

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

Steve Sheehan M.D.

Medical Director

2/24/2015

Date

Effective Date: 3/2015

Revised: February 2015

Attachment 1

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

LABEL

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 chart to determine if the inmate has been diagnosed with a SMI, if active symptoms and/or significant cognitive deficits are documented, if there has been a suicide attempt with an MHI admission within the past year, if the inmate has a DD2/DD3 CODE with cognitive impairment or other serious diagnosis/risk): 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? 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? Have you recently been physical assaulted?

Sexual abuse or sexual abusive behaviors: Have you recently been sexually abused or experienced sexual harassment? Have you recently sexually abused or sexually harassed someone?

Inmate Name and SID:

Attachment 2

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 these 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?

RISK FACTORS: (housed in DSU/IMU, recent cell change, under age 36, MH2/3, new to DOC, multiple misconduct reports, length of time remaining on sentence, slight build, first incarceration, unwillingness to defend self, perceives self as vulnerable, perceived to be gay, lesbian, bisexual, transgender, intersex, gender nonconforming):

****ACTIONS TAKEN:**

suicide watch suicide close observation crisis prevention plan hearings memo

** A verbal or written safety contract will not be used as a suicide precaution protocol

Notifications:

Consultation:

Referrals:

File Review: (documentation in a progress note of a diagnosis of SMI, active symptoms and/or significant cognitive deficits, suicide attempt with an MHI admission within the past year, if the inmate has a DD2/DD3 CODE with cognitive impairment, if the inmate has been sexually abused, sexually harassed or sexually abusive or other serious diagnosis/risks).

Provider: _____ **Date** _____ **Time** _____
(Print name below signature)

Inmate Name and SID:

Attachment 3

**BEHAVIORAL HEALTH SERVICES
MENTAL STATUS SCREENING**

Choose phrases that apply. **Describe significant information** in space below the check-off lists.
Document absence of symptoms, indicating what you asked about and/or observed.

Appearance: Looks stated age Looks older Looks younger Excessive make-up
 Well-groomed Clean Obese Underweight Untidy Dirty Looks ill

Dress: Unremarkable Casual Odd Seductive Overdressed

Orientation: Person Place Time Situation Good historian Poor historian

Behavior: Restless/fidgety Hyperactive Overly dramatic Impulsive
 Guarded Evasive Suspicious Intrusive Demanding Silly Rude
 Overly friendly Uncooperative Cooperative Withdrawn Slow/lethargic Animated
 Seductive Bizarre Tics Tremor (resting/voluntary) Staring into space Hypervigilant
 Quickly escalates, easily upset or frustrated

Rapport: Good Fair Poor Good eye contact Poor eye contact

Speech: Flows well Stutters Lisps Loud Soft Monotone Animated Inaudible
 Slow Hesitates/extended latencies Answers but no spontaneous talk Vague Mute
 Rapid Pressured/hard to interrupt Yelling/swearing Argumentative Sarcastic Slurred

Mood/Affect: No apparent distress Appropriate range of emotion Inappropriate for topic
 Cheerful/happy Elated/euphoric Calm Apathetic Constricted/blocked
 Anxious Sad Depressed Hopeless Volatile Irritable Angry Hostile

Knowledge/intelligence: Average vocabulary Poor vocabulary Superior vocabulary
 Possible above-average intelligence Possible developmental disorder Unable to grasp concepts
 Impaired problem solving Concrete/can't generalize

Perception: Normal Misinterprets real external stimuli Hears own thoughts

Hallucinations: Auditory Visual Somatic/Tactile Smell/Taste Bizarre

Command hallucinations: Violent Self-harm Must obey command Can ignore command

Thought Process: Goal-directed Coherent Sense of humor Concrete Slowed Racing
 Rambling/tangential Confused Excessive detail/circumstantial Loose associations Illogical thoughts
 Interruptions/blocking of thoughts Confabulates Makes up words Clang /rhyming

Thought Content: Within normal limits Aggressive/violent Sexual Preoccupations
 Obsessions (thoughts) Compulsions (actions) Phobias Suicidal (assess risk) Poverty of content/vague Thought broadcasting Thoughts controlled by others or controls others' thoughts

NAME: SID #:

Attachment 3

Delusions: Persecutory Paranoid Grandiose Religious Somatic Sexual
 Jealousy Bizarre Systematized

Memory/attention/concentration: Within normal limits Impaired

Check methods used to assess and results:

Immediate memory – give 3 words and ask client to repeat in order:

Serial 7's:

Serial 3's:

Spell a word forward/backward:

Alphabet forward/backward:

Memory – ask for repeat of the 3 words from above 20 minutes after initially giving them. For words not remembered, memory with clues:

Practical questions – indicate response:

What cell block are you in?

What did you have for breakfast?

What is your SID#?

What county were you convicted in?

Insight: Acknowledges problems Accepts responsibility Denies/minimizes

Blames others Uses symptoms to avoid responsibility Psychotic Denial

Understands benefits of medication/treatment Denies need for medication/treatment

Judgment: Adequate Impulsive Impaired (describe)

Social: Has community supports Has prison friends Vulnerable/mistreated in prison

Understands impact on others of appearance/behavior Does not recognize impact on others

****Overall assessment, recommendations, action taken:**

****A verbal or written safety contract will not be used as a suicide precaution protocol.**

Evaluator Name (Print): _____

Evaluator Signature: _____

Date: _____

Name:

SID#: