OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-G-05

SUBJECT: SUICIDE PREVENTION PROGRAM

POLICY: Inmates who are potentially suicidal will receive early identification, evaluation, treatment and protection from self-harm.

The purpose of this policy and procedure is to provide further guidance and direction to the Department of Corrections Rule on Suicide Prevention in correctional facilities, OAR 291-076-0010 through 291-076-0030.

REFERENCE: NCCHC Standard P-G-05
NCCHC Standard MH-G-04
ACA Standard 3-4364
OAR 291-076-0010 through OAR 291-076-0030
DOC Rule 291-076, Suicide Prevention in Correctional Facilities
DOC Policy 20.5.2, Emergency Staff Services and Critical Incident Trauma Management

DEFINITIONS:

- BHS: Behavioral Health Services within Health Services
- MHI: Mental Health Infirmary
- Mental Health Provider: Employee or contractor providing mental health treatment services.
- OIC: Officer-in-Charge:
- Prescribing Practitioner: A licensed psychiatrist or psychiatric nurse practitioner.
- Treatment Provider: A Mental Health Provider or a prescribing Practitioner.

PROCEDURE:

A. All new admissions to the Oregon Department of Corrections will receive a mental health screening interview as part of receiving screening Procedure #P-E-02. The mental health screening includes mental health history, suicide potential, evidence of psychosis, or other acute mental health emergency, i.e., drug intoxication, upon arrival.

B. All new employees will receive training regarding suicide risk and identifying factors during New Employee Orientation (NEO) and in annual in-service training. This will be documented through the Professional Development Unit.

C. Inmates who have been identified as having significant potential for self harm or who are displaying suicidal warning signs are to be referred immediately to BHS for evaluation.

D. When an inmate is at risk for suicide or self-injury, necessary steps will be taken to ensure the inmate's safety. The inmate will remain under the direct observation of a correctional officer or other institution staff until a suicide risk evaluation is completed. Possessions that the inmate could use to harm him/herself may be removed as needed.

If an inmate has already attempted suicide, necessary steps will be taken to stabilize the inmate's physical condition before admission to Mental Health Infirmary (MHI).

1. If an inmate is taken to a hospital emergency room for medical treatment due to a suicide attempt, the inmate must be re-assessed upon return to the institution by Medical Services staff and be physically stable prior to admission to MHI.

2. Once the inmate is medically assessed as not needing medical infirmary level of care, a medical services nurse will contact the appropriate Treatment Provider to arrange for MHI admission.

3. Should a staff member come upon a suicide in progress, the following steps are to be followed using universal blood and body fluid precautions.

   a. Call for assistance.
   b. If it is a hanging, cut the inmate down immediately and initiate emergency first aid.
   c. If lacerations are present, apply direct pressure and initiate first aid if indicated.
   d. Emergency first aid procedures should be followed in the event of any form of self-destructive behavior.
   e. Note the time and be prepared to write a clear and concise report of the events as they occurred.
   f. As per DOC policy, the area will be secured as a crime scene until released by Security.

4. The shift officer-in-charge shall be notified of any potential attempted or completed suicide.

5. If a suicide occurs, a formal suicide review will be completed as assigned by the Inspector General. The actual review of the health care record and related materials will be reviewed by a Medical Services Management representative and a BHS Manager who are a part of the multi-disciplinary review team.

6. Arrangements will be made for critical incident debriefing for staff as outlined in Department of Corrections procedure #45 (Emergency Staff Services and Critical Incident Trauma Management).

7. Arrangements will be made for critical incident debriefing of inmates by referral to Behavioral Health Services.

E. When an inmate has been identified as potentially suicidal, a Registered Nurse will evaluate the inmate to determine if there is a suicide risk when a Treatment Provider is not immediately available. This evaluation will be completed using the Suicide Risk Screening and the Mental Status Screening Tool (**attachments 1 and 2**). If a potential suicide risk exists, consultation with the on-call Prescribing Practitioner will occur to determine the level of monitoring. The assessment and consultation will be documented in the health care record.

F. To determine the appropriate on-call Prescribing Practitioner to contact, refer to the "BHS On-Call Schedule" (**attachment 3**). A current copy of the BHS on-call schedule is available via Outlook Public Folder.

G. If the inmate is determined to be at high risk of a suicide attempt or severe self-injury, the Treatment Provider or Registered Nurse in consultation with the on-call Prescribing Practitioner will initiate a Suicide Watch and complete a Mental Health Special Status form (**attachment 4**). This form will include instructions for the Officer in Charge, who is responsible for placing an inmate on suicide watch, and regarding what property will be issued.

H. If an inmate is placed in an infirmary cell for suicide monitoring, Medical Services will consult with Security prior to the inmate's arrival to ensure that it is as suicide-proof as possible.

I. The inmate will be dressed in a safety smock and may have a safety blanket and/or safety mat if the temperature is cold and s/he is at low risk of using the blanket or mat to hide self-injurious behavior. The inmate may have reading materials without staples, paper and non-toxic crayons at the discretion of the Treatment Provider.

J. Security staff will maintain continuous observation of the inmate while on Suicide Watch.

1. In institutions were there is 24 hour nursing coverage, Medical Services nursing staff will reassess the inmate every four hours and document the assessment in the health care record. At those institutions without 24 hour nursing coverage, an evaluation is to be completed every four hours when nursing staff are on duty, as well as at the end of the last shift of the day, and at the beginning of the shift of the following day. During the interim, specific written instructions are to be given to the Officer-in-Charge regarding what actions should be taken if the inmate's mental status appears to deteriorate, or, if any acts of self-destruction are carried out. The evaluations, as well as any written instructions which are given to the Officer-in-Charge, are to be documented in the inmate's health care record.

2. A Treatment Provider will assess the inmate at least once a day in person or through telephone consultation with a Medical Services nurse. When a Treatment Provider is not on site, a Medical Services nurse will initiate the consultation with the on-call Prescribing Practitioner and document the consultation in the health care record.

3. If the inmate remains on Suicide Watch for 48 hours and the Treatment Provider determines that the inmate cannot safely be moved to suicide close observation, the Treatment Provider will contact the MHI to make arrangements for admission.

K. If an inmate is at moderate risk of a suicide attempt or self-injury the Treatment Provider or Registered Nurse in consultation with the on-call Prescribing Practitioner will initiate a Suicide Close Observation and complete a Mental Health Special Status form (**attachment 4**). This form will include instructions for the Officer in Charge, who is responsible for placing an inmate on Suicide Close Observation, and regarding what property will be issued.

. 1. The inmate may be dressed in a safety smock. Clothing and other possessions may be removed if necessary to ensure the inmate's safety. The inmate may have a safety blanket and/or safety mat if the temperature is cold and s/he is at low risk of using the blanket/mat to hide self-injurious behavior. The inmate may have reading material without staples, paper and non-toxic crayons at the discretion of the Treatment Provider.

2. Security staff will physically observe the inmate at staggered intervals of no more than 15 minutes.

3. In institutions were there is 24 hour nursing coverage, Medical Services nursing staff will reassess the inmate every four hours and document the assessment in the health care record. At those institutions without 24 hour nursing coverage, an evaluation is to be completed every four hours when nursing staff are on duty, as well as at the end of the last shift of the day, and at the beginning of the shift of the following day. During the interim, specific written instructions are to be given to the Officer-in-Charge regarding what actions should be taken if the inmate's mental status appears to deteriorate, or, if any acts of self-destruction are carried out. The evaluations, as well as any written instructions which are given to the Officer-in-Charge, are to be documented in the inmate's health care record.

4. A Treatment Provider will assess the inmate at least once a day in person or through telephone consultation with a Medical Services nurse. When a Treatment Provider is not on site, a Medical Services nurse will initiate the consultation with the on-call Prescribing Practitioner and document the consultation in the health care record.

L. Removal from or decrease in level of monitoring:

1. An inmate can be removed from monitoring or the level may be lowered to Suicide Close Observation if after assessment, a Treatment Provider determines that some risk is still present.

2. When a Treatment Provider determines that monitoring may be decreased or discontinued, s/he will notify the Officer in Charge and the Medical Services nurse. Any follow-up recommendations will be documented.

3. When a mental health provider is not present in an institution and if there has been a change in the inmate's behavior indicating that the suicide watch may be decreased or discontinued a Registered Nurse will complete the Suicide Risk Screening form and contact the on-call Prescribing Practitioner. After review of the Suicide Risk Screening form, if both the on-call Prescribing Practitioner and the Registered Nurse agree that the suicide watch may be decreased or discontinued, the Registered Nurse will document this in the health care record and recommend to the Officer-in-Charge that the suicide watch may be decreased or discontinued. The on-call Prescribing Practitioner will document on the next working day.

M. When an inmate is placed on Suicide Watch or Suicide Close Observation, the Mental Health Special Status form (**attachment 4**) will be completed and provided to the Officer in Charge, Medical Services and the Housing Unit Correctional Officer. It will also be filed on top of the Mental Health Flow Sheet in the mental health section of the health care record for as long as the Suicide Watch or Suicide Close Observation is active. Once the Suicide Watch or Suicide Close Observation is discontinued, the form will be filed under the SUI tab.

Effective Date: ______________
Review date: October 2008
Supersedes P&P dated: October 2007

BEHAVIORAL HEALTH SERVICES
SUICIDE RISK SCREENING

(Instructions: Evaluate and comment – suggested questions are included. Add other significant information as needed.)

REFERRAL SOURCE AND REASON FOR SCREENING:

RISK FACTORS:

Current psychiatric diagnoses and medications (review mental health section of Health Services chart: What mental health services are you currently receiving? Are you on medication? When was the last time you saw mental health staff?

Previous psychiatric treatment (community or prison): Have you ever been seen by mental health staff? Before coming to prison? While in prison? What concerns were you having?

History of past suicide/self-injury attempts (review under suicide tab in mental health section of chart for previous history of suicide attempts/self-harm): Have you tried to harm yourself before? How often have you tried? When was the most recent time? When was your most serious attempt? What thoughts did you have beforehand that led to the attempt? What did you think would happen? Did you seek help afterward yourself, or did someone get help for you? Had you planned to be discovered, or were you found accidentally?

Family history (suicide attempts or severe psychiatric diagnoses): Has anyone in your family ever tried to commit suicide? Did they die? Has anyone in your family ever been hospitalized for a mental health problem?

Key symptoms (impulsivity, hopelessness, helplessness, worthlessness, anxiety/panic, insomnia, command hallucinations, etc.): Have you been feeling anxious or depressed? Have your sleep patterns changed? Has your energy level changed? Have you been feeling confused or disoriented? Have you been hearing voices?

Recent events/stressors/losses (events leading to humiliation, shame or despair. On-going medical illness): What is going on in your life right now? Have you recently been assaulted physically or sexually? Are you being extorted or pressured? Are you having thoughts of harming or killing yourself? Are there things in your life that lead you to want to escape from life or be dead?

Inmate Name and SID:

Current suicidal ideation (on-set, frequency, intensity, duration): When did you first notice such thoughts? How often have those thoughts occurred? Are you able to ignore the thoughts? How close have you come to acting on those thoughts?

Current suicide plan (timing, location, lethality, availability, level of detail, steps taken to prepare): Have you made a specific plan to harm or kill yourself? Do you have the means to do so available to you?

Current suicide risk behaviors (rehearsals, giving things away, making a will, etc.): Have you made any preparations like writing a will, sending a goodbye letter or rehearsing the plan? Have you ever started to harm yourself but stopped before doing something?

Suicide intent (degree to which the patient desires to die): Do you feel you can resist the thoughts of harming or killing yourself? How determined are you to hurt yourself? What is your level of distress from your suicidal thoughts?

PROTECTIVE FACTORS:

Internal and external (religious beliefs, responsibility to children/family, social supports): Is there anything preventing you from harming yourself? What things would lead you to feel more hopeful about the future? Do you feel you have a purpose in life?

OVERALL ASSESSMENT OF CURRENT RISK (remember increased risk factors- housed in DSU/IMU, recent cell change, under age 36, MH2/3, new to DOC, many misconduct reports, time remaining on sentence):

ACTIONS TAKEN: ______suicide watch _______suicide close observation

Other:

Notifications:

Consultation:

Referrals:

Evaluator _____________________________ **Date** ___________ **Time** ___________
(Print name below signature)

Inmate Name and SID:

BEHAVIORAL HEALTH SERVICES
MENTAL STATUS SCREENING TOOL

Check all that apply.

Appearance: Normal ________ Unusual ________

Dress and grooming: Typical _______ Odd _______ Poor ________

Orientation: Normal _______ Confused ________

Behavior: Unremarkable ________ Calm _______ Strange ________ Uncooperative _________

Eye Contact: Good _________ Fair __________ Poor __________

Speech: Flows well _________ Answers but no spontaneous talk _________ Abnormal _______

Mood/Affect: No apparent distress ________ Appropriate range of emotion ________

Sad ______ Angry _______ Cheerful ________ Afraid ________

Knowledge/intelligence: Normal _________ Impaired ________

Perception: Normal _______ Distorted ________

Hallucinations: None _______ Auditory ________ Visual ________ Other ________

Thought Process: Coherent _______ Sense of humor intact ________ Confused __________

Thought Content: Normal ________ Illogical _________ Suicidal _________ Odd ________

Delusions: None ________ Paranoid _________ Bizarre _______ Other _________

Memory/attention/concentration: Within normal limits _________ Impaired _________

Insight: Acknowledges problems _________ Lacks understanding of problems __________

Judgment: Adequate ______ Impulsive _______ Impaired ________

Social: Has community supports ________ Has prison friends ______ Vulnerable _______

Overall assessment, recommendations, action taken:

Evaluator: _____________________________________

Date: ___________________

Inmate name:
SID#:

"EXAMPLE"
Behavioral Health Services On-Call Schedule (Revised 11-05-08)

When you have a mental health crisis **after hours, on weekends or holidays**, please contact the person who is the primary on-call Psychiatric Mental Health Nurse Practitioner (PMHNP) for your institution. If you cannot reach that person within 15 minutes, then contact the secondary on-call PMHNP for that institution. If you cannot reach either of them within 30 minutes, call any other on-call PMHNP.

During regular working hours, in crisis situations please contact a Mental Health Specialist, or the Institution's BHS manager, as usual. For institutions that **do not** have on-site BHS services, contact Dr. Shari Melton, Clinical Supervisor, at 503-378-5605 (office) or 503-551-6699 (cell). Please **do not** contact the PMHNP during regular working hours. They have heavy patient schedules and need to concentrate on those responsibilities during regular working hours.

Psychiatric Mental Health Nurse Practitioners:

Name	Phone
Ted Chase	Cell Phone (541) 240-4094
Rosanne Harmon	Cell Phone (541) 279-7916
Scott Haynes	Cell Phone (503) 551-6939
Barbara Miller	Cell Phone (503) 887-1913
Becki Sauer	Cell Phone (503) 510-2988
Trudy Evans	Cell Phone (541) 215-2699

Western Oregon Institutions

CCCF – Minimum and Male Intake
Primary – Scott Haynes
Secondary – Becki Sauer

CCCF – Medium (Females)
Primary – Becki Sauer
Secondary – Scott Haynes

CRCI/SFFC
Primary – Becki Sauer
Secondary – Scott Haynes

OSCI
Primary – Barbara Miller
Secondary – Scott Haynes

OSP
Primary – Barbara Miller
Secondary – Scott Haynes

SCCI
Primary – Barbara Miller
Secondary – Becki Sauer

SCI/MCCF
Primary – Barbara Miller
Secondary – Scott Haynes

Eastern and Central Oregon Institutions

EOCI
Primary – Ted Chase
Secondary – Trudy Evans

PRCF
Primary – Trudy Evans
Secondary – Rosanne Harmon

SRCI
Primary – Trudy Evans
Secondary – Ted Chase

TRCI
Primary – Ted Chase
Secondary – Trudy Evans

WCCF
Primary – Rosanne Harmon
Secondary – Ted Chase

DRCI
Primary – Rosanne Harmon
Secondary – Ted Chase

MENTAL HEALTH SPECIAL STATUS

Start Date ____________ Time____________ Stop Date _____________ Time __________

(A new form must be completed every time there is a status change)

SUICIDE WATCH:

Continuous and unobstructed one-to-one observation of the inmate at all times. Observations are to be recorded within each 15-minute interval. Face to face assessment by Medical Services staff every 4 hours and by a Mental Health Provider (in person or via phone) every 24 hours. At those institutions without 24 hour nursing coverage, an evaluation is to be completed every four hours when nursing staff is on duty, as well as at the end of the last shift of the day, and at the beginning of the shift the following day.

Property Issued	Start Date and Time
Teflon Smock	
Teflon Blanket	
Mat	
Paper Cup/Tray/No Utensils	
Other	

SUICIDE CLOSE OBSERVATION:

Visual and unobstructed one-to-one observation of the inmate at staggered intervals at least every 15 minutes. Staff should enter the cell if necessary to determine the status of an inmate. Observations are to be recorded within each 15-minute interval. Face to face assessments by Medical Services staff every 4 hours and by a Mental Health Provider (in person or via phone) every 24 hours. At those institutions without 24 hour nursing coverage, an evaluation is to be completed every four hours when nursing staff is on duty, as well as at the end of the last shift of the day, and at the beginning of the shift the following day.

Property Issued	Start Date and Time
Teflon Smock	
Teflon Blanket	
Paper Cup/Tray/No Utensils	
Crayons	
Mat	
Reading Material/Paper	
Other	

Additional Recommendations: ____

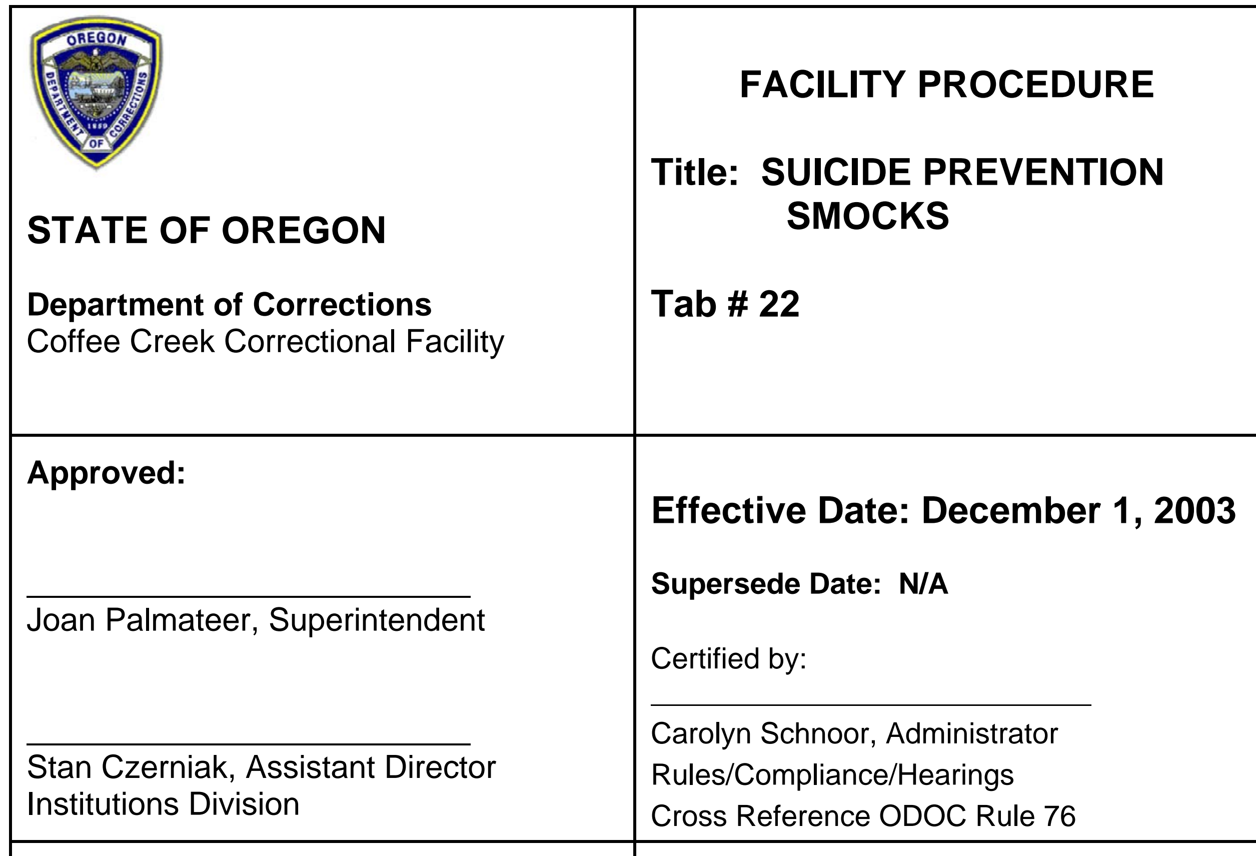
____

Mental Health ________________________________

Authorized by________________________________

Cc: OIC, BHS, Medical, Housing Unit

LABEL



STATE OF OREGON **Department of Corrections** Coffee Creek Correctional Facility	**FACILITY PROCEDURE** **Title: SUICIDE PREVENTION SMOCKS** **Tab # 22**
Approved: ________________________ Joan Palmateer, Superintendent ________________________ Stan Czerniak, Assistant Director Institutions Division	**Effective Date: December 1, 2003** **Supersede Date: N/A** Certified by: ________________________ Carolyn Schnoor, Administrator Rules/Compliance/Hearings Cross Reference ODOC Rule 76

I. Purpose

The purpose of this procedure is to establish a protocol for the use of suicide prevention smocks for the male population at Coffee Creek Correctional Facility.

II. Definitions

(1) General Population Housing: CCCF / Male Intake GP housing units – A, B, C & D.

(2) Health Services Staff: Any on duty Registered Nurse.

(3) Intake Operations Manager: Supervises intake staff and facilitates inmate transfers.

(4) Mental Health Professional: Mental Health Case Manager, on call Mental Health provider for after hours on weekdays, weekends and holidays.

(5) Officer-in-Charge: The ranking security staff member in charge of daily operation of the facility.

(6) Suicide Assessment: A brief but formal assessment of mental health conducted by a registered nurse or mental health professional, concluding with a determined level of suicide risk.

(7) Suicide Prevention Smock: An article of tear resistant clothing utilized to prevent the use of clothing for self-harm purposes.

(8) Mental Health Special Status for MALE INMATES form (attached): a form listing special status needs – Suicide Watch, Suicide Close Observation or Low-Risk Monitoring.

III. Procedures

(1) After a suicide assessment is completed and risk is determined present, an inmate may be housed in a general population while wearing a smock from 8:00 pm to 8:00 am, a Special Status form may be implemented. The timeframes listed, are in place to reduce the amount of time an inmate would be in a smock during open dayroom periods. Some variance may be expected due to the timing of the event.

(2) The inmate will be restricted to his cell unless otherwise ordered by health services or mental health.

(3) At 8:00 am on Monday through Friday, a Mental Health Professional will evaluate the inmate. If the inmate is determined not to be a threat to himself or others, his intake clothing will be returned; the Special Status form will be updated. The Mental Health Professional will update the OIC.

(4) At 8:00 am on Monday through Friday, a Mental Health Professional will evaluate the inmate. If the inmate is determined to be a threat to either himself or others, the Mental Health Professional staff will notify the OIC and the Intake Operations Manager. The Operations Manager will arrange to have the inmate transferred to a facility with a segregation unit or special housing.

(5) At 8:00 am on Saturday, Sunday and Holidays, a Registered Nurse will evaluate the inmate. The Registered Nurse will consult with the on call Mental Health Professional. After the consultation, if the inmate is determined not to be a threat, his intake clothing will be returned, the Special Status form will be updated. The Registered Nurse will update the OIC.

(6) At 8:00 am on Saturday, Sunday and Holidays, a Registered Nurse will evaluate the inmate. The Registered Nurse will consult with the on call Mental Health Professional. After the consultation, if the inmate is determined to be a threat to himself or others, the Registered Nurse will notify the OIC. The OIC will arrange to have the inmate transferred to a facility with a segregation unit or special housing.