them from having contacts with their families particularly their children. It is not helpful and indeed damaging to women with mental illness to be unable to have such communications with their families and outside social support systems. This is a practice that has no clinical justification and should be stopped immediately.