

## SUICIDE PREVENTION AND INTERVENTION

### **30 Second Review Suicide Prevention & Intervention**

**DEF:** Suicide in Progress: An act of self-harm which may result in serious bodily harm with potential for death.

**S/S:** Signs and symptoms vary depending on method or physical injuries.

**RX:** Interrupt the act of self-harm, provide medical care as indicated by injury, do not leave the patient alone, place on suicide watch, complete suicide assessment, refer to mental health professional, notify practitioner.

**Transport to ER if warranted by physical injury.**

**SKILL LEVEL:** Initial assessment by any trained or professional level. RN must review physical assessment. Consult with mental health professional on site or contact PMNHP on call.

**DEFINITION:** Suicide in Progress: An act of self-harm that may result in serious bodily harm with potential for death. The suicide intent can evolve over a period of time, or be an impulsive reaction to an environmental stressor.

**REFERENCE:**

1. DOC Administrative Rule 291-076 "Suicide Prevention in Correctional Facilities".
2. BHS Suicide Prevention Procedure #MH-G-04

### **Plan:**

Treatment of the suicidal patient depends on the physical injuries incurred as a result of a self-harm act. Refer to the appropriate nursing protocol, e.g., Puncture Wound (Severe), Lacerations, etc.).

1. Interrupt the act of self-harm.
2. Provide emergency medical care as indicated by injury.
3. Transport to Emergency Facility if warranted by physical injuries or condition.
4. If in doubt as to seriousness of physical injuries or condition, contact medical provider.

If patient's physical injuries do not necessitate Emergency Transport:

1. Patient will remain under direct observation of (correctional or health services) staff.
2. Complete a BHS Suicide Risk Screening.
3. Consult onsite mental health provider if available, or contact the PMHNP on call.
4. Determine level of watch with the mental health provider (Suicide Watch or Suicide Close Observation).
5. Notify medical provider.

## Suicide Prevention and Intervention

### Nursing Education

1. Patients require transport to an Emergency Facility after a suicide attempt only if the injuries or medical condition warrant emergency medical care.
2. All patients must be evaluated for their risk of future suicide gestures or attempts. The level of precaution (Suicide Watch or Suicide Close Observation—see attachment 1) must be determined with the assistance of a mental health provider. Contact the PMHNP on call if a mental health provider is not available on site.
3. When possible, before calling the PMHNP on call, familiarize yourself with the patient's mental health status and risk for future self harm. Review the Behavioral Health Services Suicide Risk Screening tool (attachment 2), and the Behavioral Health Services Mental Status Screening tool (attachment 3).

### APPROVED:

\_\_\_\_\_  
Medical Services Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chief Medical Officer

\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Medical Director

11/3/09  
Date

Effective Date: Oct. 2009

Revised: September 2009

**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:

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**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#:

**MENTAL HEALTH SPECIAL STATUS**

# P-C-7

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
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## 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: