

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

SUBJECT: SUICIDE PREVENTION PROGRAM

POLICY: Inmate/patients 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
MH-E-06
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 Infirmery
- ❖ 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. Inmate/patients 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/patient is at risk for suicide or self-injury, necessary steps will be taken to ensure the inmate's safety. The inmate/patient 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/patient has already attempted suicide, necessary steps will be taken to stabilize the inmate/patient's physical condition before admission to Mental Health Infirmery (MHI).

1. If an inmate/patient 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/patient is medically assessed as not needing medical infirmery 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, support affected area/extremity if possible, call for cut down tool, cut the inmate down immediately and assist with 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/patient has been identified as potentially suicidal and a **BHS Treatment Provider is not immediately available** a Registered Nurse will evaluate the inmate/patient to determine if there is a suicide risk. The 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 **BHS** on-call Emergency Prescriber will occur to determine the level of monitoring. To determine the appropriate on call Prescribing Practitioner to contact, refer to the Behavior Health Services Emergency Provider On-Call Schedule (attachment 3). A current copy of the BHS on-call schedule is available via the U:\Operations\BHSCurrent Policy and Procedure Manual\BHS Prescriber On Call Schedule 2014
- F. This initial assessment /consultation will be documented on the progress notes in the medical file. Upon completion of the screening forms as noted above, the BHS screening forms will be filed under the Suicide Tab in the BHS section of the medical record.
- G. When suicide precautions are started, the Suicide/Close Observation Guide (attachment 5) will be placed on the Mental Health PINK Flow Sheet and tracking initiated.
- 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/patient will be dressed in a safety smock and may have a safety blanket(s) if the temperature is cold and s/he is at low risk of using the blanket to hide self-injurious behavior. The inmate/patient's 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 where there is 24 hour nursing coverage, Medical Services nursing staff will reassess the inmate/patient 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. This information will include the name of the on-call BHS Emergency Prescriber and contact numbers. 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/patient 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 BHS Emergency Prescriber and document the consultation in the health care record.

3. If the inmate/patient remains on Suicide Watch for 48 hours and the Treatment Provider determines that the inmate/patient cannot safely be moved to suicide close observation, the Treatment Provider will contact the MHI to make arrangements for admission.
- K. When an inmate/patient has been identified as at moderate risk of a suicide attempt or self-injury and a **BHS Treatment Provider is not immediately available** a Registered Nurse will evaluate the inmate/patient to determine if there is a suicide risk. The 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 **BHS** on-call Emergency Prescriber will occur to determine the level of monitoring. To determine the appropriate on-call Prescribing Practitioner to contact, refer to the Behavior Health Services Emergency Provider On-Call Schedule (attachment 3). A current copy of the BHS on-call schedule is available via the *U:\Operations\BHSCurrent Policy and Procedure Manual\BHS Prescriber On Call Schedule 2014*
1. This initial assessment /consultation will be documented on the progress notes in the medical file. Upon completion of the screening forms as noted above, the BHS screening forms will be filed under the Suicide Tab in the BHS section of the medical record.
 2. When suicide precautions are started, the Suicide/Close Observation Guide (attachment 5) will be placed on the Mental Health Flow Sheet and tracking initiated.
 3. The inmate/patient may be dressed in a safety smock. Clothing and other possessions may be removed if necessary to ensure the inmate's safety. The inmate/patient may have a safety blanket(s) if the temperature is cold and s/he is at low risk of using the blanket to hide self-injurious behavior. The inmate/patient may have reading material without staples, paper and non-toxic crayons at the discretion of the Treatment Provider.
 4. Security staff will physically observe the inmate at **staggered intervals** of no more than 15 minutes.
 5. In institutions where there is 24 hour nursing coverage, Medical Services nursing staff will reassess the inmate/patient 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/patient's mental status appears to deteriorate, or, if any acts of self-destruction are carried out. This information will include the name of the on-call BHS Emergency Prescriber and contact numbers. The evaluations, as well as any written instructions which are given to the Officer-in-Charge, are to be documented in the inmate/patient's health care record.

6. A Treatment Provider will assess the inmate/patient 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 BHS Emergency Prescriber and document the consultation in the health care record.
- L. Removal from or decrease in level of monitoring:
1. An inmate/patient 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/patient'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 BHS Emergency Prescriber. After review of the Suicide Risk Screening form, if both the on-call BHS Emergency Prescriber 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 BHS Emergency Prescriber will document on the next working day.
- M. When an inmate/patient 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.
- N. Following a suicide attempt, the suicide risk screening form (attachment 1) must be completed, either by nursing staff or mental health staff. It must be done even if it is completed after the attempt or following the patient's return from an emergency trip related to the attempt.

Effective Date: _____

Review date: August 2014

Supersedes P&P dated: July 2013

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#:

Behavioral Health Services On-Call Schedule (Revised 04/25/14)

BHS ADMINISTRATORS ON CALL AFTER HOURS AND SUICIDE/CRISIS REPORTING
JANA RUSSELL: 503 932-6989 CLAUDIA FISCHER-RODRIGUEZ: 541 561-6609
CHRISTY HENNING: 503 602-2458 DARYL RUTHVEN: 503 385-7020

Central Admin On-Call Schedule:

2014 – January - Claudia February – Jana March – Christy April - Claudia
May - Christy June - Jana July – Claudia August- Christy September – Jana
October-Claudia November- Christy December - Jana

When there is 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 you may contact the **secondary** on-call PMHNP for your institution. If you cannot reach either assigned PMHNP within **30 minutes**, you may call any other PMHNP on this list. Please do not call the backup or the next PMHNP until you have waited for the primary on-call PMHNP to return your call. They may simply be in a “dead spot” for cell phone coverage at the time you call. If you get their voice mail, make sure to leave a message, the time of your call, and also your call-back number. Remember that all they will see on their phone is the facility phone number, as the DOC system does not allow extension numbers to appear on the recipient’s phone.

During regular weekday, daytime work hours, in crisis situations, for assistance please contact a Mental Health Specialist, or BHS manager assigned to your institution. However, for institutions that do not have on-site BHS staff, contact Claudia Fischer-Rodriguez, Clinical Director, at 503 378-6376 (office) or 541 561-6609 (cell). **Please do not contact the PMHNP during regular work hours.** They have heavy patient schedules and must fulfill those responsibilities during their regularly scheduled work hours.

BHS Prescriber On Call Schedule		
ODOC West Side Institutions		
Institution	Primary	Backup
CCIC	Casey Dugan	Scott Haynes
CCCF	SID ending ODD: Lynne Clark	Melanie Parker
	SID ending EVEN: Melanie Parker	Lynne Clark
CCCM	Scott Haynes	Casey Dugan
CRCI	Becki Sauer	Casey Dugan
OSCI	Barbara Miller	Casey Dugan
OSP	Barbara Miller	Becki Sauer
SCCI	Barbara Miller	Becki Sauer
SCI/MCCF	Barbara Miller	Scott Haynes
SCCF	Becki Sauer	Casey Dugan

BHS Prescriber On Call Schedule		
ODOC East Side Institutions		
Institution	Primary	Backup
DRCI (E Units)	Rosanne Harmon	Rachel Fiocchi
DRCI (F Units)	Rachel Fiocchi	Rosanne Harmon
EOCI	Ted Chase	Trudy Evans
PRCF	Trudy Evans	Rosanne Harmon
SRCI	Trudy Evans	Rachel Fiocchi
TRCI	Ted Chase	Trudy Evans
WCCF	Rosanne Harmon	Rachel Fiocchi

Westside BHS Prescriber Contact Numbers	
Lynne Clark	(503) 477-2576
Casey Dugan	(503) 572-5243
Scott Haynes	(503) 551-6939
Barbara Miller	(503) 887-1919
Melanie Parker	(503) 477-2842
Becki Sauer	(503) 510-2988

Eastside BHS Prescriber Contact Numbers	
Rachel Fiocchi	(541) 325-6601
Ted Chase	(541) 240-4094
Trudy Evans	(541) 215 2699 (after hours (541-566-2265)
Rosanne Harmon	(541) 279-7916

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(s)	
Mattress (Unless there is documented history in the medical file of mattress misuse)	
Paper Cup/Tray/No Utensils	
Other (Mat: Teflon blanket padding, etc.)	

SUICIDE CLOSE OBSERVATION:

Visual and unobstructed one-to-one observation of the inmate at staggered intervals not to exceed 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 Blankets	
Mattress (Unless there is documented history in the medical file of mattress misuse)	
Paper Cup/Tray/No Utensils	
Crayons	
Reading Material/Paper	
Other (Mat: Teflon blanket padding, etc.)	

Additional Recommendations:

Mental Health _____

Authorized by _____

Cc: OIC, BHS Mgr, Medical, Housing Unit

NAME :
SID :
DOB :

**Attachment 5
P&P P-G-05**

Inst: _____	Suicide Watch/Close Observation Guide	LOC: INF/MHI/DSU/Other_____ (mark one)
Abbreviations: SW= Suicide Watch / SCO=Suicide Close Observation		
Suicide Status Initiated		
SW/SCO Initiated	<input type="checkbox"/> on _____ at _____ am/pm, by _____	(signature)
Suicide Status Change		
SCO to SW	<input type="checkbox"/> on _____ at _____ am/pm, by _____	(signature)
SW to SCO	<input type="checkbox"/> on _____ at _____ am/pm, by _____	(signature)
Suicide Status Terminated		
SW/SCO Terminated	<input type="checkbox"/> on _____ at _____ am/pm, by _____	(signature)
Please line-through any unused lines, once SCO/SW is completed.		

8/2012