North Carolina Department Of Public Safety
Prisons

SECTION: Administrative

POLICY # TX-III-9

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SUBJECT: Suicide Prevention Program

EFFECTIVE DATE: September 1, 2016
SUPERCEDES DATE: January 15, 2015

References
Related ACA Standards

4th Edition Standards for Adult Correctional Institutions 4-4373

PURPOSE

The Division of Adult Correction-Prisons recognizes the need to have a comprehensive suicide prevention program. All Departmental staff shares the responsibility for preventing suicide by identifying those inmates who are at risk for suicide and/or in need of ongoing mental health services. Essential components of this suicide prevention program include early detection, intervention and treatment. Therefore, the program begins as soon as the inmate enters the prison system and is screened and assessed upon arrival. Continued vigilance on the part of staff enables them to develop a sound working knowledge of the individuals who make up the population; this vigilance must be maintained throughout the period of incarceration for each inmate.

To ensure early detection, intervention and treatment, the program's focus shall be on awareness through education, training, referral, assessment, treatment, monitoring and evaluation. Applicable proactive treatment and/or therapy are essential components of the Department's suicide prevention program.

PROGRAM OBJECTIVES

The expected outcomes of this program are:

A. All institution staff shall be trained and shall demonstrate knowledge and skills essential to recognizing the signs and information that may indicate an inmate is in need of mental health services.

B. All inmates who are clinically found to be in need of mental health services shall receive such services in a manner intended to ensure their health, safety and well-being.

C. All institution staff shall be trained and shall demonstrate knowledge and skill essential to recognizing potential for suicide.

D. Staff shall take action to prevent suicide with appropriate sensitivity, supervision, and referral.

E. Inmates at risk for suicide shall be assigned to an appropriate treatment setting to facilitate optimal mental health. Where physical structure within the facility permits, inmates placed on suicide watch generally should be managed in Health Services, i.e., not in a restrictive housing area, unless a Behavioral Health Restrictive Housing Unit is not available at the facility.

F. Ongoing performance improvement activities and initiatives shall be developed and implemented.

INSTITUTION RESPONSIBILITY

A. Each Facility Head shall ensure that a suicide prevention program is implemented and is consistent with this Department's suicide prevention program.

B. Each institution shall have a Coordinator for the Institution's suicide prevention program. The Coordinator shall be responsible for managing the treatment of suicidal inmates and for ensuring that the Institution's suicide prevention program conforms to the guidelines for training, identification, referral, assessment, and interventions outlined in the Department's plan. The Coordinator role must be held by a licensed Psychologist or Psychological Associate. Psychology Program Managers shall serve as the identified Suicide Prevention Program Coordinators for institutions within their area of coverage.

C. Specific rooms or cells shall be designated for suicide watch. Special care shall be taken to ensure these room(s)/cell(s) are free of any items that readily could be used to attempt/complete suicide; the room shall be inspected just prior to each watch to ensure that no structural characteristics exist, such as open-holed grates or hooks in the wall, something under the sink left behind by another inmate, etc., that would enable the inmate assigned to the room to readily engage in self-harm.

PROCEDURE

The primary focus of the suicide prevention program is awareness through education, training, referral, assessment, monitoring and evaluation. Applicable proactive treatment and/or therapy are essential components of the Department's suicide prevention program.

A. Education & Training

While the initial period of incarceration is often a critical time for detecting potential suicides, serious suicidal crises may arise at any time during the inmate's incarceration. Recent research reveals that suicidal ideation, which once was believed to be most prevalent during initial reception, may now occur at any time during the inmate's confinement. Line staff often are the first to identify signs of potential suicidal behavior because of their frequent interaction and contact with the inmate.

The Coordinator is responsible for ensuring that appropriate training is provided to staff and that all staff are trained to recognize warning signs for potential suicide, know how to appropriately safeguard and refer an inmate who may be suicidal, and are fully aware of suicide prevention techniques and the performance expectations included in the Division's Suicide Prevention Program. Accomplishment of these tasks requires the following:

1. During orientation, all newly assigned institution-based staff shall be trained to identify and appropriately refer inmates who may be in need of mental health services. Staff shall not discipline an inmate for self-harm, but shall apply alternative interventions aimed at minimizing/eliminating self-injurious/suicidal behavior. Whether or not behavior associated with the self-harm, for example, destruction of property and/or weapon possession shall be subject to discipline shall be made on a case-by-case basis and shall be clinically informed.

2. During orientation, all newly assigned institution-based staff shall be educated on the procedural details of the Self- Injurious Behavior Policy TXIII-7 and how to recognize warning signs and information that may indicate the intent of an inmate to engage in self-harm or his/her potential for suicide.

3. All institution staff who work directly with inmates shall participate in an annual in-service training on signs and information that may indicate the intent of an inmate to engage in self-harm or his/her potential for suicide. A minimum of two hours of annual refresher training shall be dedicated to this topic.

4. Facility Heads shall facilitate ongoing discussion regarding the issue of suicide at the department head unit meetings and other staff meetings. The primary purpose of the discussion shall be to heighten staff awareness regarding the need to detect and report any changes in inmate behavior that might suggest the need for behavioral health services and to appropriately refer those inmates with self-harm and/or suicidal intent for immediate risk assessment.

5. Orientation to the facility shall include the location of the cell(s) or room(s) to be used when an inmate is placed on suicide watch and/or special precautions. Special care shall be taken to ensure these room(s)/cell(s) are free of any items that readily could be used to attempt/complete suicide; the room shall be inspected just prior to each watch to ensure that no structural characteristics exist, such as open-holed grates or hooks in the wall, something under the sink left behind by another inmate, etc., that would enable the inmate assigned to the room to readily engage in self-harm.

6. Staff orientation and annual training shall include:
   a. identifying inmates who are emotionally distressed and/or mentally ill;
   b. identifying suicide risk factors;
   c. demographic/historical data pertaining to inmates who have successfully completed suicide, to include, but not limited to, past hospitalizations, past suicide attempts, location within the facility where suicides took place, typical at-risk groups, etc.;
   d. recognition of warning signs for potentially suicidal behavior;
   e. appropriate information and procedures associated with identifying and referring suicidal inmates;
   f. procedures for responding to a suicide emergency, including location and proper use of suicide cut-down tool; and
   g. name and contact information for the Suicide Prevention Program Coordinator.

7. Emergency response training for suicide prevention shall occur at all institutions and include at least three mock suicide emergencies each year, one on each shift and one of which shall be a "man-down" drill. One of the three exercises must be conducted in the restrictive housing unit, if operational within the institution. Confirmation of the mock suicide emergency training shall occur in writing to the designated department head for the institution and a copy shall be forwarded to the Suicide Prevention Program Coordinator for placement in a training documentation file. All staff who participated in the mock training shall be named on the document. Following the mock training, staff shall participate in a debriefing to discuss the outcome of the exercise. This debriefing also shall be documented in the training record.

8. Supplemental specialty training shall be provided for staff having contact with inmates who engage frequently in self-injurious or suicidal behavior. This training also shall be provided to staff who work in areas of the facility where the risk for self-injury and/or suicide generally is higher than in other areas of the institution, e.g., restrictive housing units.

9. Information about recognizing potential suicidal inmates and the procedures one must follow to help prevent suicide shall be posted in all restrictive housing units.

10. Inmates who engage in self-injurious behavior may deny suicidal intent and engage in such behaviors for a variety of reasons. However, an individual who continually engages in self-injurious behavior does present mental health and medical concerns, and, unintentionally, may engage in behavior that results in suicide. When an individual who continually engages in self-injurious behavior is identified, it is essential that the attending clinician establish a multidisciplinary team for the purpose of developing an individually tailored behavioral management plan and deciding how compliance with the plan shall be monitored and communicated across disciplines. At a minimum, the team should include Medical, Behavioral Health and Custody staff. It is critical that all staff managing a self-injurious and/or suicidal inmate are aware of and follow the treatment plan. It is not uncommon for inmates who demonstrate self-injurious/suicidal behavior to attempt to split staff in order to facilitate their behaviors.

B. **Screening and Referral**

Procedures for early identification and detection of at-risk inmates:

1. To ensure early identification and detection of at risk-inmates, all inmates newly admitted to Prison shall be provided with an initial health screening and physical examination during processing, to include, but not limited to:
   a. health screening by licensed nursing staff within twenty-four hours of arrival to the prison system, or to a different facility within the prison system as a result of transfer; this screening shall include the inmate's current mental and emotional health status and mental health history, to include any inpatient hospitalizations, diagnoses, and/or prescriptions for

psychotropic medication; a mental health referral shall be made to Behavioral Health Services staff if the inmate verbalizes past or current mental health issues;

b. diagnostic staff shall complete a mental health inventory screening on each inmate that includes any past and current mental health issues: a referral shall be made to Behavioral Health Services staff if the inmate answers "yes" to any of the screening questions pertaining to mental health;
c. the inmate shall receive a physical examination by a physician or physician extender; a referral shall be made to Behavioral Health Services staff if the inmate is identified with a mental health concern;
d. the inmate shall receive IQ testing (unless an IQ test has been completed within the past five years); a referral shall be made to Behavioral Health Services staff if the inmate cannot complete the testing or if the test yields a score of 70 or below; and
e. a qualified Behavioral Health professional shall be contacted immediately at any time during the screening process if the inmate's mental state suggests that the inmate poses a risk for self-injury or injury to others. The Behavioral Health professional shall conduct a more in-depth mental health assessment of the referred inmate.

2. A mental health crisis or complaint may emerge at any time during the inmate's incarceration and shall be addressed in accordance with the following procedures:
    a. a referral of all crises/complaints shall be made immediately to Behavioral Health Services staff, as outlined in policy, TXIII-7 Self-Injurious Behavior, and
    b. all non-emergent mental health referrals shall be initiated in compliance with policy A-12 Intersystem and Intrasystem Mental Health Services Screening, Appraisal and Evaluation.

C. **Assessment, Treatment and Monitoring**

To enable optimal mental health for inmates, assessment, treatment, and monitoring shall be provided on the basis of individual needs.

1. In compliance with policy A-12 Intersystem and Intrasystem Mental Health Services Screening, Appraisal and Evaluation, each inmate referred to Behavioral Health Services during processing into prison shall receive a Mental Health Appraisal. This policy requires the inmate to be seen on the basis of his/her clinical need(s); barring emergent need to be seen upon arrival, the inmate shall be seen within five (5) business days as the result of the referral process and/or a positive "yes" response to the item on the MHSI that indicates a current mental health concern. If the referral is the result of the MHSI with a positive history of mental health issues, but there is no currently identified mental health concern, the inmate shall be seen within 14 calendar days.

2. If, on the basis of the Mental Health Appraisal, an inmate requires continued mental health services, a Comprehensive Mental Health Assessment and Treatment Plan shall be completed, the inmate shall be assigned to a specifically named clinician, and he/she shall be seen as

frequently as his/her clinical presentation requires, but no less frequently than once every 45 days.

3. All inmates referred to Behavioral Health Services outside of the screening process at processing centers shall comply with policy A-12 Intersystem and Intrasystem Mental Health Services Screening, Appraisal and Evaluation, which requires the inmate to be seen on the basis of individual clinical need(s); barring emergent need to be seen immediately, the inmate must be seen within five (5) business days. Appropriate disposition shall be determined during the course of the appointment and shall be documented. If continued behavioral health services are required, a Comprehensive Mental Health Assessment and Treatment Plan shall be completed, the inmate shall be assigned to a specifically named clinician, and he/she shall be seen as frequently as his/her clinical presentation requires, but no less frequently than once every 45 days.

4. All inmates housed on a restrictive housing unit shall be seen on the unit by a Health Services staff member (physician, physician extender, nurse, nurse practitioner, psychologist, and/or social worker) within 24 hours of being placed in restrictive housing, and shall be assessed within 72 hours by Behavioral Health staff and once during each successive 30-day period (the assessment shall include the patient's then-current state of mind, under the domains of mood, affect, appearance, attitude, behavior, speech, thought process and content, perception, cognition, insight and judgment, and clinical judgement regarding the appropriateness of the housing assignment as it pertains to the inmate's mental health). The goal is to not place any inmates with mental illness in restricted housing units, but to place them in the least restrictive housing setting and offer treatment, to include behavioral expectations for moving to a less restrictive housing setting and incentives for meeting those expectations.

5. Nursing staff shall make a daily visit with inmates in restrictive housing and shall make an appropriate referral to Behavioral Health Services for any inmate identified to be emotionally distressed or in need of mental health services. During their daily visit to restrictive housing, nursing staff shall confer with Custody staff regarding behavioral observations relevant to the inmate's mental well-being. If an inmate refuses medication while in restrictive housing, he/she shall be referred by Nursing staff to Behavioral Health Services. This referral shall be made immediately.

6. Any inmate who appears to be adversely affected mentally and/or emotionally must be brought to the immediate attention of the Behavioral Health staff by the clinician/staff member who observed the mental/emotional decline. Any staff member may notify Behavioral Health staff of concerns about an inmate's mental/emotional decline. If placement in restrictive housing of an inmate with a serious and persistent mental illness is necessary, the placement shall be limited to 30 days or less; as placement of a mentally ill inmate in restrictive housing is discouraged and shall take place only as a last resort, such placement should be limited to 30 days in one calendar year. The clinician may determine that the negative impact of restrictive housing on the inmate's mental health supports an alternative to the then-current housing setting. In this case, the clinician shall consult with the Psychology Program Manager and/or

Assistant Director of Behavioral Health regarding other options, to include, but not limited to, recommending removal of the inmate from restrictive housing. In all cases, inmate and staff safety must be factored into this decision-making process and shall be clearly documented. Decisions for removal from restrictive housing shall be made by a multidisciplinary team that will include Behavioral Health staff, Custody, and Programs staff.

Any inmate who is referred for high security restrictive housing, known as HCON, shall receive a mental health assessment by a psychologist to determine if there are any contraindications for placement in an HCON restrictive housing unit. This assessment shall be completed prior to the inmate's placement in HCON and will be repeated every six months. A new HCON assessment is required prior to placement in HCON after each inpatient admission. If the inmate is diagnosed with a serious and persistent mental illness (SPMI) (* definition below) the placement in HCON shall require approval by the Director of Behavioral Health. Any inmate diagnosed with SPMI, and being reviewed for placement in restrictive housing, shall first be considered for alternative sanctions or referral to a Therapeutic Diversion Unit (TDU). For exceptional cases in which an inmate with SPMI presents a risk of harm to others, the inmate shall be seen by Behavioral Health staff for treatment purposes. Treatment shall include meeting with the inmate outside of the cell on a schedule determined clinically appropriate by the Behavioral Health clinician.

The Assistant Directors of Behavioral Health shall be notified of the need for extended placement in restricted housing (beyond 30 days) for all inmates diagnosed with SPMI in their region. A psychological assessment report will be completed by institutional staff and documented in the electronic record for review by the regional Assistant Director of Behavior Health who will consult with the Director of Behavioral Health prior to making a deposition. Extended placement in restrictive housing will be reviewed every 30 days.

(*Serious Mental Illness –Psychotic Disorders, Bipolar Disorders, Major Depressive Disorder and any diagnosed mental disorder (excluding substance use disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified mental health professional(s).

7. Communication across Behavioral Health and Nursing disciplines regarding refusal of medications or missed medications is required, as it is essential to the mental well-being of an inmate and, in some cases, of staff and other inmates with whom the inmate may interact. If the inmate has the potential to become violent, self-destructive or suicidal without the medication, nursing staff shall immediately notify the attending or on-call psychiatrist.

D. **Suicide Precaution and Watch**

To minimize the risk of self-inflicted injury and/or suicide within the inmate population, staff shall respond effectively to any such threat or attempts.

1. Staff must never take lightly an inmate's threats of or attempts at self-injury and/or suicide, or any information/hints received from other inmates regarding an inmate being potentially suicidal or engaging in self-injurious behavior.

2. Any staff may identify an inmate as potentially suicidal; when a staff suspects an inmate may be suicidal, the staff shall keep the inmate under direct line-of-sight supervision and initiate policy TXIII-7 Self-Injurious Behavior.

3. Although any staff may place an inmate on constant observation, pending a suicide risk assessment, only a designated psychologist, psychiatrist, or licensed clinical social worker may determine the ongoing conditions of the watch and, when indicated, remove the inmate from suicide watch. It is critical that all inmates placed on observation, or suicide watch status, receive a vinyl-covered mattress, and a tear-resistant blanket and smock.

4. Behavioral Health Services staff shall arrange to have an at-risk inmate placed in a designated room or cell and shall initiate policy TXIII-7 Self-Injurious Behavior. If the inmate's housing assignment is in restrictive housing and if the inmate's mental health state, as assessed at that time by a Behavioral Health clinician, allows, the inmate shall be returned to the restrictive housing unit once the crisis subsides to satisfy any sanction that had been imposed prior to placement on Suicide Watch and/or Special Precautions status.

5. Inmates with mental illness who are placed in restrictive housing shall be assessed for placement in the most appropriate housing, to include a TDU, a Residential Housing Unit, a Modified Housing Unit, or a Control Unit.

E. **Evaluation**

To ensure warranted changes are made to prevent recurrence of events with negative outcomes, a review of mental health services is essential. Therefore:

1. An annual program review of the Suicide Prevention Program shall be completed by the Suicide Prevention Program Coordinator at each facility and at least one staff member who is not directly involved in the Program.

2. In the event of a suicide, all evidence and documentation shall be preserved to provide data and support for subsequently assigned staff to complete a psychological autopsy and a performance improvement review. The site must be preserved as a crime scene until released by the Director, DPS/Prisons. The findings of the performance review shall be documented as a peer review event report, and processed and discussed at the Mortality Review Committee Meeting. Statistics concerning attempted (an event which could have resulted in death if immediate intervention had not been provided) and/or successful suicides shall be reported annually, with

the number of attempted suicides/suicides, locations, and the methods used to attempt/commit suicide included in the report.

3. Based on the applicable findings from the peer review event report and a root cause analysis, the facility's Executive Team shall implement a performance improvement plan, when warranted, and

4. The Health Services Continuous Quality Improvement (CQI) Committee, each year, shall recommend to Health Services leadership a performance improvement initiative that relates to the prevention of self-injurious behavior and suicide. This initiative will be based on the review data collected on individual deaths during the previous year, and will involve a systems approach to suicide and self-injury prevention.

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Director of Prisons

6/1/16
Date