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T.R., P.R., K.W., et al. v. South Carolina Department of Corrections: A Public Health Policy Proposal for Suicide Prevention within the South Carolina Department of Corrections.

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An abstract of
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Abstract

T.R., P.R., K.W., et al. v. South Carolina Department of Corrections: A Public Health Policy Proposal for Suicide Prevention within the South Carolina Department of Corrections.

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Suicide is one of the leading causes of death in South Carolina Department of Correction facilities. In 2005, a court case was filed for unconstitutional treatment of severely mentally ill inmates within the South Carolina Department of Corrections. In 2014, the inmates were found to have endured mistreatment including the following: use of force; duration in isolation; pepper spray; cleanliness and temperature of segregation cells; and, administration of psychotropic medication. The Court found a multitude of suicides, occurring mainly in isolation, to have been preventable had the inmate received proper and immediate healthcare and/or been under constant observation. The Court also found the medical records to be insufficient and requested a new system be implemented.

Six factors were deemed in need of correction in the 45-page ruling. The six factors were:1) screening and evaluating for mental illness at intake; 2) a mental health treatment program; 3) a sufficient increase in number of mental health workers; 4) mental health records that are accurate, complete and confidential; 5) supervised and evaluated administration of psychotropic medicines; and, 6) a suicide prevention program. The goal of this thesis was to come up with effective solutions for each of these factors, with a focus on a comprehensive suicide prevention program.

Methods

This thesis utilized the eight-fold pathway as the public health methodology to come up with a solution to the systemic and unconstitutional treatment of mentally ill inmates within the SCDC.

Results

We found a two-fold solution is needed that 1) addresses the need for a Mental Health Review Board to provide oversight and governance over a mental health treatment program; and, 2) created a suicide prevention program to eliminate the preventable deaths that occur yearly in the SCDC.

Conclusion

The eight-fold pathway provides an effective method that shows a way for systems to be created and implemented that can successfully mitigate seriously mentally ill inmate's suicide attempts and deaths due to suicides. The public health community can work to educate and inform the general population so that a significant reduction in the prejudice that surrounds mental illness and suicide occurs.

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Beth Bradford Walker, Matt Erber, Candy Scheff, and Hannah Albenesius, if each of your lives had not touched mine and altered my path, I would not have found my true cause and I will forever be grateful to you all for that.

Most importantly, I thank my family and friends who have enabled me to write this thesis, especially Rebecca Upton, Joanne Angel, and my parents, Beverly and Peter Thornley for your never ending encouragement and support.

Tristan Thomas Evans, this was for you, may you always be kind and have empathy for others.

For the Future Readers of this thesis,
never forget that suicide is a permanent solution to a temporary problem.

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Introduction

Suicide is the tenth leading cause of death overall in the United States (U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention [HHS], 2012). Each year suicide rates are double those of homicide nationwide (HHS, 2012). In 2012, approximately 40,600 people nationwide took their own lives and 673 of these people were from the state of South Carolina (Centers for Disease Control and Prevention [CDC](CDC, 2012a). This figure was almost double the number of homicide victims (373) that same year (CDC, 2012b). Reducing the death toll from suicides, not only statewide, but also among the vulnerable incarcerated population within the South Carolina Department of Corrections, continues to be an necessary and paramount challenge for the field of public health.

Problem Statement

Suicide is the second leading cause of death in U.S. state and federal correctional systems, behind illnesses such as cancer (30.5%), heart disease (23.9%), liver disease (9%), respiratory disease (6.4%), AIDS-related illnesses (2.2%) and all other deaths (16.1%) (Noonan & Ginder, 2014). In 2012, deaths due to suicide attributed to 6% of deaths in the correctional systems nationwide (Noonan & Ginder, 2014). In the South Carolina Department of Corrections (SCDC), 754 people died between the years of 2001-2012, of which 32 were death by suicide (Noonan & Ginder, 2014). Nationally, between those same years, the average annual mortality rate per 100,000 people for federal and state prisons combined was 475 per 100,000 people, with 25 per 100,000 suicide related deaths (Noonan & Ginder, 2014). In South Carolina state prisons, the average annual mortality rate was 12 people per 100,000suicide related deaths in the same 12-year period (Noonan & Ginder, 2014). These statistics do not include the number of suicide attempts that occurred during this time period.

In 2005, the case *T.R., P.R., K.W., et al. v. South Carolina Department of Corrections* was filed against the SCDC on behalf of 3,500 inmates who met the definition of seriously mentally ill. Several of the defendants were being represented by their families as they had all died in the department's hands. Judge Baxley ruled on the case in 2014, when he deemed the plaintiffs at fault for unconstitutional mistreatment of mentally ill inmates. Judge Braxley's ruling stated that "the evidence in this case has found that the inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain at risk for serious physical injury, mental decompensation, and profound, permanent mental illness" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014, p. 2). Judge Baxley recognized that there were lives lost leading up to the case that could have been prevented, that the defendants who lost their lives also succumbed to preventable deaths, and that even more lives had been lost due to non-action by the SCDC during the nine-years it took for the case to go to trial (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). What cannot be clearly shown is the multitude of families, friends and communities in South Carolina that were impacted emotionally, socially, and economically by the loss of these lives.

Judge Baxley acknowledged that the seriously mentally ill population within the SCDC was being underrepresented by the plaintiffs at 12%, and, based on testimonies by experts; he estimated the SCDC's mentally ill population to be as high as 20% (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Furthermore, the judge presented a 45-page order to the South Carolina Department of Corrections in which he gave the department 60 days to come up with a solution for six identified guideposts (*Ruiz* factors) that determined the SCDC had not created adequate mental health programs to protect seriously mentally ill inmates from being at "substantial risk of serious harm" (T.R., P.R., K.W., et al. v. South Carolina Department

of Corrections, p. 4). The six *Ruiz* factors are: 1) a mental health program to screen and identify inmates, 2) a mental health treatment program, 3) the employment of mental health professionals, 4) the correct maintenance of mental health treatment records, 5) proper administration of psychotropic medications 6) a " basic program to identify, treat and supervise inmates at risk for suicide" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014, pgs. 3-4). The last factor was of importance because eight of the defendants who committed suicide were found by the plaintiff's expert, Dr. Raymond Patterson, to be "foreseeable and preventable" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014, p.28). Additionally, the "SCDC's suicide prevention and crisis intervention practices create a substantial risk of serious harm to seriously mentally ill inmates" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014, p.31).

Currently, the SCDC provides "Suicide Prevention and Intervention" training provided during BASIC training and a mandatory annual suicide prevention training for specified staff. BASIC training is a six week training for officers and other staff to obtain the "basic" skills needed in the Institution" (Association of State Correctional Administration [ASCA], 2014, p.11). The case against the SCDC was in mediation for nine months in 2015, concluded in December of 2015 and as of October of 2016; the SCDC has yet to put in effect an effective suicide prevention program as recommended by Judge Braxley. Judge Braxley was clear in the closing paragraphs of his order that in the eight years it took for the state to fight this case "the hundreds of thousands of tax dollars would have been better expended to improve mental health services delivery at SCDC" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014, p. 45).

Decreasing death by suicide, eliminating harsh living conditions, decreasing the time inmates spent in solitary confinement, creating suicide-resistant environments and providing access to treatment could significantly decrease the death toll in South Carolina's correctional facilities (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). It is imperative that a suicide prevention program is developed for the SCDC. With suicide consistently ranking in the top 10 causes of death in the U.S. overall, successful suicide prevention strategies are essential for mortality prevention in various contexts. In South Carolina, as well as in federal prisons nationwide, countless deaths could be prevented and population health be improved.

Purpose Statement

The state of South Carolina faces many challenges when it comes to caring for mentally ill, incarcerated people. The purpose of this thesis is to explore the actions that need to be taken to care for and protect the inmates who are at risk for suicide. Utilizing a public health perspective, the goal is to utilize the eightfold path in order to create a policy solution that is focused on suicide prevention intervention strategies in the South Carolina Department of Corrections system. This thesis is unique in that no such systematic investigation in public health has been done before with respect to South Carolina.

Research Questions

The hypothesis that fuels this thesis is: Question 1: Are there opportunities exist to prevent death by suicide among individuals in the custody of the South Carolina Department of Corrections (SCDC)? Null Hypothesis: There are not opportunities to prevent death by suicide among individuals in the custody of the South Carolina Department of Corrections. The sub-questions include the following range of issues: 1) policies for treatment- clear criteria for

diagnosis and treatment, 2) suicide- proofing the cells, holding areas, etc., 3) access to mental health providers/counselors/psychologists/ psychiatrists, 4) triage at intake, 5) duration of solitary confinement, 6) risk assessment during initial inmate intake process, and 7) appropriate admission medical assessment and screening tools.

Significance Statement

Suicide prevention in South Carolina's correctional facilities is imperative not only for the lives that can be saved, but also for the field of public health in regard to learning and understanding better ways to help inmates who are suffering from depression, mental illness and suicidal ideation. This is also an opportunity to fix a part of the corrections system that is broken. In order to save lives, it is imperative that the information that is available about the SCDC and recommended suicide prevention strategies be assessed in order to come up with a viable prevention solution that can be utilized by mental and public health officials (across all levels) in order to save lives in South Carolina and nationwide.

Definition of Terms

Serious Mental Illness- As defined in the case *T.R., P.R., K.W., et al. v. South Carolina Department of Corrections,* 2014: "Specifically defined in the Class Certification order dated November 1, 2007, and may be succinctly stated as all SCDC inmates from the date of the filing of the complaint who have been hospitalized for psychiatric services, referred to an Intermediate Mental Health Care Services Unit, or diagnosed by a psychiatrist with the following mental illness: Schizophrenia, Schizoaffective Disorder, Cognitive Disorder, Paranoia, Major Depression, Bipolar Disorder, Psychotic Disorder, or any other mental condition that results in significant functional impairment including inability to perform activities of daily living, extreme impairment of coping skills, or behaviors that are bizarre and/or dangerous to self or others. Plaintiffs claim that their treatment within SCDC, or lack of treatment, constitutes a violation of the state constitution."

Affected by suicide- As defined by the U.S. Department of Health and Human Services in 2012: "All those who may feel the effect of suicidal behaviors, including those bereaved by suicide, community members, and others."

Behavioral health- As defined by the U.S. Department of Health and Human Services in 2012: "A state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health problems include mental and substance use disorders and suicide."

Bereaved by suicide- As defined by the U.S. Department of Health and Human Services in 2012: "Family members, friends, and others affected by the suicide of a loved one (also referred to as *survivors of suicide loss*)."

Means- As defined by the U.S. Department of Health and Human Services in 2012: "The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs)."

Methods- As defined by the U.S. Department of Health and Human Services in 2012: "Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose)."

Suicidal behaviors- As defined by the U.S. Department of Health and Human Services in 2012: "Behaviors related to suicide, including preparatory acts, suicide attempts, and deaths."

Suicidal ideation- As defined by the U.S. Department of Health and Human Services in 2012: "Thoughts of engaging in suicide-related behavior."

Suicide- As defined by the U.S. Department of Health and Human Services in 2012: "Death caused by self-directed injurious behavior with any intent to die as a result of the behavior."

Suicide attempt- As defined by the U.S. Department of Health and Human Services in 2012: "A nonfatal, self-directed, potentially injurious behavior as a result of the behavior. A suicide attempt may or may not result in injury."

Suicide crisis- As defined by the U.S. Department of Health and Human Services in 2012: "A suicide crisis, suicidal crisis, or potential suicide, is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment."

Literature Review

Introduction

In 2014, Noonan and Ginder reported that in state and federal correctional systems nationwide, suicide is the second leading cause of death. In addition, “more than 400 suicides occur each year in local jails at a rate three times greater than among the general population (HHS, p. 20, 2012), and suicide is the number one leading cause of death in local jails” (HHS, p. 20, 2012) (Noonan & Ginder, 2014). Within the South Carolina Department of Corrections (SCDC), there were 745 total deaths from 2005 to 2015 (2016b) and 39 of these people died from suicide (2016a).

It has been shown that “individuals in some settings, systems, and professions may be at an increased risk for suicidal thoughts and/or behaviors compared to the general population” (HHS, p. 20, 2012). The focus of this thesis is on persons in the custody of the South Carolina Department of Corrections and the focus an analysis of policies that could reduce rates of death by suicide in SC prisons.

Stakeholders

The Social Ecological public health theory guides this analysis, as a multitude of people and systems are affected by suicide in SCDC.

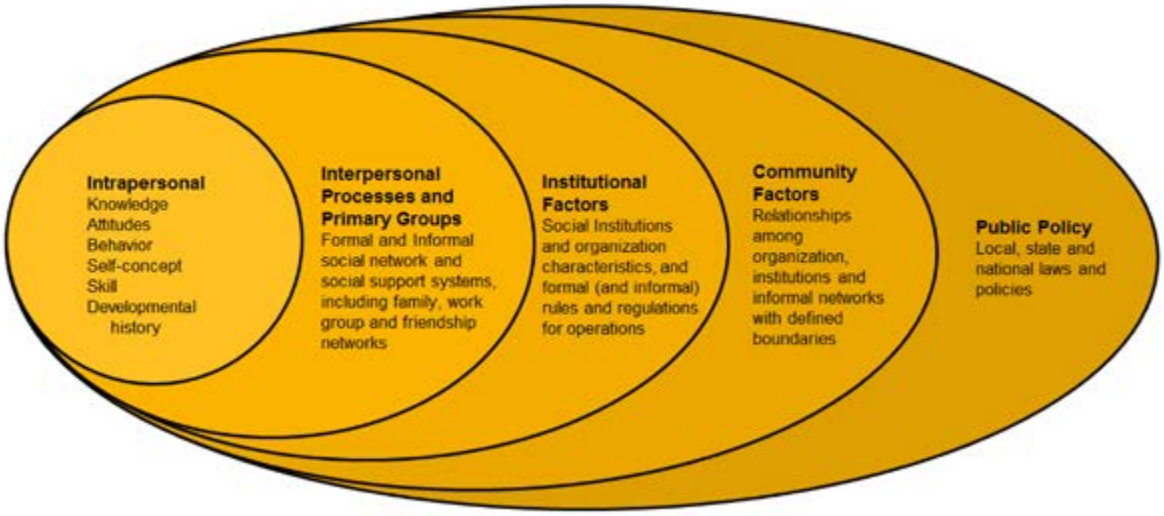

Figure 1. Adapted from McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) (1988).The social ecology of health promotion interventions.*Health Education Quarterly,* 15(4):351-377. Retrieved October 23, 2016, from http://tamhsc.academia.edu/KennethMcLeroy/Papers/81901/An_Ecological_Perspective_on_Health_Promotion_Programs

The stakeholders involved on the *interpersonal level* are the inmates (American College Health Association, n.d.). Directionally affected by their death are the *interpersonal groups*, their families, friends and co-workers (American College Health Association, n.d.). The next tier in the model is the *institutional factors*; this would be the SCDC facility that they are in and the factors that go living there, such as lighting, cleanliness of living and eating quarters, and the rules and regulations within the system (American College Health Association, n.d.). Next are the *community factors* and the impact on their communities, such as church and community leaders (American College Health Association, n.d.).

Finally, the *public policy level* is crucial to this thesis as policies are needed in order to distribute resources in order to “establish and maintain” alliances that will govern the structures

for inmates in order to create healthy living environments; from food to sanitary living quarters(American College Health Association, para. 5, n.d.). The National Institute of Health (NIH), Centers for Disease Control and Prevention (CDC), Federal and Drug Administration (FDA), South Carolina Department of Health and Environmental Control (DHEC), U.S. Department of Health and Human Services, Office of the Surgeon General and the National Action Alliance for Suicide Prevention are some of the key stakeholders in the realm of public policy. Additional stakeholders that also influence policy decisions are the multiple colleges and Universities in South Carolina, such as Medical University of South Carolina (MUSC), College of Charleston (C of C), and University of South Carolina (USC). When this case occurred, many of the university and college professors that specialized in various areas of psychiatry and psychology responded to the call to action and gave their services to the SCDC inmates.

Risk and Protective Factors

The Department of Health and Human Services recognized that "individuals in some settings, systems, and professions may be at an increased risk for suicidal thoughts and/or behaviors compared to the general population" and as "suicide is often the most common cause of death in secure justice settings", more clearly needs to be done to help this vulnerable population (p.13, 2012). To truly understand suicide, it is important to first recognize that suicide should not be perceived as "the act of a troubled person" (HHS, p.13, 2012). Suicide is instead "a complex outcome that is influenced by many factors" (HHS, p.13, 2012). The Social Ecological Model provides a solid visual of how regarding suicide, "individual characteristics may be important, but so are relationships with family, peers and others, and influences from the broader social, cultural, economic, and physical environments" (HHS, p.13, 2012). It must be emphasized that there is no single path that leads to a person committing suicide (HHS, 2012).

Instead, it is a combination of factors, throughout life, “such as serious mental illness, alcohol abuse, a painful loss, exposure to violence, or social isolation (that) may increase the risk of suicidal thoughts or behaviors” (HHS, p.13, 2012). As this thesis will show, these are all factors that touch the lives of the seriously mentally ill within the confines of the SCDC.

Risk factors are defined as “characteristics that make it more likely that a person will think about suicide or engage in suicidal behaviors” (HHS, p.13, 2012). Protective factors are defined as “not the opposite or lack of risk factors, but as conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times, thereby making suicidal behaviors less likely” (HHS, p.13, 2012).

When looking at the Risk and Protective Factors in a Social Ecological Model, risk factors at the Individual level can be: mental illness, substance abuse, a previous suicide attempt, and/or impulsivity/aggression (HHS, p.15, 2012). Whereas, protective factors on the individual level are: coping and problem solving skills, reasons for living (loved ones, children), and moral objections to suicide (HHS, p.15, 2012).

On the relationship level, risk factors can include high conflict or violent relationships or a family history of suicide (HHS, p.15, 2012). Whereas protective factors can be: connectedness to individuals, family, community, and social institutions; as well as supportive relationships with mental health care providers (HHS, p.15, 2012).

Regarding the community level, risk factors can be: Few available sources of supportive relationships and barriers to health care (e.g. lack of access to providers or medications, prejudice) (HHS, p.15, 2012). Protective factors on the community level can be: safe and supportive corrections environments and sources of continued care after psychiatric hospitalization (HHS, p.15, 2012).

Finally, the societal level lists risk factors that include: the availability of lethal means of suicide and unsafe media portrayals of suicide (HHS, p.15, 2012). Protective factors can be: the availability of physical and mental health care and restrictions on lethal means of suicide (HHS, p.15, 2012).

Prevention

A combination of selective, universal, and indicated strategies are required for suicide prevention (HHS, 2012). Selective strategies "are appropriate for subgroups that may be at an increased risk for suicidal behaviors," such as the severely mentally ill inmates in the SCDC (HHS, p.20, 2012). Indicated strategies "are designed for individuals identified as having a high risk for suicidal behaviors, including someone who has made a suicidal attempt" (HHS, p.20, 2012). It is vitally important to understand that "just as suicide has no one single cause, there is no single prevention activity that will prevent suicide" (HHS, p.20, 2012). In order "to be successful, prevention efforts must be comprehensible and coordinated across organizations and systems at the national, state/territorial, tribal, and local levels" (HHS, p.20, 2012).

Basic interventions can assist in successful prevention: Question, Persuade, Refer (QPR) someone to help are three steps that can be learned by anyone to prevent a suicide (QPR Institute, n.d.). This is "an an emergency mental health intervention for suicidal persons" with "the intent is also to identify and interrupt the crisis and direct that person to the proper care"(QPR Institute, para.6, n.d.).The QPR Institute states that "according to the Surgeon General's National Strategy for Suicide Prevention (2001), a gatekeeper is someone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide" (QPR Institute, para.3, n.d.). This includes "parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers,

firefighters, and many others who are strategically positioned to recognize and refer someone at risk of suicide" (QPR Institute, para.4, n.d.). CPR and QPR, both increase the chances of a person surviving a suicide attempt (QPR Institute, n.d.). CPR is "short for cardiopulmonary resuscitation" and is a "process is designed to stabilize people who aren't breathing or breathing intermittently and who may be in cardiac arrest until the person can reach a hospital or other care" (QPR Institute, para.5, n.d.).

Both are part of a "Chain of Survival"

Ideally, "CPR and QPR are part of systems designed to increase the chance of survival in the event of a crisis" (QPR Institute, para.7, n.d.).

The QPR Institute describes the following "Chain of Survival":

In the Chain of Survival model of emergency cardiac care, the likelihood that a victim will survive a cardiac arrest increases when each of the following four links is connected:

Early Recognition and Early access | The sooner 9-1-1 or your local emergency number is called the sooner early advanced life support arrives.
Early CPR | This helps maintain blood flow to the vital organs.
External Defibrillator | A device ready for use when advanced medical personnel arrive.
Early Advanced Life Support | Administered by trained medical personnel who provide further care and transport to hospital facilities.
Similarly, with QPR, the following Chain of Survival elements must also be in place:
Early Recognition of suicide | The sooner warning signs are detected and help sought, the better the outcome of a suicidal crisis will be.
Early QPR | Asking someone about the presence of suicidal thoughts and feelings opens up a conversation that may lead to a referral for help.
Early intervention and referral | Referral to local resources or calling 1-800-Suicide for evaluation and possible referral is critical.
Early Advanced Life Support | As with any illness, early detection and treatment results in better outcomes.
Adapted from the QPR Institute, (n.d). Our Mission:Chain of Survival Model.. Retrieved November 6, 2016 from https://www.qprinstitute.com/about-qpr

There are a multitude of strategies in regard to mentally ill inmates that prove to be effective in suicide prevention and will be discussed further on in this thesis.

Creation of the South Carolina Department of Corrections

One way to understand the present state of the SCDC is to look at the series of events that led up to the court case that was filed against the department in 2005. In 1866, South Carolina established the first state penitentiary in Columbia, South Carolina (South Carolina Department of Corrections, n.d.). It was the only penitentiary in the state until 1900 when it was recognized that a larger prison system was needed because of overcrowding (South Carolina Department of Corrections, n.d.). Thus, from the years 1900 to 1930 there was the emergence of dual prison systems (federal and state) in South Carolina and local prisons and jails were in full operation by the year 1930 (South Carolina Department of Corrections, n.d.).

In 1960, the South Carolina Department of Corrections (SCDC) was established by Governor Ernest "Fritz" Hollings because he wanted to end abuses in the prison system such as chain gangs and the political reward of being afforded the use of convict labor for work on private properties (South Carolina Department of Corrections, n.d.). This formal department was created to have a body of people who had oversight over the growing prison system in South Carolina.

1960-2008: Events Leading to the Deterioration of the South Carolina Corrections System

Starting in the 1960's, multiple events lead up to the deterioration of the system and ultimately these events highly attributed to the situation that the SCDC finds itself in today. To begin, from 1960-1973, the state focused on expansions in facilities and a new emphasis on rehabilitation programs evolved (South Carolina Department of Corrections, n.d.). Next, from 1974 to 1994, there was a dramatic increase in the inmate population, prison overcrowding, and objective classification system (South Carolina Department of Corrections, n.d.).

In 2001-2003, the first major budget crisis occurred causing the department to make cost-cutting decisions and focus on the shrinkage of facilities and programs (South Carolina Department of Corrections, n.d.). There was a significant decline in state revenues, from 2000 to 2003 the SCDC's budget was reduced by 21%; the most significant percentage reduction of any correctional system nationwide (South Carolina Department of Corrections, n.d.). In addition, two institutions, Givens and State Park Correctional Institutions, were closed due to lack of support (South Carolina Department of Corrections, n.d.). Finally, in 2003, the SCDC: 1) reduced its staff by over 1,000 employees (South Carolina Department of Corrections, n.d.). 2) SCDC implemented a reduction-in-force plan and 148 non-security staff left SCDC employment in order to absorb budget cuts (South Carolina Department of Corrections, n.d.). These staff cuts, the gross understaffing in terms of mental health counselors, psychologists and psychiatrists, significantly reduced the quality of mental health care that the severely mentally ill received within the SCDC (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Ultimately these oversights and lack of capacity to treat the severely mentally ill led to the court case discussed in this thesis.

Lawsuit on behalf of 3,500 state inmates

In the June of 2005, the plaintiffs known by the initials T.R., P.R. and K.W. filed a lawsuit on behalf of themselves and other severely mentally ill persons and the Protection and Advocacy for People with Disabilities, Inc., against the defendants, the South Carolina Department of Corrections and its agency director, William R. Byars, Jr. (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). It would be an eight-year litigation. The following provides details about the conditions and details the overall experiences of the

experiences of multiple South Carolina severely mentally ill inmates during their time in various statewide facilities operated by the South Carolina Department of Corrections.

Solitary Confinement

From February of 2001 to February of 2008, *Leslie Cox* was in solitary confinement for 2,565 consecutive days, over seven years (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Another inmate, *James Wilson*, spent 2,491 consecutive days or almost seven years in solitary confinement (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). *Rowland Dowling*- SCDC records conflict that he spent either 1,777 or 2,200 consecutive days in solitary confinement (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). This means Rowland spent more or less, six years of his life locked away from other human contact. As of January of 2012, the plaintiffs found that time spent in solitary confinement was an average cumulative of 647 days for mentally ill vs 383 for non-mentally ill inmates in the SCDC (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

Excessive Force

The case found that from January of 2008 to September of 2011, excessive force was used against inmates in the form of pepper-spray (OC), crowd foggers, and physical restraints (ie., restraint chairs) (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Concerning the mentally ill, 27% versus 11% of non-mentally ill inmates were subjected to a disproportionate use-of-force (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

James Howard, housed at Gilliam Psychiatric Hospital, was found to have been subjected to 81 incidents of use-of-force; he was hospitalized on five separate occasions during this same time period (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

On February 7, 2008, *Jerome Laudman*, a man who was diagnosed as a schizophrenic and was also intellectually disabled and had a speech impediment, was sprayed with chemicals and physically beaten while being transferred into a Lee Supermax cell (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). He was then stripped naked when put into the isolation cell which consisted of nothing except a cold, concrete floor(T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). On February 11th, four-days later, Jerome stopped eating and taking his medications (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). That same day a correctional officer made the observation that Jerome was weak and sick, but submitted no oral or written report of it (T.R., P.R., K.W., et al. v. South Carolina, 2014). By February 18th, eleven-days after being placed in the cell, Jerome lay all morning in his own feces and vomit with 15-20 trays of molded and rotted food in his cell (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). A correctional officer saw him lying there in this manner that morning and the SCDC investigative report stated that "he lay there "all morning" until two nurses were called between 1:30 or 2:00pm and noted the aforementioned conditions of his cell (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

The correctional officers and nurses, both, refused to go in to retrieve the body and further delay occurred until they obtained two inmates to remove Jerome, who was alive, but unconscious (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). He was then removed at 2 o'clock in the afternoon and taken to the hospital where he died of a heart

attack with noted hypothermia (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). A cover-up of the filthy conditions of his cell and also the videotape of Jerome's transferal abuse was attempted by correctional officers; as the former had been "cleaned" before photographs and the later was for the most part blank when a SCDC investigator went to view it (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Despite the cleaning, the cell was shown in the investigators photographs to be in a "dirty, deplorable state" (T.R., P.R., K.W., et al. v. South Carolina, p.16, 2014). Even after Jerome's death and the subsequent investigation into it, Lee Supermax did not undergo quality improvement reviews by the SCDC concerning procedures and practices (T.R., P.R., K.W., et al. v. South Carolina, 2014).

When testifying on behalf of the plaintiffs, Drs. Metzner and Patterson stated that they went to inspect the Lee Supermax in September of 2008 and described it as "filthy" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). During the case it was also discovered that, Jerome's mental health counselor, who reported that Jerome was neither threatening or aggressive, had no notification at the time that he had been transferred to Lee Supermax (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

Suicides

During the same period in time, on February 11th, *James Bell* committed suicide in Perry by overdosing on Amitriptyline after being in solitary confinement for six years (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014) (Mental Health for Inmates, n.d.) (Mental Health for Inmates, n.d.). James' death could have possibly been prevented, as on February 9th, his Aunt received a suicidal letter and called the Perry chaplain, but two days passed before a mental health counselor or any staff decided to check on him, at which

time the mental health counselor found him dead (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014) (Mental Health for Inmates, n.d.). He had been dead for 12 hours (Mental Health for Inmates, n.d.).

On March 8, 2008, *Baxter Vinson*, diagnosed with Borderline Personality Disorder, committed suicide by cutting open his abdomen and both arms (Mental Health for Inmates, n.d.). Discovered at 11pm, at 12:23 am multiple officers, despite his protests, strapped him to a restraint chair and a nurse attempted to push his intestines back into his abdominal wall (Mental Health for Inmates, n.d.). Two hours after being put in the chair, (3 hours since initial wound discovery) at 2:23am he was transported by a van to the hospital where he died (Mental Health for Inmates, n.d.).

Then on September 1, 2009, *Jerod Cook*, who had been diagnosed with major Depression with Psychotic Features, cut his own arm while he was in solitary confinement at Perry Correctional Institution at 9:35pm at night (Mental Health for Inmates, n.d.). At 11:00 pm, he was placed in a stretcher and then was strapped into a restraint chair in a Solitary Confinement Cell with blood forming a pool on the floor around his chair (Mental Health for Inmates, n.d.). He was then removed four-hours later and after being stripped naked, he was placed in a Crisis Intervention Cell where he died (Mental Health for Inmates, n.d.). It must be noted that his death occurred approximately five and a half hours after he had first cut himself.

On January 11, 2011, *Laura Cumbee*, diagnosed with a Personality Disorder, commits suicide by hanging while in a solitary confinement cell in Camille Graham Correctional Institution (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Laura also tried a previous attempt in December 21, 2010, a month prior (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). The day of suicide it was noted by several

inmates and officers that she was emotionally upset and one officer heard her talking about it (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Another officer even saw her standing on her cell sink with her sheet tied to the smoke detector box (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). It was noted that there was a sheet over her window at 7:00 pm, at which time she said she was going to the bathroom(T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

Laura was found at 7:30 PM and pronounced dead at 8:29 PM (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

Lack of Mental Health Treatment and Access

During the time period of July, 2008 to August, 2011, *Edward Barton*, a schizophrenic was recommended to see a mental health counselor every 30 days and a psychiatrist every 90 days (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). From July, 2008 to November 2010, Edward went without seeing a mental health counselor; six times he went over 30-days, four of these six occasions were over 60-days and one time was 9 months in duration during this almost two and a half year period (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). In addition, Edward went for almost a year barely getting psychiatric help. From September, 2010 to August, 2011, it was twice over 120 days and once over six months before he saw a psychiatrist for his schizophrenia (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

Inspections of Correctional Institutions

On September 15th and 16th of 2008, an *Inspection of Lee Correctional Institution* found the Supermax isolation units to be filthy, smelly and generally unsanitary environments (Mental Health for Inmates, 2008). Along with inadequate living and medical conditions, there were

found to be multiple issues concerning psychiatric care for the mentally ill inmates, from short and infrequent visitations with some just a couple minutes long and generally over 90-days; by understaffed psychiatrists and counselors (Mental Health for Inmates, 2008).

During the days of August 23rd and 24th in 2010 th**e** *Inspection of Camille Graham Correctional Institution* occurred (Mental Health for Inmates, 2010a). To name a few of the findings: inadequate treatment programs (in multiple areas), mentally ill inmates reported frequently running out of medications and waiting three to seven days for refills, inmates were denied requests to see counselors on weekends, holidays and if the monthly visitation had already occurred (Mental Health for Inmates, 2010a). In the Isolation Unit, they were usually stripped naked, adding to the decline in mental wellness (Mental Health for Inmates, 2010a).. Then upon being released from the Isolation Unit, they were further penalized by the following rule: "six-month program restriction and all therapeutic activities are taken away including faith-based programs" (Mental Health for Inmates, 2010a). Regarding the Shock Boot Camp for women, inmates reported no treatment team meetings and a lack of confidentiality by guards (Mental Health for Inmates, 2010a). In addition, investigators found multiple issues with isolation units that ranged from "lack of a mattress", to lack of crisis intervention (timely or otherwise), and inadequate staffing (Mental Health for Inmates, 2010a).

On November 8, 2010, *Inspection of Alternative Crisis Intervention Placements at Lieber Correctional Institution* after inspectors stated they had "initially an incomplete tour due to the staff apparently not knowing where all such placements occurred"(Mental Health for Inmates, 2010b).The following crisis intervention issues were reported about four specific folding environment utilized in Lieber: 1) **Crisis intervention cells** were found to be not suicide resistant (pipes, holes, windows) and walls made observation inadequate (Mental Health for

Inmates, 2010b). These cells were also reported by the inmates as being used for crisis intervention unbeknownst to the warden (Mental Health for Inmates, 2010b). 2) S**hakedown area** wire mesh on cages that could easily facilitate suicides by hanging (Mental Health for Inmates, 2010b). There was no bathroom in the shakedown areas (reliant on staff to take them or give them a plastic bottle- or defecate/urinate within) (Mental Health for Inmates, 2010b). Inmates also reported being naked, exposed and without suicide proof blankets (Mental Health for Inmates, 2010b). 3) S**hower areas** were small, dark, and some lacked wire mesh on doors and had inadequate visibility (Mental Health for Inmates, 2010b). 4) I**nterview rooms** used for crisis interventions had poor lighting and holes in walls (Mental Health for Inmates, 2010b). One inmate reported being placed in a shower on two occasions from seven hours to overnight while naked (Mental Health for Inmates, 2010b). Additional mentally ill inmates describe similar unpleasant experiences of being placed in interview booths, nakedness, urinating on the floor, no lighting, and being escorted naked down hallways to defecate, to name a few (Mental Health for Inmates, 2010b). Food served was with finger food or served without utensils – inmates reported not wanting to eat with hands because of unsanitary environment (Mental Health for Inmates, 2010b).

All inmates total reported being confined within a multitude of holding environments from a range of seven-hours to 168-hours (or seven days) (Mental Health for Inmates, 2010b). Several inmates reported being placed in holding cells naked with another inmate with no outside observation causing the inmate to feel “frightened and paranoid” (Mental Health for Inmates, p. 10, 2010b). In addition, mentally ill inmates reported experiences of being gassed, being put in the restraint chair, described living conditions as “pro-suicidal” and being told to “go ahead and kill themselves” (Mental Health for Inmates, pgs. 10-13, 2010b).

In 2011, the S.C. Department of Corrections data reported that of the 23,000 inmates within the system, there were more than 3,000 who had been diagnosed with a serious mental illness (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). That is 12.9% of the SC inmates according to the SCDC, the National Institute of Mental Health states that it should actually be a higher figure as it is 15-20% in a standard Department of Corrections (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). After several key specialists gave credible and detailed analysis, Judge Baxter stated that a seriously mentally ill population of 17% within the SCDC was credible (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014).

February, 2012: 5-week Trial Begins

Opposing Viewpoints

Nelson, Mullins, Riley, & Scarborough LLP., Attorneys, Dan Westbrook and Stuart Andrews represented plaintiffs and argued the mental health treatment of SCDC past and current inmates was against the constitution in the following mental health areas: “crisis intervention, solitary confinement, clinical staffing, record keeping, mental health screening, use of force, and medication administration.” (Mental Health for Inmates, 2016, para. 13). Whereas, SCDC attorney Andrew Lindemann’s, of Davidson & Lindemann, LLP, argument was “that the court should dismiss the case on a variety of legal grounds, including lack of standing and the separation of powers doctrine.” (Mental Health for Inmates, 2016, para. 14).

In 2013, the SCDC implemented several significant changes in the system. First, Bryan Stirling was appointed as the new director of the Department of Corrections (Post and Courier, 2015). Secondly, they created a new policy that prohibited solitary confinement for more than 60 days as punishment (Post and Courier, 2015). Lastly, the Department of Corrections agreed to

hire 40 more mental health and medical workers; the department received the necessary state money in July (Post and Courier, 2015).

Ruling

On January 8, 2014, the ruling was given by Circuit Judge Michael Baxley of 45-pages ordering the South Carolina Department of Corrections to submit a plan in six-months that corrected constitutional violations by[1]:

1. A systematic program for screening and evaluating inmates to identify those in need of mental health care;
2. A treatment program that involves more than segregation and close supervision of mentally ill inmates;
3. Employment of a sufficient number of trained mental health professionals;
4. Maintenance of accurate, complete, and confidential mental health treatment records;
5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation; and
6. A basic program to identify, treat, and supervise inmates at risk for suicide.

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[1]**The six factors were taken directly from: T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, pgs.4-5, 2014.**

Judge Baxley also commented that in his 14-years as a South Carolina Judge and 70,000 cases that he had presided over that “this case, far above others, is the most troubling.” (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, p.1, 2014).

Aftermath of the Ruling

On March 28th of 2014, Circuit Judge Michael Baxley declined to reverse his position when lawyers from the SCDC came before him in court and asked him to do so (Post and

Courier, 2014). After nine months of mediations, a preliminary agreement in 2014 was the first step toward a mental health solution with the goal of creating a 3-year budget, as well as a facilities and staffing plan (Post and Courier, 2014).

The Proposed Plan Involves:

- The modification of security policies and procedures regarding care of inmates.
- Training staff on curriculum and Crisis Intervention Training; as well as appropriate culture.
- The development of a systematic program to identify inmates that are in need of care.
- Governor Nikki Haley increased the funding for increase in staff and to improve facilities.
- It stipulated that the SCDC needs funding from the Executive and Legislative branches.

Adapted from the Post and Courier. (2014). Judge Won't Revisit SC Inmate Mental Health Ruling.Retrieved March 5, 2016 from http://www.postandcourier.com/article/20140328/PC1610/140329363/

Conclusions and Recommendations

First filed in 2005, it became an eight-year litigation where hundreds of thousands of dollars would be spent by the SCDC in defending. Centered on delays, recalcitrance and missing deadlines, it was such a gross misuse of money that the ruling judge would remark in his concluding paragraph that it would have been better spent on mental health improvements within the SCDC (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). Then time was further delayed by the plaintiffs asking the judge to rescind his order and then furthermore by the eight months in mediation in 2015. As of the writing of this thesis, the mediation agreement waits to be signed off by Legislation.

Methods

Introduction

This thesis utilized the eightfold path to come up with a policy proposal for suicide prevention for the South Carolina Department of Corrections. A semi-systematic review of the case literature between 2005 and 2015 was conducted in the year of 2016. Documents utilized were peer-reviewed public health journal articles, court documents, newspaper articles, 2012 National Strategy for Suicide Prevention and the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Analytic Plan

The eightfold path was chosen as the method for this thesis because it is an analytic approach that allows policymakers to create structure for the problem-solving process of policy analysis (Bardach & Patashnik, 2016). Use of this approach was also chosen because it expedites the conception of a systematic and structured policy solution for suicide prevention in the state of South Carolina's correctional facilities (Bardach & Patashnik, 2016). The eight steps enable a policy maker to thoroughly explore the problem and come to a methodical solution.

The Eightfold Path consists of the following eight steps:

1. **Define the Problem**
2. **Assemble Some Evidence**
3. **Construct the Alternatives**
4. **Select the Criteria**
5. **Project the Outcomes**
6. **Confront the Trade-offs**
7. **Decide**
8. **Tell Your Story**

Step One: Define the Problem

Bardach and Patashnik, the creators of this method, explain that creating a "problem definition" is vitally important, as it gives not only a reason to do all the work needed to finish the project, but also creates a "sense of direction" during the evidence-gathering in step two (p.1, 2016). In addition, the authors state that the "final problem definition" will likely help structure how the story is told in step eight, the final step (Bardach & Patashnik, p. 1, 2016). It is suggested in this step to think of the problem in "terms of deficit and excess" (Bardach & Patashnik, p.1, 2016).

The authors suggest that it is important in this step to also try to create an evaluative definition to enable the situation to be viewed as a market failure (Bardach & Patashnik, 2016). That an often used practical and philosophical question is this: "What private troubles warrant definition as public problems and thereby legitimately raise claims for ameliorations by public resources?" (Bardach & Patashnik, p.2, 2016). In this situation, the mentally ill inmates in the SCDC have a constitutional right to be taken care of and protected from harming themselves. It is very legitimate claim for fiscal resources, both state and federal, that will improve the human conditions within the SCDC. In addition, Bardach and Patashnik point out that another situation where troubles that are private can be justified as being defined as a public problem are when people are being discriminated against because they are a minority.

Bardach and Patashnik acknowledge that just because there is evidence that a market failure exists; it is not guaranteed that the situation will be improved by the government intervening (2016). A caveat to this is that the multiple stakeholders involved may have their own agendas and interests. This leads to a theory that the authors call "governmental failure" and acknowledge as being a currently underdeveloped notion (Bardach & Patashnik, p.4, 2016).

The authors point out that evaluation addresses the problem of uncertainty and evaluation fits into the eightfold path's framework by answering questions that regarding the future (Bardach & Patashnik, 2016). This is best summed up by recognizing that the end goal in policy analysis is to work toward "answering questions about the future" ((Bardach & Patashnik, p.6, 2016).) Stated succinctly: by looking at what has occurred in the past, conclusions can be formed to shape the future actions (Bardach & Patashnik, 2016).

Depending on this past assessment of performance, several actions that could be performed in the future for a program could be: 1) expanding it, 2)cutting it back, 3) eliminating it completely, 4) adding another site and starting it there or 5)modifying the program (Bardach & Patashnik, 2016).

Bardach and Patashnik add that it is important to quantify the problem definition as magnitude should be attached if there is an assertion of excess. In this case, with regard to the problem definition where "too many" people are dying in the SCDC from suicide-related deaths, how many suicides occur in the SCDC? This becomes important when gathering evidence for step two. In addition it is helpful to identify conditions that cause problems in connection with the root issue (Bardach & Patashnik, 2016). This can be advantageous as it can enable policy makers to identify a condition and then "define it as a problem that can be mitigated or removed" (Bardach & Patashnik, p.7, 2016). Bardach and Patashnik recommend utilizing the term "the odds are" when talking about anything that is potentially uncertain in your policy analysis (2016). It lets others know the risks involved and utilizes probabilistic language in a situation where outcomes can be described approximately or debated (Bardach & Patashnik, 2016).

Step Two: Assemble Some Evidence

The goal to economize on generally time consuming data collection activities is try to obtain data that can be turned into "information" and then, converted into "evidence" that has some bearing on the problem (Bardach & Patashnik, p. 13, 2016). Bardach and Patashnik explain several key points: 1) data are facts about the world, 2) information is made up of data that have "meaning" that can enable the world to be sorted into categories that are empirical or logical, and 3) evidence is "information" that can affect stakeholders current beliefs about a problem's "significant features" and how it may be avoided or solved (p.13, 2016). In order to achieve the goal of a policy outcome that is realistic and possible, evidence is needed for three principal purposes: 1) "to assess the nature and extent of the problem(s) you are trying to define"; 2) "to assess the particular features of the concrete policy situation" that is being studied; and, 3) "to assess policies that have been thought, by at least some people, to have worked effectively in situations apparently similar to your own, in other jurisdictions" (Bardach & Patashnik, p. 13, 2016).

In step two, Bardach and Patashnik (2016) also recommend thinking before collecting data as they are complementary activities and this action makes data collection more efficient. Also, the authors caution others to remember the value of evidence and recommend weighing its "likely cost against its likely value" (Bardach & Patashnik, p. 14, 2016). This is best exemplified in utilizing decision trees, where it must be remembered "that the process of making a decision involves a great many elements prior to the moment of actual choice, such as defining a useful problem, thinking up better candidate solutions, and selecting a useful model" (Bardach & Patashnik, p. 14., 2016).

In reviewing the available literature, the authors recommend utilizing a critical eye when evaluating research by focusing on not just the bottom line of a research study, but also its strengths, limitations and relevance (Bardach & Patashnik, 2016). It is also useful to use analogies; in this case, it is beneficial to look at not only the treatment of the inmates, but also that of the expected duties of the guards in charge of them. This enables a policy to be created that can show potential usefulness and possible limitations; thus enabling policymakers to establish caveats that can mitigate these potential limitations (Bardach & Patashnik, 2016). Finally, the authors recommend starting early; reaching out to supporters to improve a policy and stress the importance of also contacting those you would expect to disagree when assembling evidence (Bardach & Patashnik, 2016).

Step Three: Construct the Alternatives

When constructing the alternatives, alternatives are defined as "policy options" or "alternative courses of action, or "alternative strategies of intervention to solve or mitigate a problem" (Bardach & Patashnik, p. 18, 2016). In step three, the recommendation is to *start out comprehensive and have the end product be focused* (Bardach & Patashnik, 2016). This is best explained by the fact that in the beginning it is prudent to "err on the side of comprehensiveness", whereas in the last steps of policy analysis, the goal is to not have more than two to three possible solutions or alternatives (Bardach & Patashnik, p. 19, 2016). Bardach and Patashnik suggest being creative by utilizing brainstorming to come up with solutions that are out-of-the-box and may be worthwhile to consider further (2016). In doing this, there are three questions that are worth asking: 1) "how would you solve a problem if cost were no object?", 2) "where else would it work?" and 3) "why not?" as it "often leads to creative thinking" (Bardach & Patashnik, p. 20, 2016).

Another helpful part of constructing an alternative can be *modeling the system in which the problem is located* as it is common when thinking about different approaches to solving a problem as potential *interventions* in "the system that holds the problem in place or keeps it going"(Bardach & Patashnik, p.21, 2016). Bardach and Patashnik stress that a causal model can be a useful strategy for identifying potential "intervention points" (p.22, 2016). There are Market Models, Production Models, Conformity Models and Evolutionary Models (Bardach & Patashnik, 2016). The Social Ecological Theory Model was chosen for use in this thesis as it provides a solid framework of all the societal systems that can be impacted by the death of a loved one due to suicide.

Once a final list of alternatives is in order, it is recommended to *conceptualize and simplify the list of alternatives,* where the key is to come up with a short sentence or phrase that sums up the strategy of the alternative (Bardach & Patashnik, pgs.24-25, 2016).

Step Four: Select the Criteria

Bardach and Patashnik recommend thinking of any "policy story as having two interconnected but separable plotlines, the analytic and the evaluative" (Bardach & Patashnik, p. 27, 2016). Facts and consequence projections make up the analytic plotline and value judgements make up the evaluative (Bardach & Patashnik, 2016). The authors recognize that people who are analytically minded will be able to understand how the analytic plotline shows clear reasons on if A, B, or C are likely to occur and how this is less likely to be the point of view with the evaluative, which is freer in regard to social philosophy and more subjective; here we learn if A, B, or C is good or bad in its effect on the world (Bardach & Patashnik, 2016).

Step four focuses on the evaluative plotline for the most part, as it was the most critical step that introduced philosophy and values into the SCDC policy analysis (Bardach & Patashnik,

2016). At this stage, Bardach and Patashnik also state that the evaluative criteria that are clearly the most important is the projected outcome and whether it will or will not solve the policy problem (Bardach & Patashnik, 2016). Therefore, judgement was critical at this stage to be able to identify how each course of outcome could affect the SCDC in multiple ways; and thus judge "whether or not and why" it might be preferable (Bardach & Patashnik, p. 28, 2016).

Bardach and Patashnik (2016) list some *commonly used evaluative criteria* as: 1) hitting the target or achieving goals by a specific date, 2) efficiency (benefit-cost), 3) equality, equity, fairness, justice (ideas to keep in mind), 4) freedom, community and other ideas (used to stimulate thought), and 5) process values (remember to stay broad and equitable when consulting).

Also used in this policy analysis were the *commonly used practical criteria,* which were: 1) legality (the policy must avoid violating rights that are constitutional, common law or statutory, 2) political acceptability, 3) administrative robustness and improvability (implementation process), 4) policy sustainability (it must endure over a set time to achieve impacts), and 5) linear programming (mathematical and computer-accessible technique that optimizes choice) (Bardach & Patashnik, 2016).

Step Five: Project the Outcomes

Bardach and Patashnik, suggest looking at each of the alternatives and realistically projecting how things will look in the future (2016). They acknowledge that it is difficult to do this as realism makes people uncomfortable and people are driven to be confident about projections out of self-defense (Bardach & Patashnik, 2016).They suggest utilizing common sense, to utilize "the logic of combining models and evidence to produce usable projections of policy outcomes for the various alternatives being considered"(Bardach & Patashnik, p. 47, 2016). The authors

suggest choosing a base case, which is “whatever condition exists today, and that condition is not expected to change, then each outcome should be described in terms of the difference between what would (probably) exist) tomorrow and what (arguably) exists today” (Bardach & Patashnik, p. 49, 2016). They also suggest using magnitude estimates to reduce the likelihood that misinterpretations will occur with an analysis (Bardach & Patashnik, 2016).

Step Six: Confront the Trade-offs

In the sixth step it was important for the stakeholders to identify the potential trade-offs that occurred with the future outcomes that were associated with the SCDC policy option (Bardach & Patashnik, 2016). For example, $300,000 may be spent yearly educating SCDC guards to identify if an inmate is suicidal, but the potential outcome could be a 50% reduction in lives lost to suicide. The authors recommended that commensurability be established for the advantageous reason that money used as a metric is an extremely good idea and almost always works better than imagined (Bardach & Patashnik, 2016). Specifically advantageous to this SCDC policy analysis was, “the value of life” was described very well in the metric “willingness to pay X dollars for a reduction in the risk of death by Y percent a year” (Bardach & Patashnik, pgs. 66-67, 2016). Here is where break-even analysis was needed to help solve problems in commensurability, or more plainly explained in the example of safety regulations, where a policy seeks to trade off money against risks to lives (Bardach & Patashnik, 2016). The hardest part in this step was figuring out the real worth of a human life (Bardach & Patashnik, 2016).

Step Seven: Stop, Focus, Narrow, Deepen, Decide!

There were two key things to think extremely seriously about in step seven, the first being “the politics of getting this alternative legitimated and adopted and the second, “the design of the ongoing institutional features that will have the power and resources to implement the

policy or program in the long run" (Bardach & Patashnik, p.71, 2016). These two are checkpoints that show that the policy solution has been done well to this point (Bardach & Patashnik, 2016).

Step Eight: Tell Your Story

This step involved preparing to present the SCDC policy solution to the key stakeholders in order to gain political support. Bardach and Patashnik recommended simplifying it into terms and a storyline that someone who is not familiar with the case, public health, policy analysis, etc., would understand and refer to it as "the Grandma Bessie Test" (p.73, 2016). This hypothetical grandmother is assumed to be intelligent, but not politically sophisticated (Bardach & Patashnik, 2016). This makes it more accessible to a lay audience.

When asking about what you do for a living by Grandma Bessie:

"You say you are a "policy analyst who working for…" She says, "What's that?" You explain that you have been working on "the problem of …" She says, "So, what's the answer?" You have one minute to offer a coherent, down-to-earth explanation before her eyes glaze over. If you feel yourself starting to hem and haw, you haven't really understood your own conclusions at a deep enough level to make sense to others, and probably not yourself, either. Back to the drawing board until you get it straight." (Bardach & Patashnik, p.73, 2016)

The goal being to be able to simplify the basic story to others in not only simple terms, but also with a logical narrative that flows, in order to enable others to carry out the task of public education that is democratic in nature (Bardach & Patashnik, 2016).

Findings

Introduction

In 2014, Judge Baxley wrote that the specific mental illness' that the SCDC inmates had been hospitalized, received referrals to Intermediate Mental Health Care Services Units or diagnosed by a psychiatrist with were: "Schizophrenia, Schizoaffective Disorder, Cognitive Disorder, Paranoia, Major Depression, Bipolar Disorder, Psychotic Disorder, or any other mental condition that results in significant functional impairment including inability to perform activities of daily living, extreme impairment of coping skills, or behaviors that are bizarre and/or dangerous to self or others"(T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., pgs.1-2). Judge Baxley went on to state that the evidence from the case proved that "inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness" T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.2, 2014). In addition, he stated that "as a society, and as citizen jurors and judges make decisions that send people to prison, we have the reasonable expectation that those in prison - even though it is prison - will have their basic health needs met by the state that imprisons them"; "and this includes mental health" T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.2, 2014). Judge Baxley also pointed out that evidence from the case shows that those suffering from a severe mental illness within the SCDC to be 17% and went on to state that "if 17 percent of the prison population had advanced cancer and there was inadequate and in some cases nonexistent treatment for cancer in prisons, the public would be outraged"; "yet this is the case for serious mental illness" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.2, 2014).

During the case, one doctor identified seven mentally ill inmates who died from both foreseeable and preventable deaths by suicide between the years 2008-2008 (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). It was noted that six were suicides, the seventh was occurred because of a failed suicide attempt and the Court found that there were two more SCDC inmate suicides occurred during the time of the trial (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, 2014). As a result, Judge Baxley asked the SCDC to develop six remedial factors and guidelines to address the constitutional deficiencies in this court case, they were: 1) the development of a mental health screening and evaluation program for incoming inmates, 2) the development of a mental health treatment program with an increase in the access of care and a reduction in segregation (isolation) and use of force, 3) the employment of a sufficient amount of trained mental health professionals, 4) maintenance of complete, accurate and confidential mental health treatment records, and 5) administration of psychotropic medications with periodic evaluation and appropriate supervision (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., pgs.39-43, 2014).

The sixth remedial factor was a call to action to create a suicide prevention program within the department. It is clear from this list that there are a multitude of programs that need to be developed to improve mental health care within the SCDC that are intertwined with the reduction of suicide attempts and deaths. Despite the fact that it will be expensive to implement, there are lives that could be saved by education, observation and simple actions. Therefore, it is imperative that the SCDC comes up with a suitable suicide prevention program that identifies treats and supervises the inmates in their facilities who are at risk for suicide.

Key Findings

The Eightfold Path consists of the following eight steps:

1. **Define the Problem**
2. **Assemble Some Evidence**
3. **Construct the Alternatives**
4. **Select the Criteria**
5. **Project the Outcomes**
6. **Confront the Trade-offs**
7. **Decide**
8. **Tell Your Story**

Step One: Define the Problem

Creating a "problem definition" provides a reason to do all the work needed to finish the project, as well as giving this thesis a "sense of direction" (Bardach & Patashnik, p.1, 2016). It is suggested in this step to think of the problem in "terms of deficit and excess" In this case: *There are too many people dying in the SCDC facilities from preventable suicide-related deaths.* It was important in this step to create an evaluative definition to enable the situation to be viewed as a market failure; "What private troubles warrant definition as public problems and thereby legitimately raise claims for ameliorations by public resources?" (Bardach & Patashnik, p.2, 2016). In this situation, the mentally ill inmates in the SCDC have a constitutional right to be taken care of and protected from harming themselves. It is very legitimate claim for fiscal resources, both state and federal, that will improve the human conditions within the SCDC. It can also be justified as a public problem as there was clear evidence of discrimination and

maltreatment against this group of people who were a mentally ill minority and therefore were under the protection of the Americans with Disabilities Act.

Bardach and Patashnik stated succinctly: by looking at what has occurred in the past, conclusions can be formed to shape the future actions within the SCDC (2016). Depending on this past assessment of performance, several actions that could be performed in the future for the SCDC could be expanding it or modifying the suicide prevention program, as the odds are it is a problem that could be eliminated.

Step Two:Assemble Some Evidence

Data show that there were two factors in this case that increase suicidality: 1) Individuals in Justice Settings and 2) Individuals with Mental Disorders. Therefore, the solution has to be a two-fold factor solution that takes both the *risk factors* and the *protective factors* for the severely mentally ill inmates in the SCDC into consideration.

Individuals in Justice Settings

As previously stated, suicide is often the "single most common cause of death in secure justice settings" (HHS, p. 106, 2012). Suicide *risk factors* for adult and juvenile inmates include: "a history of existing mental illness and substance abuse; a history of suicidal behaviors; lack of mental health care; a history of abuse (e.g., emotional, physical, sexual); family discord, abuse; impulsive aggression; a history of interpersonal conflict; prior involvement in special education; legal/disciplinary problems; family history of suicide; poor family support; prior offenses; referral to juvenile court; and coming from a single parent home" (HHS, p.106, 2012).

Suicidal *protective factors* concerning adult and juvenile inmates include: "a sense of control over one's own destiny; problem-solving and conflict resolution skills, adaptable temperament; support from and connections to family and community; positive school or

employment experience; specific plans for the future; religious/spiritual/cultural beliefs that protect against suicide; housing that is "suicide-resistant" (i.e., free of protruding objects and means/methods for suicide) and that is proximal to staff and peers; and availability of mental health services that are provided consistently by qualified, trained, and supportive staff who provide strong community linkages and referrals and ensure continuity of care" (HHS, p.106, 2012).

It is theorized by experts that there may be two primary causes for jail suicides: 1) "jail environments are conducive to suicidal behaviors and 2) the inmate faces a crisis situation" (HHS, p.107, 2012).

Individuals with Mental Disorders

There are multiple mental disorders mentioned throughout this thesis. Specific mental disorders, that are evidenced to have higher rates of suicidality, were mentioned in the case against the SCDC are severely mentally ill inmates diagnosed with borderline personality disorder, schizophrenia, and the mood disorders, major depressive disorder and bipolar disorder. Anxiety disorder is not specifically mentioned, but is often comorbid with depression, a key symptom in both major depressive disorder and bipolar disorder. Therefore, anxiety disorder is included among the mental disorders described below. It must also be noted that "having a substance use disorder along with a mental disorder may be particularly likely to increase suicide risk" (HHS, p. 117, 2012).

Mood Disorders

Mood disorders are among the most common psychiatric illnesses and may be the most life-threatening of psychiatric illnesses (HHS, p. 115, 2012). Individuals with mood disorders make up over 60 percent of the deaths from suicide (HHS, 2012). There are several factors that

can cause an increase in risk for suicide among those with mood disorders, these include: “a recent suicide attempt and a severe major depressive episode, often accompanied by feelings of hopelessness and guilt, a belief that there are few reasons for living, thoughts of suicide, agitation, insomnia, appetite and weight loss, and psychotic features” (HHS, p.116, 2012). Of great concern is the finding that, “suicidal behaviors among mood disorder patients occur almost exclusively during an acute, severe, major depressive episode” (HHS, p.116, 2012). The two mood disorders that are of main focus throughout this case and are also described by the National Strategy for Suicide Prevention are: 1) major depressive disorder and 2) bipolar disorder.

Major Depressive Disorder

Estimates show that 12 to 17 percent of individuals in their lifetime will experience a major depressive episode and many will have several episodes in their life span (HHS, 2016). Major depressive disorder is “characterized by a combination of symptoms, such as sadness and loss of interest or pleasure in once-pleasurable activities, which interfere with everyday life (HHS, p.115, 2012).

Risk factors for suicide among those diagnosed with major depressive disorder “include other comorbid psychiatric conditions, such as post-traumatic stress disorder (PTSD), dependent personality disorder, borderline personality disorder, and substance use disorders” (HHS, p. 116, 2012). In addition, “major depressive disorder often fails to be recognized, diagnosed, or treated” (HHS, p. 116, 2012).

Bipolar Disorders

Bipolar disorders are also referred to as manic-depressive illness, as this disorder is “characterized by dramatic mood swings, going from overly energetic “high” (mania) to sadness and hopelessness (depression)” (HHS, p.115, 2012). There are two types of bipolar disorders:

Type I and Type II. Type I is described as a person having had “at least one manic episode along with periods of major depression” (HHS, p. 115, 2012). Whereas, type II individuals “have periods of high energy levels and impulsiveness that are not as extreme as mania and also alternate with episodes of major depression”(HHS, p. 115, 2012). There is a 1.3 to 5 percent estimated lifetime prevalence of bipolar disorders (HHS, p. 115, 2012).

Bipolar disorder has a higher suicide risk as the disorder has a strong association with suicidal behaviors and thoughts (HHS, 2012). Of note, 80 percent of people with bipolar disorder have “either suicidal ideation or ideation plus suicide attempts” over their lifetime” (HHS, p. 116, 2012). Regretfully, “15 to 19 percent of patients with Bipolar disorder die from suicide” and up to “56 percent attempt suicide at least once in their lifetime” (HHS, p.116, 2012).

Compared to the suicide rate of the general population, it is estimated that the suicide rate among patients with bipolar disorder is “more than 25 times higher” (HHS, p.116, 2012). Risk factors among those with bipolar disorder “include a family history of suicide, early onset of bipolar disorders, increasing severity of affective disorders, presence of mixed affective states, and abuse of alcohol or drugs” (HHS, p. 116, 2012).

Anxiety Disorders

About 40 million American adults (about 18%) from the age of 18 and up are affected by anxiety disorders every year (HHS, 2012).These disorders “last at least 6 months and can become worse if not treated” (HHS, p. 116, 2012). Anxiety disorders include the following: obsessive-compulsive disorder (OCD), PTSD, agoraphobia (the fear of being trapped in a place), social phobia, simple phobia, generalized anxiety disorder and panic disorder (HHS, 2012). Suicide attempts and ideation is significantly associated with the presence of any anxiety disorder and it is common for these disorders to occur with other physical and mental illnesses

(HHS, 2012). In particular, alcohol or substance abuse may mask symptoms of anxiety or make the symptoms worse (HHS, p. 115, 2012). Also, it has been found that people who have any anxiety disorder combined with a mood disorder, the likelihood of suicide attempts increases versus a mood disorder alone (HHS, 2012).

Borderline Personality Disorder

Borderline personality disorder (BPD) is defined as "an emotional disorder characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and emotions" (HHS, p. 117, 2012). This disorder has multiple defining features that include extreme problems with regulation of emotions, a vast range of behaviors that are impulsive, instability in interpersonal relationships, unstable mood, chronic suicidal ideation, and suicide (HHS, 2012). Between 3 and 10 percent of BPD patients die by suicide according to estimates (HHS, 2012). Emergency and inpatient treatment are often the result of recurrent suicide attempts, impulsive aggressive acts, and self-injurious behaviors that are commonly associated with BPD (HHS, 2012).It is usually in the later stages of the course of the illness and after extended courses of unsuccessful treatment that suicides occur in BPD patients (HHS, 2012).

Schizophrenia

Schizophrenia is "a severe, chronic disorder characterized by disturbance in perception, thought, language, and social function" (HHS, p. 117, 2012). Patients are at the highest risk for suicide in the "first 3-5 years of onset" or early stages of the illness and "almost 5 percent of schizophrenic patients will die by suicide" in their lifetimes (U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention, p. 117, 2012). Regarding suicide risk, the greatest indicator is "active psychotic illness (e.g., delusions) combined with symptoms of depression" and the greater their "insight

into the psychotic illness itself, the need for treatment, and the consequences of the disorder are strongly related to suicide risk" (HHS, p. 117, 2012). Finally, higher socioeconomic status and higher levels of education are also associated with increased risk for suicide among schizophrenic patients (HHS, 2012).

Interventions that Reduce Suicide

Successful interventions for these mental illnesses can lead to a reduction in suicide. Regarding mood disorders, studies show that if primary care providers are educated on how to effectively assess, treat and manage depression there is a reduction in suicides (HHS, 2012). The HHS recommends, "appropriate acute and long-term treatment of depressive disorders, including both pharmacological and non-pharmacological methods (especially cognitive behavioral therapy), greatly reduces the risk of suicide and attempted suicide in this high-risk population" (HHS, p. 116, 2012).Specific to those suffering from bipolar disorder, "large-scale, long-term, European observational studies of former inpatients", "show that long-term use of mood stabilizers reduces the risk of suicide compared to patients who stop taking medication" (HHS, p.116, 2012).

Concerning patients that have borderline personality disorder, new data in the past few years has shown psychotherapies that are specifically designed for borderline patients to be effective (HHS, 2012).

In particular, Dialectical Behavior Therapy (DBT) has been shown to be effective at reducing self-injurious behaviors, as it aims specifically to "modify the regulation of negative emotion" (HHS, p.117, 2012). Research has found that the "main outcomes of DBT are reduced overdose; ED visits for suicidal behaviors, frequency of self-directed violence, and hospital

admissions"(HHS, p.117, 2012). There has been no firmly established data on the efficacy of medications for BPD (HHS, 2012).

Finally, "newer non-pharmacological therapies, such as cognitive enhancement therapy, may have great potential for improving the individual's social and occupational functioning" (HHS, p.117, 2012). A recent review found that "an integrated psychosocial and pharmacological approach may be useful and that treating depressive symptoms in patients with schizophrenia is an important component of suicide risk reduction"(HHS, p.117, 2012).

The Evidence from the Court Case

There were two components, objective and subjective, that were utilized by Judge Baxley in order to satisfy the ruling of deliberate indifference in the case. The *objective component* was based on evidence from the case of: deficiencies in the department's mental health program, the major contributing factor to the deficiencies was "the lack of a formal, comprehensive quality management program," and the judge finding the Plaintiff's psychiatric and correctional experts to be more credible than the Defendant's experts (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.31, 2014). He concluded the summary of the objective component with the following statement: "based on the testimony of these experts and the other evidence at trial, the Court finds that SCDC's mental health program exposes inmate with serious mental illness to a substantial risk of serious harm" and "plaintiffs have therefore satisfied the objective component of the deliberate indifference standard" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., pgs.31-32, 2014).

The *subjective component* required "proof that the SCDC knew that Plaintiffs were exposed to substantial risk of serious harm, but failed to take reasonable measures to abate the risk", this is in accordance to *Farmer*, 511 U.S. at 847(T.R., P.R., K.W., et al. v. South Carolina

Department of Corrections, et al., p.32, 2014). Furthermore, it was stated that this component "should be determined in light of the prison authorities "attitudes and conduct at the time suit is brought and persisting thereafter." *Id.* at 845-846 (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p. 32, 2014). Regarding the subjective component, by dating the evidence back to 1999, Judge Baxley found that the department knew for over a decade that the severely mentally ill inmates were at risk and despite this knowledge, "did virtually nothing to address, much less eliminate, the substantial risks of serious harm to which the class members were exposed" and "what limited action SCDC has taken since the filing of this lawsuit has had little to no effect in abating the unconstitutional deficiencies this Court has found" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., pgs.33-34, 2014).

Step Three: Construct the Alternatives

Judge Baxley called for the development of six remedial factors and guidelines: 1) the development of a mental health screening and evaluation program for incoming inmates, 2) the development of a mental health treatment program with an increase in the access of care and a reduction in segregation (isolation) and use of force, 3) the employment of a sufficient amount of trained mental health professionals, 4) maintenance of complete, accurate and confidential mental health treatment records, 5) administration of psychotropic medications with periodic evaluation and appropriate supervision and 6) a suicide prevention program to identify, supervise and treat those at risk (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., pgs.39-44, 2014).

Alternative 1: Continue with Current Improvements

During the trial, the SCDC indicated the improvement measures that had occurred since 2005 in order to improve the mental health program, these measures included: “the hiring of new administrators and some administrative support staff, an increase in psychiatric staff FTE’s” (full-time equivalents), “a reorganization of group therapy, a new protocol for addressing self-injuring behavior (“SIB”), mental health dorms, increased use of tele-psychiatry, new training programs for clinical and security staff, and counselor audits”(T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.34, 2014).

Alternative 2: Placing the Severely Mentally Ill in Community Settings

In South Carolina’s neighboring state of Georgia, the *Olmstead vs. LC*, 527 US 581 case of 1999, the Supreme court concluded that under Title II of the American’s with Disabilities Act, it would be required of States to put mentally ill people in a community setting instead of a correctional or institutional facility (Olmstead vs. LC, pgs. 596-603.1999). This was because the Supreme Court: 1) found mental illness to be a disability and 2) because of that, the mentally ill that are incarcerated are without justification - isolated, which 3) constitutes as discrimination based on a disability and is therefore, 4) protected by the Americans with Disabilities Act (Olmstead vs. LC, pgs. 596-597, 1999). It was ruled that the mentally ill could not "be excluded from participation in, or be denied the benefits of, a public entity's services, programs, or activities"(Olmstead vs. LC, pgs. 596-597, 1999). § 12132.

Alternative 3: A Two-Part Solution

Alternative three involves the full implementation of the six factors with an emphasis on the sixth factor for suicide prevention. The following is broken into two parts to form a whole solution. Part one provides a solution for an overall management program that can oversee the implementation of all six steps. Whereas part two's main focus is on the development of a suicide prevention program based on suicide prevention strategies recommended by 2012 national strategy for suicide prevention. Essentially all these parts form a whole solution that will work to improve the mental wellness of mentally ill inmates, reduce the occurrence of future mental illness' in healthy inmate populations and most importantly, decrease the lives lost due to suicide, as well as suicide attempts.

PART 1 Solution: SCDC Management Program

To have better oversight on these six court ordered factors, the best solution would be to implement within the Department of Corrections, a review board that is similar in nature to, and based on the Human Subjects Protection Program's Institutional Review Board (IRB). The main goal of an IRB is to protect individuals from psychological or physical harm in research. This is the fundamental problem within the SCDC.The IRB's function is to protect individuals from psychological and physical harm by reviewing protocols and other materials. The SCDC could create a Regulatory Authority that does the same. This makes a lot of sense, as for these things to be corrected mental health screening practices need to be reviewed and ongoing audits will need to take place within the SCDC, to name a few.

As this is a systemic problem that is statewide and based on the fact that the Department of Corrections has twenty-three institutions that are separated into three regions, the Upstate, Midlands and Coastal/Lowcountry (see Appendix A). Therefore, it is logical to have three

separate SCDC Mental Health Review Boards (MHRB). They would be comprised of medical, legal, mental health experts, scientific and community members designated by the SCDC. They would continually review and strive for improvement in the treatment of mentally ill inmates, with a focus on their mental, physical and environmental well-being. They would ensure the successful development and implementation of the six criteria that Judge Baxley ordered: a program to identify inmates needing mental health care, timely and comprehensive mental health treatment with reduction of segregation and increased access to higher levels of care, the employment of a sufficient number of mental health professionals, maintenance of mental health treatment records, supervised and periodically evaluated administration of medications and a suicide prevention program. In addition, the MHRB would ensure that there is correct and timely enforcement of SCDC policies.

The MHRB would be authorized by SCDC Director Bryan P. Stirling to serve at the local level to regulate and enforce the regulations for protection of mentally ill inmates (Sonne, 2016). In addition, they would be authorized to review and evaluate the efficacy of the screening process at intake and the forthcoming mental health treatment for mentally ill inmates (Sonne, 2016). The board would review the situations in which use of force had occurred and determine whether the risks involved were reasonable in comparison to the benefits (ie. stopping a mentally ill inmate from harming themselves or others) (Sonne, 2016). The MHRB would follow the same goals of the Belmont Report: 1) Beneficence- “Do no harm” and secure the wellbeing of mentally ill inmates by protecting them from harm and ensure that the risks are justified by the expected benefits, 2) Justice- with the focus on treating inmates fairly with no systematic selection of a class of individuals (ie. mentally ill inmates in solitary confinement), and 3)

Respect for Persons- striving to protect the vulnerable and their dignity; especially those with diminished autonomy (Sonne, 2016).

As shown in Appendix B, in abbreviated form, the SCDC branches of organization start at the top with **Bryan Stirling, the Agency Director** and then extend down to **Michael McCall, the Deputy Director of Operations**, and then to **Dennis Patterson the Assistant Deputy Director.** Dennis Patterson is in charge of the **three Region Directors: Bernard McKie (Region 1), Juanita Gaston (Region 2), and Wayne McCabe (Region 3).** Under each of these three Regional Directors is **the Warden for each of the three regions correctional facilities** and there are an average of **eight Wardens** per region. Similar to an IRB, where a Principal Investigator is primarily responsible for the conduct of a research study, the MHRB would have each of the Regional Directors assume responsibility for the conduct of their staff, all procedures conducted and all data collected. They may delegate the work, which would be ultimately conducted and collected by the Wardens of each correctional facility, but they retain the responsibility. The primary reason behind this is that for the issues to be corrected, a top-down approach needs to be taken, where all employees within the system assume responsibility for improving the SCDC. In addition, the MHRB would work with the aforementioned administrative bodies to come up with Standard Operating Procedures that are binding only to the organization and have the goal of achieving compliance with state and federal laws and regulations (Sonne, 2016). They will also ensure that a confidential Medication Administration Records (MAR) database is created to enable nurses who administer psychotropic medications to patients can maintain accurate and complete records. The mental health counselors have been in charge of making sure that the MARs are accurately filled out. As this has not been shown to work, it would make sense to have the counselors, psychologists and psychiatrists meet once a

month to go over them and make sure that they are 1) being kept confidential, 2) inmates are receiving the correct dosage(s), and 3) are accurate and complete. They would also be in charge of checking on a weekly basis that the psychotropic medications are being dispensed to inmates in their cells, negating the issues of long pill lines and inmates waking in the middle of the night to receive their medication. The MHRB would also see to it that the measures taken by the SCDC to improve were transparent to the stakeholders. In other words, make certain that data are honestly, accurately and informatively represented to the general public (Sonne, 2016).

The three MHRB would meet every three months to make sure that they are in-line with the goals of the board. This would also empower them to discuss situations that have arisen that the boards may be able to solve together based on their separate regional experiences.

Organization of Goals and Objectives of the 2012 National Strategy for Suicide Prevention

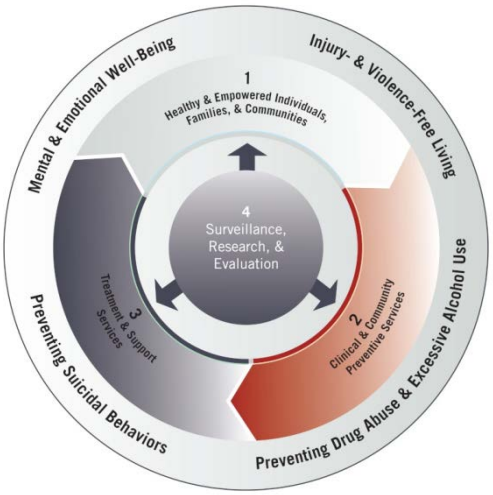

Figure 2. Adapted from U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012).*2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, p.24. Washington, DC: HHS. Retrieved October 1, 2016 from https://www.ncbi.nlm.nih.gov/books/NBK109917/

As shown in the figure above, there are four interconnecting strategic directions that the 2012 National Strategy for Strategic Prevention is organized into:

1. Healthy and Empowered Individuals, Families, and Communities
2. Clinical and Community Preventive Services
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation

The "four strategic directions are interrelated and interactive, rather than stand-alone areas" and "although some groups have higher rates of suicidal behaviors than others, the goals and objectives do not focus on specific populations or settings, but "are meant to be adaptive to meet the specific needs of each group" (HHS, p. 24, 2012).

Judge Baxley ruled that the SCDC needed a basic suicide prevention program that effectively worked to identify, treat, and supervise at-risk inmates (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., 2016). He placed emphasis in his ruling on Crisis Intervention (CI) inmates and the CI cells used in the SCDC. There were eight sub-factors listed under the sixth factor. They are as follows: 1) the ability to locate all the CI cells within a healthcare setting; 2) prohibit using alternative spaces for CI purposes (ie. holding cells, rec cages, shower stalls, and interview booths); 3) implementation of continuous observation for suicidal inmates; 4) CI inmates should be provided access to confidential meetings with psychiatrists, psychiatric nurse practitioners, and mental health counselors; 5) the cleanliness and temperature of CI cells should undergo significant improvement that is documented; 6) CI inmates will be given increased access to showers; 7) inmates in CI cells will be provided with clean, suicide-resistant clothing, blankets and mattresses; and 8) crisis intervention practices

should be reviewed by implementing a formal quality management program (MHRB) (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., 2016).

Step 1: Policies and Procedures

According to the Suicide Prevention Resource Center (SPRC), "correctional facilities should have written policies and procedures for both preventing suicides, responding to attempts that may occur, and all staff at the facilities should be trained on when and how to implement these plans" (Suicide Prevention Resource Center [SPRC], p. 3, 2007).Suicide protocols should contain information about "assessing suicide risk and imminent suicide risk" (SPRC, p.3, 2007). CI cells need to be moved away from segregation units and close to a medical setting. This would allow staff to quickly get medical attention for inmates that need it. The SCDC needs to write a policy that facilitates constant observation of inmates in CI cells.

Step 2: Training of SCDC Staff

Correctional officers, mental health and medical staff need to be trained both initially and annually on how to recognize and respond to suicide risk (SPRC, 2007) (Hayes, 2013). In addition, they need to be trained on first aid, how to do CPR and also know that in the case of finding a person unresponsive, they need to begin CPR immediately (SPRC, 2007). The correctional facilities need to have available "appropriate first aid safety equipment, including latex gloves, resuscitation breathing masks, defibrillators, and tools for opening jammed cell doors and cutting down a hanging inmate"(SPRC, p.4, 2007).

Training on Warning Signs of Suicide:

According to the 2012 National Strategy for Suicide Prevention, the following are warning signs of suicide, the risk of suicide becomes higher the more of these signs a person shows. Hayes says "Simply stated, correctional staff, as well as medical and mental health

personnel, cannot detect, make an assessment, nor prevent a suicide for which they have little, if any, useful training" (Hayes, para.24, 2013).

It is important that "all suicide prevention training must be meaningful, i.e., timely, long-lasting information that is reflective of our current knowledge base of the problem" (Hayes, para.24, 2013). Hayes recommends that "although webinar-based and/or e-learning question-answer formatted training have become popular cost-effective alternatives to traditional classroom training, such technology should be discouraged in this area" (para.24, 2013). This is because "the topic of suicide prevention is one that is best provided in a live, interactive environment amongst correctional, mental health, and medical personnel" (Hayes, para.24, 2013).

It is crucial that annual training occur as, "without regular suicide prevention training, staff often make wrong and/or ill-informed decisions, demonstrate inaction, become complacent, or react contrary to standard correctional practice, thereby incurring unnecessary liability" (Hayes, para.24, 2013). They will be trained on the basic interventions that can assist in successful prevention such as: Question, Persuade, Refer (QPR) someone to help; three steps that can be learned by anyone to prevent a suicide (QPR Institute, n.d.). The following explains suicide warning signs and prevention strategies in more depth.

Warning Signs SCDC Staff need to be aware of:

- Talking about: wanting to die, feeling hopeless, having no purpose, feeling trapped, being a burden to others, being in unbearable pain and feeling isolated
- Looking for ways to kill themselves
- Sleeping too much or too little
- Withdrawing

- Talking about ways to achieve revenge
- Showing rage
- Acting reckless, agitated or anxious
- Displaying mood swings that are extreme in nature

(National Strategy for Suicide Prevention, 2012).

What To Do

What SCDC Staff can do if an inmate exhibits warning signs of suicide:

- Don't leave them alone (National Strategy for Suicide Prevention, 2012).
- Remove objects that could potentially be used in a suicide attempt (National Strategy for Suicide Prevention, 2012).
- Effective communication about suicide risk (SPRC, p.3, 2007).

(National Strategy for Suicide Prevention, 2012).

The "knowledge about an inmate's risk status and history can be lost as he or she is transferred between units or facilities (or as shifts change)"(SPRC, p.3, 2007). The establishment of "formal procedures for communicating knowledge about suicide risk of particular inmates will help staff maintain and target their vigilance" (SPRC, p.3, 2007). The "information that needs to "follow" the prisoner includes the following: 1) suicide threats by the inmate, 2) behaviors that indicate he or she may be depressed, 3) a history of psychiatric care and medication, and 4) whether the inmate is in protective custody" (SPRC, p.3, 2007). In addition, if the patient is taking medications, it is critical that the next unit or facility knows that the inmate is in the Medication Administration Records (MAR) database.

While “a formal intake suicide risk and mental health assessment is an essential part” of the intake process, “an inmate’s risk status can change dramatically over time; staff need to be trained to recognize and respond to changes in an inmate’s mental condition” (SPRC, 2007).

Step 3: Intake Screening

At intake, the MINI International Neuropsychiatric Interview (M.I.N.I.) will be the assessment tool that is utilized to rate if an incoming inmate is mentally ill. It is a structured psychiatric diagnostic instrument for interviewing that is commonly used, is brief in duration, and requires only “yes” or “no” answers. In addition, it is divided into different modules that correspond to various diagnostic categories. Employees utilizing the M.I.N.I. will be trained on how to use this assessment tool.

The *Columbia Suicide Severity Rating Scale* (C-SSRS), version 1/14/09 will be utilized for baseline screening of suicidality upon intake assessment. The C-SSRS can be found in appendix D of this thesis. The questions in the C-SSRS are suggested probes and only individuals who have been trained on administration of the assessment will be permitted to screen incoming inmates (Posner et al., 2009). This is because determining if the inmate is presenting suicidal ideations or behaviors lies on the screener’s judgment (Posner et al., 2009). Hayes states that “screening for suicide risk during the initial booking and intake process should be viewed as something similar to taking one’s temperature – it can identify a current fever, but not a future cold” (para.15, 2013).. As the “shelf life of current behavior that is observed and/or self-reported during intake screening is time-limited, and we often place far too much weight upon this initial data collection stage” (Hayes, para.15, 2013). After an inmate commits suicide, “it is not unusual for the mortality review process to focus exclusively upon whether the victim threatened suicide during the initial intake stage, a time period that could be far removed from

the date of suicide" (Hayes, para.15, 2013). Then if it is found that "the victim had answered in the negative to suicide risk during intake, there is often a sense of relief expressed by participants of the mortality review process, as well as a misguided conclusion that the death was not preventable" (Hayes, para.15, 2013). Haynes warns that "although the intake screening form remains a valuable front-end prevention tool, the more important determination of suicide risk is the *current* behavior expressed and/or displayed by the inmate during their confinement" (para.15, 2013). In addition, "most suicide prevention policies are heavy on explaining the intake screening process, but light on most of the other critical areas of identification" (Hayes, para.15, 2013).

Step 4: Safety Measures

The SCDC needs to be "consistent with national correctional standards, where inmates on suicide precautions are now required to be housed in "suicide-resistant" cells which contain tamper-proof light fixtures, smoke detectors, sprinkler heads, and ceiling/wall air vents that are protrusion-free" (Hayes, para.7, 2013). The "fiberglass-molded bunks in these cells" should have no tie-off points and have edges that are rounded (Hayes, para.7, 2013). The SCDC also needs to install clothing hooks that are collapsible and modify towel racks, sinks, radiator vents to reduce their use as anchoring devices for hanging (Hayes, para.7, 2013). Finally, corded telephones need to be replaced with cordless telephones, as they are "an obvious suicide hazard" (Hayes, para.7, 2013). The SCDC needs to provide mattresses, "safety smocks and blankets, made of heavy nylon fabric that is very heavy and difficult to tear" (Hayes, para.6, 2013).

Step 5: Check-up and Check-in

The "correctional personnel should not be afraid to ask an inmate if he or she has considered suicide or other self-destructive acts", as "asking someone if he or she has thought

about suicide will NOT increase the risk of suicide" (SPRC, p.3, 2007). The SPRC also suggests that "correctional staff may want to be very direct and simply ask the question "Are you thinking about killing yourself?" (p.3, 2007).If there is "any suspicion that a prisoner may be actively at risk of suicide should be communicated to a mental health professional" (SPRC, p.3, 2007). It is critical that "any suspicion that a prisoner may be in imminent danger should be reported" (SPRC, p.3, 2007). It is also imperative that "reports of such suspicions by inmates' families or other inmates should also be taken seriously" (SPRC, p.3, 2007). Reporting should follow a chain of command and first go to a mental health counselor, if they are not available, then the staff psychiatrist should be notified and ultimately the warden if no one can be reached.

Step 6: Documentation of all actions

Documentation of all actions associated with suicide prevention efforts should occur immediately by each staff member who has to take action. In addition, the MHRB for each region should focus on ongoing reviews of incidents, such as suicide attempts and suicides. The MHRB has the authority to implement changes that are seen as necessary based on these reviews.

Step Four: Select the Criteria

Alternative 1: Continue with Current Improvements

The Court found that all of these measures had little impact on the SCDC. The court found that at least 14.5 psychiatric staff FTE's were needed, whereas the SCDC's staff consisted (at the time of the ruling) of 5.5 FTE's and had remained that way since 2008 (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., 2014). In addition, the judge pointed out that "counselor and psychologist FTE's are far too low" and the solution of hiring "administrators to replace other administrators is not necessarily an improvement"(T.R., P.R.,

K.W., et al. v. South Carolina Department of Corrections, et al., p.34, 2014). The reorganized "group therapy sessions were found to have been frequently cancelled and unavailable for most inmates in segregation and crisis intervention" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.34, 2014). The court found that creating mental health dorms was no substitute for a mental health program with adequate staffing (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., 2014). The new self-injuring behavior (SIB) protocol had no evidence behind it of improving issues related to SIB (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., 2014). Regarding the increase in use of tele-psychiatry services the SCDC had identified, it was found that a tele-psychiatry feasibility study had been requested, but the SCDC had not expanded these services as of the time of the trial (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., 2014). The Court also found that the SCDC's training programs for security and clinical staff were "limited in scope and poorly attended" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.34, 2014). Finally, "counselors were the only mental health clinicians subject to formal audits" which revealed deficiencies that were alarming and many failed their audits "despite a low bar for passing" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.34, 2014).

The steps taken by the SCDC since 2005 were "characterized by the SCDC as "Band-Aids", many of which were instituted shortly and even during trial, that have failed to adequately address the known systemic deficiencies in its mental health program"(T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.35, 2014). To continue using these measures as a method of correcting the SCDC's deficiencies would be, as the Judge stated in 2014, "neither reasonable, timely, nor effective" and would continue to satisfy the "finding of

deliberate indifference" (T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, et al., p.35, 2014).

Alternative 2: Placing the Mentally Ill in Community Settings

In 2014, the Atlanta Journal and Constitution reported that Georgia was supposed to have transferred "all state hospital patients with developmental disabilities to community settings" by that date on July 1st of 2015 (Judd, para.5, 2014). At that point in time, 482 people had been deinstitutionalized, but Judd found that many of those deinstitutionalized appear to be just as badly treated, if not worse than when they were in the state's psychiatric facilities (Judd, 2014).

Judd wrote the following:

> "Most ominously, residents of many group homes have encountered similar patterns of mistreatment that plagued the state hospitals. At least three-fourths of the facilities have been cited for violating standards of care or have been investigated over patient deaths or abuse and neglect reports since 2010. Officials have documented 76 reports of physical or psychological abuse, 48 of neglect, and 60 accidental injuries. In 93 other cases, group home residents allegedly assaulted one another, their caregivers or others (Judd, para. 9, 2014)."

It was a dismal failure because 3/4 of the facilities violated standards of care (Judd, 2014). So it was almost as bad or equally as bad as what was happening to mentally ill inmates in the South Carolina Department of Corrections. Another interesting parallel is that Georgia timeline is similar to the South Carolina timeline regarding budget cuts.

Step Five: Project the Outcomes

In the future, Alternative 1 will not reduce the amount of people who die from suicides in the SCDC every year. In addition, it is projected that the inhumane and unconstitutional

treatment of inmates will continue. Alternative 2 will also result in maltreatment and lives lost due to negligence and maltreatment. In the future, alternative 3 will cost millions of dollars to implement. It will also require ongoing political support for its funding that may not be there. Additionally, there is a chance that five years from now, due to lack of public interest, program resources will be scarce and the available resources will be misspent.

Step 6: Confront the Trade-offs

Alternative 1 seems to be cost-effective, but not the best solution for remedying the issues brought forth and proven unconstitutional by the lawsuit. Alternative 2 is a very humanistic solution, but has been proven to be just as bad as the correctional facilities. Alternative 3 will be expensive to implement, but mentally ill inmates will live in cleaner, healthier environments and lives will indubitably be saved by an effective suicide prevention program.

Conclusion (Decision)

Alternative 2 is the best solution to the SCDC's mentally ill inmate population as it thoroughly addresses all 6 of the factors issued for correction by Judge Baxley. The creation of a Mental Health Review Board would provide the needed oversight for the regulations, policies and procedures regarding the mentally ill inmates in the SCDC. Utilizing the 2012 National Strategy for Suicide Prevention's interconnected strategic directions, along with other sources with suicide prevention recommendations, is the best choice for creating a suicide prevention plan for the SCDC.

The choice was based on the fact that the goals and objectives that make up the organization of the 2012 National Strategy for Suicide Prevention don't focus on specific settings or populations, but can be adapted to meet the unique needs of a specific group (2012).

This adaptability is particularly useful as this is a subgroup that has been identified as being “at an increased risk for suicidal behavior” (p. 24, 2016).

Discussion

Introduction

This study builds on the South Carolina Department of Corrections court case that was filed on behalf of severely mentally ill inmates in 2005, the subsequent trial in 2012, and the 2014 decision by Judge Baxley where he ruled in favor of the plaintiffs and called for reform within the department to eliminate the unconstitutional treatment through the development and implementation of six factors: 1) screening and evaluating for mental illness at intake, 2) a mental health treatment program, 3) a sufficient increase in number of mental health workers, 4) mental health records that are accurate, complete and confidential, 5) supervised and evaluated administration of psychotropic medicines and 6) a suicide prevention program. The goal of this thesis was to come up with effective solutions for each of these factors, with a focus on a comprehensive suicide prevention program.

Summary of the Study

This thesis utilizes the eightfold pathway as the public health methodology to come up with a two-fold solution to the systemic and unconstitutional treatment of mentally ill inmates within the SCDC. It is two-fold in that it 1) addresses the need for a Mental Health Review Board to provide oversight and governance over a mental health treatment program and 2) created a suicide prevention program to eliminate the preventable deaths that occur yearly in the SCDC. This SCDC thesis encapsulated the constitution and ethical human rights of severely mentally ill inmates and how public health solutions can effectively solve the multitude of factors expressed by Judge Baxley.

Limitations

There are limitations to this study that deserve some recognition. First, interviews with the key players in this thesis would have added depth in knowledge. It would have been informative to interview not only key personnel that work for the South Carolina Department of Corrections, but also the plaintiff's lawyers. In addition, an interview with the plaintiffs themselves or the ruling Judge Baxley would have been beneficial. Future research could focus on the qualitative aspect of this court case.

Specifically, not being able to discuss this case with the SCDC is a limitation as it could have provided critical insight as to what it is like for the correctional officers, medical and mental health staff to care for mentally ill inmates and suicide prevention. It must be acknowledged that correctional officers are hired to take care of "regular" inmates on a daily basis, not take care of the seriously mentally ill. Yet, given that 17 percent of the inmates in the SCDC meet the criteria for seriously mentally ill, these are the officer's charges.

Another limitation to this thesis is there could have been an entire chapter devoted solely to the economic downturn in the United States in 2003, then the unmentioned financial recession that occurred in 2008 and how these financial pressures played a part in the decline in resources within the SCDC. This would be important to provide important information on how this financial decline historically impacted the future of the SCDC and provide insight on potential measures that could be taken to avoid these occurrences during future recessions.

There also needs to be more research within the SCDC prison settings as there is a lack of peer-reviewed information. It is likely that the SCDC being a federal and state funded agency that has just gone through a very public lawsuit is hesitant to do so. It is also challenging to implement research within a prison setting, as not only inmates, but the fact that they are

severely mentally ill inmates, fall under any research facilities IRB qualifications for an extremely vulnerable population and even more so if they are suicidal.

Implications for Public Health

The key issues in relation to mental illness and incarceration are significant distress to the individual and the conflict with society. Many of these severely mentally ill inmates are released back into society and find themselves rejected by their relatives and communities due to their illness. They are often homeless and lack the healthcare they so desperately need. This often creates a cycle where they find themselves arrested and incarcerated again. The public health community needs to recognize a plethora of benefits can occur for our general society if action is taken to: 1) take care of the currently mentally ill population and 2) recognize and reduce the stressors that put people at risk for developing profound permanent mental illnesses.

As explained by this thesis, the public health community recognizes that improved understanding and acceptance of suicide can lead to a multitude of lives being saved not only in the SCDC, but also can reduce the effects on the family members, friends and community and institutional staff that are affected by the loss of an inmate (HHS, 2012). Social support is a critical factor in prevention.

Future Directions

This thesis found that there are a lot of barriers that prevent us from knowing how prevalent suicidal behaviors are within the general population and subgroups within. As suicides and suicide attempts are extremely underreported, we need better surveillance methods in regard to data collection instruments and sources (HHS, 2012). The National Violent Death Reporting System, as of 2012, was only available in 18 states (HHS) and could provide more complete information if it were available in all 50 states.

In the future there needs to be more focus within the SCDC on preventing mental decompensation and permanent mental illness within the facilities. The Plaintiff's and Defendant's lawyers went through mediation for nine months in 2015. This thesis proves to be timely as they recently filed for approval from the Supreme Court for the solutions agreed upon in mediation. Hopefully the solutions will provide access to basic mental health care, eliminate those at risk for serious physical injury from pepper spray and excessive use of force. Concerning those incarcerated for too long in isolation units, it must not be forgotten that the Court found that out of the ten longest periods of isolation that lasted beyond release dates, nine were served by mentally ill inmates (T.R, P.R., and K.W. et.al. vs. SCDC, 2014). It can also be hoped that an extreme limitation on use and time spent in isolation units is put in place, as the time spent in isolation has been proven to cause mental decompensation, profound permanent mental illness and loss of lives to suicide within the SCDC.

Additionally, there are two likely correlations that are appropriate for further investigation. It could be debated that mental illness is the main cause of persons going to jail versus incarceration attributing to the behavior. Secondly, there could be a possible correlation between encountering the justice system (arrest, trial, etc.) and a decline in mental health. If time constraints were not a concern, these variables could have been more thoroughly explored and determined.

Conclusion

In conclusion, this thesis shows the cruel, unconstitutional treatment and gross negligence that the severely mentally ill inmates endured for years within the walls of the SCDC. It also reveals that lives were lost due to the aforementioned treatment and negligence while this court case was stalled by the SCDC's lawyers. By utilizing the eightfold pathway, an effective method has been found to show a way for systems to be created and implemented that can successfully mitigate the inhumane treatment of seriously mentally ill inmate's, suicide attempts and deaths due to suicides in the future. It is important for theses such as these to be written to shed light on contemporary issues in public health.

In the future the public health community can work to educate and inform the general population so that a significant reduction in the stigma that surrounds mental illness and suicide occurs. The people who struggle daily from mental illness and/or suicidal ideation, and the future people who will struggle daily need substantive equity that assures appropriate intervention, effective treatment and support, as well as acceptance and understanding from their support systems; as stigma often undermines treatment. Finally, for the sake of the mentally ill that are in their care, it is imperative that the South Carolina Department of Corrections finds a solution to this multi-factor systemic problem.

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Appendix References

Appendix A: SCDC Institutions

Retrieved on November 5, 2016 from http://www.doc.sc.gov/pubweb/institutions/institutions.jsp

Appendix B: SCDC Organizational Chart

Retrieved on November 5, 2016 from http://www.doc.sc.gov/pubweb/InternetOrgChart.pdf

Appendix C: MINI

Appendix D: C-SSRS

Appendix E: Court Case

T.R., P.R., K.W., et al. v. South Carolina Department of Corrections, Court of Common Pleas, Fifth Judicial Circuit (SC), Case No. 2005-CP-40-02925. Retrieved March 5, 2016 from http://www.mentalhealth4inmates.org/docudepto/T%OR%20%2Oct%20al%20%20v%20%29SCDC%20final%20order%20and%20judgment%20for%20Plaintiffs%20%28Richland%20%2001-08-14.pdf

Appendix A

INSTITUTIONS

The Department of Corrections has twenty-three **institutions** and they are categorized into four distinct security levels: high security (level 3), medium security (level 2), minimum security (level 1B) and community-based pre-release/work centers (level 1A). The architectural design of the institution, type of housing, operational procedures, and the level of security staffing determine an institution´s security level. Inmates are assigned to institutions to meet their specific security, programming, medical, educational, and work requirements.

LEVEL 1-A (L1-A)
Level 1-A facilities are community-based pre-release/work centers that house minimum-security non-violent inmates who are within 36 months of release. These units are work and program oriented, providing intensive specialized programs that prepare the inmates for release to the community. Housing is mainly double bunk, open-bay wards with unfenced perimeters.

LEVEL 1-B (L1-B)
Level 1-B institutions are minimum-security facilities that house inmates with relatively short sentences or time to serve. Housing is mainly double bunk cubicles with unfenced perimeters. Operational procedures at Level 1-B facilities impart a higher level of security compared to level 1-A facilities.

LEVEL 2 (L2)
Level 2 facilities are medium-security institutions. Housing is primarily double bunk, cell type with some institutions having double-bunk cubicles. With single fenced perimeters and electronic surveillance, level 2 institutions provide a higher level of security than level 1 facilities.

LEVEL 3 (L3)
Level 3 facilities are high-security institutions designed primarily to house violent offenders with longer sentences, and inmates who exhibit behavioral problems. Housing consists of single and double cells, and all perimeters are double-fenced with extensive electronic surveillance. Inmates at level 3 facilities are closely supervised and their activities and movement within the institution are highly restricted.

Headquarters
P. O. Box 21787
4444 Broad River Road
Columbia, SC 29210
803-896-8500
corrections.info@doc.state.sc.us

Region 1 (7 institutions)

Broad River Correctional Institution (L3)
Region 1
Dennis Bush, Warden
4460 Broad River Road
Columbia, SC 29210
803-896-2234

McCormick Correctional Institution (L3)
Region 1
Leroy Cartledge, Warden
386 Redemption Way
McCormick, SC 29899
864-443-2114 or 803-734-0330

Goodman Correctional Institution
Region 1
4556 Broad River Road
Columbia, SC 29210
803-896-8565

Perry Correctional Institution (L3)
Region 1
Scott Lewis, Warden
430 Oaklawn Road
Pelzer, SC 29669
864-243-4700

Ridgeland Correctional Institution (L2)
Region 1
LeVern Cohen, Warden
5 Correctional Road
Ridgeland, SC 29936
803-896-3200 or 843-726-6888
Mailing Address:
P. O. Box 2039
Ridgeland, SC 29936

Turbeville Correctional Institution (L2)
Region 1
Richard Cothran, Warden
1578 Clarence Coker Hwy
Turbeville, SC 29162
843-659-4800 or 803-896-3100

Lieber Correctional Institution (L3)
Region 1
Joseph McFadden, Warden
136 Wilborn Avenue
P.O. Box 205
Ridgeville, SC 29472
843-875-3332 or 803-896-3700

Region 2 (8 instituions/centers)

Kirkland Reception and Evaluation Center (L3)
Tim Riley, Warden
4344 Broad River Road
Columbia, SC 29210
803-896-1521

Catawba Pre-Release Center (L1-A)
Region 2
Glenn Stone, Warden
1030 Milling Road
Rock Hill, SC 29730
803-324-5361 or 803-734-9946

Graham (Camille Griffin) Correctional
Region 2
Institution (Women L2)
Marian Boulware, Warden
4450 Broad River Road
Columbia, SC 29210
803-896-8590

Leath Correctional Institution
Region 2
(Women L2)
Angelia Rawski, Warden
2809 Airport Road
Greenwood, SC 29649
803-896-1000 or 864-229-5709

Livesay Correctional Institution
Region 2
"A" Camp *formerly Livesay PRC* (L1-A)
"B" Camp *formerly Northside CI* (L1-B)
Robert Mauney, Warden
104 Broadcast Drive
Spartanburg, SC 29303
803-734-1375 or 864-594-4915
Mailing Address:
P.O. Box 580
Una, SC 29378

Manning Reentry/Work Release Center (L1-B)
Region 2
Nena Walker-Staley, Warden
502 Beckman Drive
Columbia, SC 29203
803-935-6000

Palmer Pre-Release Center (L1-A)
Region 2
Aaron Joyner, Warden
2012 Pisgah Road
Florence, SC 29501
843-661-4770 or 803-734-9487

Walden Correctional Institution (L1-B)
Region 2
Stevenson Camp *formerly Stevenson CI* (L1-B)
Kenneth Weedon, Warden
4340 Broad River Road
Columbia, SC 29210
803-896-8580

Region 3 (8 institutions)

Allendale Correctional Institution (L2)
Region 3
John R. Pate, Warden
1057 Revolutionary Trail
Fairfax, SC 29827
803-632-2561 or 803-734-0653
Mailing Address:
P. O. Box 1151
Fairfax. SC 29827

Evans Correctional Institution (L2)
Region 3
Willie Eagleton, Warden
610 Highway 9 West
Bennettsville, SC 29512
843-479-4181 or 803-896-4900
Mailing Address:
P.O. Box 2951202
Bennettsville, SC 29512

Kershaw Correctional Institution (L2)
Region 3
David Dunlap, Warden
4848 Goldmine Highway
Kershaw, SC 29067
803-475-5770 or 803-896-3301

Lee Correctional Institution (L3)
Region 3
Cecllia Reynolds, Warden
990 Wisacky Highway
Bishopville, SC 29010
803-428-2800 or 803-896-2400

MacDougall Correctional Institution (L2)
Region 3
Edsel Taylor, Warden
1516 Old Gilliard Road
Ridgeville, SC 29472
843-688-5251 or 803-737-3036
or 843-875-0880

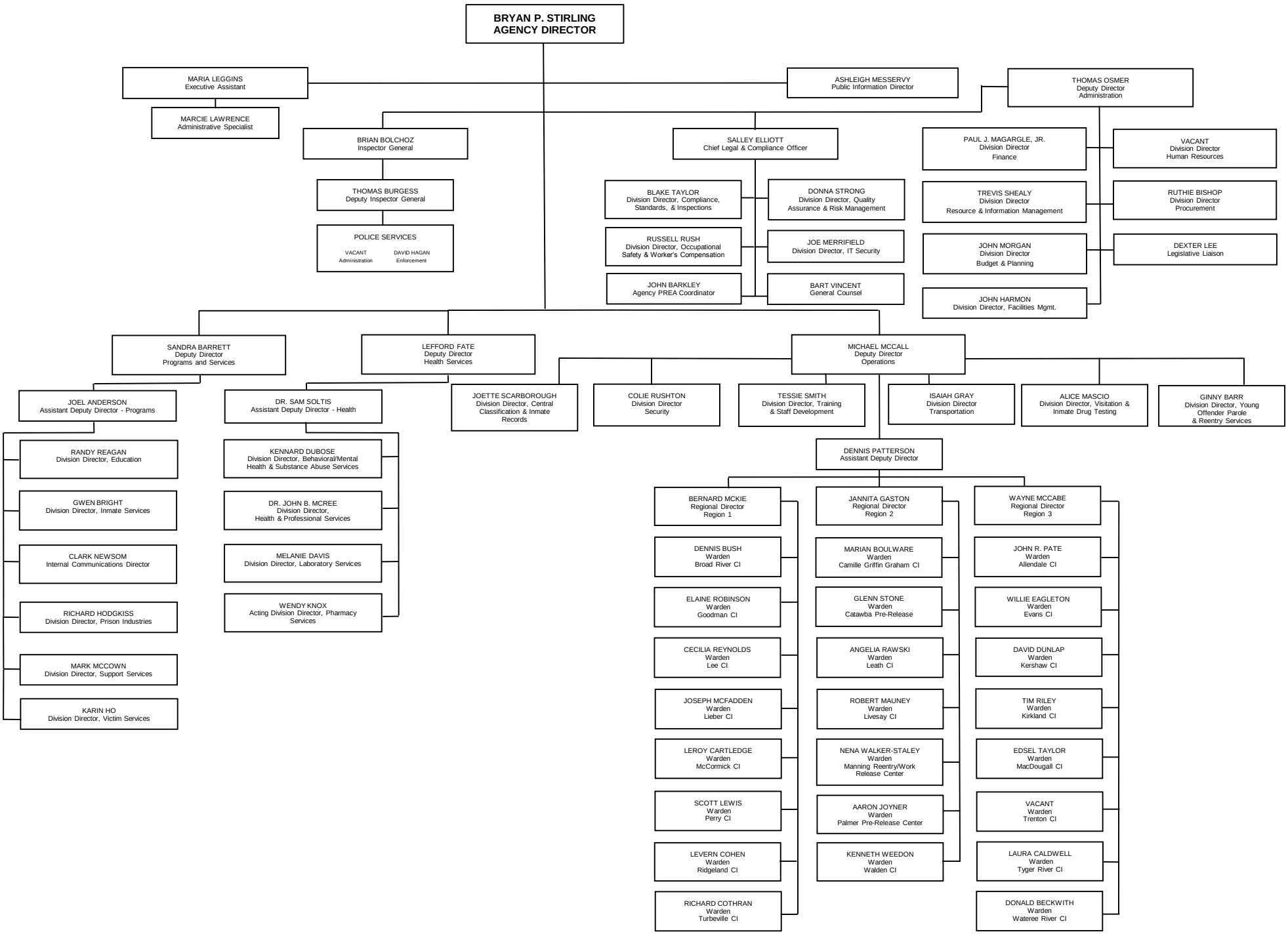
Trenton Correctional Institution (L2)
Region 3
Vacant, Warden
84 Greenhouse Road
Trenton, SC 29847
803-896-3000 or 803-278-0010
803-275-3301

Tyger River Correctional Institution (L2)
Region 3
Laura Caldwell, Warden
100-200 Prison Road
Enoree, SC 29335
803-896-3501 or 803-896-3601
864-583-6056

Wateree River Correctional Institution (L2)
Region 3
Donald Beckwith, Warden
Highway 261
Rembert, SC 29128
803-432-6191 or 803-896-3400
Mailing Address:
P. O. Box 189
Rembert, SC 29128

Appendix B

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
ORGANIZATIONAL CHART



Appendix C

M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 7.0.0

FOR

DSM-5

DISCLAIMER

Our aim is to assist in the assessment and tracking of patients with greater efficiency and accuracy. Before action is taken on any data collected and processed by this program, it should be reviewed and interpreted by a licensed clinician.

This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician – psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel. It is not a diagnostic test.

Patient Name:		***Patient Number:***	
Date of Birth:		***Time Interview Began:***	
Interviewer's Name:		***Time Interview Ended:***	
Date of Interview:		***Total Time:***	

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-5	ICD-10	PRIMARY DIAGNOSIS
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	❒			
		Past	❒			
		Recurrent	❒			
	MAJOR DEPRESSIVE DISORDER	Current (2 weeks)	❒	296.20-296.26 Single	F32.x	❒
		Past	❒	296.20-296.26 Single	F32.x	❒
		Recurrent	❒	296.30-296.36 Recurrent	F33.x	❒
B	SUICIDALITY	Current (Past Month)	❒			❒
		Lifetime attempt	❒	❒ Low ❒ Moderate ❒ High		❒
	SUICIDE BEHAVIOR DISORDER	Current	❒	(In Past Year)		❒
		In early remission	❒	(1 - 2 Years Ago)		❒
C	MANIC EPISODE	Current	❒			
		Past	❒			
	HYPOMANIC EPISODE	Current	❒			
		Past	❒	❒ Not Explored		
	BIPOLAR I DISORDER	Current	❒	296.41-296.56	F31.0--F31.76	❒
		Past	❒	296.41-296.56	F31.0- F31.76	❒
	BIPOLAR II DISORDER	Current	❒	296.89	F31.81	❒
		Past	❒	296.89	F31.81	❒
	BIPOLAR DISORDER UNSPECIFIED	Current	❒	296.40/296.50	F31.9	❒
		Past	❒	296.40/296.50	F31.9	❒
	BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current	❒	296.44/296.54	F31.2/31.5	❒
		Past	❒	296.44/296.54	F31.2/31.5	❒
D	PANIC DISORDER	Current (Past Month)	❒	300.01	F41.0	❒
		Lifetime	❒	300.01	F40.0	❒
E	AGORAPHOBIA	Current	❒	300.22	F40.00	❒
F	SOCIAL ANXIETY DISORDER (Social Phobia)	Current (Past Month)	❒	300.23	F40.10	❒
G	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	❒	300.3	F42	❒
H	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	❒	309.81	F43.10	❒
I	ALCOHOL USE DISORDER	Past 12 Months	❒	303.9	F10.10-20	❒
J	SUBSTANCE USE DISORDER (Non-alcohol)	Past 12 Months	❒	304.00-.90/305.20-.90	F11.1x-F19.288	❒
K	PSYCHOTIC DISORDERS	Lifetime	❒	297.3/297.9/ 293.81/298.83/298.89	F20.81-F29	❒
		Current	❒	297.3/297.9/ 293.81/298.83/298.89	F20.81-F29	❒
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	❒	296.24/296.34-296.44 296.54	F31.2/F32.2/F33.3	❒
		Current	❒	296.24/296.34/296.44/296.54	F31.2/F32.2/F33. 3	❒
L	ANOREXIA NERVOSA	Current (Past 3 Months)	❒	307.1	F50.01-02	❒
M	BULIMIA NERVOSA	Current (Past 3 Months)	❒	307.51	F50.2	❒
MB	BINGE-EATING DISORDER	Current (Past 3 Months)	❒	307.51	F50.8	❒
N	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	❒	300.02	F41.1	❒
O	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT		❒ No	❒ Yes	❒ Uncertain	
P	ANTISOCIAL PERSONALITY DISORDER	Lifetime	❒	301.7	F60.2	❒

IDENTIFY THE PRIMARY DIAGNOSIS BY CHECKING THE APPROPRIATE CHECK BOX.
(Which problem troubles you the most or dominates the others or came first in the natural history?)

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-5 and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-III-R and the CIDI (a structured interview developed by the World Health Organization). The results of these studies show that the M.I.N.I. has similar reliability and validity properties, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. Clinicians can use it, after a brief training session. Lay interviewers require more extensive training.

INTERVIEW:

In order to keep the interview as brief as possible, inform the patient that you will conduct a clinical interview that is more structured than usual, with very precise questions about psychological problems which require a yes or no answer.

GENERAL FORMAT:

The M.I.N.I. is divided into **modules** identified by letters, each corresponding to a diagnostic category.

- At the beginning of each diagnostic module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a **gray box**.
- At the end of each module, diagnostic box(es) permit the clinician to indicate whether diagnostic criteria are met.

CONVENTIONS:

Sentences written in « normal font » should be read exactly as written to the patient in order to standardize the assessment of diagnostic criteria.

Sentences written in « CAPITALS » should not be read to the patient. They are instructions for the interviewer to assist in the scoring of the diagnostic algorithms.

Sentences written in « **bold** » indicate the time frame being investigated. The interviewer should read them as often as necessary. Only symptoms occurring during the time frame indicated should be considered in scoring the responses.

Answers with an arrow above them (➡) indicate that one of the criteria necessary for the diagnosis or diagnoses is not met. In this case, the interviewer should go to the end of the module, circle « **NO** » in all the diagnostic boxes and move to the next module.

When terms are separated by a *slash (/)* the interviewer should read only those symptoms known to be present in the patient (for example, question G6).

Phrases in (parentheses) are clinical examples of the symptom. These may be read to the patient to clarify the question.

RATING INSTRUCTIONS:

All questions must be rated. The rating is done at the right of each question by circling either Yes or No. Clinical judgment by the rater should be used in coding the responses. Interviewers need to be sensitive to the diversity of cultural beliefs in their administration of questions and rating of responses. The rater should ask for examples when necessary, to ensure accurate coding. The patient should be encouraged to ask for clarification on any question that is not absolutely clear.
The clinician should be sure that each dimension of the question is taken into account by the patient (for example, time frame, frequency, severity, and/or alternatives).
Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I. The M.I.N.I. has questions that investigate these issues.

For any questions, suggestions, need for a training session or information about updates of the M.I.N.I., please contact:
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A. MAJOR DEPRESSIVE EPISODE

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE **NO** IN THE DIAGNOSTIC BOX, AND MOVE TO THE NEXT MODULE)

A1	a	Were you ever depressed or down, or felt sad, empty or hopeless most of the day, nearly every day, for two weeks? IF NO, CODE NO TO **A1b**: IF **YES** ASK:	NO	YES
	b	For the past two weeks, were you depressed or down, or felt sad, empty or hopeless most of the day, nearly every day?	NO	YES
A2	a	Were you ever much less interested in most things or much less able to enjoy the things you used to enjoy most of the time, for two weeks? IF NO, CODE NO TO **A2b**: IF **YES** ASK:	NO	YES
	b	In the past two weeks, were you much less interested in most things or much less able to enjoy the things you used to enjoy, most of the time?	NO	YES
		➡ IS **A1a** OR **A2a** CODED **YES**?	NO	YES

A3 IF **A1b** OR **A2b** = **YES**: EXPLORE THE **CURRENT** AND THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE
IF **A1b** AND **A2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

Over that two week period, when you felt depressed or uninterested:

		Past 2 Weeks		Past Episode	
a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by ±5% of body weight or ±8 lb or ± 3.5 kg, for a 160 lb/70 kg person in a month)? IF **YES** TO EITHER, CODE **YES**.	NO	YES	NO	YES
b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day? Did anyone notice this?	NO	YES	NO	YES
d	Did you feel tired or without energy almost every day?	NO	YES	NO	YES
e	Did you feel worthless or guilty almost every day?	NO	YES	NO	YES
	IF **YES**, ASK FOR EXAMPLES. LOOK FOR DELUSIONS OF FAILURE, OF INADEQUACY, OF RUIN OR OF GUILT, OR OF NEEDING PUNISHMENT OR DELUSIONS OF DISEASE OR DEATH OR NIHILISTIC OR SOMATIC DELUSIONS. THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode ☐ No ☐ Yes Past Episode ☐ No ☐ Yes				
f	Did you have difficulty concentrating, thinking or making decisions almost every day?	NO	YES	NO	YES
g	Did you repeatedly think about death **(FEAR OF DYING DOES NOT COUNT HERE)**, or have any thoughts of killing yourself, or have any intent or plan to kill yourself? Did you attempt suicide? IF **YES TO EITHER, CODE YES.**	NO	YES	NO	YES
A4	Did these symptoms cause significant distress or problems at home, at work, at school, socially, in your relationships, or in some other important way, and are they a change from your previous functioning?	NO	YES	NO	YES

A5 In between 2 episodes of depression, did you ever have an interval of at least 2 months, without any significant depression or any significant loss of interest? N/A NO YES

ARE **5** OR MORE ANSWERS (**A1-A3**) CODED **YES** AND IS **A4** CODED YES FOR THAT TIME FRAME?

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **A5** IS CODED **YES,** CODE **YES** FOR RECURRENT.

NO	**YES**
MAJOR DEPRESSIVE EPISODE	
CURRENT	☐
PAST	☐
RECURRENT	☐

A6 a How many episodes of depression did you have in your lifetime? _____

Between each episode there must be at least 2 months without any significant depression.

B. SUICIDALITY

In the past month did you:

				Points
B1	Have any accident? This includes taking too much of your medication accidentally. IF NO TO B1, SKIP TO B2; IF YES, ASK B1a:	NO	YES	0
B1a	Plan or intend to hurt yourself in any accident, either by not avoiding a risk or by causing the accident on purpose?	NO	YES	0
	IF NO TO B1a, SKIP TO B2: IF YES, ASK B1b:			
B1b	Intend to die as a result of any accident?	NO	YES	0
B2	Think (even momentarily) that you would be better off dead or wish you were dead or needed to be dead?	NO	YES	1
B3	Think (even momentarily) about harming or of hurting or of injuring yourself - with at least some intent or awareness that you might die as a result - or think about suicide (i.e. about killing yourself)?	NO	YES	6

IF NO TO B2 + B3, SKIP TO B4. OTHERWISE ASK:

Frequency		Intensity	
Occasionally	☐	Mild	☐
Often	☐	Moderate	☐
Very often	☐	Severe	☐

B4	Hear a voice or voices telling you to kill yourself or have dreams with any suicidal content? If YES, was it either or both: ☐ was it a voice or voices? ☐ was it a dream?	NO	YES	4
B5	Have a suicide method in mind (i.e. how)?	NO	YES	8
B6	Have a suicide means in mind (i.e. with what)?	NO	YES	8
B7	Have any place in mind to attempt suicide (i.e. where)?	NO	YES	8
B8	Have any date/timeframe in mind to attempt suicide (i.e. when)?	NO	YES	8
B9	Think about any task you would like to complete before trying to kill yourself? (e.g. writing a suicide note)	NO	YES	8
B10	Intend to act on thoughts of killing yourself? If YES, mark either or both: ☐ did you intend to act at the time? ☐ did you intend to act at some time in the future?	NO	YES	8
B11	Intend to die as a result of a suicidal act? If YES, mark either or both: ☐ did you intend to die by suicide at the time? ☐ did you intend to die by suicide at some time in the future?	NO	YES	8
B12	Feel the need or impulse to kill yourself or to plan to kill yourself sooner rather than later? If YES, mark either or both: ☐ was this to kill yourself? ☐ was this to plan to kill yourself? If YES, mark either or both: ☐ was this largely unprovoked? ☐ was this provoked?	NO	YES	8

IN ASSESSING WHETHER THIS WAS LARGELY UNPROVOKED ASK: "5 minutes before this Impulse, could you have predicted it would occur at that time?"

B13	Have difficulty resisting these impulses?	NO	YES	8
B14	Take any active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)? This includes times when you were going to kill yourself, but were interrupted or stopped yourself, before harming yourself. IF NO TO B14, SKIP TO B15.	NO	YES	
B14a	Take active steps to prepare to kill yourself, but you **did not start** the suicide attempt?	NO	YES	9
B14b	Take active steps to prepare to kill yourself, but then **you stopped yourself just before** harming yourself ("aborted").	NO	YES	10
B14c	Take active steps to prepare to kill yourself, but then **someone or something stopped you just before** harming yourself ("interrupted")?	NO	YES	11
B15	Injure yourself on purpose without intending to kill yourself?	NO	YES	0
B16	Attempt suicide (to kill yourself)? IF NO TO B16, SKIP TO B17.	NO	YES	
B16a	Start a suicide attempt (to kill yourself), but then **you decided to stop** and did not finish the attempt?	NO	YES	12
B16b	Start a suicide attempt (to kill yourself), but then **you were interrupted** and did not finish the attempt?	NO	YES	13
B16c	Went through with a suicide attempt (to kill yourself), **completely** as you meant to? A suicide attempt means you did something where you could possibly be injured, with at least a slight intent to die. IF NO, SKIP TO B17:	NO	YES	14

Hope to be rescued / survive ☐

Expected / intended to die ☐

B17 **TIME SPENT PER DAY WITH ANY SUICIDAL IMPULSES, THOUGHTS OR ACTIONS:**

Usual time spent per day: ____ hours ____ minutes.
Least amount of time spent per day: ____ hours ____ minutes.
Most amount of time spent per day: ____ hours ____ minutes.

In your lifetime:

B18	Did you ever make a suicide attempt (try to kill yourself)? If YES, how many times? _____ If YES, when was the last suicide attempt?	NO	YES	4

Current: within the past 12 months ☐

In early remission: between 12 and 24 months ago ☐

In remission: more than 24 months ago ☐

"A suicide attempt is any self injurious behavior, with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him-or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance. For example, it is defined as a suicide attempt if it is clearly not an accident or if the individual thinks the act could be lethal, even though denying intent." (FDA Guidance for Industry Suicidal Ideation and Behavior Document 2012 and C-CASA definition). Posner K et al. Am J Psychiatry 2007; 164 (7): 1035-1043 & http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/

B19	How likely are you to try to kill yourself within the next 3 months on a scale of 0-100% _____% ANY LIKELIHOOD > 0% ON B19 SHOULD BE CODED YES	NO	YES	13

IS AT LEAST **1** OF THE ABOVE (EXCEPT B1) CODED **YES**?

IF YES, ADD THE TOTAL POINTS FOR THE ANSWERS (B1-B19) CHECKED 'YES' AND SPECIFY THE SUICIDALITY SCORE CATEGORY AS INDICATED IN THE DIAGNOSTIC BOX:

INDICATE WHETHER THE SUICIDALITY IS CURRENT (PAST MONTH) OR A LIFETIME SUICIDE ATTEMPT OR BOTH BY MARKING THE APPROPRIATE BOXES OR BY LEAVING EITHER OR BOTH OF THEM UNMARKED. CURRENT = ANY POSITIVE RESPONSE IN B1a THROUGH B16c OR ANY TIME SPENT IN B17. LIFETIME ATTEMPT = B18 CODED YES.
LIKELY IN THE NEAR FUTURE = B19 CODED YES.

MAKE ANY ADDITIONAL COMMENTS ABOUT YOUR ASSESSMENT OF THIS PATIENT'S CURRENT AND NEAR FUTURE SUICIDALITY IN THE SPACE BELOW:

NO **YES**

SUICIDALITY

1-8 points Low ☐
9-16 points Moderate ☐
≥ 17 points High ☐

CURRENT ☐

LIFETIME ATTEMPT ☐

LIKELY IN NEAR FUTURE ☐

IS **B18** CODED YES?

AND A YES RESPONSE TO

Was the suicidal act started when the subject not in a state of confusion or delirium?

AND A YES RESPONSE TO

Was the suicidal act done without a political or religious purpose?
IF YES, SPECIFY WHETHER THE DISORDER IS CURRENT, IN EARLY REMISSION OR IN REMISSION.

NO **YES**

SUICIDAL BEHAVIOR DISORDER

CURRENT

Current ☐
In early remission ☐
In remission ☐

C. MANIC AND HYPOMANIC EPISODES

(➡ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN MANIC AND HYPOMANIC DIAGNOSTIC BOXES, AND MOVE TO NEXT MODULE)

Do you have any family history of manic-depressive illness or bipolar disorder, or any family member who had mood swings treated with a medication like lithium, sodium valproate (Depakote) or lamotrigine (Lamictal)? NO YES

THIS QUESTION IS NOT A CRITERION FOR BIPOLAR DISORDER, BUT IS ASKED TO INCREASE THE CLINICIAN'S VIGILANCE ABOUT THE RISK FOR BIPOLAR DISORDER.

IF YES, PLEASE SPECIFY WHO:_____

C1 a Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper' or so full of energy or full of yourself that you got into trouble, - or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) NO YES

IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP' OR 'HIGH' OR 'HYPER', CLARIFY AS FOLLOWS: By 'up' or 'high' or 'hyper' I mean: having elated mood; increased energy or increased activity; needing less sleep; having rapid thoughts; being full of ideas; having an increase in productivity, motivation, creativity, or impulsive behavior; phoning or working excessively or spending more money.

IF NO, CODE NO TO **C1b**: IF **YES** ASK:

b Are you currently feeling 'up' or 'high' or 'hyper' or full of energy? NO YES

C2 a Have you **ever** been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? NO YES

IF NO, CODE NO TO **C2b**: IF **YES** ASK:

b Are you currently feeling persistently irritable? NO YES

➡

IS **C1a** OR **C2a** CODED **YES**? NO YES

C3 IF **C1b** OR **C2b** = **YES**: EXPLORE THE **CURRENT** FIRST AND THEN THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE IF **C1b** AND **C2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

WHEN EXPLORING THE CURRENT EPISODE, PREFACE EACH QUESTION AS FOLLOWS:
Over the past few days including today, when you felt high, full of energy or irritable, did you:

WHEN EXPLORING THE PAST EPISODE, PREFACE EACH QUESTION AS FOLLOWS:
Over a period of a few days in the past, when you felt most high, most full of energy or most irritable, did you:

	Current Episode		Past Episode	
a Feel that you could do things others couldn't do, or that you were an especially important person? IF **YES**, ASK FOR EXAMPLES.	NO	YES	NO	YES
THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode ☐ No ☐ Yes; Past Episode ☐ No ☐ Yes				
b Need less sleep (for example, feel rested after only a few hours sleep)?	NO	YES	NO	YES

		Current Episode		Past Episode	
c	Talk too much without stopping, or felt a pressure to keep talking?	NO	YES	NO	YES
d	Notice your thoughts going very fast or running together or racing or moving very quickly from one subject to another?	NO	YES	NO	YES
e	Become easily distracted so that any little interruption could distract you?	NO	YES	NO	YES
f	Have a significant increase in your activity or drive, at work, at school, socially or sexually or did you become physically or mentally restless? This increase in activity may be with or without a purpose.	NO	YES	NO	YES
g	Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)?	NO	YES	NO	YES

C3 SUMMARY: WHEN RATING CURRENT EPISODE: NO YES NO YES

IF C1b IS NO, ARE 4 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?
IF C1b IS YES, ARE 3 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?

WHEN RATING PAST EPISODE:
IF C1a IS NO, ARE 4 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?
IF C1a IS YES, ARE 3 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?

CODE YES ONLY IF THE ABOVE 3 OR 4 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.

RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE C3 SYMPTOMS, WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE C3 SYMPTOMS.

C4 What is the longest time these symptoms lasted (most of the day nearly every day)?
ASSESS THIS DURATION FROM THE VERY START TO THE VERY END OF SYMPTOMS, NOT JUST THE PEAK.

a)	3 days or less	☐		☐
b)	4 days or more	☐		☐
c)	7 days or more	☐		☐

C5	Were you hospitalized for these problems?	NO	YES	NO	YES
	IF YES, CIRCLE YES IN MANIC EPISODE FOR THAT TIME FRAME AND GO TO C7.				
C6	Did these symptoms cause significant problems at home, at work, socially in your relationships, at school or in some other important way?	NO	YES	NO	YES
C7	Were these symptoms associated with a clear change in the way that you previously functioned and that was different from the way that you usually are?	NO	YES	NO	YES

ARE **C3** SUMMARY AND **C7** AND (**C4c** OR **C5** OR **C6** OR ANY PSYCHOTIC FEATURE IN **K1** THROUGH **K8**) CODED **YES**

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

NO **YES**

MANIC EPISODE

CURRENT ☐
PAST ☐

IS **C3** SUMMARY CODED **YES** AND ARE **C5** AND **C6** CODED **NO** AND **C7** CODED **YES**,
AND IS EITHER **C4b** OR **C4c** CODED **YES?**
AND
IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?
AND
ARE ALL PSYCHOTIC FEATURES IN K1 THROUGH K8 CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **YES** TO CURRENT MANIC EPISODE, THEN CODE CURRENT HYPOMANIC EPISODE AS **NO.**

IF **YES** TO PAST MANIC EPISODE, THEN CODE PAST HYPOMANIC EPISODE AS **NOT EXPLORED.**

HYPOMANIC EPISODE

CURRENT ☐ **NO**
☐ **YES**

PAST ☐ **NO**
☐ **YES**
☐ **NOT EXPLORED**

ARE **C3** SUMMARY AND **C4a** CODED **YES** AND IS **C5** CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **YES** TO CURRENT MANIC EPISODE OR HYPOMANIC EPISODE,
THEN CODE CURRENT HYPOMANIC SYMPTOMS AS **NO.**

IF **YES** TO PAST MANIC EPISODE OR YES TO PAST HYPOMANIC EPISODE,
THEN CODE PAST HYPOMANIC SYMPTOMS AS **NOT EXPLORED.**

HYPOMANIC SYMPTOMS

CURRENT ☐ **NO**
☐ **YES**

PAST ☐ **NO**
☐ **YES**
☐ **NOT EXPLORED**

C8 a) IF MANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
Did you have 2 or more of these (manic) episodes lasting 7 days or more (**C4c**) in your lifetime (including the current episode if present)? NO YES

b) IF MANIC OR HYPOMANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
Did you have 2 or more of these (hypomanic) episodes lasting 4 days or more (**C4b**) in your lifetime (including the current episode)? NO YES

c) IF THE PAST "HYPOMANIC SYMPTOMS" CATEGORY IS CODED POSITIVE ASK:
Did you have these hypomanic symptoms lasting only 1 to 3 days (**C4a**) 2 or more times in your lifetime, (including the current episode if present)? NO YES

D. PANIC DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE **NO** AND MOVE TO THE NEXT MODULE)

D1	a	Have you, on more than one occasion, had spells or attacks when you **suddenly** felt anxious, very frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	➡ NO	YES
	b	Did the spells surge to a peak within 10 minutes of starting?	➡ NO	YES
D2		At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	➡ NO	YES
D3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack - or did you make any significant change in your behavior because of the attacks (e.g., avoiding unfamiliar situations, or avoiding leaving your house or shopping alone, or doing things to avoid having a panic attack or visiting your doctor or the emergency room more frequently)?	NO	YES
D4		**During the worst attack that you can remember:**		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing or a smothering sensation?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or feel faint?	NO	YES
	i	Did you have hot flushes or chills?	NO	YES
	j	Did you have tingling or numbness in parts of your body?	NO	YES
	k	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES
	l	Did you fear that you were losing control or going crazy?	NO	YES
	m	Did you fear that you were dying?	NO	YES
D5		ARE BOTH **D3,** AND **4** OR MORE **D4** ANSWERS, CODED **YES**?	➡ NO	YES ***PANIC DISORDER LIFETIME***
D6		In the past month did you have persistent concern about having another attack, or worry about the consequences of the attacks, or did you change your behavior in any way because of the attacks?	NO	YES ***PANIC DISORDER CURRENT***

IS EITHER **D5** OR **D6** CODED **YES**,

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR LIFETIME.

NO **YES**

PANIC DISORDER

LIFETIME ☐

CURRENT ☐

E. AGORAPHOBIA

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

E1	Do you feel anxious or uneasy in places or situations where help might not be available or escape might be difficult if you had a panic attack or panic-like or embarrassing symptoms, like: being in a crowd, or standing in a line (queue), being in an open space or when crossing a bridge, being in an enclosed space, when you are alone away from home, or alone at home, or traveling in a bus, train or car or using public transportation?	➡ NO	YES
	ARE 2 OR MORE **E1** SITUATIONS CODED YES?	➡ NO	YES
E2	Do these situations almost always bring on fear or anxiety?	➡ NO	YES
E3	Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them?	➡ NO	YES
E4	Is this fear or anxiety excessive or out of proportion to the real danger in the situation?	➡ NO	YES
E5	Did this avoidance, fear or anxiety persist for at least 6 months?	➡ NO	YES
E6	Did these symptoms cause significant distress or problems at home, at work, socially, at school or in some other important way?	➡ NO	YES

IS **E6** CODED **YES?**

NO **YES**

AGORAPHOBIA CURRENT

F. SOCIAL ANXIETY DISORDER (Social Phobia)

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

F1	In the past month, did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed or rejected? This includes things like speaking in public, eating in public or with others, writing while someone watches, performing in front of others or being in social situations.	➡ NO	YES

EXAMPLES OF SUCH SOCIAL SITUATIONS TYPICALLY INCLUDE

- INITIATING OR MAINTAINING A CONVERSATION,
- PARTICIPATING IN SMALL GROUPS,
- DATING,
- SPEAKING TO AUTHORITY FIGURES,
- ATTENDING PARTIES,
- PUBLIC SPEAKING,
- EATING IN FRONT OF OTHERS,
- PERFORMING IN FRONT OF OTHERS,
- URINATING IN A PUBLIC WASHROOM, ETC.

F2	Do these social situations almost always bring on fear or anxiety?	➡ NO	YES
F3	Do you fear these social situations so much that you avoid them, or suffer through them, or need a companion to face them?	➡ NO	YES
F4	Is this social fear or anxiety excessive or unreasonable in these social situations?	➡ NO	YES
F5	Did this social avoidance, fear or anxiety persist for at least 6 months?	➡ NO	YES
F6	Did these social fears cause significant distress or interfere with your ability to function at work, at school or socially or in your relationships or in some other important way?	➡ NO	YES

IS **F6** CODED **YES**

and

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NOTE TO INTERVIEWER: PLEASE SPECIFY IF THE SUBJECT'S FEARS ARE RESTRICTED TO SPEAKING OR PERFORMING IN PUBLIC.

NO **YES**

SOCIAL ANXIETY DISORDER
(Social Phobia)
CURRENT

RESTRICTED TO PERFORMANCE SAD ONLY ☐

G. OBSESSIVE-COMPULSIVE DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

G1a	In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? - (For example, the idea that you were dirty, contaminated or had germs, **or** fear of contaminating others, **or** fear of harming someone even though it disturbs or distresses you, or fear you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** religious obsessions.)	NO YES ↓ SKIP TO **G3**a
G1b	In the past month, did you try to suppress these thoughts, impulses, or images or to neutralize or to reduce them with some other thought or action? - (DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO HOARDING, HAIR PULLING, SKIN PICKING, BODY DYSMORPHIC DISORDER, EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)	NO YES ↓ SKIP TO **G3**a
G2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO YES **obsessions**
G3a	In the past month, did you feel driven to do something repeatedly in response to an obsession or in response to a rigid rule, like washing or cleaning excessively, counting or checking things over and over, or repeating or arranging things, or other superstitious rituals?	NO YES
G3b	Are these rituals done to prevent or reduce anxiety or distress or to prevent something bad from happening and are they excessive or unreasonable?	NO YES **compulsions**

➡

ARE (**G1**a AND **G1**b AND G2) OR (**G3**a AND **G3**b) CODED **YES**? NO YES

G4 In the past month, did these obsessive thoughts and/or compulsive behaviors cause significant distress, or interfere with your ability to function at home, at work, at school or socially or in your relationships or in some other important way or did they take more than one hour a day?

and

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?
(CHECK FOR ANY OC SYMPTOMS STARTING WITHIN 3 WEEKS OF AN INFECTION)

SPECIFY THE LEVEL OF INSIGHT AND IF THE EPISODE IS TIC-RELATED.

NO **YES**

O.C.D. CURRENT

INSIGHT:

- GOOD OR FAIR ☐
- POOR ☐
- ABSENT ☐
- DELUSIONAL ☐

TIC-RELATED ☐

H. POSTTRAUMATIC STRESS DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

H1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, WAR, OR NATURAL DISASTER, WITNESSING THE VIOLENT OR SUDDEN DEATH OF SOMEONE CLOSE TO YOU, OR A LIFE THREATENING ILLNESS.	➡ NO	YES
H2	Starting after the traumatic event, did you repeatedly re-experience the event in an unwanted mentally distressing way, (such as in recurrent dreams related to the event, intense recollections or memories, or flashbacks or as if the event was recurring) or did you have intense physical or psychological reactions when you were reminded about the event or exposed to a similar event?	➡ NO	YES

H3	**In the past month:**		
a	Did you persistently try to avoid thinking about or remembering details or feelings related to the event ?	NO	YES
b	Did you persistently try to avoid people, conversations, activities, places, situations, activities or things that bring back distressing recollections of the event?	NO	YES
	ARE **1** OR MORE **H3** ANSWERS CODED **YES**?	➡ NO	YES
H4	**In the past month:**		
a	Did you have trouble recalling some important part of the trauma? (but not because of or related to head trauma, alcohol or drugs).	NO	YES
b	Were you constantly and unreasonably negative about yourself or others or the world?	NO	YES
c	Did you constantly blame yourself or others in unreasonable ways for the trauma?	NO	YES
d	Were your feelings always negative?	NO	YES
e	Have you become much less interested in participating in activities that were meaningful to you before?	NO	YES
f	Did you feel detached or estranged from others?	NO	YES
g	Were you unable to experience any good feelings?	NO	YES
	ARE **2** OR MORE **H4** ANSWERS CODED **YES**?	➡ NO	YES
H5	**In the past month:**		
a	Were you especially irritable or did you have outbursts of anger with little or no provocation?	NO	YES
b	Were you more reckless or more self destructive?	NO	YES
c	Were you more nervous or constantly on your guard?	NO	YES

d Were you more easily startled? NO YES

e Did you have more difficulty concentrating? NO YES

f Did you have more difficulty sleeping? NO YES

➡

ARE **2** OR MORE **H5** ANSWERS CODED **YES**? NO YES

➡

H6 Did all these problems start after the traumatic event and last for more than one month? NO YES

H7 During the past month, did these problems cause significant distress, or interfere with your ability to function at home, at work, at school or socially or in your relationships or in some other important way?

and

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE CONDITION IS ASSOCIATED WITH DEPERSONALIZATION, DEREALIZATION OR WITH DELAYED EXPRESSION.

NO **YES**

POSTTRAUMATIC STRESS DISORDER CURRENT

WITH
DEPERSONALIZATION ☐
DEREALIZATION ☐
DELAYED EXPRESSION ☐

I. ALCOHOL USE DISORDER

(➡ MEANS: GO TO DIAGNOSTIC BOX, CIRCLE **NO** AND MOVE TO THE NEXT MODULE)

		➡	
I1	**In the past 12 months**, have you had 3 or more alcoholic drinks, - within a 3 hour period, - on 3 or more occasions?	NO	YES

I2 **In the past 12 months**:

a. During the times when you drank alcohol, did you end up drinking more than you planned when you started? NO YES

b. Did you repeatedly want to reduce or control your alcohol use? NO YES
Did you try to cut down or control your alcohol use, but failed?
IF **YES** TO EITHER, CODE **YES**.

c. On the days that you drank, did you spend substantial time obtaining alcohol, drinking, or recovering from the effects of alcohol? NO YES

d. Did you crave or have a strong desire or urge to use alcohol? NO YES

e. Did you spend less time meeting your responsibilities at work, at school, or at home, because of your repeated drinking? NO YES

f. If your drinking caused problems with your family or other people, did you still keep on drinking? NO YES

g. Were you intoxicated more than once in any situation where you or others were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.? NO YES

h. Did you continue to use alcohol, even though it was clear that the alcohol had caused or worsened psychological or physical problems? NO YES

i. Did you reduce or give up important work, social or recreational activities because of your drinking? NO YES

j. Did you need to drink a lot more in order to get the same effect that you got when you first started drinking or did you get much less effect with continued use of the same amount? NO YES

k1. When you cut down on heavy or prolonged drinking did you have any of the following: NO YES

1. increased sweating or increased heart rate, ☐
2. hand tremor or "the shakes" ☐
3. trouble sleeping ☐
4. nausea or vomiting ☐
5. hearing or seeing things other people could not see or hear or having sensations in your skin for no apparent reason ☐
6. agitation ☐
7. anxiety ☐
8. seizures ☐

IF **YES** TO 2 OR MORE OF THE ABOVE 8, CODE k1 AS **YES**.

k2. Did you drink alcohol to reduce or avoid withdrawal symptoms or to avoid being hung-over? NO YES

K SUMMARY: IF **YES** TO BOTH k1 AND k2, CODE **YES** NO YES

ARE **2** OR MORE **I2** ANSWERS FROM **I2a** THROUGH J AND **K SUSUMMARY** CODED **YES**?

NO **YES**

ALCOHOL USE DISORDER

PAST 12 MONTHS

SPECIFIERS FOR ALCOHOL USE DISORDER:

MILD = 2-3 OF THE I2 SYMPTOMS
MODERATE = 4-5 OF THE I2 SYMPTOMS
SEVERE = 6 OR MORE OF THE I2 SYMPTOMS

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS
IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE
(BOTH WITH THE EXCEPTION OF CRITERION d. – (CRAVING) ABOVE).

IN A CONTROLLED ENVIRONMENT = WHERE ALCOHOL ACCESS IS RESTRICTED

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐

IN EARLY REMISSION ☐
IN SUSTAINED REMISSION ☐

IN A CONTROLLED ENVIRONMENT ☐

J. SUBSTANCE USE DISORDER (NON-ALCOHOL)

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

Now I am going to show you / read to you a list of street drugs or medicines.

			➡ NO	YES
J1	a	**In the past 12 months**, did you take any of these drugs more than once, to get high, to feel elated, to get "a buzz" or to change your mood?		

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Opiates: heroin, morphine, Dilaudid, opium, Demerol, methadone, Darvon, codeine, Percodan, Vicodin, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA.

Dissociative Drugs: PCP (Phencyclidine ,"Angel Dust", "Peace Pill", "Tranq", "Hog"), or ketamine ("Special K").

Inhalants: "glue", ethyl chloride, "rush", nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers").

Cannabis: marijuana, hashish ("hash"), THC, "pot", "grass", "weed", "reefer".

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown, GHB, Roofinol, "Roofies".

Miscellaneous: steroids, nonprescription sleep or diet pills. Cough Medicine? Any others?

SPECIFY THE MOST USED DRUG(S): _____

WHICH DRUG(S) CAUSE THE BIGGEST PROBLEMS? _____

FIRST EXPLORE THE DRUG CAUSING THE BIGGEST PROBLEMS AND MOST LIKELY TO MEET DEPENDENCE / ABUSE CRITERIA.

IF MEETS CRITERIA FOR ABUSE OR DEPENDENCE, SKIP TO THE NEXT MODULE. OTHERWISE, EXPLORE THE NEXT MOST PROBLEMATIC DRUG.

J2 **Considering your use of (NAME OF DRUG / DRUG CLASS SELECTED), in the past 12 months:**

a.	During the times when you used the drug, did you end up using more (NAME OF DRUG / DRUG CLASS SELECTED) than you planned when you started?	NO	YES
b.	Did you repeatedly want to reduce or control your (NAME OF DRUG / DRUG CLASS SELECTED) use? Did you try to cut down or control your (NAME OF DRUG / DRUG CLASS SELECTED) use, but failed? IF **YES** TO EITHER, CODE **YES**.	NO	YES
c.	On the days that you used more (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time obtaining (NAME OF DRUG / DRUG CLASS SELECTED), using it, or recovering from the its effects?	NO	YES
d.	Did you crave or have a strong desire or urge to use (NAME OF DRUG / DRUG CLASS SELECTED)?	NO	YES
e.	Did you spend less time meeting your responsibilities at work, at school, or at home, because of your repeated (NAME OF DRUG / DRUG CLASS SELECTED) use?	NO	YES
f.	If your (NAME OF DRUG / DRUG CLASS SELECTED) use caused problems with your family or other people, did you still keep on using it?	NO	YES
g.	Did you use the drug more than once in any situation where you or others were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
h.	Did you continue to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it was clear that the (NAME OF DRUG / DRUG CLASS SELECTED) had caused or worsened psychological or physical problems?	NO	YES

i. Did you reduce or give up important work, social or recreational activities because of your (NAME OF DRUG / DRUG CLASS SELECTED) use? NO YES

j. Did you need to use (NAME OF DRUG / DRUG CLASS SELECTED) a lot more in order to get the same effect that you got when you first started using it or did you get much less effect with continued use of the same amount? NO YES
THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.

k1. When you cut down on heavy or prolonged use of the drug did you have any of the following withdrawal symptoms: NO YES
IF **YES** TO THE REQUIRED NUMBER OF WITHDRAWAL SYMPTOMS FOR EACH CLASS, CODE J2k1 AS **YES**.
THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.

Sedative, Hypnotic or Anxiolytic (2 or more)
1. increased sweating or increased heart rate ☐
2. hand tremor or "the shakes" ☐
3. trouble sleeping ☐
4. nausea or vomiting ☐
5. hearing or seeing things other people could not see or hear or having sensations in your skin for no apparent reason ☐
6. agitation ☐
7. anxiety ☐
8. seizures ☐

Opiates (3 or more)
1. feeling depressed ☐
2. nausea or vomiting ☐
3. muscle aches ☐
4. runny nose or teary eyes ☐
5. dilated pupils, goose bumps or hair standing on end or sweating ☐
6. diarrhea ☐
7. yawning ☐
8. hot flashes ☐
9. trouble sleeping ☐

Stimulants (2 or more)
1. fatigue ☐
2. vivid or unpleasant dreams ☐
3. difficulty sleeping or sleeping too much ☐
4. increased appetite ☐
5. feeling or looking physically or mentally slowed down ☐

Cannabis (3 or more)
1. irritability, anger or aggression ☐
2. nervousness or anxiety ☐
3. trouble sleeping ☐
4. appetite or weight loss ☐
5. restlessness ☐
6. feeling depressed ☐
7. significant discomfort from one of the following: "stomach pain", tremors or "shakes", sweating, hot flashes, chills, headaches. ☐

k2. Did you use (NAME OF DRUG / DRUG CLASS SELECTED) to reduce or avoid withdrawal symptoms? NO YES

J2k **SUMMARY**: IF **YES** TO BOTH J2k1 AND J2k2, CODE **YES** NO YES

ARE **2** OR MORE **J2** ANSWERS FROM **J2a** THROUGH **J2k SUMMARY** CODED **YES**?
(**J2**k1 AND **J2**k2 TOGETHER COUNT AS ONE AMONG THESE CHOICES)

NO **YES**

SUBSTANCE
(Drug or Drug Class Name)
USE DISORDER

PAST 12 MONTHS

SPECIFIERS FOR SUBSTANCE USE DISORDER:

MILD = 2-3 OF THE I2 SYMPTOMS
MODERATE = 4-5 OF THE I2 SYMPTOMS
SEVERE = 6 OR MORE OF THE I2 SYMPTOMS

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS
IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE
(BOTH WITH THE EXCEPTION OF CRITERION d. – (CRAVING) ABOVE).

IN A CONTROLLED ENVIRONMENT = WHERE SUBSTANCE / DRUG ACCESS IS RESTRICTED

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐

IN EARLY REMISSION ☐
IN SUSTAINED REMISSION ☐

IN A CONTROLLED ENVIRONMENT ☐

K. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE **YES** ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. THE PURPOSE OF THIS MODULE IS TO EXCLUDE PATIENTS WITH PSYCHOTIC DISORDERS. THIS MODULE NEEDS EXPERIENCE.

Now I am going to ask you about unusual experiences that some people have.

K1 a Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? NO YES
NOTE: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.

b **IF YES:** do you currently believe these things? NO YES

K2 a Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking? NO YES

b **IF YES:** do you currently believe these things? NO YES

K3 a Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? NO YES
CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.

b **IF YES:** do you currently believe these things? NO YES

K4 a Have you ever believed that you were being sent special messages through the TV, radio, internet, newspapers, books, or magazines or that a person you did not personally know was particularly interested in you? NO YES

b **IF YES:** do you currently believe these things? NO YES

K5 a Have your relatives or friends ever considered any of your beliefs odd or unusual? NO YES
INTERVIEWER: ASK FOR EXAMPLES. ONLY CODE YES IF THE EXAMPLES ARE CLEARLY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS K1 TO K4, FOR EXAMPLE, RELIGIOUS, DEATH, DISEASE OR SOMATIC DELUSIONS, DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, OR OF GUILT, FAILURE, INADEQUACY, RUIN, OR DESTITUTION, OR NIHILISTIC DELUSIONS.

b **IF YES:** do they currently consider your beliefs strange or unusual? NO YES

K6 a Have you ever heard things other people couldn't hear, such as voices? NO YES

IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other? NO YES

b **IF YES TO K6a:** have you heard sounds / voices in the past month? NO YES

IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other? NO YES

K7 a Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES

CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

b **IF YES:** have you seen these things in the past month? NO YES

CLINICIAN'S JUDGMENT

K8 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED, INCOHERENT OR DERAILED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

K8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED OR DERAILED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

K9 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

K9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

K10 a DID PATIENT EVER IN THE PAST HAVE NEGATIVE SYMPTOMS, E.G. SIGNIFICANT REDUCTION OF EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION)? NO YES

K10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT REDUCTION OF EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES

K11 a ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K7a, CODED **YES**?

ARE AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT, RECURRENT OR PAST)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**? NO YES
↳ **K13**

HOW LONG HAS THE MOOD EPISODE LASTED? _____
HOW LONG HAS THE PSYCHOTIC EPISODE LASTED? _____
IF SUCH A MOOD EPISODE IS PRESENT, IT MUST BE PRESENT FOR THE MAJORITY OF THE TOTAL DURATION OF THE ACTIVE AND RESIDUAL PERIODS OF THE PSYCHOTIC SYMPTOMS. OTHERWISE CODE NO TO K11a.

IF NO TO K11a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO K13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

Were the beliefs and experiences you just described (SYMPTOMS CODED **YES** FROM **K1**a TO **K7**a) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER IS NO TO THIS DISORDER GROUPING, ALSO CIRCLE NO TO K12 AND MOVE TO K13

NO **YES**

MOOD DISORDER WITH *PSYCHOTIC FEATURES*

LIFETIME

K12 a IS 1 OR MORE « b » QUESTION FROM K1b TO K7b CODED **YES** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE (CURRENT)
OR
MANIC OR HYPOMANIC EPISODE (CURRENT) CODED **YES**?

IF THE ANSWER IS YES TO THIS DISORDER (LIFETIME OR CURRENT), CIRCLE NO TO K13 AND K14 AND MOVE TO THE NEXT MODULE.

NO **YES**

MOOD DISORDER WITH *PSYCHOTIC FEATURES*

CURRENT

K13 ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K8b, CODED **YES**?

AND

ARE 2 OR MORE « b » QUESTIONS FROM K1b TO K10b, CODED **YES**?

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NO **YES**

PSYCHOTIC DISORDER
CURRENT

K14 IS **K13** CODED **YES**

OR

(ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K8a, CODED **YES**?

AND

ARE 2 OR MORE « a » QUESTIONS FROM K1a TO K10a, CODED **YES**

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?)

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NO	**YES**

PSYCHOTIC DISORDER
LIFETIME

L. ANOREXIA NERVOSA

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

L1	a	How tall are you?	☐ ft ☐☐ in. ☐☐☐ cm
	b.	What was your lowest weight in the past 3 months?	☐☐☐ lb ☐☐☐ kg
	c	IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW)	➡ NO YES

In the past 3 months:

L2		In spite of this low weight, have you tried not to gain weight or to restrict your food intake?	➡ NO YES
L3		Have you intensely feared gaining weight or becoming fat, even though you were underweight?	➡ NO YES
L4	a	Have you considered yourself too big / fat or that part of your body was too big / fat?	NO YES
	b	Has your body weight or shape greatly influenced how you felt about yourself?	NO YES
	c	Have you thought that your current low body weight was normal or excessive?	NO YES
L5		ARE 1 OR MORE ITEMS FROM **L4** CODED **YES**?	➡ NO YES

IS **L5** CODED **YES**?

NO **YES**

ANOREXIA NERVOSA
CURRENT

HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.0 KG/M^2

Height/Weight														
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lb	79	82	84	87	90	93	96	99	102	106	109	112	115	119
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kg	36	37	38.5	39.5	41	42.5	43.5	45.5	46.5	48	49	51	52	54

Height/Weight					
ft/in	5'11	6'0	6'1	6'2	6'3
lb	122	125	129	133	136
cm	180	183	185	188	191
kg	55	57	58.5	60	62

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.0 kg/m^2 for the patient's height using the Center of Disease Control & Prevention BMI Calculator. This is the threshold guideline below which a person is deemed underweight by the DSM-5 for Anorexia Nervosa.

M. BULIMIA NERVOSA

(➡ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

M1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	NO YES ↳ **M3**
M2	During these binges, did you feel that your eating was out of control?	NO YES

M3	Did you do anything to compensate for, or to prevent a weight gain, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications? Did you do this as often as once a week? CODE YES TO M3 ONLY IF THE ANSWER TO BOTH THESE M3 QUESTIONS IS YES.	➡ NO YES
M3a	Number of Episodes of Inappropriate Compensatory Behaviors per Week? _____ Number of Days of Inappropriate Compensatory Behaviors per Week? _____	
M4	In the last 3 months, did you have eating binges as often as once a week?	➡ NO YES
M5	Does your body weight or shape greatly influence how you feel about yourself?	➡ NO YES
M6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO YES ↓ Skip to M8
M7	Do these binges occur only when you are under (_____lb/kg)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO YES

M8 IS **M5** CODED **YES** AND IS EITHER **M6** OR **M7** CODED **NO**?

NO **YES**

BULIMIA NERVOSA
CURRENT

IS **M7** CODED **YES**?

NO **YES**

ANOREXIA NERVOSA
Binge Eating/Purging Type
CURRENT

DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?

AND

ARE M2 AND M3 CODED NO?

NO **YES**

ANOREXIA NERVOSA
Restricting Type
CURRENT

SPECIFIERS OF EATING DISORDER:

MILD = 1-3 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
MODERATE = 4-7 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
SEVERE = 8-13 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
EXTREME = 14 OR MORE EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐
EXTREME ☐

MB. BINGE EATING DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

MB1	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO	➡ YES
MB2	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR BULIMIA NERVOSA?	NO	➡ YES
MB3	M2 IS CODED YES	➡ NO	YES
MB4	M3 IS CODED YES	NO	➡ YES
MB5	M4 IS CODED YES	➡ NO	YES
	In the last 3 months during the binging did you:		
MB6a	Eat more rapidly than normal?	NO	YES
MB6b	Eat until you felt uncomfortably full?	NO	YES
MB6c	Eat large amounts of food when you were not hungry?	NO	YES
MB6d	Eat alone because you felt embarrassed about how much you were eating?	NO	YES
MB6e	Feel guilty, depressed or disgusted with yourself after binging?	NO	YES
	ARE 3 OR MORE **MB6** QUESTIONS CODED YES?	➡ NO	YES

MB7 Does your binging distress you a lot? ➡ NO YES

MB8 Number of Binge Eating Episodes per Week? _____

Number of Binge Eating Days per Week? _____

IS MB7 CODED YES?

NO YES

BINGE-EATING DISORDER

CURRENT

SPECIFIERS OF EATING DISORDER:

MILD = 1-3 EPISODES OF BINGE EATING EPISODES PER WEEK
MODERATE = 4-7 EPISODES OF BINGE EATING EPISODES PER WEEK
SEVERE = 8-13 EPISODES OF BINGE EATING EPISODES PER WEEK
EXTREME = 14 OR MORE EPISODES OF BINGE EATING EPISODES PER WEEK

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐
EXTREME ☐

N. GENERALIZED ANXIETY DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

N1	a	Were you excessively anxious or worried about several routine things, over the past 6 months? IN ENGLISH, IF THE PATIENT IS UNCLEAR ABOUT WHAT YOU MEAN, PROBE BY ASKING (Do others think that you are a worrier or a "worry wart"?) AND GET EXAMPLES.	➡ NO	YES
	b	Are these anxieties and worries present most days?	➡ NO	YES
		ARE THE PATIENT'S ANXIETY AND WORRIES RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	➡ NO	YES
N2		Do you find it difficult to control the worries?	➡ NO	YES
N3		FOR THE FOLLOWING, CODE **NO** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT**.**		
		When you were anxious over the past 6 months, did you, most of the time:		
	a	Feel restless, keyed up or on edge?	NO	YES
	b	Have muscle tension?	NO	YES
	c	Feel tired, weak or exhausted easily?	NO	YES
	d	Have difficulty concentrating or find your mind going blank?	NO	YES
	e	Feel irritable?	NO	YES
	f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES
		ARE **3** OR MORE **N3** ANSWERS CODED **YES?**	➡ NO	YES
N4		Do these anxieties and worries significantly disrupt your ability to work, to function socially or in your relationships or in other important areas of your life or cause you significant distress? AND IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?	**NO**	**YES** ***GENERALIZED ANXIETY DISORDER*** **CURRENT**

O. RULE OUT MEDICAL, ORGANIC OR DRUG CAUSES FOR ALL DISORDERS

IF THE PATIENT CODES POSITIVE FOR ANY CURRENT DISORDER ASK:

Just before these symptoms began:

O1a	Were you taking any drugs or medicines or in withdrawal from any of these?	❒ No	❒ Yes	❒ Uncertain
O1b	Did you have any medical illness?	❒ No	❒ Yes	❒ Uncertain
O2	IF O1a OR O1b IS CODED YES, IN THE CLINICIAN'S JUDGMENT IS EITHER LIKELY TO BE A DIRECT CAUSE OF THE PATIENT'S DISORDER? IF NECESSARY, ASK ADDITIONAL OPEN-ENDED QUESTIONS.			
O2 SUMMARY: HAS AN "ORGANIC" / MEDICAL / DRUG RELATED CAUSE BEEN RULED OUT?		❒ No	❒ Yes	❒ Uncertain

P. ANTISOCIAL PERSONALITY DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX AND CIRCLE NO)

P1 **Before you were 15 years old, did you:**

a	repeatedly skip school or run away from home overnight or stayed out at night against your parent's rules?	NO	YES
b	repeatedly lie, cheat, "con" others, or steal or broken into someone's house or car?	NO	YES
c	start fights or bully, threaten, or intimidate others?	NO	YES
d	deliberately destroy things or start fires?	NO	YES
e	deliberately hurt animals or people?	NO	YES
f	force someone into sexual activity?	NO	YES

➡

ARE **2** OR MORE **P1** ANSWERS CODED **YES**? NO YES

DO NOT CODE **YES** TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED**.**

P2 **Since you were 15 years old, have you:**

a	done things that are illegal or would be grounds to get arrested, even if you didn't get caught (for example destroying property, shoplifting, stealing, selling drugs, or committing a felony)?	NO	YES
b	often lied or "conned" other people to get money or pleasure, or lied just for fun?	NO	YES
c	been impulsive and didn't care about planning ahead?	NO	YES
d	been in physical fights repeatedly or assaulted others (including physical fights with your spouse or children)?	NO	YES
e	exposed others or yourself to danger without caring?	NO	YES
f	repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself?	NO	YES
g	felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property?	NO	YES

ARE **3** OR MORE **P2** QUESTIONS CODED **YES**?

NO	**YES**
ANTISOCIAL PERSONALITY DISORDER **LIFETIME**	

THIS CONCLUDES THE INTERVIEW

MOOD DISORDERS: DIAGNOSTIC ALGORITHM

Consult Modules:

A	Major Depressive Episode
C	(Hypo)manic Episode
K	Psychotic Disorders

MODULE K:

1a	IS **K11b** CODED YES?	NO	YES
1b	IS **K12a** CODED YES?	NO	YES

MODULES A and C:		Current	Past
2	a CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN **A3e** OR ANY PSYCHOTIC FEATURE IN **K1** THROUGH **K7**	YES	YES
	b CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN **C3a** OR ANY PSYCHOTIC FEATURE IN **K1** THROUGH **K7**	YES	YES

c Is a Major Depressive Episode coded YES (current or past)?
and
is Manic Episode coded NO (current and past)?
and
is Hypomanic Episode coded NO (current and past)?
and
is **"**Hypomanic Symptoms" coded NO (current and past)?
and
is **"**Rule out Organic Cause (O2 Summary)" coded YES?

Specify:

- If the depressive episode is **current** or **past** or both
- **With Psychotic Features** Current: If 1b or 2a (current) = YES
  With Psychotic Features Past: If 1a or 2a (past) = YES

MAJOR DEPRESSIVE DISORDER

	current	past
MDD	❑	❑

With Psychotic Features

Current	❑
Past	❑

d Is a Manic Episode coded YES (current or past)?

Specify:

- If the Bipolar I Disorder is **current** or **past** or both
- With **Single Manic Episode**: If Manic episode (current or past) = YES and MDE (current and past) = NO
- **With Psychotic Features** Current: If 1b or 2a (current) or 2b (current) = YES
  With Psychotic Features Past: If 1a or 2a (past) or 2b (past) = YES
- If the **most recent episode** is manic, depressed, or hypomanic or unspecified (all mutually exclusive)
- **Most Recent Episode Unspecified** if the Past Manic Episode is coded YES

AND

(If any current C3 symptoms are coded YES and current C3 Summary is coded NO)

OR

(If current C3 Summary is coded YES
AND
If current Manic Episode diagnostic box is coded NO current)

BIPOLAR I DISORDER

	current	past
Bipolar I Disorder	❑	❑
Single Manic Episode	❑	❑

With Psychotic Features

Current	❑
Past	❑

Most Recent Episode

Manic	❑
Depressed	❑
Hypomanic	❑
Unspecified	❑

Most Recent Episode

Mild	❑
Moderate	❑
Severe	❑

e Is Major Depressive Episode coded YES (current or past)
and
Is Hypomanic Episode coded YES (current or past)
and
Is Manic Episode coded NO (current and past)?

Specify:

- If the Bipolar Disorder is **current** or **past** or both
- If the most recent mood episode is **hypomanic** or **depressed** (mutually exclusive)
- **Most Recent Episode Unspecified** if the Past Manic / Hypomanic Episode is coded YES

AND

(If any current C3 symptoms are coded YES and current C3 Summary is coded NO)

OR

(If current C3 Summary is coded YES
AND
If current Hypomanic Episode diagnostic box is coded NO current)

BIPOLAR II DISORDER

	current	past
Bipolar II Disorder	❑	❑

Most Recent Episode

Hypomanic	❑
Depressed	❑
Hypomanic	❑
Unspecified	❑

Most Recent Episode

Mild	❑
Moderate	❑
Severe	❑

f Is MDE coded NO (current and past)
and
Is Manic Episode coded NO (current and past
and
Is C4b coded YES for the appropriate time frame
and
Is C8b coded YES?

---

or

Is Manic Episode coded NO (current and past)
and
Is Hypomanic Episode coded NO (current and past)
and
Is C4a coded YES for the appropriate time frame
and
Is C8c coded YES?

Specify if the Bipolar Disorder Unspecified is **current** or **past** or both.

BIPOLAR DISORDER UNSPECIFIED

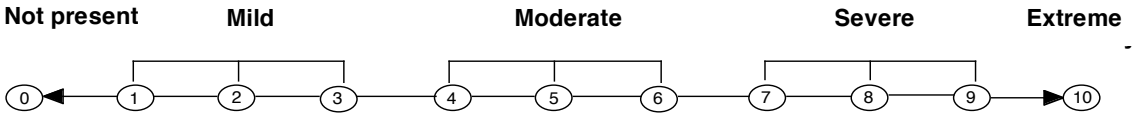
	current	past
Bipolar Disorder Unspecified	❑	❑

OPTIONAL ASSESSMENT MEASURES TO TRACK CHANGES OVER TIME

A: CROSS CUTTING MEASURES

SEVERITY OF SYMPTOM

Use this scale to rate the severity of your symptom in the score column in the table below:



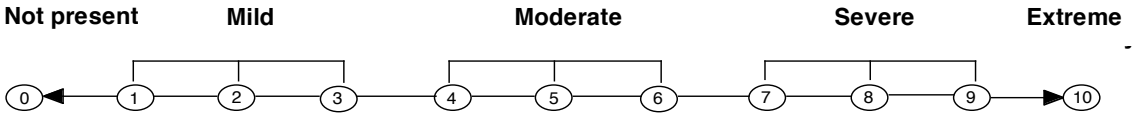
Assessment of Symptoms That Cut Across Disorders

	Symptom Name	Score
1	Depression	
2	Anger	
3	Mania (feeling up or high or hyper or full of energy with racing thoughts)	
4	Anxiety	
5	Physical (somatic) symptoms	
6	Suicidal thoughts (having ANY thoughts of killing yourself)	
7	Hearing sounds or voices others can't hear or fearing someone can hear or read your thoughts or believing things others don't accept as true e.g. that people are spying on you or plotting against you or talking about you (Psychosis)	
8	Sleep problems	
9	Memory problems	
10	Repetitive thoughts or behaviors	
11	Feeling things around you are strange, unreal, detached or unfamiliar, or feeling outside or detached from part or all of your body (Dissociation)	
12	Ability to function at work, at home, in your life, or in your relationships (Personality functioning)	
13	Overusing alcohol or drugs	

B: DISABILITY / FUNCTIONAL IMPAIRMENT

SEVERITY OF DISABILITY / IMPAIRMENT

Use this scale to rate in the score column of the table below, how much your symptoms have disrupted your ability to function in the following areas of your life:



Assessment of Impairment of Functioning /Disability

	Domain Name	Score
1	Work or school work	
2	Social life or leisure activities (like hobbies or things you do for enjoyment)	
3	Family life and / or home responsibilities	
4	Ability to get along with people	
5	Personal and social relationships	
6	Ability to understand and to communicate with others	
7	Ability to take care of yourself (washing, showering, bathing, dressing properly, brushing teeth, laundry, combing / brushing hair, eating regularly)	
8	Made you disruptive or aggressive towards others	
9	Financially (ability to manage your money)	
10	Ability to get around physically	
11	Spiritual or religious life	
12	How much did your condition have an impact on other people in your family?	

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M.I.N.I. PLUS

The shaded modules below are additional modules available in the MINI PLUS beyond what is available in the standard MINI. The un-shaded modules below are in the standard MINI.

These MINI PLUS modules can be inserted into or used in place of the standard MINI modules, as dictated by the specific needs of any study.

	MODULES	TIME FRAME		
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks) Past Recurrent		
	MAJOR DEPRESSIVE DISORDER	Current (2 weeks) Past Recurrent		
	MDE WITH MELANCHOLIC FEATURES	Current (2 weeks)		
	MDE WITH CATATONIC FEATURES	Current (2 weeks)		
	MDE WITH ATYPICAL FEATURES	Current (2 weeks)		
	MAJOR DEPRESSIVE DISORDER WITH PSYCHOTIC FEATURES	Current Past		
	MINOR DEPRESSIVE DISORDER (DEPRESSIVE DISORDER UNSPECIFIED)	Current (2 weeks) Past Recurrent		
	MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current (2 weeks) Past		
	SUBSTANCE INDUCED MOOD DISORDER	Current (2 weeks) Past		
AY	DYSTHYMIA	Current		
B	SUICIDALITY	Current (Past Month) Lifetime attempt	❒ ❒	❒ Low ❒ Moderate ❒ High
	SUICIDE BEHAVIOR DISORDER	Current In early remission	❒ ❒	(In Past Year) (1 - 2 Years Ago)
C	MANIC EPISODE	Current Past		
	HYPOMANIC EPISODE	Current Past		
	BIPOLAR I DISORDER	Current Past		
	BIPOLAR II DISORDER	Current Past		
	BIPOLAR DISORDER UNSPECIFIED	Current Past		
	BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current Past		
	MANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current (2 weeks) Past		
	HYPOMANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current (2 weeks) Past		
	SUBSTANCE INDUCED MANIC EPISODE	Current (2 weeks) Past		

	SUBSTANCE INDUCED HYPOMANIC EPISODE	Current (2 weeks) Past
	MOOD DISORDER UNSPECIFIED	Lifetime
D	PANIC DISORDER	Current (Past Month) Lifetime
	ANXIETY DISORDER WITH PANIC ATTACKS DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED ANXIETY DISORDER WITH PANIC ATTACKS	Current
E	AGORAPHOBIA	Current
F	SOCIAL ANXIETY DISORDER (Social Phobia)	Current (Past Month) Generalized Non-Generalized
FA	SPECIFIC PHOBIA	Current
G	OBSESSIVE-COMPULSIVE DISORDER (OCD)	Current (Past Month)
	OCD DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED OCD	Current
H	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)
HL	POSTTRAUMATIC STRESS DISORDER	Lifetime
I	ALCOHOL USE DISORDER	Past 12 Months
IL	ALCOHOL USE DISORDER	Lifetime
J	SUBSTANCE DEPENDENCE (Non-alcohol) SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months Past 12 Months
JL	SUBSTANCE USE DISORDER (Non-alcohol)	Lifetime
K	PSYCHOTIC DISORDERS	Lifetime Current
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Current
	SCHIZOPHRENIA	Current Lifetime
	SCHIZOAFFECTIVE DISORDER	Current Lifetime
	SCHIZOPHRENIFORM DISORDER	Current Lifetime
	BRIEF PSYCHOTIC DISORDER	Current Lifetime
	DELUSIONAL DISORDER	Current Lifetime
	PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current Lifetime
	SUBSTANCE INDUCED PSYCHOTIC DISORDER	Current Lifetime

	PSYCHOTIC DISORDER UNSPECIFIED	Current Lifetime
L	ANOREXIA NERVOSA	Current (Past 3 Months)
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current
	ANOREXIA NERVOSA, RESTRICTING TYPE	Current
M	BULIMIA NERVOSA	Current (Past 3 Months)
	BULMIA NERVOSA, PURGING TYPE	Current
	BULMIA NERVOSA, NON-PURGING TYPE	Current
MB	BINGE-EATING DISORDER	Current (Past 3 Months)
N	GENERALIZED ANXIETY DISORDER (GAD)	Current (Past 6 Months)
	GAD DUE TO A GENERAL MEDICAL CONDITION SUBSTANCE INDUCED GAD	Current Current
O	SOMATIZATION DISORDER	Current Lifetime
P	HYPOCHONDRIASIS	Current
Q	BODY DYSMORPHIC DISORDER	Current
R	PAIN DISORDER	Current
S	CONDUCT DISORDER	Current (past 12 months)
T	ATTENTION DEFICIT/ HYPERACTIVITY DISORDER	Current (Past 6 months) (Children /Adolescents)
	ADHD COMBINED	
	ADHD INATTENTIVE	
	ADHD HYPERACTIVE / IMPULSIVE	
TA	ATTENTION DEFICIT/ HYPERACTIVITY DISORDER	Current (Past 6 months) (Adults)
	ADHD COMBINED	
	ADHD INATTENTIVE	
	ADHD HYPERACTIVE / IMPULSIVE	
U	PREMENSTRUAL DYSPHORIC DISORDER	Current
V	MIXED ANXIETY DEPRESSIVE DISORDER	Current
W	ADJUSTMENT DISORDERS	Current
X	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT	
Y	ANTISOCIAL PERSONALITY DISORDER	Lifetime

For Schizophrenia and psychotic disorder studies and for psychotic disorder subtyping in clinical settings, use the MINI for Psychotic Disorders instead of the standard MINI. For many clinical settings this level of psychotic disorder subtyping detail is not necessary.
For children and adolescents, use the MINI Kid or the MINI Kid Parent of the MIN Kid for Psychotic Disorders.
A computerized version of the MINI is available from Medical Outcomes Systems https://www.medical-outcomes.com

Appendix D

ID:
Date:
Visit: BL 4 8 1mo. 3mo. 6mo.

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Baseline/Screening Version

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@childpsych.columbia.edu

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 6 Months
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

	Most Severe	Most Severe
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***) Past X Months - ***Most Severe Ideation:*** _____ (***Type # (1-5)***) _____ (***Description of Ideation***)		
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 6 Months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted 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 _____	**Yes** ☐ **No** ☐ Total # of aborted _____
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** ☐	**Yes** ☐ **No** ☐
Suicidal Behavior: Suicidal behavior was present during the assessment period?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

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

Appendix E

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND T.R., P.R., and K.W., on behalf of themselves and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc., Plaintiffs, v. South Carolina Department of Corrections and William R. Byars, Jr., as Agency Director of the South Carolina Department of Corrections Defendants.	IN THE COURT OF COMMON PLEAS FIFTH JUDICIAL CIRCUIT C/A No.: 2005-CP-40-2925 **ORDER GRANTING JUDGMENT IN FAVOR OF PLAINTIFFS**

It has been the privilege of this writer to serve the State of South Carolina as a general jurisdiction judge for fourteen years. At the time this case was heard, Court Administration reported there were more than 5,000 new case filings per year for each of our state's circuit court judges. Thus, over 70,000 cases of every imaginable sort have come to this Court over the years. This case, far above all others, is the most troubling.

This case is a class action brought on behalf of approximately 3.500 state inmates who meet the definition of being seriously mentally ill. For purposes of this suit, the term "serious mental illness" was specifically defined in the Class Certification order dated November 1, 2007, and may be succinctly stated as all SCDC inmates from the date of the filing of the complaint who have been hospitalized for psychiatric services, referred to an Intermediate Mental Health Care Services Unit, or diagnosed by a psychiatrist with the following mental illness: Schizophrenia, Schizoaffective Disorder, Cognitive Disorder, Paranoia, Major Depression, Bipolar Disorder, Psychotic Disorder, or any other mental condition that results in significant

functional impairment including inability to perform activities of daily living, extreme impairment of coping skills, or behaviors that are bizarre and/or dangerous to self or others. Plaintiffs claim that their treatment within SCDC, or lack of treatment, constitutes a violation of the state constitution.

The evidence in this case has proved that inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness. As a society, and as citizen jurors and judges make decisions that send people to prison, we have the reasonable expectation that those in prison – even though it is prison – will have their basic health needs met by the state that imprisons them. And this includes mental health. The evidence in this case has shown that expectation to be misplaced in many instances.

Economic downturn and financial pressures have brought great change to our country. One of these is that the various state departments of corrections are now more than ever the collection place of the seriously mentally ill among the citizenry. The incidence of serious mental illness within the general population is less than four (4%) percent[1]. In the typical Department of Corrections, it is between 15 and 20 percent. In South Carolina, the evidence in this case shows it to be approximately 17 percent, in spite of the Department's claim that it is 12.9 percent. If 17 percent of the prison population had advanced cancer and there was inadequate and in some cases nonexistent treatment for cancer in prison, the public would be outraged. Yet this is the case for serious mental illness.

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[1] Figures vary depending upon the source, demographics, and differences in various definitions of "serious mental illness." The Court takes judicial notice of the statistical findings of the National Institute of Mental Health, which places the general population figure at 3.9%. Further statistical information may be obtained from the NIH at www.nimh.nih.gov/statistics/SMI_AASR.shtml.

This litigation does not occur in a vacuum. What happens at the Department of Corrections impacts all of us, whether it is from the discharge of untreated seriously mentally ill individuals from prison into the general population, or tremendously increased costs for treatment and care that might have been prevented, or the needless increase in human suffering when use of force replaces medical care. The decisions of our Courts reflect the values of our society. To that end, our state can no longer tolerate a mental health system at the South Carolina Department of Corrections that has broken down due to lack of finances and focus.

While the Court finds the inadequacy of the mental health system at SCDC has not occurred by design, but instead by default, the Court further finds this decision in favor of Plaintiffs should not come as a shock to SCDC. Previous internal and external reviews of the SCDC mental health system have found multiple inadequacies and failures. Despite its knowledge of the grave risks these deficiencies pose to mentally ill inmates, SCDC has failed through the years to take reasonable steps to abate those risks. The Court recognizes that the Department is underfunded and understaffed in many particulars, not just mental health services delivery. The operation of any state agency is a matter of competing priorities, and the General Assembly, as keeper of the public purse, is not in a position to excessively fund any entity. Thus, this decision will ultimately require an increase in priority for mental health services commensurate with the level of serious mental illness within the prison population.

DECISION

In its prior Order Setting Forth Applicable Constitutional Standards ("Standards Order"), the Court delineated the standard of liability and burden of proof applicable to Plaintiffs' constitutional claim under Article I, § 15 of the South Carolina Constitution, which prohibits "cruel and unusual punishment." To prevail on a claim under Article I, § 15, the Court stated

that Plaintiffs must prove that Defendants acted with "deliberate indifference to serious medical needs of prisoners." Standards Order at 3 (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). This deliberate indifference standard contains both an objective and subjective component. *See Farmer v. Brennan*, 511 U.S. 825, 834-37 (1994). To satisfy the objective component, Plaintiffs must demonstrate that they are subjected to a substantial risk of harm that is sufficiently serious. *Id.* The objective component is not limited to past harm, but also protects inmates from an unreasonable risk of future harm. *Helling v McKinney*, 509 U.S. 25, 35 (1993). Plaintiffs may satisfy the objective component by showing that systemic deficiencies in a prison mental health system expose inmates with serious mental illness to a substantial risk of serious future harm. Standards Order at 7-8, *citing Helling*; 509 U.S. at 35; *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Flynn v. Doyle*, 2009 WL 4262746 at *19 (E.D. Wis. 2009); *Madrid v. Gomez*, 889 F. Supp. 1146, 1256 (N.D. Cal. 1995); *Neiberger v. Hawkins*, 208 F.R.D. 301, 317 (D. Colo. 2002).

The Court noted the need for guideposts in determining whether Plaintiffs satisfied the objective component of the deliberate indifference standard. Accordingly, within this legal framework, the Court identified and articulated six factors that would serve as benchmarks for determining whether SCDC's mental health program exposed mentally ill inmates to a substantial risk of serious harm. Stated succinctly, the evidence at trial should establish whether the SCDC mental health services system contained the following adequately functional components:

1. A systematic program for screening and evaluating inmates to identify those in need of mental health care;

2. A treatment program that involves more than segregation and close supervision of mentally ill inmates;

3. Employment of a sufficient number of trained mental health professionals;

4. Maintenance of accurate, complete, and confidential mental health treatment records;

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation; and

6. A basic program to identify, treat, and supervise inmates at risk for suicide.

Standards Order at 8-10, *citing Ruiz v. Estelle,* 503 F. Supp. 1265, 1339 (S.C. Tex. 1980) *aff'd in part, rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part,* 688 F.2d 266 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983).

Employing these factors in the context of the objective component of the deliberate indifference standard, the Court finds by a preponderance of the evidence that the Plaintiffs have met the burden of proof and makes the following threshold findings.

First, the mental health program at SCDC is severely understaffed, particularly with respect to mental health professionals, to such a degree as to impede the proper administration of mental health services. This deficiency has a substantial impact on every aspect of the mental health program, beginning at Reception and Evaluation ("R&E"), where inmates are screened and evaluated for mental health needs, continuing into the treatment programs for seriously mentally ill inmates, and ending with deficient discharge planning for seriously mentally ill inmates being returned to the general public.

Second, seriously mentally ill inmates are exposed to a disproportionate use of force and segregation (solitary confinement) when compared with non-mentally ill inmates. Segregation and use of force are often used in lieu of treatment, with severe consequences for inmates with

serious mental illness. The inappropriate and extended reliance on segregation to manage inmates with serious mental illness, particularly those in crisis, exposes them to a substantial risk of serious harm by limiting their access to mental health counselors and psychiatrists, disturbing their eating and sleeping cycles, disrupting the administration of medications, and deepening their mental illnesses. These conditions have contributed to the deaths of multiple inmates in segregation, while placing other inmates and staff at risk. They have also led to the stigmatization of mental illness within SCDC that discourages inmates from seeking the limited mental health care the agency does provide.

Third, mental health services at SCDC lack a sufficiently systematic program that maintains accurate and complete treatment records to chart overall treatment, progress, or regression of inmates with serious mental illness.

Fourth, SCDC's screening and evaluation process is ineffective in identifying inmates with serious mental illness and in providing those it does identify with timely treatment.

Fifth, SCDC's administration of psychotropic medications is inadequately supervised and evaluated.

Sixth, SCDC's current policies and practices concerning suicide prevention and crisis intervention[2] are inadequate and have resulted in the unnecessary loss of life among seriously mentally ill inmates.

As a result of the above findings, the Court further finds that SCDC's mental health system exposes seriously mentally ill inmates to a substantial risk of serious harm and Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

[2] "Crisis intervention" refers to SCDC's response to an actively mentally ill inmate who poses an immediate danger and must be sequestered for his own protection or the protection of other inmates and correctional officers.

The subjective component is met by proof that a defendant "knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer*, 511 U.S. at 834-837. At trial, the Plaintiffs presented overwhelming evidence that SCDC has known for years that its policies and practices expose seriously mentally ill inmates to a substantial risk of serious harm but has failed to take reasonable measures to abate that risk. The Court finds, therefore, that the Plaintiffs have satisfied the subjective component of the deliberate indifference standard.

As a result of the above findings, the Court grants judgment in favor of the Plaintiffs.

Below, the Court has separated the remainder of this Final Order into two sections. The first section articulates the factual findings and conclusions underlying the Court's decision with respect to the objective component by examining each of the six *Ruiz* factors listed above. The first section then articulates the factual findings and conclusions related to the subjective component. The findings made therein are by a preponderance of the evidence. Section Two then addresses the remedy the Court will grant in this case and the mechanism used to achieve it.

With regard to the factual findings and conclusions mentioned below in Section One, there are several references to individual circumstances involving specific inmates. The Department argued at trial that reference to an individual inmate and his/her particular situation was anecdotal and not indicative of the general administration of mental health services. Moreover, counsel for SCDC essentially argued that some of the specific inmate situations were "outliers" in that such was a constellation of unique events and circumstances that brought about an unfortunate result. The Court specifically rejects that argument. While no system involving thousands of inmates is expected to be perfect, the Court finds that the individual circumstances

referred to below are the result of a system that is inherently flawed in many respects, understaffed, underfunded, and inadequate.

I. FACTUAL FINDINGS/DISCUSSION

A. Objective Component

1. A systematic program for screening and evaluating inmates to identify those in need of medical care

As of 2011, 12-13 percent of the SCDC inmate population had been diagnosed by SCDC with a mental illness and was on the Department's mental health caseload. From that data, with a total inmate population at the time of trial of 23,306, a 12.9 percent fraction yields an approximate figure of 3,006 inmates that have been diagnosed as mentally ill.[3] Based on universally accepted national statistics, evidence presented to the Court at trial strongly indicates this percentage should be much higher. Multiple studies conducted nationwide suggest that a more accurate percentage of inmates with a serious mental illness should be somewhere in the range of 15 to 20 percent. SCDC's expert, Dr. Scott Haas, testified that seriously mentally ill inmates ordinarily comprise 18 percent of a prison population. Plaintiffs' expert, Dr. Raymond F. Patterson, testified that after detailed analysis, 17 percent was a conservative estimate of SCDC's seriously mentally ill population, and the Court finds the basis of his analysis to be credible.

The Court further finds this low, acknowledged percentage of mentally ill inmates at SCDC troubling because it indicates a high likelihood that there are hundreds of inmates with a serious mental illness at SCDC who are not receiving any treatment due to deficiencies in the screening and evaluation process used to identify and classify those with a serious mental illness.

[3] Exact numbers fluctuate due to the constant intake and release of inmates.

This low identification of mentally ill inmates has a synergistic impact on the mentally ill population, as it leads to a reduction in mental health professionals, the further disproportionate cutting of costs in difficult economic times within the mental health system because of a perceived lack of need for services, and a skewed analysis as to the efficacy of the existing mental health system. R&E serves as the intake facility for inmates entering into SCDC. If inmates with mental illnesses are not identified and appropriately classified at R&E, the Court finds that these inmates face a substantial risk of serious harm.

In addition to the concerns mentioned above, there was also evidence presented to the Court of regular violations of the SCDC mental health policy, two of which are particularly relevant to the Court as they relate to the screening and evaluation process at R&E. First, SCDC policy requires that a mental health counselor must meet with an inmate within 48 hours of the inmate being assigned to that counselor's caseload. At trial, there was evidence submitted to the Court of regular and persistent violations of this policy. Second, inmates are not being seen by a psychiatrist within thirty days of the counselor's initial assessment when a need for psychiatric treatment is indicated, also a violation of SCDC policy. Consequently, this results in inmates who are referred to a psychiatrist at R&E, but are then transferred into SCDC general population prior to assessment by that psychiatrist, creating a risk of harm for all inmates.

The Court finds, due to the concerns listed above, that the program used by SCDC for screening and evaluation fails to adequately identify and classify those inmates suffering from serious mental illness, thereby exposing them to a substantial risk of serious harm.

2. <u>A treatment program that involves more than segregation and close supervision of mentally ill inmates</u>

a. <u>Segregation</u>

The treatment program at SCDC places heavy reliance on segregation and use of physical force against seriously mentally ill inmates, as opposed to treatment.

Mentally ill inmates are substantially overrepresented in segregation units, known as Special Management Units ("SMU"), within SCDC. Inmates in segregation stay in solitary confinement in their cells 23-24 hours a day. Visitation, telephone, and other privileges are significantly restricted. As of September 2011, the percentage of mentally ill inmates in SMUs at the three SCDC institutions where the majority of men with serious mental illness are assigned ("Area Mental Health Institutions") demonstrates the disproportionate use of segregation to which members of the Plaintiff class are subjected. At Lee Correctional Institution ("Lee"), 16 percent of the total inmate population was mentally ill, yet 27 percent of its inmates in SMU were mentally ill.[4] The corresponding numbers at Perry Correctional Institution ("Perry") were 24 percent and 40 percent. At Lieber Correctional Institution ("Lieber"), the differential was even greater, where mentally ill inmates comprised 20 percent of all inmates, yet 42 percent of the inmates that were in segregation. During this same period, the percentage of mentally ill inmates in SMUs in all SCDC institutions was 23 percent, even though they represented less than 13 percent of the total inmate population.

Taking the entire population into consideration, a mentally ill inmate is twice as likely to be placed in segregation as a non-mentally ill inmate. As of September 2011, 16 percent of inmates on the mental health caseload were in SMUs in contrast with 8 percent of non-mentally ill inmates. For security detention, the most restrictive form of segregation, where inmates are placed in solitary confinement for indefinite periods, mentally ill inmates are more than three

[4] These percentages are based on the SCDC mental health caseload.

times more likely to be assigned this status than other inmates, at a rate of 8.7 percent compared with 2.8 percent.[5]

Not only are mentally ill inmates overrepresented in SMUs, they also spend disproportionately longer periods of time in the SMUs. For many mentally ill inmates, this period of isolation in SMU has lasted for several years. For example, the average cumulative disciplinary detention sentence for inmates with mental illness as of January 13, 2012 was 647 days, compared to 383 days for non-mentally ill inmates. These averages include extremely long periods of segregation for inmates whose disciplinary detention sentences exceeded their projected release date from SCDC. Again, these extended sentences were meted out against mentally ill inmates at over twice the rate of other inmates. The lengths of these sentences in segregation were also far greater for members of the Plaintiff class, exceeding their projected release date on average by 1,968 days or 5.39 years, compared with 1,065 days or 2.92 years for other inmates. Of the ten longest periods of disciplinary detention sentences beyond projected release dates, nine of the inmates were mentally ill. Their cumulative sentences for solitary confinement ranged from 20-36 years.

The evidence showed that these extended periods of segregation too often reflect the accumulation of disciplinary detention sentences for non-assaultive behavior of mentally ill inmates. For example, one 51-year-old mentally ill inmate who had been hospitalized at SCDC's psychiatric facility accumulated 19 years of disciplinary detention sentences from 2005-2008. For one non-assaultive offense in which he threatened harm, he received 999 days of disciplinary detention and lost visitation for three years. In interviews with Plaintiffs' experts, he was

[5] The two principal forms of punitive segregation are security detention and disciplinary detention. Disciplinary detention consists of sentences served in segregation for a specific period of time for violation of SCDC administrative rules. Security detention is a classification assigned to inmates determined to present a particular risk to other inmates or staff that often remains in effect for periods lasting several years.

distressed that he was being denied "400 million dollars in his bank" and was set to appear on the television program "The Rich and Famous."

A 27-year-old female mentally ill inmate accumulated six and a half years of disciplinary detention segregation and lost access to the telephone and visitation for eight years for non-assaultive offenses, most of which were verbal or profane threats to staff or other inmates. One of the charges was prompted when she threatened two inmates who were making derogatory remarks about a medical condition that required her to wear diapers.

The evidence revealed that the great majority of the extreme periods in segregation are in fact served. For example, Leslie Cox, a member of the Plaintiff class, was confined in SMU for at least 2,565 consecutive days, from February 2001 - February 2008. James Wilson, another mentally ill inmate, was confined in SMU for at least 2,491 consecutive days.[6] SCDC records provide conflicting information about mentally ill inmate Rowland Dowling, who spent either 1,777 or 2,200 consecutive days in solitary. Other mentally ill inmates were confined in solitary for similarly lengthy periods.

SCDC's Guilty But Not Accountable ("GBNA") policy should theoretically reduce the number of mentally ill inmates in segregation but, in fact, has had a negligible effect. SCDC counselors are responsible for recommending findings of GBNA but this Court finds that, as Dr. Patterson testified, many SCDC counselors are not qualified to analyze accountability. Only 2 percent of mentally ill inmates receiving segregation sentences are determined to meet GBNA criteria.[7] Moreover, of those found to be GBNA, the finding has had no effect on their

[6] SCDC records indicate that inmates Cox and Wilson were still in segregation as of February 25, 2008. It is unknown how much longer they remained in segregation after that date.

[7] Evidence introduced by Plaintiffs also showed that a small percentage of the disciplinary detention sentences for male mentally ill inmates at Area Mental Health Institutions were reduced or waived during a 21-month review period between 2010 and 2011.

sentences. Of all inmates in SCDC custody on September 1, 2011 who had been found GBNA, 25 were mentally ill. Despite being found "not accountable," all 25 had been sentenced to segregation.

The American Correctional Association ("ACA") defines disciplinary detention or punitive segregation as follows:

> A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined by the disciplinary committee or other authorized group for ***short periods of time*** to individual cells separated from the general population.

ACA *Standards for Adult Correctional Institutions Supplement*, p. 306 (2008) (emphasis added).

The ACA standards also recognize the potentially harmful effects of punitive segregation on the mental health of any inmate:

> Inmates whose movements are restricted in segregation units may develop symptoms of acute anxiety or other mental health problems; regular psychological assessment is necessary to ensure the mental health of any inmate confined in such a unit beyond 30 days.

ACA *Standards for Adult Correctional Institutions*, 3rd Edition, Standard 3-4244 (2008).

The evidence presented by Plaintiffs demonstrates that SCDC consistently showed little to no regard for the mental health of inmates in imposing periods of disciplinary or security detention, in the lengths of the segregation imposed, or in the effects on mentally ill inmates. The Department's practice consistently violates the ACA standards. Neither the disciplinary detention sentences nor classifications in security detention are for short periods of time. Once in segregation, the level of therapeutic care or intervention to address the needs of mentally ill inmates is grossly inadequate.

Dr. Janet Woolery, the principal psychiatrist at Lee, estimated that approximately 40-50 percent of the Lee SMU inmates she saw were demonstrating active psychotic symptoms.

Rather than placing mentally ill inmates into treatment programs, it appears that they are merely placed in SMUs. SMU patients receive no group therapy and sessions with both psychiatrists and mental health counselors are seldom held in a confidential setting. Sixty-three percent of the counselor audits produced by SCDC noted deficiencies for untimely psychiatric sessions and 77 percent noted deficiencies for untimely counselor assessments. Patient medical records provide further evidence that SMU patients often do not see psychiatrists or counselors on a timely basis. For example, SCDC policy requires that Edward Barton, diagnosed with schizophrenia and classified as an Area Mental Health patient, be seen by a mental health counselor at least once every 30 days, as well as by a psychiatrist at least once every 90 days. Yet, from July 2008 – November 2010, while confined in an SMU, Barton on six occasions went over 30 days without seeing a counselor; on four of those occasions he went over 60 days without seeing a counselor; and once he went 9 months without seeing a counselor. From September 2010 – August 2011, Barton twice went over 120 days without seeing a psychiatrist and once went over 6 months.

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SCDC's heavy reliance on segregation of mentally ill inmates raises serious concerns for the Court. As acknowledged by SCDC Mental Health Regional Coordinator Jacqueline Strong, risk factors for psychosis and suicide increase while an inmate is in SMU. It is not uncommon for an inmate in SMU to develop depression and experience a disturbance in eating and sleeping cycles.[8]

[8] Defendants relied upon a Colorado Department of Corrections study to assert that long-term segregation has no significant detrimental effect on mental health. However, the Court finds that the Colorado study is distinguishable from the situation at SCDC for two reasons. First, the Colorado study was limited to inmates who had spent no more than twelve consecutive months in segregation. Many SCDC mentally ill inmates stay in segregation for much longer periods of time. Second, the Colorado study was expressly limited to SMUs with substantially similar conditions to the Colorado State Penitentiary. Plaintiffs' two psychiatric experts, Dr. Metzner and Dr. Patterson, each testified they were familiar with the Colorado State Penitentiary and that conditions in SCDC segregation units were much harsher. As Dr. Patterson testified, the difference was like "night and day."

Moreover, evidence in the case shows conditions in SMUs fall below what is acceptable for a 21st century correctional institution. SMU cells are both extremely cold and inordinately filthy, often with the blood and feces of previous occupants smeared on the floor and walls.

Within the SMU of Lee Correctional Institution is a special 8-cell unit known as "Lee Supermax." On February 7, 2008, inmate Jerome Laudman was transferred to a cell in Lee Supermax. Laudman was schizophrenic, intellectually disabled, and had a speech impediment. According to his mental health counselor, he was neither aggressive nor threatening. No one notified the counselor of Laudman's transfer to Lee Supermax. According to an internal SCDC investigative report, Laudman was sprayed with chemical munitions and physically abused by a correctional officer during the transfer to Lee Supermax. The move was videotaped pursuant to policy, but when viewed by the SCDC investigator, the tape was, inexplicably, mostly blank. Laudman was stripped naked and left in a completely empty Supermax cell.

On February 11, a correctional officer observed that Laudman was sick and weak but did not report it. At some point after February 11, Laudman stopped eating and taking medication. On the morning of February 18, a correctional officer saw Laudman lying on the cell floor in feces and vomit. He lay there "all morning," according to the SCDC investigative report. At approximately 1:30 or 2:00 p.m., two nurses were called. They reported that, in addition to feces and vomit, 15-20 trays of rotting, molding food were in the cell. Both the nurses and the correctional officers refused to retrieve the body. After a further delay, two inmates came to retrieve Laudman, who was unconscious but alive. Later that afternoon, however, he died in a local hospital ER of a heart attack. The hospital report noted the presence of hypothermia. The SCDC investigator found evidence of an attempted cover-up by correctional officers who cleaned Laudman's cell before photographs could be taken. Even after the cleaning, the

photographs taken by the investigator show the cell in a deplorably dirty state. After Laudman's death, SCDC did no quality improvement reviews of Lee Supermax procedures and practices. In September 2008, seven months after Laudman's death, Dr. Metzner and Dr. Patterson inspected Lee Supermax and described it as "filthy."

b. Use of force

Mentally ill inmates also suffer from disproportionate, unnecessary, and excessive uses of force.

i. Disproportionate Use of Force. Between January 2008 and September 2011, mentally ill inmates were subjected to uses of force at a rate two and half times greater than non-mentally ill inmates. During this period, 27 percent of the Plaintiff class was subjected to the use of force in contrast to only 11 percent of other inmates. At the Area Mental Health Institutions for men, the reliance on use of force was even greater. At Lee, Lieber, and Perry, 40 percent, 43 percent, and 44 percent of mentally ill inmates were subjected to force, respectively, while the corresponding numbers of non-mentally ill inmates subjected to force at these institutions were 23 percent, 21 percent, and 16 percent, respectively. Although force was applied far less frequently at Camille G. Graham Correctional Institution ("Graham"), the Area Mental Health Institution for women, the same pattern was present. During the relevant review period, only fourteen use-of-force incidents were reported; however, ten of these incidents were directed toward mentally ill women, even though members of the Plaintiff class constituted less than half of the total inmates at Graham.

The evidence was clear and compelling that SCDC resorts to use of force in the agency's attempt to manage the conduct of mentally ill inmates. Of the inmates who were subjected to use of force, each mentally ill inmate who had been the object of a reported use of force during this

period was subjected on average to 3.35 separate incidents, while the use-of-force rate for other inmates was almost half that, at 1.72 incidents per inmate.

Of the thirty inmates most frequently subjected to the use of force, twenty-six were on the mental health caseload. The mental health conditions were so serious for many of these individuals that fifteen of the twenty-six required hospitalization during the same period at Gilliam Psychiatric Hospital ("Gilliam" or "GPH"). Ten of these fifteen inmates were hospitalized on multiple occasions. James Howard was subjected to 81 separate use-of-force incidents. Mr. Howard was hospitalized for psychiatric treatment on five separate occasions during this same period between January 2008 and September 2011.

SCDC's overreliance on the use of force in attempting to manage mentally ill inmates is, in part, a direct effect of the lack of training correctional officers receive. SCDC training coordinator Yolanda Delgado testified in deposition only twelve days before trial that "less than a handful" of correctional officers attended training sessions intended to improve the staff's knowledge and skills in dealing with mentally ill inmates.

ii. Unnecessary and Excessive Use of Force. Plaintiffs' corrections expert, Steve J. Martin, testified that while SCDC's use-of-force policy was consistent with national correctional standards, its use-of-force practices were not. Based on his review of over 1,000 incident reports at SCDC involving OC spray (pepper spray), Mr. Martin testified a pattern and practice existed that violated national standards and SCDC's own use-of-force policy. First, Mr. Martin testified in detail about eighteen case examples at SCDC of the unnecessary use of force where no threat of harm or other urgent circumstances were present and, in some cases, where OC spray was used simply as punishment. Mr. Martin testified, and the Court finds, that these cases were representative of the more than 1,000 incidents he

reviewed. Second, Mr. Martin found it common for SCDC correctional officers to use excessive force. For example, contrary to SCDC policy, SCDC officers routinely gas inmates with OC spray in amounts that exceed manufacturer instructions and at closer distances than the manufacturer directs. Mr. Martin identified nine case examples, documented in SCDC reports, where SCDC officers had used MK-9 crowd control fogger devices in large disbursements in individual closed cells, again contrary to manufacturer instructions and SCDC policy. In fact, Mr. Martin testified that having reviewed thousands of uses of OC spray in prisons and jails throughout the country, he had "never seen MK-9, a crowd control contaminant, so frequently used by a correctional force inappropriately." The use of such force is without penalogical justification.

SCDC's unnecessary and excessive use of OC spray on mentally ill inmates is consistent with its unnecessary and excessive use of physical restraints. Contrary to its policy and national correctional standards, SCDC places inmates in restraint chairs for predetermined blocks of time in set, four-hour increments.[9] For example, on December 12, 2007, inmate Steven Patterson was transferred to Perry from Gilliam but, by SCDC's mistake, with only five days' worth of psychotropic medications. On January 2, 2008, Patterson's medical record noted that he had not received medication since December 17, 2007 "and he's not doing well." That same day, he cut himself with a plastic spoon and was placed naked in a restraint chair for twelve hours, even though the videotape of his time in the chair shows him calm and cooperative. On January 3, he was returned to Gilliam.

[9] SCDC witnesses testified this practice was changed shortly before the start of this trial so that inmates no longer will be placed in restraint chairs for predetermined blocks of time. The timing of this change concerns the Court, however, for "practices may be reinstated as swiftly as they were suspended." *Thomas v. Bryant*, 614 F.3d 1288, 1320 (11th Cir. 2010).

Mr. Patterson's experience was only one example of how SCDC uses restraint chairs as a substitute for medical treatment. Plaintiffs entered into evidence two gruesome SCDC videotapes of inmates with self-inflicted wounds who were kept in the restraint chair for extended periods of time before receiving adequate medical treatment. Inmate Jerod Cook cut himself on his arm. Approximately 90 minutes after being discovered, he was placed in a restraint chair where he remained for four hours. The videotape shows a pool of blood on the floor of Mr. Cook's cell. He is hardly able to stand before being placed in the restraint chair. He continues to bleed while in the restraint chair and pleads with correctional officers for medical help. As Dr. Patterson testified, the decision by security staff – rather than by medical staff – to keep Mr. Cook in a restraint chair for four hours under those conditions was an "outrageous, horrific response."

Inmate Baxter Vinson underwent a similar experience, cutting himself in the abdomen while in his cell. Approximately three hours and twenty minutes after his wound was discovered, security staff placed him in a restraint chair where he remained for approximately two hours before being transported to a hospital. The videotape shows that while in the restraint chair, Mr. Vinson is eviscerating, with his intestine coming out of the abdominal wall. The tape shows correctional officers tightening the restraints, thereby putting additional pressure on his abdomen. As Dr. Patterson testified, this was a medical emergency that required a sterile environment. The videotape gives further evidence of what Dr. Patterson characterized as "a broken system."

Inmates are often placed naked in restraint chairs. Bathroom breaks are infrequent, so that at times they are forced to urinate in the chair. A common practice at Perry when placing inmates in a restraint chair is to secure them in a painful, "crucifix" position, demonstrated to

Mr. Martin both by Perry correctional officers and inmates. Inmates Richard Patterson and Jonathan Roe both testified about spending hours in what they characterized as the "Jesus" position.

OC spray and restraint chairs are not the only methods of physical force employed by SCDC against mentally ill inmates. Shawn Wiles, a mentally ill inmate in SCDC's Maximum Security Unit, testified that correctional officers restrained his arms in a twisted position, soaked him with water, and left him outside for approximately an hour on a cold December night.

While SCDC contends these are isolated examples of inappropriate conduct by correctional officers, it offered little or no evidence of effective supervisory oversight of the use of force. Mr. Martin testified that one of the standard protections prison systems use to guard against excessive use of force is review of use-of-force incidents. The first element of an effective review process is an examination of the cases that are referred to senior management for review of questionable uses of force. The second element consists of an assessment of the findings concerning allegations of inappropriate force and corrective actions taken. Of the more than one thousand cases Mr. Martin reviewed, very few were referred to senior SCDC officials to assess an alleged inappropriate use of force. Mr. Martin found that of the few cases that were referred, SCDC officials made virtually no findings of excessive or unnecessary force.

In a prison system of more than 23,000 inmates, Mr. Martin testified that the almost complete absence of the identification by managers of inappropriate uses of force is a "huge red flag" that raises serious questions about the existence of an effective system to manage the use of force by correctional officers. Mr. Martin testified that the risk of harm to mentally ill inmates from the unnecessary and excessive use of force, if left unattended and not corrected, is ongoing

and substantial. The Court finds Mr. Martin's testimony, and the bases for his opinions, to be credible.

The Court is concerned by the absence of referrals for investigation of the cases presented by Mr. Martin, and the absence of findings by senior SCDC managers that those cases raise serious questions about the application of force against mentally ill inmates. The Court finds that such excessive uses of force have been largely unreported, uninvestigated, and unmanaged. The Court further finds that Plaintiffs have proven a pattern and practice of the use of unnecessary and excessive force.

c. Limited involvement of psychiatrists

A substantial contributing factor to the lack of an effective treatment program is the limited involvement of psychiatrists in creating and administering treatment plans for mentally ill inmates. Psychiatrists at SCDC have no administrative or policy-making duties, and there is evidence that they do not attend meetings to create and develop treatment plans for inmates. The Court finds that psychiatrists, as the lead mental health professionals in the mental health program, must be more directly involved in creating and developing treatment plans. Furthermore, deposition testimony of some psychiatrists reveals an alarming lack of knowledge of policies and procedures at SCDC, the levels of care and criteria for referral to a particular level of care, and the role of the counselor in the mental illness treatment process. For example, SCDC psychiatrist Dr. Poiletman did not know what the terms SMU and CI stood for – meaning Special Management Unit and Crisis Intervention – terms inextricably tied to mentally ill inmates at SCDC. He did not know the difference between Area Mental Health patients and outpatients, did not know what mental health counselors do, and had "no idea" who drafted treatment plans. Likewise, Dr. Crawford, the principal psychiatrist at Graham, could not

describe the distinction between an Intermediate Care Services patient and an Area Mental Health Patient. She did not review treatment plans and did not start attending treatment team meetings until after her deposition. Dr. Woolery, the principal psychiatrist at Lee, was unfamiliar with treatment plans, did not know whether any of her patients were in Lee Supermax, and had never seen Lee Supermax herself. The Court finds these examples both illuminating and disturbing. For psychiatrists and other mental health staff at SCDC to provide effective services, they must have a more intimate knowledge of the processes and procedures vital to the mental health services system they are expected to direct.

d. Limited access to higher levels of care

Finally, SCDC's treatment program fails to provide mentally ill inmates with sufficient access to higher levels of care. All correctional mental health systems are organized by levels of care, and SCDC's system comprises four levels. From lowest to highest, these are outpatient, area, intermediate (ICS), and inpatient. The higher the level, the more services and staffing are required.

SCDC's Mental Health Director, Pamela Whitley, estimated that in 2008 the combined ICS and Area Mental Health caseload at SCDC was 515. In 2012, however, the combined ICS and area caseload was only 310, a 40 percent reduction. In February 2008, at Lee and Lieber combined there were 212 area and 211 outpatient mental health inmates, a 50/50 split. By September 2011, however, there were only 83 area inmates at Lee and Lieber (14.8 percent), while the outpatients numbered 478 (85.2 percent). From 2003 to 2011, male ICS inmates decreased from 315 to 135. The women's ICS program was discontinued, then revived, but at the time of trial consisted of only five inmates. In the 1990s Gilliam, the 88-bed inpatient psychiatric facility for male inmates, operated at full capacity, but at the time of trial only 47

beds were filled. It is undisputed that women inmates have a higher rate of mental illness than male inmates, but from 2007-2009 SCDC referred only 13 women to Geo Care (formerly "Just Care"), a private company with which SCDC contracts for inpatient psychiatric services for female inmates. SCDC offered no persuasive explanation for the decline in the number of inmates receiving higher levels of services during a period when the overall inmate population and mental health case load remained flat.

e. Conclusion

This Court finds that SCDC's use of force and segregation, as opposed to treatment, in a mental health system where psychiatrists have limited roles and where inmates face systemic obstacles in accessing higher levels of care, creates a substantial risk of serious harm for inmates with serious mental illness.

3. Employment of a sufficient number of trained mental health professionals

The Court finds that the mental health program at SCDC is substantially understaffed. This has a causal effect for many insufficient aspects of the mental health program and greatly inhibits SCDC's ability to provide effective services to its mentally ill inmate population.

From 2008-2011, psychiatric staff at SCDC (psychiatrists and psychiatric nurse practitioners) ranged from 4.5 to 5.5 full-time equivalents (FTEs). At the time of this trial, SCDC had 5.5 FTE psychiatric staff serving an estimated 2,409 inmates on psychotropic medication, for a ratio of 1:437. If 17 percent of SCDC's population is mentally ill, rather than the 12.9 percent diagnosed by SCDC, the estimated number of inmates on psychotropic medication should be 3,170 and the ratio then is 1:575. Based on the testimony of Dr. Metzner and Dr. Patterson, the Court finds an appropriate ratio would be one FTE psychiatrist/psychiatric

nurse practitioner to every 150-200 inmates on psychotropic medication. At Gilliam, there are 1.2 FTE psychiatrists and psychiatric nurse practitioners for 62 patients, a 1:52 ratio. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for an inpatient setting would be 1:20. For the ICS program, there is currently .7 FTE psychiatric staff for 135 patients, a ratio of 1:193. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for intermediate care would be 1:150.

The Court also finds that SCDC is understaffed in clinical psychologists. In 2003, SCDC employed or retained four FTE clinical psychologists but needed, by its own admission, seven. From 2007-2011, however, SCDC averaged only .3 FTE psychologists.[10] To add some context, SCDC's expert, Dr. Haas, testified that the Kentucky Department of Corrections, his former employer, had 15-16 FTE psychologists to serve a total population of 12,000 – 13,000 inmates, a ratio of approximately 1:800. By contrast, SCDC's .3 FTE psychologists serve a total population of approximately 23,000 inmates, a ratio of 1:69,697.

Likewise, the ratio for counselors at Area Mental Health Institutions as of January 2012 is also problematic: 1:72 at Lee; 1:84 at Perry, and 1:100 at Lieber. In response to this information, Dr. Patterson and Ms. Whitley, SCDC's Mental Health Director, agreed that a more appropriate ratio for counselors at the Area Mental Health Institutions is 1:40. Counselor staffing at outpatient prisons is also insufficient. Ms. Whitley testified she became "very concerned" when counselor-patient ratios at outpatient prisons exceeded 1:65, and Dr. Patterson agreed. SCDC data, however, shows that counselor ratios at most of its outpatient prisons exceed 1:65. At the time of trial, the counselor-patient ratio at McCormick Correctional Institution was 1:157 and at Turbeville Correctional Institution 1:183.

[10] Shortly before trial, SCDC increased its psychologists to .7 FTE.

In total, Dr. Patterson recommended that SCDC employ at least an additional 20 FTE counselors, 14.5 FTE psychiatrists, and 17 FTE other types of mental health professionals. The Court accords great weight to Dr. Patterson's recommendations for staffing.

While it is clear that SCDC does not have enough counselors, it is equally clear that many of the counselors they do employ are unqualified. Hiring unqualified counselors can lead to the kind of deterioration in the delivery of mental health services that Perry experienced in 2009-2010. Within a period of a few months, all five of Perry's counselors were fired or resigned under investigation or following a serious reprimand. As Dr. Patterson testified, those counselor departures had a significant effect on mental health services provided at Perry, resulting in the cancellation of many psychiatric clinics and group therapy sessions. Disciplinary reprimands in counselor personnel files give further evidence of the overall poor quality of SCDC counselor services.

In 2009, SCDC began conducting internal audits of its mental health counselors. As Dr. Patterson and Dr. Metzner testified, the audits document a wide range of serious counselor deficiencies. Scores were particularly poor for Lee, Lieber, and Perry, the male Area Mental Health Institutions, where 55 percent of the audits were either "unsatisfactory" or "satisfactory, but with major concerns." Some of the deficiencies listed are disturbing. They include numerous instances of mentally ill inmates going for many months without seeing a counselor or psychiatrist, in violation of SCDC policy; treatment plans that were out of date and incomplete; and inadequate documentation of medication administration and group therapy sessions. Some counselors repeatedly failed their audits.

The Court finds that inadequate mental health staffing at all levels within SCDC represents a substantial risk of serious harm to inmates with serious mental illness.

4. Maintenance of accurate, complete, and confidential mental health treatment records

A treatment plan is intended to be a dynamic and fluid process that continues on a regularly scheduled basis, supplemented by constant updates and revisions. In order to be effective, treatment plans must be accurate, complete, readily accessible to professional staff, and confidential. During trial, evidence was presented to the Court indicating that documentation and maintenance of these records is poor. The treatment plans and automated medical records ("AMR") do not clearly state problems, objectives, goals, or even identify plan-responsible staff.

The importance of maintaining accurate and complete treatment records is vital to any medical services delivery system. For mentally ill inmates in particular, treatment plans and AMRs are critical for assessing progress as well as the effect of medication and therapy.

In addition, Dr. Metzner offered several examples of basic information about its mental health program that SCDC's aged computer system is unable to provide. For example, SCDC's computer system cannot retrieve the names or numbers of all inmates referred to the ICS program; the number of women inmates referred to Geo Care for inpatient psychiatric services; the number of inmates who have made serious suicide attempts; or the number of inmates whose psychotropic medications have expired without being timely renewed.

In summary, the evidence in this case shows that the recordkeeping system for SCDC is outmoded, poorly maintained, and not readily accessible to all staff. The Court finds that SCDC's failure to maintain accurate and complete mental health treatment records represents a substantial risk of serious harm to mentally ill inmates.

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation

In evaluating this factor, some of the same concerns overlap with those of the previous factor – maintenance of accurate, complete, and confidential mental health treatment plans. The Court, however, will note three specific issues that raise further concerns. First, Medication Administration Records ("MAR") of mentally ill inmates provide crucial information upon which psychiatrists rely. SCDC uses standard MAR forms where nurses are required to sign their initials to confirm that medication was provided and administered. At trial, various MARs were introduced indicating the absence of initials and absence of any record that medications were provided at all. This indicates either the medication was not provided or the nurses failed to maintain accurate records. For example, in October and November 2008, inmate Jonathan Mathis was prescribed one medication to be taken twice a day and two other medications to be taken once a day. From his MAR, however, it appears he received no medications either month, without explanation.

Although counselors monitor MARs, the Court agrees with Dr. Patterson that SCDC counselors are not qualified to do so, as evidenced by counselor audits showing deficient MARs. Ms. Delgado acknowledged that a failure to adequately monitor MARs has no effect on a counselor's audit score. For example, the only audit that one Lieber counselor has ever passed was an audit in which 14 of the 15 MARs reviewed for which she was responsible were found incomplete or outdated.

The second issue of concern involves the suicide of Robert Hamberg. SCDC records show that Mr. Hamberg's morning medications had expired – specifically his anti-psychotic medicine Geodon – which he was supposed to receive twice a day. Nevertheless, his counselor

was still recording that he was compliant with his medication – that he was receiving it in the mornings and evenings. Thus, Mr. Hamberg was only receiving half of his prescribed dosage of anti-psychotic medication. Mr. Hamberg committed suicide on June 9, 2010 at Perry Correctional Institution.

The third issue of major concern in the area of medication administration involves pill lines. As Dr. Patterson testified, medication compliance is especially difficult for many mentally ill inmates, due to medication side effects and the nature of their illness. At many institutions, pill lines occur between 3:00 - 4:00 a.m., and mentally ill inmates are often left to their own devices to timely awake, stand in line, and then take their medication. The timing, press of business, and lack of individual attention at the pill line lends itself to inmates failing to take psychotropic medications.

This Court finds that the failure to appropriately supervise, evaluate, and dispense psychotropic medications creates a substantial risk of serious harm to inmates with serious mental illness.

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6. A basic program to identify, treat, and supervise inmates at risk for suicide

a. The setting of Crisis Intervention ("CI") cells

At trial, Dr. Patterson identified seven mentally ill inmates at SCDC, in addition to Jerome Laudman, whose deaths from 2008-2011 were both foreseeable and preventable.[11] In his opinion, two common factors contributed to these deaths. First, crisis intervention cells are located in segregation units, not in a medical setting, and thus lack sufficient medical interaction

[11] Six of these were suicides. The seventh, Stephen Jeter, was not ruled a suicide, but his death was related to a failed suicide attempt. Moreover, the Court is aware that two more SCDC inmate suicides occurred while this trial was actually in progress, one at Lee and one at Lieber, with both decedents either on or should have been on the mental health caseload.

and treatment. For example, CI inmates are not being assessed daily for mental health purposes. As of the date of trial, SCDC policy only required that inmates in CI be seen Monday through Friday, excluding holidays, and this policy is often violated. Inmates in CI cells spend the entire day in those cells, and are held for long periods of time – typically one to two weeks – but sometimes longer. CI cells, like other SMU cells, are cold and filthy, with trash, blood, and feces scattered or smeared about. Inmates are placed naked in CI cells. They often are not provided a blanket, and when one is provided it often is not clean. CI cells do not have mattresses. Inmates sleep directly on a cold steel or concrete slab. Inmate Richard Patterson testified how he tore up his Styrofoam food trays, then spread the pieces on his concrete slab to serve as a form of mattress. In addition, most inmates in CI do not see a psychiatrist and are not allowed group therapy. Interaction with counselors is brief, limited, and not confidential.

For at least a three-year period, from 2008-2010, correctional officers at Lieber, at times with the acquiescence of mental health staff and at other times without their knowledge, routinely placed CI inmates naked in shower stalls, "rec cages," interview booths, and holding cells for hours and even days at a time. Most of these alternative CI spaces did not have toilets and none were suicide resistant. Details of these placements are contained in Dr. Metzner and Patterson's inspection report, entered into evidence, as well as in their testimony and the testimony of various inmates. SCDC's own logs document over 100 of these alternative placements during the 27 months for which logs were provided.[12] The Court finds that the vast majority, if not all, of these placements were for inmates on crisis intervention. SCDC logs show that 55 of these placements at Lieber were for twelve hours or longer and 29 exceeded 24 hours. Inmate Isaac Anderson was confined over 86 consecutive hours in a Lieber rec cage from April

[12] SCDC could not locate Lieber SMU logs for several of the months requested.

2-6, 2009, with his first documented bathroom break coming after 42 hours in the cage. The interview booths and showers used for CI were often filthy and too small a space in which to lie down. Correctional officers brought CI inmates "finger food" meals to these spaces. Since inmates were not always provided bathroom breaks, some were forced to urinate and defecate in the same spaces where they were fed. Moreover, the Court finds that the use of such inappropriate spaces for CI has not been limited to Lieber. Plaintiffs presented inmate testimony and other evidence that SCDC has placed CI inmates in such spaces at other institutions prior to 2008 and after 2010. For the reasons discussed, the Court finds that SCDC's normal CI placements expose inmates with serious mental illness to a substantial risk of serious harm. The dehumanizing conditions of SCDC's alternative CI placements expose inmates to even greater risk.

b. <u>Lack of constant observation</u>

Second, SCDC's policy does not require constant observation; rather, inmates in CI cells are checked on 15-minute intervals, documented in cell-check logs. The evidence before the Court contains proven instances of fabricated cell check logs. For example, the cell check log of inmate Edward Broxton noted that at 6:30 a.m. on February 2, 2010, he was eating breakfast, even though an hour earlier, at 5:30 a.m., Broxton had hanged himself in his CI cell at Lee. Many of the cell check logs for Jerome Laudman were initialed "GM," although the only Lee Supermax correctional officer with those initials denied making the entries or authorizing anyone to use his signature. The SCDC Inspector General report on the drug overdose suicide at Perry of inmate James Bell documented evidence that his cell check logs had also been falsified. To make matters worse, on the Saturday before Bell's suicide his aunt, in an upset state, phoned SCDC to warn them of a "goodbye letter," suicidal in nature, she had received from her nephew.

SCDC mental health staff did not check on Bell until two days later, on Monday afternoon, when a counselor found him dead in his cell.

SCDC's expert, Dr. Haas, agreed with Dr. Patterson and Dr. Metzner that inmates on suicide watch require continuous observation. In 2008, inmate Brian Schriefer committed suicide while on CI at Gilliam by stuffing either toilet paper or a paper gown down his throat. As a result of Schriefer's death, SCDC stopped distributing gowns to CI inmates, instead requiring them to remain naked while in CI. SCDC did not change its policy, however, on continuous observation of suicidal inmates. Continuous observation would have prevented Schriefer's death.

The Court finds that SCDC's suicide prevention and crisis intervention practices create a substantial risk of serious harm to seriously mentally ill inmates.

7. Summary of objective component

As detailed above, this Court finds that the evidence in this case has proved SCDC's mental health program is inherently flawed and systemically deficient in all major areas. The Court further finds that a major contributing factor to the deficiencies in the SCDC program is the lack of a formal, comprehensive quality management program.

Finally, having observed the testimony of the psychiatric and correctional experts for both Plaintiffs and Defendants, this Court finds Plaintiffs' experts more credible. In part, this finding is due to a comparison of their credentials and experience; in part, due to their relative persuasiveness on the witness stand; and in part, due to the wide disparity between Plaintiffs' and Defendants' experts in case preparation and particular knowledge of the SCDC system.

Based on the testimony of these experts and the other evidence presented at trial, the Court finds that SCDC's mental health program exposes inmates with serious mental illness to a

substantial risk of serious harm. Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

B. Subjective Component

The subjective component of the deliberate indifference standard requires proof that SCDC knew that Plaintiffs were exposed to a substantial risk of serious harm, but failed to take reasonable measures to abate the risk. *Farmer*, 511 U.S. at 847. The subjective component should be determined in light of the prison authorities' "attitudes and conduct at the time suit is brought and persisting thereafter." *Id.* at 845-846.

The evidence is overwhelming that SCDC has known for over a decade that its system exposes seriously mentally ill inmates to a substantial risk of serious harm. In 1999, SCDC retained Dr. Patterson (Plaintiffs' expert), through a grant, to inspect its mental health program. His report, issued in 2000, characterized the program as being in a state of "profound crisis." In October 2000, a Joint Legislative Proviso Committee report concluded that "inmates with mental illness are not receiving adequate treatment . . . and oftentimes leave prisons worse off than when they entered." In April 2003, a South Carolina Task Force whose members included three former SCDC Directors issued a report that concluded Gilliam was "clearly inadequate." In May 2003, the South Carolina Department of Mental Health issued a report on SCDC's mental health program, noting "[t]he lack of psychiatric coverage has resulted in a critical situation, with extremes of poor care, inhumane treatment, and dangerousness . . . ." In September 2003, SCDC Director Jon Ozmint, in an application for technical assistance, stated that "[t]he current plight of persons with mental illness at SCDC is at a crisis level." In June 2005, the Plaintiffs filed their Complaint in this case, alleging constitutional deficiencies in SCDC's program. From 2006-2010 Plaintiffs' experts issued eight site inspection reports criticizing conditions in SCDC

facilities. In October 2007, SCDC psychiatrist Dr. Michael Kirby wrote a letter to his supervisor noting several serious problems with SCDC's mental health system. In June 2008, SCDC investigator Lloyd Greer issued his report on the death at Lee Supermax of Jerome Laudman. From 2008-2010, Lieber SMU logs documented the use of shower stalls and other inappropriate spaces for CI placements. In 2009-2010, SCDC was aware that the counselor shortage at Perry created serious deficiencies in the delivery of mental health services. In January 2010, a United States Department of Justice report was highly critical of SCDC's medication management and administration practices. SCDC's own counselor audits from 2010-2011 revealed numerous unsatisfactory practices and major deficiencies. January 2012 internal data showed counselor-to-patient ratios at many SCDC facilities that were excessively high. Finally, through the discovery process in the litigation of this case from 2005-2012, SCDC was made aware of the serious allegations raised by Plaintiffs and their experts, many of which are supported by SCDC's own records.

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The Court finds from this evidence that SCDC knows and has known, since before this lawsuit was filed, and persisting thereafter until the time of trial and even to present date, that its mental health program is systemically deficient and exposes seriously mentally ill inmates to a substantial risk of serious harm.

That, however, does not end the analysis. The second element of the subjective component focuses on action: has SCDC taken reasonable measures to abate the risks of which it is aware? The evidence shows that from 1999 until the filing of this action in 2005, SCDC did virtually nothing to address, much less eliminate, the substantial risks of serious harm to which class members were exposed. What limited action SCDC has taken since the filing of this lawsuit has had little to no effect in abating the unconstitutional deficiencies this Court has

found. "[T]o rely on intervening events occurring after suit has been filed the defendants must satisfy the heavy burden of establishing that these such events 'have completely and irrevocably eradicated the effects of the alleged violations.'" *Thomas v. Bryant*, 614 F.3d 1288, 1320-21 (11th Cir. 2010).

SCDC has failed to meet this "heavy burden." At trial SCDC identified the measures it has taken since 2005 to improve its mental health program. These include the hiring of two administrators and some administrative support staff, an increase in psychiatric staff FTEs, a re-organization of group therapy, a new protocol for addressing self-injuring behavior ("SIB"), mental health dorms, increased use of tele-psychiatry, new training programs for clinical and security staff, and counselor audits.

The Court finds that these are small steps that have had little impact on the systemic deficiencies in SCDC's mental health program. The mere hire of administrators to replace other administrators is not necessarily an improvement. Additional administrative support staff does not address the dire need for more clinical staff. Since 2008, SCDC's psychiatric staff has remained relatively flat and currently consists of 5.5 FTEs, although this Court has found that at least 14.5 FTEs are needed. As discussed, counselor and psychologist FTEs are far too low. Reorganized or not, group therapy sessions are frequently cancelled and unavailable for most inmates in segregation and crisis intervention. SCDC introduced no persuasive evidence that its new, decentralized SIB protocol has improved SIB-related issues. SCDC's concentration of some mentally ill inmates in designated dorms is no substitute for an adequately staffed mental health program. At the time of trial, SCDC had not implemented expanded tele-psychiatry services, but had merely requested a feasibility study. SCDC's training programs are limited in scope and poorly attended. Counselors are the only mental health clinicians subject to formal

audits, and those audits, though limited in scope, reveal alarming deficiencies. Despite a low bar for passing, many counselors fail their audits, some repeatedly.

Half-hearted measures will not foreclose a finding of deliberate indifference. "Patently ineffective gestures purportedly directed towards remedying objectively unconstitutional conditions do not prove a lack of deliberate indifference, they demonstrate it." Standards Order at 13, (quoting *Coleman v. Wilson,* 912 F. Supp. 1282, 1319) (E.D. Cal. 1995)). *See also Thomas*, 614 F.3d at 1320 (11th Cir. 2010) ("practices may be reinstated as swiftly as they were suspended"). The steps SCDC has taken have been small ones, characterized by SCDC itself as "band aids,"[13] many of which were instituted shortly before and even during trial, that have failed to adequately address the known systemic deficiencies in its mental health program. The SCDC mental health program needs far more than band aids, and the Court finds that the measures taken by SCDC to correct its systemic deficiencies are neither reasonable, timely, nor effective. Plaintiffs have therefore satisfied the subjective component of the deliberate indifference standard.

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II. REMEDY TO ADDRESS CONSTITUTIONAL VIOLATIONS

A. Overview

In devising a remedy for the constitutional deficiencies at SCDC, the Court is required to balance two competing interests. First, it is not the role of this Court to micromanage the daily administration of the mental health program at SCDC. Moreover, this decision comes in a time of economic recession and heavy scrutiny of governmental expenses. However, "[c]ourts may not allow constitutional violations to continue simply because a remedy could involve intrusion into the realm of prison administration." *Brown v. Plata,* 131 S.Ct. 1910, 1928-29 (2011).

[13] SCDC's June 8, 2009 Memorandum on Applicable Standards contended that SCDC had a "well-developed mental health system . . . in place for decades," that needed nothing more than "band aids or other minor remedies."

Additionally, the economic "cost of protecting a constitutional right cannot justify its total denial." *Bounds v. Smith,* 430 U.S. 817, 825 (1977). "A plea of lack of funds is an insufficient justification for the failure of the executive department" to provide constitutionally mandated treatment programs. *Crain v. Bordenkircher,* 176 W.Va. 338, 364, 342 S.E.2d 422, 449 (1986), (quoting *Moore v Starcher,* 167 W.Va. 848 - 853, 280 S.E.2d 693, 696 (1981)).

Second, under the separation of powers doctrine, this Court may not usurp the authority of other branches of government. The separation of powers doctrine, however, "is not fixed and immutable." *State v. Langford*, 400 S.C. 421, 434, 735 S.E.2d 471, 478 (2012). On the contrary, the doctrine contains "grey areas" and an "overlap of authority" among governmental branches. *Id.*

> "Separation of powers does not require that the branches of government be hermetically sealed; the doctrine of separation requires a cooperative accommodation among the three branches of government; a rigid and inflexible classification of powers would render government unworkable." At its core the doctrine therefore "is directed only to those powers which belong exclusively to a single branch of government."

Id. (quoting 16A Am.Jur.2d, *Constitutional Law* § 244, 246).

In *Blaney v. Cmmr. of Corrections*, 374 Mass. 337, 372 N.E.2d 770 (1978), following defendants' submission of deficient plans to remedy prison conditions, the court entered a remedial order giving explicit directions for defendants to follow. The court rejected defendants' argument that the order violated separation of powers, noting that courts have power to direct public officials to carry out their lawful obligations. 374 Mass at 339-42, 372 N.E.2d at 773-74. "As to judges' authority to fashion detailed orders to correct established violations of constitutional rights . . . [s]uch functions are judicial, and in no way usurp the power of the executive." 374 Mass. at 342-43, 372 N.E.2d at 774, *citing Swann v. Charlotte-Mecklenburg*

County Bd. of Educ., 402 U.S. 1, 15 (1971); *U.S. v. Montgomery County Bd. of Educ.*, 395 U.S. 225, 234-36 (1969). *See also In re K.C.*, 325 Ill. App. 3d 771, 779-80, 759 N.E.2d 15, 23 (2001) ("When the legislature creates a statute that contemplates an interplay between the courts and the executive branch, court orders directing the actions of the executive agencies do not violate the doctrine of the separation of powers."); *Crain,* 176 W.Va. at 364, 342 S.E.2d at 449 (where a court ordered the West Virginia Department of Corrections to implement an extensive remedial plan addressing constitutionally deficient prison conditions.); *Haley v Barbour Cnty.,* 885 So. 2d 783, 790 (Miss. 2004) (noting court regulation of the number of inmates a county may deliver to a prison does not violate separation of powers.); *Massameno v. Statewide Grievance Comm.*, 234 Conn. 539, 567, 663 A.2d 317, 333 (1995) (stating a court does not violate separation of powers doctrine by supervising and disciplining executive branch prosecutors.)

Finally, this Court is bound to uphold the South Carolina Constitution and protect the rights of the mentally ill inmates at SCDC. Moreover, it is the action of a circuit court that triggers the placement of an inmate into the custody of SCDC, under Court authority, and thus this Court has the inherent power - and responsibility – to see that the imprisonment of that inmate complies with constitutional mandates. The Court is convinced that to view the evidence put forth in this case and then do nothing could be a great miscarriage of justice.

To address the constitutional deficiencies in the mental health system at SCDC, Plaintiffs have proposed a remedial plan comprised of three components. First, SCDC would be required to submit a written plan for remedying the systemic deficiencies identified by the Court. Second, SCDC must rely upon factors and guidelines identified by the Court in creating this plan, which the Court will then review and either approve or disapprove. Third, the Court will retain jurisdiction of this case and appoint expert monitors and/or a special master who will report

periodically to the Court. SCDC has raised objections to this plan, arguing that it constitutes an impermissible burden shift and is violative of the separation of powers doctrine.

The Court denies SCDC's objections. It would be highly impractical for Plaintiffs to identify and create a plan to implement changes to the mental health system at SCDC. Rather, once the Court has ruled, SCDC is in the best position to propose steps and changes to its existing system. *See Alexander S. v. Boyd*, 876 F. Supp. 773, 804-04 (D.S.C. 1995) (where a court ordered the South Carolina Department of Juvenile Justice to submit remedial plan within 120 days of order); *Crain*, 176 W.Va. at 341, 342 S.E.2d at 426 (where a court ordered the West Virginia Department of Corrections to submit remedial plan within 180 days of order). As a result, the Court adopts Plaintiffs' proposals and requires SCDC to submit a written plan to the Court within 180 days of the date of the Final Order in this case. In executing the remedial plan to be submitted by SCDC, the Court will retain jurisdiction but also intends to appoint a monitor who will report periodically to the Court. The Court will provide the parties, through motions, an opportunity to suggest the appropriate appointee(s) to oversee this process.

B. Remedial Factors and Guidelines

In formulating specific factors and guidelines for SCDC's remedial plan, the Court will again utilize the *Ruiz* factors above, along with additional sub-factors and components listed thereunder. In devising a plan to remedy the constitutional deficiencies identified by the Court, SCDC shall be directed in the Order to prepare a written plan that includes, at a minimum, the following:

1. **<u>The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care</u>**

   i. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of increasing the number of inmates recognized as mentally ill and being admitted to the mental health program by a minimum of two percentage points (14.9 percent of the inmate population);

   ii. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;

   iii. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and

   iv. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

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2. **<u>The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC</u>**

   a. Access to Higher Levels of Care

   i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefor;

   ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefor;

   iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam

Psychiatric Hospital, or its demolition for construction of a new facility;

iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and

v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

b. Segregation

i. Provide access for segregated inmates to group and individual therapy services;

ii. Provide more out-of-cell time for segregated mentally ill inmates;

iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

iv. Provide access for segregated inmates to higher levels of mental health services when needed;

v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

c. Use of Force

i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

ii. The plan will further require that all instruments of force, (e.g, chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;

iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;

vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;

vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and

xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

3. **Employment of a sufficient number of trained mental health professionals**

i. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

ii. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;

iii. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

iv. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;

v. Require appropriate credentialing of mental health counselors;

vi. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

vii. Implement a formal quality management program under which clinical staff is reviewed.

4. **Maintenance of accurate, complete, and confidential mental health treatment records**

i. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:

- Names and numbers of FTE clinicians who provide mental health services;

- Inmates transferred for ICS and inpatient services;
- Segregation and crisis intervention logs;
- Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);
- Use of force documentation and videotapes;
- Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;
- Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;
- Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;
- Quality management documents; and
- Medical, medication administration, and disciplinary records.

ii. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

5. <u>Administration of psychotropic medication only with appropriate supervision and periodic evaluation</u>

i. Improve the quality of MAR documentation;

ii. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

iii. Review the reasonableness of times scheduled for pill lines; and

iv. Develop a formal quality management program under which medication administration records are reviewed.

6. **A basic program to identify, treat, and supervise inmates at risk for suicide**

i. Locate all CI cells in a healthcare setting;

ii. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

iii. Implement the practice of continuous observation of suicidal inmates;

iv. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

v. Increase access to showers for CI inmates;

vi. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

vii. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and

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viii. Implement a formal quality management program under which crisis intervention practices are reviewed.

CONCLUSION

Even the most brief and facile view of the evidence put forth by Plaintiffs in this case reveals obvious, significant, and longstanding problems with mental health services delivery at SCDC. Prior to trial, this Court tried its very best to bring the parties together for settlement purposes, even requiring the Director of SCDC and the guardian for the Plaintiffs, attorneys for both sides, and other interested parties to meet in an effort to resolve the case. The Court was not present for these discussions and thus cannot determine why they were unsuccessful.

We are now eight years into this litigation. Rather than accept the obvious at some point and come forward in a meaningful way to try and improve its mental health system, Defendants

have fought this case tooth and nail—on the facts, on the law, on the constitutional issues, portraying itself as beleaguered by the burdensomeness of Plaintiffs' discovery, and generally harrumphed by the invasive nature of Plaintiffs' counsels' tactics and strategies. This Court has spent dozens of hours in hearings and conferences in an effort to resolve discovery disputes, most of which involved delay, missed deadlines, and recalcitrance on the part of the Defendants.

This Court can never criticize any party for a vigorous exercise of offense or defense in civil litigation, for such is the foundation of our adversarial system of justice. But justice in this case is not really about who wins or loses this lawsuit. The hundreds of thousands of tax dollars spent defending this lawsuit, at trial and most likely now on appeal, would be better expended to improve mental health services delivery at SCDC.

For the reasons set forth above, the Court grants judgment in favor of the Plaintiffs and orders SCDC to submit a proposed written remedial plan consistent with this Order.

IT IS SO ORDERED.

J. Michael Baxley
Presiding Judge
Complex Jurisdiction

Hartsville, South Carolina

January 8, 2014