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TITLE: Suicide Prevention Program **PAGE 1 OF 15**

SUBJECT:

Suicide Prevention (Essential)

POLICY/PURPOSE:

To outline specific procedures designed to prevent suicide and harm resulting from intentional self-injurious behaviors and identify behaviors and characteristics in inmates at risk of suicide.

To establish staff roles and responsibilities relative to all aspects of suicide prevention.

To maintain a suicide prevention program that fulfills all of the standard requirements for suicide prevention in the correctional environment that include:

Training	Communication
Identification	Intervention
Referral	Notification
Evaluation	Reporting
Housing	Review
Monitoring	Critical Incident Debriefing

The guidelines herein are not exhaustive and should only be used as a foundation on which the sound clinical judgment of the responsible mental health or medical professional is based.

SUPERCEDES

This policy replaces the CMS Mental Health Suicide Prevention Program, NO: JBH-G-05 and Management of Potentially Suicidal Inmates, NO: JBH-G-05.01

CROSS-REFERENCE

1. This policy cross-references CMS Policy and Procedure JBH-A-10.1 Mortality and Morbidity Review – Completed Suicides and Serious Suicide Attempts; JBH-E-02 Receiving Screening-Intake Unit; JBH-E-03 NCCHC Receiving Screening of Intrasystem Transfers; JBH-E-03 ACA

Screening of Intrasystem Transfers; JBH-E-05 Mental Health Screening and Evaluation; JBH-E-09 Segregated Inmates; JBH-I-02 Emergency Psychotropic Medications; JBH-I-01.01 Use of Clinical (Therapeutic) Restraints; JBH-I-01.02 Security Applied Restraints-Medical Monitoring; JBH-A-10.0 Procedure In The Event Of An Inmate Death; Medical Affairs Policy; Procedure 10-11, Mortality, Morbidity, and Sentinel Event Report and Review.

DEFINITIONS:

Qualified Mental Health Professionals – Includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

Serious Suicide Attempt – An act of self-harm by an inmate resulting in the need for emergent or urgent medical treatment, such as the level of care provided in a hospital emergency department. Examples: Hunger strike, attempted hanging, overdose, self-inflicted lacerations or burns, ingestion of foreign substance, etc. resulting in the aforementioned need for emergent or urgent medical treatment. *(If in doubt as to whether morbidity review is required, contact Corporate CMS Behavioral Health Department.)*

GENERAL CONSIDERATIONS:

1. There are critical periods and risk factors that may be indicative of increased suicide risk for some inmates. Such critical periods and risk factors include the first 24 hours of incarceration, arrival at prison, intoxication and/or substance abuse, acute or chronic mental illness, debilitating physical illness, isolation (segregation, single cell), long sentence, court proceedings (added charges, denied parole, unexpected outcome), significant loss (job, significant other, death), “bad news” (divorce, break-up, foreclosure), significant position in community, feels unsafe in the facility, history of prior suicide attempts and/or self-injury, and juvenile status.
2. All staff have a role and responsibilities in the identification, referral, and management of suicidal and self-injurious behavior. However, it is the responsibility of mental and medical staff to assess suicide risk, assign level of risk/care, evaluate changes in the inmate’s status, communicate specific information about the status of the risk to the appropriate multidisciplinary staff members, and provide clinically indicated treatment and follow-up. Such responsibilities do not end with the Intake period but continue through the entire period of incarceration.
3. Regular communication with correctional staff regarding day-to-day observations of inmate behaviors and operations in housing units is an essential component in preventing inmate suicides. CMS and CMS-subcontracted mental health staff are expected to take a lead role in developing and maintaining cohesive working relationships with correctional staff.

PROCEDURE:

A. **Staff Training:**

1. All healthcare staff who have regular contact with inmates shall receive initial training in the identification and management of suicide risk as well as in all components of the site-specific CMS Suicide Prevention Program policy.

   a. Initial training should encompass why the environments of correctional facilities are conducive to suicidal behavior

   b. Staff attitudes about suicide, potential predisposing factors to suicide

   c. High-risk suicide periods

   d. Warning signs and symptoms

   e. identifying suicidal inmates despite their denial of risk

   f. Components of the facility's suicide prevention policy

   g. Critical incident stress debriefing

   h. Liability issues associated with inmate suicide.

2. All staff who have regular contact with inmates shall receive annual suicide prevention training encompassing a review of:

   a. Predisposing risk factors

   b. Warning signs and symptoms

   c. Identifying suicidal inmates despite their denial of risk

   d. Review all of the facility's policies and procedures relative to suicide prevention.

   Annual training should include general discussion of any recent suicides and/or recent suicide attempts in the facility.

4. The site Health Service Administrator shall maintain documented evidence of initial and annual suicide prevention training in every healthcare employee's file.

5. Independent contractors and providers subcontracted by CMS are expected to complete the above-referenced suicide prevention training. If the training is provided via a non-CMS suicide prevention program, the contractor must provide a certificate of attendance from an appropriately accredited organization. The site Health Service Administrator is responsible for ensuring that evidence of initial and annual suicide prevention training is present in the independent contractor and subcontracted provider personnel files.

6. Site Mental Health Directors are responsible for designing and implementing initial and annual suicide prevention training courses at their designated sites utilizing material available from CMS

Corporate educational resources and/or development of a site-specific program that encompasses all of the above-referenced training components. For sites without a Mental Health Director, the site Health Service Administrator is responsible for coordinating with site mental health staff to develop and implement initial and annual suicide prevention training.

7. As part of the annual suicide prevention training, site Health Service Administrator shall collaborate with correctional administrative staff to coordinate a "mock drill" training, such as mock attempted hanging. The purpose of this training is to evaluate staff response and make any improvements necessary to ensure a prompt and appropriate emergency response to all suicide attempts.

    a. Training should include review of site's emergency response policies and procedures and review roles and responsibilities for each medical, mental health, and correctional position.

8. Training of correctional staff in the identification and management of suicide risk is outlined in Policy and Procedure JBH-C-04.

B. **Identification/Referral**

1. All inmates shall be screened by qualified health care staff for potential signs and symptoms of suicide risk prior to placement in any housing unit and referred for mental health intervention, as appropriate, in accordance with the following applicable CMS Policy and Procedures: JBH-E-02 Receiving Screening-Intake Unit; JBH-E-03 NCCHC Receiving Screening of Intrasystem Transfers; and/or JBH-E-03 ACA Screening of Intrasystem Transfers.

2. In the event that the Booking, Arresting and/or Transporting Officer note inmate behaviors indicative of potential suicide risk, the officer notifies the PSU staff by phone call. A PSU mental health staff member will perform an emergent assessment and facilitate placement of the inmate in the appropriate level of monitoring.

3. Upon referral to PSU, the mental health clinician will access the MDC EJS system to ascertain whether the inmate has a previous history of receiving mental health services at MDC.

4. Intake staff performing such screenings shall exercise prudent clinical judgment in assessing the risk of suicide and initiating mental health referrals. Staff should not rely exclusively on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior or previous confinement suggests otherwise.

5. All staff members shall be constantly alert for signs of potentially self-injurious or suicidal behaviors in inmates throughout the entire incarceration period and are expected to promptly communicate such information to mental health staff and/or other medical/correctional supervisory staff.

6. The referral process for inmates exhibiting potentially self-injurious or suicidal behaviors is as follows:

a. Any staff member of the institution concerned that an inmate may be potentially suicidal will inform mental health staff immediately in accordance with site-specific notification protocols. Such referrals will also be accepted by detainees.

b. Mental health staff shall evaluate as soon as possible any inmate identified as potentially suicidal. It is the expectation that the site has a process to ensure that the inmate will be kept in a safe environment under constant observation by correctional staff until the evaluation is completed.

c. Upon initiation of Suicide Precautions, the Mental Health Clinician will forward a copy of the CDO-42 "Standard Referral Form" to correctional staff on the designated pod as notification of individual inmate precautions.

C. **Evaluation**

1. Inmates with positive mental health screening results shall receive a mental health evaluation by a mental health professional in accordance with CMS Policy and Procedure JBH-E-05 Mental Health Screening and Evaluation.

2. Evaluation of inmates by mental health staff will include but not be limited to assessment of:

   a. Mental status;

   b. Inmate's self-report of behavior resulting in the referral;

   c. Current suicide risk: active/passive ideation, plans, lethality of plan, recent stressors, goal of behavior;

   d. History of suicidal behavior/ideation: When, method used or contemplated, reason/triggering event for attempt, consequences of prior attempts/gestures;

   e. Inmate's report of his/her potential for suicidal behavior

   f. Inmate's willingness to verbally agree that he/she will not engage in self-injurious behaviors and will notify staff immediately if such feelings occur

3. Mental health staff will request a psychiatric consult whenever clinically indicated.

4. Inmates who continue to engage in self-injurious behaviors after placement in Suicide Precautions will be referred to the psychiatrist and considered for transfer to an inpatient psychiatric setting.

D. **Housing**

1. The Health Service Administrator and/or Mental Health Director will work collaboratively with site Administration to facilitate appropriate housing for inmates placed on Suicide Precautions. Cells

designated for such inmates should be made as suicide-resistant as is reasonably possible and have the highest level of visibility to staff.

a. Suicide precaution placement is limited to Segregation 1, PAC 5, PAC 6, and the Infirmary.

2. Prior to placement of an inmate in a Suicide Precautions cell, correctional staff is expected to conduct an inspection of the cell to ensure that it is free of items that may be used by the inmate to self-inflict injury.

3. If it is determined to remove clothing from a suicidal inmate, they shall be issued a suicide-resistant safety garment.

4. The use of any physical restraints shall be avoided whenever possible and used only as a last resort when the inmate is physically engaging in self-destructive behavior that is unresponsive to less restrictive intervention.

E. **Monitoring/Communication**

1. "Suicide Precautions" is considered an observational status placed upon inmates deemed to be at risk for suicide and requiring increased surveillance and management by staff.

2. A mental health staff member is available through the PSU office 24 hours per day, 7 days per week and are also available via radio to respond to potentially suicidal inmate reports.

3. The following components are specified in the PSU assessment and treatment and clearly communicated to all staff who have regular contact with inmates:

a. Clothing restriction;

b. Location and type of meal (i.e., finger food or regular meal with soft plastic spoon);

c. Bedding allowed;

d. Frequency of correctional monitoring;

e. Personal Property Restriction

f. Level of security escort when out of cell;

g. Personal hygiene schedule, (i.e., daily shower, personal hygiene items allowed in officer's presence, etc.); and

h. Recreation permitted.

4. Suicide Precautions at MDC consist of the following levels:

a. Constant Observation – Reserved for the inmate who is actively suicidal, either threatening or engaging in self-injurious behavior. These inmates are typically monitored

by direct and continuous visual observation by correctional staff and documented in accordance with correctional administrative policy.

i. Location – Segregation 1, PAC 5, PAC 6, and Infirmary
ii. Clothing – Suicide Smock ; Suicide blanket (as ordered by MH Clinician)
iii. Meals – Finger Food
iv. Bedding – Bunk/Boat and mattress to be determined and ordered by mental health clinician
v. Correctional Monitoring – Inmate will be constantly monitored in a cell by correctional officer or will be placed on bunk restriction on the floor of the unit dayroom and must remain on bunk in direct view of the officer.
vi. Personal Property – None. No towels allowed in cells.
vii. Level of Security escort when out of cell – Must be in direct view of correctional officer at all times.
viii. Personal Hygiene – Must be monitored for showering and may not keep personal hygiene items in possession.
ix. Recreation – Restricted from recreation area.

b. Close Observation – Reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (i.e., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior OR an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other behaviors suspicious for potential self-injury as noted by the inmate's actions, current circumstances, or recent history. Documented observation intervals by correctional staff are ideally staggered but not to exceed every 15 minutes.

i. Location – Segregation 1, PAC 5, PAC 6, and Infirmary in stripped cell
ii. Clothing – Suicide Smock ; Suicide blanket (as ordered by MH Clinician)
iii. Meals – Finger Food
iv. Bedding – Bunk/Boat and mattress to be determined and ordered by mental health clinician
v. Correctional Monitoring – Inmate will be constantly monitored by correctional officer at least every 15 minutes.
vi. Personal Property – Suicide resistant sheets for mattress. No towels allowed in cells.
vii. Level of Security escort when out of cell – Must be in direct view of correctional officer at all times.
viii. Personal Hygiene – Must be monitored for showering and may not keep personal hygiene items in possession.
ix. Recreation – Supervised by correctional officer

c. Routine Watch – Reserved for the inmate who can function in his current environment, including housing placement, has not expressed suicidal ideation, but has certain risk factors suggesting a higher potential for becoming severely depressed/suicidal as

compared to the inmate without such risk factors. Typically, correctional staff should perform and document one-to-one visual monitoring every 30 minutes and engage the inmate in regular communication so that any behavior and/or mood changes may be identified. Upon identification of such behavior or mood changes, it is the expectation that correctional staff contact mental health staff via urgent or emergent referral, based upon the severity of the symptoms. Mental health staff shall conduct further clinical assessment and implement changes to the inmate's level of suicide monitoring as appropriate.

i. Location –PAC in dayroom or in a cell as ordered by psychiatrist
ii. Clothing – Facility-issued uniform
iii. Meals – Regular or per special diet order for medical condition
iv. Bedding – Bunk/Boat and mattress in dayroom
v. Correctional Monitoring – Inmate will be monitored by correctional officer every 30 minutes.
vi. Personal Property – Allowed in dayroom
vii. Level of Security escort when out of cell – Must be in direct view of correctional officer at all times.
viii. Personal Hygiene – Must be monitored for showering
ix. Recreation – Allowed access to recreation area.

5. A psychiatrist and mental health staff member shall assess and interact with all inmates on Suicide Precautions on a daily basis. This assessment will be documented in SOAPE format in the inmate's medical record.
    a. A treatment plan will be developed or the current treatment plan updated for all inmates placed on suicide precautions
    b. Placement on Suicide Precautions should be documented on the Problem List.
6. Only a psychiatrist may remove an inmate from suicide precautions.
7. When appropriate, inmates on the highest level of Suicide Precautions shall be downgraded to the next lower level for a reasonable period of time before being discharged from Suicide Precautions.
    a. The decision to continue or remove an inmate on Suicide Precautions is optimally achieved following a multidisciplinary discussion among correctional and healthcare staff. As part of the daily interaction with and assessment of inmates on suicide precautions, mental health staff shall proactively seek input from the correctional officers regarding the inmate's behavior, mood, sleeping pattern, appetite, communication, as well as any other pertinent factors.
    b. When feasible, it is recommended that sites convene a daily conference with representation from medical, mental health, and correctional staff to review all inmates on

Suicide Precautions and collectively determine whether precautions should be discontinued, continued at the same level of observation, or continued at a reduced level of observation.

8. In order to ensure continuity of care for suicidal inmates, all inmates discharged from Suicide Precautions shall receive regularly scheduled follow-up assessment by mental health staff for as long as is clinically indicated or as directed by the inmate's individual treatment plan. All assessments will be documented in SOAPE format in the inmate's medical record.
    a. Recommended post-Suicide Precautions assessment by mental health is as follows:
        i. Within 24 hours of removal
        ii. Five to seven days post-removal
        iii. Twenty-one to thirty days post-removal
9. Documentation by a qualified health professional will be done at a minimum once per eight hour shift for inmates on suicide precautions.
10. The Mental Health Director is responsible for ensuring that staff document daily on the PSU report sheet all inmates on Suicide Precautions.
11. For inmates that have been transferred to an off-site inpatient psychiatric unit, mental health staff and/or the site psychiatrist will contact the hospital attending psychiatrist to discuss the inmate's plan of care while hospitalized, goals for discharge, and post-discharge mental health service care plan.
    a. Mental Health staff will contact the inmate's attending psychiatrist and obtain a copy of the discharge summary for review and placement in the inmate's correctional medical record.
    b. All inmates returning from the hospital for emergency or inpatient treatment following a suicide attempt/gesture are held in the Infirmary until they receive an evaluation by mental health staff. Based on the results of this assessment, the mental health clinician will recommend appropriate housing placement.
12. In addition to providing notification of Suicide Precaution initiation and discontinuation to corrections staff via the MDC-42 "Standard Referral Form", the MDC-42 "Standard Referral Form", correctional staff contact the PSU office on a daily basis to obtain a verbal update on all inmates currently on Suicide Precautions.
13. All healthcare staff shall recognize the increased risk of suicide among inmates in "special management" environments, such as disciplinary and/or administrative segregation. Segregation rounds shall be conducted in accordance with CMS Policy and Procedure JBH-E-09 Segregated Inmates.

14. It is recommended that a Suicide Prevention Task Force be convened at every site and include representation from medical, mental health, and correctional disciplines. Functions of the Suicide Prevention Task Force include but are not limited to regularly scheduled meetings to:

    a. Review and discuss recent suicides and/or serious suicide/self-injurious acts at the site.
    b. Review current site processes and policies relative to suicide prevention.
    c. Develop recommendations for improvement or revision to current site processes and policies for the purpose of improving quality of inmate care and decreasing risk. Recommendations will be forwarded to the appropriate site correctional, medical, and mental health administrative leaders in accordance with site policies.
    d. Develop and implement improvement plans as well as audit tools for measuring the effectiveness of improvement actions.
    e. Collaborate and design meaningful suicide prevention staff education programs for medical, mental health, and correctional staff at the site level.

F. **Intervention**

1. Upon verification by correctional staff that environment has been secured, immediate medical attention will be provided to any inmate who has attempted suicide or self-injurious act. CMS and CMS-subcontracted staff must be fully aware of site's safety and security policies and procedures, including those relative to emergency response.
2. Hanging attempts will be handled in accordance with the procedure "Disposition Following a Hanging Attempt." (Attachment A)
3. Once emergency medical treatment is completed, mental health staff will perform a clinical evaluation, including mental status, review of staff and inmate's report of self-injurious act, and inmate's risk of lethality. Based on the results of this evaluation, mental health staff will determine the need for further mental health and/or psychiatric intervention as well as recommendation for level of suicide precaution placement.
    a. The on-call psychiatrist shall be contacted for suicide watch orders to be given to nursing.
4. When clinically indicated, administration of emergency psychotropic medication to suicidal inmates shall be in accordance with CMS Policy and Procedure JBH-I-02 Emergency Psychotropic Medications.
5. Application of restraint, when clinically indicated, shall be in accordance with the applicable CMS Policy and Procedure JBH-I-01.01 Use of Clinical (Therapeutic) Restraints or JBH-I-01.02 Security Applied Restraints-Medical Monitoring.
6. Mental health and medical staff shall work collaboratively with correctional staff to monitor and ensure that all housing units maintain emergency response/first aid kits that include an emergency rescue (cutdown) tool.

G. **Notification/Reporting**

1. Notification and reporting of inmate death and/or suicide attempt will remain in accordance with the following CMS policies and procedures: JBH-A-10.0 Procedure In The Event Of An Inmate Death; Medical Affairs Policy and Procedure 10-11, Mortality, Morbidity, and Sentinel Event Report and Review.
2. Security staff is responsible for notifying family members and any applicable outside authority regarding attempted or completed suicides.
3. All medical and mental health staff who came into to contact with the victim before the incident shall provide input to the Health Service Administrator and/or Mental Health Director, as requested, regarding their knowledge of the victim and the incident.

H. **Review**

1. The Administrative Mortality/Morbidity Review Guide for Suicides and Serious Suicide Attempts shall be completed for all serious suicide attempts and completed suicides occurring at sites where CMS is responsible for the mental health care services either directly or via a subcontracted provider. This process shall occur in accordance with CMS Policy and Procedure JBH-A-10.1 Mortality and Morbidity Review of Completed Suicides and Serious Suicide Attempts.
2. The Health Services Administrator is responsible for coordinating morbidity and mortality review activity within 30 days of the event.
3. A copy of the autopsy report should be obtained for review and verification that suicide was ruled as the manner of death for all suspected suicides.

I. **Critical Incident Debriefing**

1. In the event of a serious suicide attempt or completed suicide, mental health staff will provide critical incident debriefing to all correctional and healthcare staff as well as inmates affected by the incident.
2. The site Mental Health staff will provide psychological support to all affected individuals in group and/or individual settings. Intervention goals are to mitigate the adverse emotional impact of trauma, facilitate closure to critical incidents, and expedite the return of personnel and inmates to routine functioning.
    a. Utilizing standard psychological service protocols, support will be directed toward stabilization of the situation, acknowledgment of crisis, understanding of adaptive coping and restoration to independent functioning.
    b. In the event that the Mental Health staff identify healthcare or correctional staff members in need of psychological support beyond such crisis stabilization, mental health staff will confer with the appropriate healthcare and/or correctional administrator to facilitate referral to the designated employee mental health assistance entity for professional intervention

as needed. CMS and CMS-contracted mental health staff do not provide ongoing psychological support services to healthcare or correctional staff. (Attachment B – optional debriefing aid)

c. For inmates in need of additional psychological services, mental health staff will perform a mental health evaluation and develop a treatment plan to provide psychological and/or psychiatric services necessary to prevent psychological decompensation and promote optimal functioning of the inmate within the correctional environment.

3. Mental health staff shall assist the facility's incident management staff in determining the nature and extent to which the intervention services are needed as well as the individuals recommended to participate in the intervention.

    a. Unless otherwise mandated by local or state policy, participation by healthcare staff, correctional staff, and inmates is voluntary.

4. For the purposes of debriefing, it is recommended that employees be grouped according to job duties, type, and exposure to critical incident.

5. Any employee who has a direct working relationship with the affected employee(s) shall not provide debriefing services.

6. For maximum effectiveness, the critical incident debriefing and other appropriate support services shall occur within 24 to 72 hours following the critical incident.

References:

National Commission on Correctional Mental Health Care: Standards & Guidelines for Delivering Services, 2003 M-A-10.

American Correctional Association: Standards for Adult Correctional Institution, 4th Edition, 2003 4-442