GILLIAM PSYCHIATRIC HOSPITAL (GPH)

Number: HS - 19.13
Date: June 1, 2016

Location:

Gilliam Psychiatric Hospital is located at the South Carolina Department of Correction's Kirkland Reception and Evaluation Center in Columbia, South Carolina.

Facilities /Scope of Program

Gilliam Psychiatric Hospital (GPH) is an eighty-seven bed, single-celled, licensed psychiatric hospital, which serves as the South Carolina Department of Correction's inpatient psychiatric care facility for the male inmate population. Gilliam's mission is to provide twenty-four hour psychiatric care and monitoring of its mentally ill inmates. This care includes psychiatric evaluations, psychological evaluation, group therapy, individual therapy, case management, medication management and discharge planning. Gilliam provides services to individuals who manifest symptoms of severe psychiatric disorders that require acute care, complex treatment management or stabilization prior to referral to another level of care. It may also house individuals who exhibit chronic treatment needs that cannot be managed better at an alternate level of care.

Gilliam Psychiatric Hospital also houses a small cadre of inmate workers who are non-mentally ill inmates that assist in housekeeping, food service, cleaning, and clerical support (prepare daily rosters, etc.). These inmates earn work credits for the jobs they perform at GPH.

Definitions:

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

Case Management - Correctional professionals assisting inmates in meeting and maintaining mental health treatment goals and objectives through advocacy, on-going assessment and evaluation, planning, communication, education, resource management, and service facilitation.

Contingency Management Program (CMP) - A system of levels with increased privileges where an inmate's behavior is rewarded for adhering to the Treatment Plan and program rules.

Continuity of Care - Ensuring care from the point of admission to discharge to transition into the community.

Custody Levels - SCDC Security/ Custody Levels assigned to inmates by Classification staff based on the inmate's criminal and incarceration history, current offenses and sentences, medical status and special program needs.

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

GPH - Gilliam Psychiatric Hospital

Group Status – (G) - A status assigned to inmates on Level "SP" that are eligible for therapeutic group intervention.

Guilty But Mentally Ill - A sentence imposed by a trial judge under the SC Code of Laws, whereby the incarcerated inmate must be first taken to a facility designated by the Department of Corrections for treatment and retained there until it is the opinion of the staff at the facility that the inmate may be safely moved to the General Population to serve the remainder of the sentence.

Healthcare Setting - A therapeutic environment with a nursing station on the unit that is staffed 24/7.

Individual Treatment Plan (ITP) - A document that details an inmate's current mental health problems and outlines the goals and strategies that will assist the inmate in overcoming his or her mental health issues.

Initial Assessment - Face-to-face interaction with a psychiatrist, QMHP, nurse and a newly arrived inmate to review and document the referral information, current mental status and immediate treatment/management needs of the inmate.

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

Inpatient Care - Voluntary or involuntary commitment to a psychiatric hospital.

Intake Assessments - An extensive interview/evaluation process designed to gather information from inmates who are newly admitted to the hospital or are being readmitted. Information gathered is used to formulate provisional diagnoses, initial treatment plan, and assure safe and therapeutic management of the inmate.

Level of Care (LOC) - A hierarchical coding system that reflects an inmate's current medical and mental health classification, mental health service need(s) and the intensity of treatment an individual will receive. All inmates admitted to GPH receive a Level of Care classification of L1- Hospitalization.

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

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

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

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

Mental Health Technician - Staff members with at least a bachelor level degree in counseling related profession who provides adjunct services to mentally ill inmates under the supervision of licensed clinical staff.

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

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

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

Psychologist - Mental health practitioner licensed by the State of South Carolina as a psychologist.

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

Referral (Mental Health) - Request for mental health services.

Qualified Healthcare Practitioner (QHP) - Physician, Physician's Assistant, Nurse Practitioner

Qualified Mental Health Professional (QMHP) – Psychiatrist, Licensed Psychologist, Licensed Professional Counselor, Licensed Professional Counselor - Licensed Martial and Family Therapist (LMFT), Supervisor, Licensed Independent Social Worker, or Psychiatric Nurse Practitioner. Also includes Licensed Master Social Worker, LMFT-Intern, and Licensed Professional Counselor- Intern, with appropriate supervision.

Restricted Status (R) - A GPH status designated for inmates who are exhibiting agitation, physically threatening behavior or are verbally threatening to harm others.

Columbia Suicide Severity Rating Scale (C-SSRS) - is a suicidal ideation rating scale created by researchers at Columbia University to evaluate suicidality in persons ages 12 and up. The C-SSRS identifies behaviors which may be indicative of an individual's intent to commit suicide. Versions of the C-SSRS utilized by SCDC include the Lifetime/Recent form, the Risk Assessment form, the Daily/Shift Screener form, and the Discharge Screener form.
LOC – Level of care

Safe Cell - A safe cell is a suicide resistant cell free of all obvious protrusions. These cells should contain tamper-proof light fixtures and ceiling air vents, and surfaces that are protrusion-free and not conducive to hanging.

Stipulated Factor Status (S) - A GPH status which allows for the modification of privileges in the Contingency Management Program. These inmates may require special supervision of activities and behavior.

Suicide Precautions (SP) - Intervention measures to reduce physical self-harm by an inmate identified as a risk for suicidal behavior.

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

- A sanitary and humane environment
- Adequate medical and mental health staffing
- Adequate allocation of resources for the prevention of suicide, self-injury, and assault
- Adequate observation, treatment, and supervision
- Social interactions that foster recovery

Treatment Team - Multidisciplinary group including but not limited to mental health staff (Psychiatry, Psychology, QMHPs, Mental Health Technicians) medical personnel, and uniform staff, who discuss integrated therapeutic services, collaborate, and share appropriate information based on the inmate's level of care, for the purpose of treatment of mentally ill inmates and continuity of care.

I. Program Staffing

Hospital Administrator - 1 FTE
Psychiatrists – 4 FTE
Psychologists – 1.5 FTE
Qualified Mental Health Professionals (QMHPs) – (previously known as licensed clinical correctional counselors) 9 FTE's
Support Staff – 2 FTE
Mental Health Technicians – 16 FTE's
Nursing – 27 FTE's
Activity Therapist (Recreation Therapist) - 1 FTE (with additional support from contract services)

Adequate Security staff will be assigned to GPH to maintain a safe treatment environment for inmate patients, a safe working environment for staff, and to support activities and movement on both sides of the unit.

Program Staffing may be supplemented with contract staff and consideration will be given to use of part time clinical staff and position sharing where necessary to meet program needs.

II. Admissions/Referrals

Inmates determined to be in need of inpatient psychiatric care will be classified as L1 and may be admitted to GPH directly after the Reception and Evaluation assessment, or at any time thereafter, if their mental status is such that it warrants further evaluation or treatment not available at other levels of mental health classification. In general, inmates admitted to GPH will have been determined to be suffering from acute, severe or unstable mental illness or to be in need of further evaluation or treatment that cannot be accomplished outside of a hospital setting. Admissions occur upon the order of a psychiatrist. Where possible admissions will be processed during regular business hours Monday through Friday.

Referrals for admission are made to the Chief Psychiatrist or designee and are coordinated through the Hospital Administrator. After hour requests for admissions will be handled by on call psychiatric and QMHP staff.

Inmates can be referred to Gilliam Psychiatric Hospital on a voluntary basis, involuntary basis, pursuant to a court order, or because of a status designation determined by the court.

A. **Voluntary Admissions**: Inmates that are in need of and agree to participate in, psychiatric treatment. Inmates may be referred to the Chief Psychiatrist for consideration for admission by any mental health or medical staff member.

B. **Involuntary Admissions**: Inmates that are in need of inpatient care, are a danger to themselves or others, are not capable to sign in voluntarily, or who refuse to sign a voluntary consent for treatment form, may be considered for involuntary admission. Admissions occur by court order, only after evaluation by a psychiatrist and completion of the forms "Application for Involuntary Emergency Hospitalization for Mental Illness" and "Certificate of Licensed Physician- Mental Examination for Psychiatric Treatment", and judicial review of the need for admission.

C. **Guilty But Mentally Ill Admission (GBMI)**: Inmates who are Court ordered to undergo a psychological evaluation as part of their sentence before institutional placement is made will be admitted for that evaluation and further disposition planning.

III. Discharges

Inmates will be discharged from hospital level care when it is determined that their mental health needs can be met at a different mental health classification level. All inmate requests for discharge will be reviewed by the treatment team to determine current treatment progress and future treatment needs. Inmates can only be discharged from GPH on the order of a psychiatrist.

A. **Inmates Released By Probate Court**:

1. Inmates who are involuntarily admitted to GPH will be formally assessed by two Designated Examiners (a Psychiatrist and another QMHP) within five days of admission. If the inmate is determined to no longer pose a danger to himself or others or does not otherwise meet the criteria for involuntary inpatient hospitalization, the Designated Examiners will recommend the inmate's release from the hospital. The Designated Examiners' reports will be filed with the Probate Court and an Order of Release will be issued by Probate Court. The inmate may be allowed to sign in as a Voluntary admission to continue treatment on a voluntary basis. Otherwise, the Hospital Administrator, or designee, will coordinate the inmate's discharge with SCDC Central Classification and will inform the institutional mental health and medical staff at the receiving institution of the scheduled transfer.

2. If the inmate is recommended for further inpatient psychiatric treatment by the Designated Examiners, the Probate Court will order the inmate to be detained and will schedule a date for a full Probate Court

Hearing. If the inmate has improved and no longer meets the criteria for inpatient hospitalization based on his psychiatrist's assessment, the Probate Court may order the inmate to be released.

B. **Inmates Who Request Discharge**:

1. Inmates may request a discharge from Gilliam Psychiatric Hospital at any time. Requests for discharge will be directed to the Treatment Team. The inmate's psychiatrist will discuss the case and the inmate will be seen at Team and interviewed regarding suitability for discharge. The Psychiatrist will make the final determination regarding discharging the inmate. The final diagnoses will be determined by the psychiatrist and recorded in the AMR. Recommendations will be made for further treatment and for the appropriate level of care (residential or outpatient). The actual discharge date will be scheduled by the Hospital Administrator through Central Classification. The medical and Mental Health staff at the receiving program/institution will be informed and a formal discharge summary will be available within the GPH medical record.

2. An Inmate whose mental condition deteriorates before discharge placement can be obtained may need to have his discharge rescinded. The case will be reconsidered by the Treatment Team and further treatment recommendations will be made. A voluntary inmate who requests a discharge but whose mental condition necessitates involuntary hospitalization and treatment as determined by the Treatment Team, must have the "Application for Emergency Admission" completed. The Probate Court will make the determination of whether the inmate is "Mentally Ill" and in need of treatment or may discharge the inmate on grounds that he is "Not Mentally Ill".

3. An inmate who is scheduled to be released from the South Carolina Department of Corrections and who may continue to be a danger to himself or others or meets the requirements of inpatient hospitalization may be committed to a psychiatric hospital in the community or may have their judicial commitment order transferred to a designated mental health hospital. All other inmates who are scheduled for release from SCDC will have discharge plans completed to assist with transition to the community. Plans will address housing, Disability or Social Security Supplemental Income, referrals for continued treatment and services at the local mental health center, substance abuse, vocational rehabilitation and use of any other services or facilities recommended to support mental health and safe transition to the community.

IV. Treatment

Treatment will follow adequate assessment and can include individual counseling, group counseling, activity therapies, other out of cell structured activities, medication administration, and recreation therapy. Each inmate's treatment will be documented on an individualized treatment plan that has been developed with input from the inmate, will evolve over time, and will be available in the GPH record.

The goal will be to provide treatment in the least restrictive setting appropriate with the inmate's mental health and security needs. Attention will be paid to provision of out of cell therapeutic activities and recreation time. All inmates will be scheduled for a minimum of four hours of structured therapeutic programming a day, Monday through Friday. Exceptions will be clinically determined by the Treatment Team.

A. **Initial Assessment**: Inmates admitted to GPH are assessed by a psychiatrist, other QMHP and a nurse following arrival, who will document review of the referral information, current mental status and immediate treatment/management needs, in the AMR. The results of the assessment will determine assignment to an initial Contingency Management Level based on the inmate's needs and level of functioning. The psychiatrist will write an order for assignment to the appropriate contingency management level. All inmates will be seen by a psychiatrist or psychiatric nurse practitioner as soon as possible following admission but no later than 24 hours after admission. Prior to the in person interview of the inmate (if the psychiatrist is not in house or on the unit), the nurse and a QMHP will discuss the case by phone with the assigned or on call psychiatrist, and the nurse will obtain an order for admission and any treatment orders (including medication orders, need for suicide precautions, etc.) to assure initial management and continuity of care.

Inmates are housed in single cell rooms while in the hospital. If needed, inmates may be placed on Suicide Precaution "SP" status for closer observation and to ensure safety.

B. **Intake Assessments**: GPH Intake Assessments are an extensive interview/evaluation process designed to gather information from inmates who are newly admitted to the hospital or are being readmitted. Information gathered is used to formulate provisional diagnoses, initial treatment plan, and assure safe and therapeutic management of the inmate. Assignments to psychiatrists and QMHPs will routinely be done on a rotating basis with attention given to size of caseload, past knowledge of a particular case, or specific treatment needs of the inmate. Intake staffing will be held the first business day following admission. The Intake Staffing Team will consist of a staff psychiatrist, a psychologist, other QMHPs, a nurse, and an operational staff member. Team members gather clinical, medical and social information to accurately plan for provision of services to the inmate. An updated Clinical Assessment form is completed. The initial psychiatric assessment is documented in the AMR. The psychiatrist will review the need for any psychotropic medications and any additional medical or laboratory studies.

C. **Suicide Risk Assessments**: QMHP staff will assess for suicide risk in accordance with SCDC Suicide Prevention and Crisis Intervention policy HS-19.03 and complete the Columbia Suicide Severity Rating Scale (C-SSRS)-Lifetime/Recent form on all inmates upon arrival to GPH. The results will be discussed with the psychiatrist. The psychiatrist will determine if Suicide Precaution status is warranted. If an inmate is placed on SP status, the QMHP will assess the inmate daily and will complete the C-SSRS Daily/Shift Screener form and the C-SSRS Risk Assessment form. The Assessments will be documented in the AMR. The psychiatrist will assess the current suicide risk independently prior to removing an inmate from Suicide Precaution status. A QMHP will reassess the inmate within 24 hours and will again complete a Suicide Risk Assessment form. The inmate will be assessed every 48 hours for the first seven days and then weekly for one month.

D. **Case Management**: Each inmate at GPH is assigned a primary QMHP who will serve both as a case manager and counselor to the inmate. They will work with the rest of the team to ensure continuity and quality of care throughout the inmate's hospital stay. Case Management includes ensuring that initial assessments, treatment planning, individual counseling, treatment team participation, referrals to group therapy sessions and discharge planning are completed as clinically indicated or scheduled. QMHPs also provide individual counseling at least weekly to each inmate and coordinate the development of individualized treatment plans. Progress towards goals is evaluated weekly and updated as needed.

E. **Individual Treatment**: All GPH inmates will be seen for individual treatment by their assigned psychiatrist and assigned QMHP. They may also be seen individually by other members of the treatment team as clinically indicated. Frequency of sessions is determined by clinical symptom presentation and treatment needs. Newly admitted inmates and acutely/ severely ill inmates will be seen for formal individual sessions at least weekly. Individual interactions with the inmates that are of clinical significance or summarize behavior or treatment progress will be documented when they occur in the AMR. Longer term patients will be seen at least every other week.

F. **Group Therapy**: Group Therapy Sessions are provided daily, Monday through Friday, on the unit and in adjacent treatment areas during identified morning or afternoon group treatment time periods. They are routinely conducted by QMHPs and nursing staff. The groups at GPH are continuous and open-ended, and inmates may be referred to, or removed from, groups by the Treatment Team. Group Therapy sessions offer inmates a safe place to work through problems or situations with their peers, learn new skills and provide opportunities for inmates to relate to and socialize with others.

1. GPH will offer a variety of Group Therapy sessions. Available groups may include:
    a. Community meetings
    b. Substance Abuse
    c. Stress Management
    d. Managing Emotions Effectively
    e. Leisure Skills
    f. Discussion/Doing Our Time
    g. Assertiveness
    h. Patient Education (including symptom recognition and management)
    i. Coping with Depression/Anxiety
    j. CBT
    k. Cognitive Enhancement

l. Improving Activities of daily Living
m. Understanding psychiatric medications and side effects
n. Anger management

G. **Recreational Therapy**: The Recreational Therapist will plan, direct and coordinate recreation programs for the inmates. He/she will be assisted by mental health technicians. Activities will be held with small groups of inmates throughout the day and with larger groups during scheduled recreation times.

1. The Therapist will observe, analyze, and record inmates' participation, reactions, and progress during treatment sessions, modifying treatment programs as needed.

2. Develop treatment plans to meet the needs of inmates, based on needs assessment, patient interests and objectives of therapy.

3. Encourage inmates with special needs and circumstances to acquire new skills and get involved in health-promoting leisure activities, such as sports, games, arts and crafts, and gardening.

4. Counsel and encourage inmates to develop leisure activities.

5. Confer with members of treatment team to plan and evaluate therapy programs.

H. **Unstructured Recreational/Leisure Activities**: GPH inmates will be offered out of cell recreation 7 days a week. Inmates on restricted housing status will be offered a minimum of 2 hours of unstructured out of cell activities per day. Inmates will have access to outdoor recreation, use of the day room areas, television viewing, and reading materials.

I. **Treatment Plans**: Individualized Treatment Plans are established by the attending psychiatrist and assigned QMHP, in conjunction with the Treatment Team and the inmate, and are documented in the AMR. They are designed to set treatment goals and monitor measurable progress. Treatment plans are updated regularly. Treatment plans will be reviewed and discussed with the inmate during individual sessions and Treatment Team meetings. Initially, the inmate will be asked to sign the Treatment Plan indicating his understanding of the plan of treatment. An Initial Treatment Plan will be completed within 72 hours of intake and the master (ongoing) plan will be in place within 14 days. Additional treatment plan reviews will be conducted monthly or more often if clinically indicated.

J. **Treatment Teams/Treatment Team Meetings**: Treatment Teams are multi-disciplinary for each inmate and are made up of a Psychiatrist (team leader), Psychologist, other QMHPs, nursing staff, mental health technician, activity staff and a representative of correctional services.

The purpose of Treatment Team meetings is to discuss the progress, or lack of progress, and treatment strategies for each inmate. Any staff member may make recommendations to the Team based on an inmate's progress and behavior. Treatment Team members meet formally weekly and daily for case updates. Each inmate's case is staffed each week. The Treatment Team will discuss Contingency Management Level increases or decreases of an inmate's level, discuss Group Therapy Referrals and discuss upcoming discharges. Inmates will be presented to and interviewed, in person, by the GPH Treatment Team following their admission (when stable enough to participate) and subsequently at a minimum one time a month (or more often if clinically indicated), and when the attending psychiatrist has determined the inmate is ready for discharge. Inmates may also be brought in front of the treatment team at any time to discuss changes in behavior or to discuss treatment plan changes. Inmates are not routinely brought to daily team meetings.

V. Contingency Management Program (CMP)

Contingency Management is a central part of the Gilliam Psychiatric Hospital program. Contingency Management allows the hospital staff to address security concerns, monitor and evaluate the status of the inmates, as well as to appropriately implement therapeutic interventions, while supporting concepts such as reinforcement of healthy behavior and understanding consequences of disruptive or self-defeating behaviors.

Contingency Management levels include I, II and III. The initial level is determined by the attending psychiatrist with input from the team. Changes of levels are determined by the Treatment Team, and the change is implemented through order of the psychiatrist. A staff member may put forward, for review and approval of the Treatment Team, a request to change levels. An inmate may also request a level change through discussion with any team member.

Inmates may earn incentives based upon their progress towards individualized goals.

Special statuses (see below) may be assigned to an inmate on any level. These include, SP (Suicide Precautions), R (Restricted Status), and S (Stipulated Factors) and may also be changed upon the recommendation of any staff member with a psychiatrist's order, where necessary, or agreement of the Treatment Team.

The Contingency Management Plan allows inmates to move from more restrictive to less restrictive levels. Higher levels allow inmates to have more privileges, but also place more responsibility on the inmate. Each inmate's level is documented in the AMR and posted on his cell door.

The following is an outline of rights, privileges and responsibilities for each designation in the Contingency Management Plan:

A. **Assignment of Levels/Status**:

Each inmate will be assigned a level and (possibly a Status) upon admission by the admitting Psychiatrist. The level assignment will be based on the inmate's mental status, results of initial assessments, and any pertinent presenting problems as identified by the referring staff/institution.

1. The inmate will be interviewed by the Intake Team the next working day (Monday-Friday) following admission. The inmate's overall status will be reviewed and the level may remain the same or be adjusted.

B. **Changing Levels and Statuses**:

1. Changes in level/status may be recommended by any staff member. Any recommendations for changes in level/status will be brought to the attention of the psychiatrist and will be discussed in Treatment Team. It may be necessary to lower an inmate's level or status prior to Treatment Team due to indications of suicidal behaviors or intent, for security reasons or for violations of a written contract previously established for the inmate. In these situations, a QMHP or nurse will consult with the attending psychiatrist or psychiatrist on call.

2. An inmate's SCDC Custody Level (see below) cannot be changed by hospital staff. Custody Levels are reviewed by SCDC Classification staff.

C. **Custody Levels**:

1. Custody Levels will be recognized by letters of the alphabet. The alphabet will represent treatment and security limitations assigned to inmates within Gilliam Psychiatric Hospital. The Custody Levels assigned may, in some cases, supersede the privileges authorized by the level assignments, as some Custody Levels have predetermined restrictions and limitations.

2. Explanations of "Custody Levels" are listed below:

GP	General Population (IN, MO, MR, MI, ME)
PC	Protective Custody
ST	Short Term Lock-Up
DD	Disciplinary Detention
SD	Security Detention
SSR	Substantiated Security Risk
SK	Safe-Keeper and Death Row

3. **General Population - GP (also known as straight level):** The Majority of inmates referred to GPH will fall under a General Population Custody Level. These Levels can only be changed by Classification Caseworkers and according to SCDC policy. The General Population Custodies include IN - (Intake-Reception and Evaluation Status), MR - (Minimum Restricted), MI - (Minimum Custody) and ME (Medium Custody). These inmates do not require restraints when out of their room unless they are placed on a Restricted (R) status by GPH staff. Privileges such as canteen spending limit and number of visits are determined by their custody levels.

4. **Protective Custody – (PC)**: Most Gilliam Psychiatric Hospital inmates will not be in Protective Custody status. However, if they are on PC, they must be isolated from other inmates. They will not be in restraints when taken out of their cell, unless otherwise specified with a Special Status or by their Custody Level. They will be showered separately. They will participate in recreation separately from other inmates. They will not be allowed to participate in group activities except with other PC inmates if not otherwise contraindicated. Admission to Gilliam Psychiatric Hospital of an inmate in PC status may result in the modification of the management of this inmate and the usual restrictions for clinical reasons if dictated by the Treatment Team.

5. **Short Term Lock-Up, Disciplinary Detention, Security Detention – (ST, DD and SD)**: Inmates assigned these Custody Levels have been sentenced to Short Term Lock-Up, Disciplinary Detention, or Security Detention. Admission to Gilliam Psychiatric Hospital of an inmate on Short Term Lock-Up, Disciplinary Detention, or Security Detention may result in the modification of the management of this inmate and the usual restrictions for clinical reasons if dictated by the Treatment Team.

6. **Substantiated Security Risk - (SSR)**: Inmates in this category constitute a Substantiated Security Risk (SSR) to themselves, other inmates, employees or to institutional security and operations. They will be retained in this status unless removed by Classification. Admission to Gilliam Psychiatric Hospital of an inmate in SSR status may result in the modification of the management of this inmate and the usual restrictions for clinical reasons if dictated by the Treatment Team.

7. **Safe-Keeper – (SK) and Death Row**: Safe-Keeper is a designation assigned to an inmate from a city or county detention center who is transferred to the South Carolina Department of Corrections while awaiting trial. This is typically an inmate that is an escape risk or is unmanageable. This designation cannot be changed by the Gilliam Psychiatric Hospital staff. These inmates are not allowed outside of the residential area unless restrained with belly chains and leg irons and/or other restraints. These inmates must also be escorted by Correctional Officer staff at all times. Separate recreation and shower times are scheduled for inmates in this designation. Inmates in this designation are allowed supervised visits only after approval of the Warden's office. Inmates admitted from Death Row are also treated under these conditions. Admission to Gilliam Psychiatric Hospital of an inmate on Safe-Keeper status may result in the modification of the management of this inmate and the usual restrictions for clinical reasons if dictated by the Treatment Team.

VI. CONTINGENCY MANAGEMENT PLAN LEVELS AND PRIVILEGES

The Contingency Management Plan utilizes three levels: I, II and III. Levels II and III are used alone while Level I is often used in combination with Special Statuses. Special Statuses utilized by Gilliam Psychiatric Hospital staff include the following:

SP	-	Suicide Precaution
R	-	Restricted
S	-	Stipulated Factors
G	-	Group

An inmate may be assigned to a Custody Level (SD), Contingency Management Level of I and one or more of the Special Statuses (SP). For the purpose of determining privileges, the most restrictive custody level is utilized.

It is recognized that different reinforcement or incentives may have different meaning or utility to different inmates (i.e. phone calls and visits) and thus the treatment team will maintain the ability to modify those available at any contingency level in conjunction with the inmate's treatment plan.

A. **Suicide Precaution – "SP"**: Suicide Precaution ("SP") is a designation assigned by a psychiatrist at Gilliam Psychiatric Hospital. This designation is assigned to any inmate that is thought to be at risk for self-harm. Any staff having knowledge that an inmate poses a risk to himself must consult with the psychiatrist who may recommend placement on SP. These inmates are placed in a safe cell. Their clothing and property are removed and they are continuously monitored, with documentation occurring at least once every fifteen (15) minutes, twenty-four (24) hours per day. They are allowed to have a security mattress with no holes or tears, a Suicide Precaution (tear proof) blanket and a Suicide Precaution smock. An inmate should be placed in a camera cell if available. An inmate may be placed on SP status on an emergency basis, but this must be immediately followed by a physician's order.

   Schedules and privileges for inmates on SP are listed below:

   a. Inmates will be provided the opportunity for showering under supervision a minimum of 3 times a week. Daily showers will be offered when if adequate staffing is available. Hygiene items are not allowed to be kept in the room but will be provided by Mental Health Technician staff who will monitor the inmates while using the items and will account for/remove the items after use.

   b. Inmates may participate in treatment groups as approved by the Treatment Team. Inmates authorized to attend groups will have the Special Status of "G" (Groups) assigned.

   c. The psychiatrist may order the inmate to be allowed the following: books, therapeutic reading materials (handouts), crayons and paper, playing cards, and/ or puzzles. It is recognized that the availability of these materials may serve a therapeutic purpose and provision of such materials will be authorized unless it is determined by the ordering clinician that their availability would pose a risk of harm to the individual inmate

B. **Restricted – R**: This category is assigned by the Gilliam Psychiatric Hospital staff to inmates who are exhibiting agitation, physically threatening behavior or are verbally threatening to harm others. They are reviewed at least weekly.

   Possible Restrictions that may be applied include:

   a. Inmates will be restrained in handcuffs (in the rear) or restraint belt when removed from the cell. Restraints will be removed during the recreation period.

   b. Inmates will be afforded the opportunity for recreation for a minimum of five (5) days per week with at least one (1) hour per day, and evening recreation as staffing and weather permits.

   c. Inmates will be offered an opportunity to shower daily. Restraints will be removed once the individual is secured in the shower.

   d. Visits will take place in the Security Visiting Room, and must be prearranged by the GPH Visitation Coordinator. Restraints will be used when the inmate is taken to visit and will remain in place during the visit.

C. **Stipulated Factor – (S)**: "S" indicates a stipulated factor associated with an inmate. This status allows for modification of privileges. These inmates may require special supervision of activities and behavior due to intellectual deficits, psychotic symptoms, inappropriate behavior, physical problems, and/or other reasons as determined by the Treatment Team and documented on the door card and in the treatment plan.

D. **Group – (G)**: "G" indicates Group. This status will be assigned to inmates on Level "SP" that are eligible for therapeutic group intervention. In each case, approval of the Treatment Team is mandatory.

E. **Contingency Management Level "I"**: Level I is a designation assigned by the GPH staff. Level I is the most basic level for any inmate. This level may be used in combination with restrictions. Progress in treatment will result in advancing the inmate to a higher level.

The following apply:

a. Inmates will be provided the opportunity for showering a minimum of 3 times a week. Daily showers will be offered when if adequate staffing is available.

b. Inmates may have two (2) personal phone calls for a maximum of fifteen (15) minutes each per week. Mental Health Technicians will only monitor the number of calls. These inmates will take responsibility for selecting calling times.

c. Visits must be prearranged by the Gilliam Psychiatric Hospital Visiting Coordinator. A Security Officer must supervise the visit. Supervised visits are scheduled on Tuesdays and are two (2) hours in length.

d. Inmates will be afforded the opportunity to participate in outdoor recreation seven (7) days a week.

e. Inmates may have reading materials in their cells as approved by the treatment team.

F. **Contingency Management Level "II"**: Level II is a more advanced level for inmates who have shown progress in treatment. An inmate on Level II has demonstrated the ability to handle more responsibilities and is granted more privileges. The Inmate must be cooperative with all areas of treatment and must abide by all rules. To advance to a Level II, inmates are expected to maintain appropriate hygiene, keep their rooms neat and orderly, participate in recreation, staffing with the psychiatrist and Individual Counselling sessions. Inmates must be compliant with prescribed medication and participate in at least 50 % of Group Therapy and other Structured Activities.

The following apply:

a. Inmates may shower daily. Inmates will be provided the opportunity for showering under supervision a minimum of 3 times a week. Daily showers will be offered when if adequate staffing is available.

b. Inmates may have three (3) personal phone calls per week for a maximum of fifteen (15) minutes each. Mental Health Technicians will monitor the number of calls only. The inmate is expected to take responsibility for selecting calling times.

c. Visits are scheduled on the weekends in the General Population Visitation Room with other inmates. Visits are 4 hours in length.

d. Inmates will be afforded the opportunity to participate in recreation seven (7) days per week. Evening recreation time will also be scheduled. Additional time for out of cell leisure activities is allowed.

e. Inmates may have additional reading materials in their cells.

f. Inmates are allowed to purchase items from the canteen.

G. **Contingency Management Level "III"**: Level III is the highest Contingency Management Level. Expectations for inmates on Level III are that they can function safely in an open unit. The goal is to be prepared to return to a more generalized housing setting. They are expected to be cooperative with all areas of treatment and abide by all rules. To advance to a Level III, Inmates must participate in 80% of Structured Activities and maintain medication compliance.

The following apply:

a. Inmates may shower daily. Inmates will be provided the opportunity for showering under supervision a minimum of 3 times a week. Daily showers will be offered when if adequate staffing is available.

b. Inmates may have seven (7) personal phone calls a week, one call per day, at fifteen (15) minutes per call. The inmate is expected to be considerate of staff and other inmates in phone usage.

c. Visits are scheduled on the weekends in the General Population Visitation Room with other inmates. Visits are 4 hours in length. Level III inmates are also allowed Holiday visits.

d. Inmates will be afforded the opportunity to participate in recreation seven (7) days per week. Evening recreation time will also be scheduled. Additional time will be scheduled for out of cell leisure participation.

e. Evening Day Room usage for out of room television viewing.

f. Inmates may have reading materials in their cells.

g. Inmates are allowed to purchase items from the canteen.

VII. GOALS AND EXPECTATIONS FOR INMATES

A. All inmates are expected to maintain good personal hygiene including showering, brushing their teeth, shaving or keeping facial hair neat. They are also expected to keep their rooms and clothing clean and neat. Inmates who need assistance with ADLs will be provided that. Inmates are expected to cooperate with all areas of treatment. They may attend groups if referred by the Treatment Team. They are expected to abide by all rules and to get along with other inmates.

B. Levels may be elevated or lowered as to level assignment as a result of changes in behavior and symptom presentation. Information contained in the log book, discussed in morning briefing and during Treatment Team meetings will be considered in determining appropriate levels, any restriction of privileges and/or special treatment strategies.

C. Strategies for dealing with identified behaviors will be fully discussed in Treatment Team or morning briefing and shared with the inmate and other staff. Violation of policies may result in disciplinary charges.

D. Inmates can be discharged from the hospital once they are stabilized and able to function in a less restrictive environment.

VIII. **Training**: The South Carolina Department of Corrections and the Division of Health Services provide security and non-security staff on-going training opportunities to provide professional growth and development. All employees will receive 20 hours of job related training in addition to 40 hours of orientation their first year. Employees will receive 20 hours of training per year thereafter.

Training will focus in/on the following areas/subjects at a minimum:

A. Suicide Prevention
B. Understanding signs and symptoms of mental illness
C. Legal issues involving treatment of the mentally ill
D. Emergency Preparedness
E. Professionalism and Ethics
F. Prison Rape Elimination Act
G. Fire Extinguishers use
H. Meeting OSHA requirements
I. Employee/Inmate Relations
J. Sexual Harassment
K. TB/Blood-borne Pathogens
L. Workplace Violence
M. IT Security Awareness
N. Identifying and Managing Problems with ADLs
O. CPR
P. First Aid

Q. CIT Training for all Security Staff

The Agency provides several elective trainings as well.

IX. Quality Management:

The Director of Quality Management and assistants will audit the operation and programs of GPH through an ongoing continuous auditing / quality management program with reports being generated on at least a quarterly basis.

Internal audits will be conducted on each QHMP twice annually to ensure that services are being delivered. The internal audits will consist of evaluation of groups, individual sessions and if the program is meeting the required standard hours of structured and unstructured activities. Random clients files will be selected for auditing in order to ensure documentation and Treatment Plans are being completed and updated in a timely manner.

DHEC also conducts routine and unannounced inspections.

Appendix

FORMS

Consent for Voluntary Admission and Treatment

GPH Referral

Application for Involuntary Hospitalization

Nursing Admission Assessment

GPH Intake Assessment

Initial Treatment Plan

Treatment Plan Update

Columbia-Suicide Severity Rating Scale (C-SSRS) – Lifetime/Recent

Columbia-Suicide Severity Rating Scale (C-SSRS) - Risk Assessment

Columbia-Suicide Severity Rating Scale (C-SSRS) – Daily/Shift Screen

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
Division of Health Services
Consent for Gilliam Psychiatric Hospital Admission and Treatment

I, _____, hereby agree to be voluntarily admitted to the South Carolina Department of Corrections Gilliam Psychiatric Hospital for the purposes of undergoing psychiatric and psychological evaluation and possible mental health treatment. I further understand that the staff will devise a program of care and treatment that is in my best interest. I agree to abide by whatever standard mental health treatment they recommend including the administration of psychotropic medication, either daily or by injection, daily activity programs, psychological testing and psychotherapy. I further understand that I will remain in the Psychiatric Hospital until such time that the Psychiatric Center professional staff feels I have improved or, for whatever other viable reason, I may no longer received services. I understand that at any time after my admission I may request to be discharged from hospitalization and treatment, but that prior to being discharged I will be examined by the professional staff at the psychiatric center to determine whether I am in need of psychiatric hospitalization and treatment on an involuntary basis. If it is determined that I am in need of continued evaluation and treatment, the staff will seek a court order for involuntary hospitalization and treatment in compliance with the statutes of SC governing involuntary commitment. I will continue to be housed at GPH until that process is completed. I further understand that information about me may be shared with SCDC officials on a need to know basis as necessary for my well-being. I further understand that any agency or person outside the SCDC requesting information about me will receive such information only after I have given my written consent.

_____	_____	_____
Inmate	SCDC #	Date

_____	_____
Staff Witness	Date

_____
Facility

_____ I have read this consent form on my own and understand its content.

_____ I have had the staff witness read this consent form to me and I fully understand its content.

SCDC M-65 (August 1988)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
Division of Health Services
Gilliam Psychiatric Center Inpatient Referral

1. Name: _____ SCDC#: _____

2. Offense: _____ Sentence: _____ Date Sentence Began: _____

3. Referring Institution: _____ Referral Date: _____

4. Referring Official: _____

5. History of Present Illness / Situational Factors Contributing to Need for Admission (i.e. problems with staff or other inmates, recent sexual trauma, recent lock up, reaction to current charges or classification, loss of significant relationships, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. Present Behavior/ Current Mental Status:

_____

_____

_____

_____

_____

7. This individual will be routinely be expected to be returned to your institution upon discharge form GPH. If there is any reason he should not be returned please identify that reason and indicate institution of planned reassignment:

8. Is this person on any medication at present? If so, list with start dates, dosages, and note any compliance issues.

9. Is there any other pertinent information concerning medications, i.e. problems, reactions, non-compliance, side effects, etc.

Signature: _____

Title: _____

Date: _____

SCDC 24-83
(Rev. Aug 88)

APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

FOR HOSPITAL USE ONLY
Date Admitted
Hospital Register No.
Approval of Hospital Official
Signature Date

(Complete in Triplicate)
STATE OF SOUTH CAROLINA)
COUNTY OF _____)

IN THE MATTER OF:

Person alleged to be mentally ill | Sex | Birthdate | Age | Race | Marital Status

Street Address | City | State | Zip | Phone # | Length of Time Residing There

TO THE HOSPITAL DIRECTOR:

Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the aboved-named person to a SCDMH Psychiatric Hospital

or to _____
NAME OF NON-SCDMH HOSPITAL

for the following reasons:
That the undersigned believes that the aboved-named person is mentally ill, and because of this mental condition is likely to cause serious harm to self or others if not immediately hospitalized.

1. The specific type of serious harm thought probable is:

2. That the applicant bases his/her belief on the following grounds:

3. That the applicant understands that for Involuntary Emergency Admission to occur that the said person must be examined and certified by at least one licensed physician (Part II, Certificate of Licensed Physician for Mental Illness) as required by Section 44-17-410, S.C. Code, 1976, as amended. If the said person has not been examined, listed below are the reasons:

4. That next-of-kin of allegedly mental ill person is _____
Name

Relation _____ Whose address is _____
RFD or Street | City and State | Zip | Phone Number

In case of next-of-kin cannot be contacted, notify _____

Relation | Address | City and State | Zip | Phone Number

SWORN to before me this

_____ day of _____.

_____
Notary Public for South Carolina or Probate Judge

My Commission Expires: _____

WHEREFORE, the undersigned requests that the person named above be admitted to a psychiatric hospital for treatment as authorized by law.

X _____
Applicant's Signature

_____
Name of Applicant (typed or printed)

_____
Address of Applicant

_____
Telephone Number of Applicant

_____
Relation to Patient or Title, if any

(See reverse side which must be completed)

SCDMH FORM
APR. 89 (REV. JUL 13) MH-FCC-2 M-130 Pg. 1 of 2 RED INK/FORM MUST BE PRINTED IN COLOR

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

NAME OF PERSON EXAMINED _____ AGE _____ COUNTY OF RESIDENCE _____

PLACE OF EXAMINATION _____ HOUR AND DATE OF EXAMINATION _____

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

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

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

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

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

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

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

_____
ADDRESS

_____

All information MUST be typed or clearly printed

SCDMH FORM
APR. 89 (REV JUL 2013) Section 44-17-410(2) M-131
MH-FCC-2

RED INK/FORM MUST BE PRINTED IN COLOR

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF HEALTH SERVICES
MEDICAL SCREEN

NAME: _____ **SCDC#:** _____ **INSTITUTION:** _____

This questionnaire should be filled in by a trained person who interviews the inmate when he/she is received at the institution.

1. Do you have any current medical/mental health, emotional or dental problems? Yes ____ No ____
   IF YES, DESCRIBE:

_____

_____

High Blood Pressure: _____ Allergies: _____ Seizures: _____
Diabetes: _____ Heart Trouble: _____ Special Diet: _____
Ulcer: _____ Recent Surgery: _____ Other: _____
Communicable Illness: _____ Serious Infections: _____
Treatment: _____
Are you on any medication? Yes ____ No ____ IF YES, DESCRIBE: _____

_____

Mode of usage: _____ Amount Used: _____ Frequency Used: _____
Date and Time of last usage: _____
History of any problems as result of stopping usage: Yes ____ No ____
IF YES, DESCRIBE: _____
Past/Present treatment or hospitalization for mental disturbance or suicide: _____

_____

Have you ever attempted suicide? Yes ____ No ____ IF YES, WHEN? _____
Are you presently thinking about suicide? Yes ____ No ____ ***(IF YES, REFER TO MEDICAL IMMEDIATELY)***
Does the inmate appear to hear or see things others don't hear or see? Yes ____ No ____
Describe, if yes _____
Does the inmate appear: Depressed? Yes ____ No ____
Anxious? Yes ____ No ____
Aggressive? Yes ____ No ____
Pregnancy: Yes ____ No ____ History of problems during pregnancy: Yes ____ No ____
INMATE SIGNATURE: _____ **DATE:** _____

OBSERVATIONS: Completed by trained employee
General Appearance:
Physical deformities? Yes ____ No ____ IF YES, DESCRIBE: _____

_____

Skin: Jaundice, rashes, etc. _____
Needle Marks: Yes ____ No ____ IF YES, DESCRIBE: _____
Evidence of trauma i.e., bruises, abrasions? Yes ____ No ____ IF YES, DESCRIBE: _____

_____

BEHAVIOR:
Appearance: WNL ____ No ____ Tremors: Yes ____ No ____ Sweating: Yes ____ No ____
Cooperative: Yes ____ No ____ Alert to person, place & time: Yes ____ No ____
DISPOSITION OF INMATE/PLACMENT RECOMMENDATION:
Room and/or Dorm: _____
1. General Population _____
2. General Population with referral to health care: Yes ____ No ____
3. Referral for emergency care: Yes ____ No ____

Signature of Person completing form: _____ **Date:** _____

COMMENTS:

Orientation to Medical verbally and in writing given: _____

cc: Inmate Health Record and Inmate Institutional Record
SCDC M-14 (Rev. July 2004)

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
CLINICAL ASSESSMENT

Evaluation Date: _____

NAME:	**SCDC#:**

I. **IDENTIFYING INFORMATION**:

DOB: _____ Age: _____ Race: _____ Sex: _____

Marital Status: _____ Place of Residence: _____

Current Sentence: _____ Projected Max Out Date: _____

Crime: _____

Referring Institution: _____ Admission Status: _____

II. **REASON FOR REFERRAL**: _____

_____

Inmate's Conception of Problem:

_____

_____

III. **MENTAL HEALTH HISTORY**:

HISTORY	**Yes**	**No**	**Explain**
Alcohol and Illicit Drug Use			
Hospitalization for Psychiatric Problems			
Currently Suicidal			
Currently Homicidal			
History of Assaultive or Suicidal Behavior			
Treatment for Substance Abuse			When: Where:
Risk for Violence of Self Harm			High Moderate Low
Prescribed Medication			Present: Past:
Efficacy/Compliance:			
Sleep Difficulties			
Appetite Problems			

IV. SOCIAL HISTORY

Mental Health History of Family: _____

_____

_____

Criminal History of Family: _____

_____

_____

Family Support: None ___ Minimal ___ Moderate ___ Very Supportive ___
(Name/Address/Telephone Number of Next-of-Kin): _____

_____

_____

Education: 1 2 3 4 5 6 7 8 9 10 11 12 GED 13 14 15 16

Special Education: Yes _____ No _____

Employment History: _____

_____

_____

_____

Marital History: _____

_____

_____

Physical Abuse/Neglect and/or Sexual Abuse History: _____

_____

_____

Juvenile Incarcerations: _____

_____

_____

V. ALCOHOL/DRUG HISTORY

	ALCOHOL	DRUG(S)	OTHER
Age at first use			
Type first used?			
Drink of choice			
Date last used?			

Describe your frequency and pattern of use: _____

_____

From _____ To _____
From _____ To _____
From _____ To _____

Why? _____

_____

STATEMENT	Yes	No
Drugs/Alcohol use has affected my personal and family relationships.		
My judgment has been impaired while using drugs/alcohol.		
Family members have expressed concern about my using/drinking.		
I feel that I would be a better person if I did not use/drink.		
I have used drugs/alcohol in spite of efforts or promises not to.		
I have experienced a preference to use/drink rather than do what is expected of me.		
I have been arrested or convicted of an offence that was drug or alcohol related.		
I have continued using drugs/alcohol in spite of serious harmful consequences.		
I have been abusive to others when using/drinking.		
I have taken more drugs/alcohol to feel its effects more quickly.		
I have had problems on the job because of my drug/alcohol use.		
I have used drugs:		
to calm down		
to relieve physical pain		
to forget		
when feeling lonely		
when depressed		
to gain social acceptance		

VI. **MENTAL STATUS EXAM**: *(Circle all that apply):*

Orientation:	Person	Place	Time	Location
Ability to Concentrate:	Good	Fair	Poor	Unable to Assess
Recent Memory:	Good	Fair	Poor	Unable to Assess
Remote Memory:	Good	Fair	Poor	Unable to Assess
Judgment:	Good	Fair	Poor	Unable to Assess
Insight:	Good	Fair	Poor	Unable to Assess
Abstract Reasoning:	Good	Fair	Poor	Unable to Assess
Suicidal Ideations:	Denies	Suicidal	Homicidal	
Sleeping:	2-4 hours	4-6 hours	6-8 hours	8 or more
Appetite:	Meals Eaten: 1 2 3		Increased	Decreased
	Weight Gain/Loss		Binge	Purge

Perceptual Disturbances: *(Circle all that apply):*

Thought Content:	Appropriate	Confused	Ideas of Reference		Hopeless
Thought Process:	Appropriate	Illogical	Loose Associations		Circumstantial
	Tangential		Flight of Ideas		
Hallucinations:	Auditory	Visual	Tactile	Gustatory	Olfactory Denies
Delusions:	Persecutory	Phobic	Paranoid	Religiosity	Denies

Other Impressions: *(Choose one)*

Attitude:	Guarded	Hostile	Open		
Affect:	Elated	Flat	Depressed		
Speech:	Pressured	Relaxed	Rapid	Slow	Within Normal Limits
Eye Contact:		Good	Adequate	Poor	
Psychomotor Activity:		Excessive	Impaired	Within Normal Limits	

Additional Observations: _____

_____

_____

VII. DSM-5 SELF RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE - ADULT

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past TWO (2) WEEKS, how much (or how often have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicine **ON YOUR OWN,** that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	0	1	2	3	4	

DSM-5 SELF RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE – ADULT - continued:

Instructions to Clinicians – This is a self- or informant-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. In addition, the measure may be used to track changes in the individual's symptom presentation over time.

This version of the measure consists of 23 questions that assess 13 psychiatric domains, including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance use. Each item inquires about how much (or how often) the individual as been bothered by the specific symptom during the past 2 weeks. If the individual is of impaired capacity and unable to complete the form (e.g., an individual with dementia), a knowledgeable adult informant may complete the measure. The measure was found to be clinically useful and to have good test-retest reliability in the DSM-5 Field Trials that were conducted in adult clinical samples across the United States and in Canada.

Scoring and Interpretation
Each item on the measure is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the "Highest Domain Score" column. A rating of mild (i.e., 2) or greater on any item within a domain (except for substance use, suicidal ideation, and psychosis) may serve as a guide for additional inquiry and follow up to determine if a more detailed assessment for that domain is necessary. For substance use, suicidal ideation, and psychosis, a rating of slight (i.e., 1) or greater on any item within the domain may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is needed. The DSM-5 Level 2 Cross-Cutting Symptom Measures may be used to provide more detailed information on the symptoms associated with some of the Level 1 domains (see Table 1 below).

Frequency of Use
To track change in the individual's symptom presentation over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. For individuals with impaired capacity, it is preferable that the same knowledgeable informant completes the measures at follow-up appointments. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

Table I: Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: domains, thresholds for further inquiry and associated Level 2 measures for adults 18 and over

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Depression	Mild or greater	LEVEL 2 – Depression – Adult (PROMIS Emotional Distress – Depression – Short Form)[1]
II.	Anger	Mild or greater	LEVEL 2 – Anger – Adult (PROMIS Emotional Distress – Anger – Short Form)[1]
III.	Mania	Mild or greater	LEVEL 2 – Mania – Adult (Altman Self-Rating Mania Scale)
IV.	Anxiety	Mild or greater	LEVEL 2 – Anxiety – Adult (PROMIS Emotional Distress – Anxiety – Short Form)[1]
V.	Somatic Symptoms	Mild or greater	LEVEL 2 – Somatic Symptom – Adult (Patient Health Questionnaire 15 Somatic Symptom Severity [PHQ015])
VI.	Suicidal Ideation	Slight or greater	None
VII.	Psychosis	Slight or greater	None
VIII.	Sleep Problems	Mild or greater	LEVEL 2 – Sleep Disturbance – Adult (PROMIS Sleep Disturbance - Short Form)[1]
IX.	Memory	Mild or greater	None
X.	Repetitive Thoughts and Behaviors	Mild or greater	LEVEL 2 – Repetitive Thoughts and Behaviors – Adult (adapted from the Florida Obsessive-Compulsive Inventory (FOCI) Severity Scale [Part B])
XI.	Dissociation	Mild or greater	None
XII.	Personality Functioning	Mild or greater	None
XIII.	Substance Use	Slight or greater	LEVEL 2 – Substance Use – Adult (adapted from the NIDA-modified ASSIST)

[1]The PROMIS Short Forms have not been validated as an informant report scale by the PROMIS group.

VIII. **SUICIDAL/SELF-INJURIOUS HISTORY**:

Have you ever cut yourself, burned yourself, etc. for some reason other than trying to commit suicide? If so, elaborate?

IX. **QMHP SUMMARY AND IMPRESSIONS**:

Assessed by: _____
(Name) (Job Title)

Date: _____

South Carolina Department of Corrections
Division of Behavioral/Mental Health and Substance Abuse Services
Gilliam Psychiatric Hospital
Master Treatment Plan

Current diagnoses (DSM-V)

Psychiatric
1.
2.
3.
4.
Medical
1.
2.
3.

Reason for admission:_____

_____

_____

Strengths and assets: _____

_____

Liabilities which can negatively impact treatment (include both direct [learning disability/MR, illiterate, active psychosis] and indirect [lack of insight/judgment, presence of secondary gain for being hospitalized] barriers to learning):_____

_____

_____

Cultural factors affecting treatment (language, religious beliefs, gang membership, etc.):

_____

Criteria for termination of treatment (discharge):

□-Remission/stabilization of presenting symptoms (psychiatric/medical) for ___ continuous weeks
□-Behaviorally appropriate for ___ continuous weeks
□-Communicating needs/wants appropriately for ___ continuous weeks
□-Interacting with other inmates appropriately for ___ continuous weeks
□-Free from SI/HI and has not been on special precautions for ___ continuous weeks
□-Maintain ADL's appropriately and without assistance for ___ continuous weeks
□-Medication compliance for ___ continuous weeks
□-Able to articulate a viable plan for avoiding continued/further substance abuse.
□-Appropriate placement secured
□-Other:_____

Name: _____ SCDC#: _____
Form name/number (v8-20Aug15)

Presenting Problems (behaviorally stated):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Short term objectives:

Use the following codes to indicate objectives and intervention modalities (method):

Objective:

A-Will exhibit no overt signs of hallucinations.
B- Will deny the experience of hallucinations.
C-Will not spontaneously voice beliefs inconsistent w/reality.
D-Will be able to have a goal oriented conversation of at least 5 minutes 2-5 times/day.
E-Will display calm and controlled behavior w/o s/s mania.
F-Will exhibit no overt signs of depression.
G-Will deny the experience of troublesome depressive thoughts and will rate their level of depression <= 4 on a 0-10 scale (10 worst).
H-Will exhibit no overt signs of anxiety.
I-Will deny the experience of troublesome anxiety provoking thoughts.
J-Will display no signs of inappropriate aggressiveness and will deny HI.
K-Will deny uncontrollable feelings of anger.
L-Will display situationally appropriate frustration tolerance/ lack of impulsivity.
M-Will deny SI and will verbalize three reasons to live.
N-Will not display s/s c/w SI/HI.
O-Will maintain ADL's adequately and independently.
P-Will verbalize three benefits of each medication prescribed as well as his intent to be medication compliant.
Q-Lab values and observed measurements will be within commonly accepted limits for the identified condition.
R-Will verbalize two harmful consequences of substance use and two methods of avoiding further use.
S-_____

Methods

AA-1:1 counseling/treatment
BB-Group counseling
BB1-Self-esteem
BB2-Assertiveness
BB3-Anger Management
BB4-Leisure Skills
BB5-Communication Skills
BB6-Symptom Management/Relapse Prevention
BB7-Chaplain Group
BB8-Medication Education
BB9-Substance Abuse
BB10-Coping skills for Lock up clients
BB11-Stress Management
BB12-Managing Emotions
BB13-Discussion
BB14-DBT
BB15-CBT
BB16-Hygiene
BB17-_____
CC-Medical Clinic
DD-Medications
EE-Consultation with MD/PA/NP
FF-Labs
GG-Psychological Assessment/Evaluation
HH-Recreation
II-Recreational Therapy
JJ-_____

Name: _____ SCDC#: _____

Form name/number (v8-20Aug15)

Problem #	Begin Date	Objective	Time Frame	Method/Frequency	Staff Assigned	Goal met on

Contingency Management Level:_____ Attitudinal Approach:_____

Suicide Risk Assessment completed on _____

Staff Members Present:

_____ _____

Psychiatrist/LPP Date QMHP Date

_____ _____

Psychologist Date Nurse Date

_____ _____

MH Technician Date Other Date

"This plan was read to me. My signature does not necessarily indicate that I agree with its content." Any comments I may have are recorded below:

_____

Inmate Date

Comments: _____

_____

Name: _____ SCDC#: _____

Form name/number (v8-20Aug15)

South Carolina Department of Corrections
Division of Behavioral/Mental Health and Substance Abuse Services
Gilliam Psychiatric Hospital
Master Treatment Plan Update

Date completed:_____ Contingency Management Level_____

Previously identified problems/concerns (use the following codes to denote status):

D-deterioration in condition O-ongoing w/o positive change
I-improved R-resolved

Problem	Status	Current condition and recommended changes in treatment (if any)

Newly identified problems/concerns (number consecutively from last identified problem):
Problem number and statement of problem: _____

_____

Problem #	Begin Date	Objective	Time Frame	Method/Frequency	Staff Assigned	Goal met on

Previously identified problems/concerns that have been resolved since the last treatment team meeting: _____

Note any changes in diagnoses: _____

_____ _____
Psychiatrist/LPP Date QMHP Date

_____ _____
Psychologist Date Nurse Date

_____ _____
MH Technician Date Other Date

_____
Inmate Date

Inmate's Name: _____ SCDC#: _____
Form name/number (v8-20Aug15)

Short term objectives:

Use the following codes to indicate objectives and intervention modalities (method):

Objective:

A-Will exhibit no overt signs of hallucinations.
B- Will deny the experience of hallucinations.
C-Will not spontaneously voice beliefs inconsistent w/reality.
D-Will be able to have a goal oriented conversation of at least 5 minutes 2-5 times/day.
E-Will display calm and controlled behavior w/o s/s mania.
F-Will exhibit no overt signs of depression.
G-Will deny the experience of troublesome depressive thoughts and will rate their level of depression <= 4 on a 0-10 scale (10 worst).
H-Will exhibit no overt signs of anxiety.
I-Will deny the experience of troublesome anxiety provoking thoughts.
J-Will display no signs of inappropriate aggressiveness and will deny HI.
K-Will deny uncontrollable feelings of anger.
L-Will display situationally appropriate frustration tolerance/ lack of impulsivity.
M-Will deny SI and will verbalize three reasons to live.
N-Will not display s/s c/w SI/HI.
O-Will maintain ADL's adequately and independently.
P-Will verbalize three benefits of each medication prescribed as well as his intent to be medication compliant.
Q-Lab values and observed measurements will be within commonly accepted limits for the identified condition.
R-Will verbalize two harmful consequences of substance use and two methods of avoiding further use.
S-_____

Methods

AA-1:1 counseling/treatment
BB-Group counseling
- BB1-Self-esteem
- BB2-Assertiveness
- BB3-Anger Management
- BB4-Leisure Skills
- BB5-Communication Skills
- BB6-Symptom Management/Relapse Prevention
- BB7-Chaplain Group
- BB8-Medication Education
- BB9-Substance Abuse
- BB10-Coping skills for Lock up clients
- BB11-Stress Management
- BB12-Managing Emotions
- BB13-Discussion
- BB14-DBT
- BB15-CBT
- BB16-Hygiene
- BB17-_____

CC-Medical Clinic
DD-Medications
EE-Consultation with MD/PA/NP
FF-Labs
GG-Psychological Assessment/Evaluation
HH-Recreation
II-Recreational Therapy
JJ-_____

Inmate's Name: _____ SCDC #:_____

Form name/number (v3-20 Aug15)

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime Recent - Clinical

Version 1/14/09

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice, *pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ (***Type # (1-5)***) _____ (***Description of Ideation***) Recent - ***Most Severe Ideation:*** _____ (***Type # (1-5)***) _____ (***Description of Ideation***)	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	___	___
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	___	___
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	___	___
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	___	___

Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	___	___

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill herself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	Yes ☐ No ☐ Total # of Attempts _____	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts _____	Yes ☐ No ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Daily/Shift Screen

Ask questions that are bold and underlined	**Since Last Asked**	
Ask Question 2*	**YES**	**NO**
2) Suicidal Thoughts: ***Since you were last asked, have you actually had thoughts about killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. ***If YES, what did you do?*** _____ _____		

*** Note – for frequent assessment purposes, Question 1 has been omitted**