Minnesota Department of Corrections

Policy Number:	**500.306**
Title:	**Suicide and Self-Injury Prevention**
Effective Date:	**2/18/20**

PURPOSE: To reduce the risk of offender/resident suicide or self-injury through staff training, identification, reporting and management procedures, and professional assessment and treatment standards.

APPLICABILITY: All facility staff

DEFINITIONS:

Continuing observation status (COS) – a status involving staff observation of the offender/resident (physically or electronically) on a continuing and frequent basis, with all medications administered by directly-observed-therapy. At some facilities, a step-down status is available involving increased behavioral monitoring in a normal living unit, allowing the offender/resident to participate in normal activities and programming.

Razor restriction – a status in which an offender/resident is prevented from having access to razors.

PROCEDURES:

A. Assessment

1. All staff are trained on an annual basis and must be alert to recognize offenders/residents who are suicidal or self-injurious. Whenever an offender/resident indicates by word or action that the offender/resident may be suicidal or self-injurious, staff must immediately inform mental health services, or the watch commander after business hours. Staff must continuously observe the offender/resident until appropriate placement is determined.

2. At the time of an offender's/resident's admission as a new commit, transfer, or release violator, security staff complete an intake interview that includes suicide and self-injury inquiries. Staff must also evaluate the offender's/resident's presentation in relation to possible mental health concerns (see Policies 202.040, "Offender Intake Screening and Processing," and 202.041, "Juvenile Facility Admissions").

3. Within 24 hours of an offender's/resident's arrival at a facility as a new commit, transfer, or release violator, health services staff conduct health and sexual violence screenings that identify mental health, suicide, and self-injury concerns (see Policy 500.050, "Health Screenings and Full Health Appraisals").

4. Within 14 days of an offender's/resident's arrival at a facility as a new commit or a release violator, mental health staff administer an admission mental health screening. This interview includes questions relating to past and present mental health treatment and concerns, including suicide and self-injury (see Policy 500.303, "Mental Health Assessment").

5. At any time, any DOC employee may make a referral to mental health services for an evaluation of an offender's/resident's suicide or self-injury potential. A professional

evaluation must be conducted as soon as possible, which may include a review of Suicide Risk and Protective Factors (available on the behavioral health private iShare site).

6. If an offender/resident is identified as at risk for suicide or self-injury outside of normal business hours, the on-call mental health provider must be contacted (see Policy 500.305, "Mental Health Services On-Call"). If deemed necessary by the on-call provider, the offender/resident is placed on continuing observation status (COS) and is assessed by facility mental health staff the next working day.

B. Intervention and management

1. After assessing an offender's/resident's risk of suicide or self-injury (with consideration of the standardized Suicide Risk and Protective Factors), a mental health provider determines appropriate intervention. Depending on the assessed risk, the provider may:

a) Provide no further services if there is no readily apparent risk.

b) Provide clinical services as indicated.

c) Provide counseling to the offender/resident while the offender/resident remains in normal housing. This is used if the offender/resident is a minimal risk, the stress is a special event that will pass soon, and/or it is desirable to use the support of the offender's/resident's regular unit and program assignment. This may include increased behavioral monitoring status.

d) Place the offender/resident on razor restriction (see Procedure C, below).

e) Initiate COS in situations involving moderate or high risk of harm.

(1) Under normal circumstances, a mental health provider orders COS using a Continuing Observation Order form (available on the general behavioral health iShare site), and specifies the conditions necessary for the safety of the offender. (See Policy 500.300, "Mental Health Observation.")

(2) Subsequent modifications of the conditions of COS or the termination of this status must be determined by a DOC-employed, licensed mental health provider, or an unlicensed mental health provider in consultation with a licensed provider. The decision to remove an offender/resident from COS must include completion of the Suicide Risk and Protective Factors form.

(3) The watch commander must notify mental health services and health services whenever an offender/resident is placed on COS, and a nurse assesses the offender/resident on each working day.

(4) On each working day, a mental health provider must visit and review any offender/resident on COS; must consult with the facility mental health director regarding the case; and must document the contact in the offender's/resident's mental health file.

(5) If an offender/resident on COS is unable to effectively communicate, a mental health provider must request that health services staff assess the offender/resident.

(6) A transfer to in-patient mental health care must be considered and documented for any offender/resident on COS.

2. In urgent situations, a watch commander may place an offender/resident on COS after office hours, and then immediately consult with the on-call mental health provider. When ordered by a watch commander, the initial observation conditions must be the most restrictive.

3. Following removal from COS, a mental health provider may:
   a) Provide continued assessment and counseling after the offender's/resident's return to the general population as clinically indicated, but at least once within the week following removal from COS. This follow up is not necessary if it is determined, in consultation with the facility mental health director, the offender/resident was not initially at risk for suicide and the COS placement was not justified (e.g., the COS placement was a decision by an on-call provider, acting with insufficient information).

   b) Initiate a referral to supportive living services for offenders/residents who need less monitoring than COS, but more intervention than can be provided through only outpatient care.

   c) Initiate involvement in an offender/resident companion program, if available at the facility.

   d) Initiate offender admission to residential mental health care, for offenders needing more intensive mental health services. (For adult male offenders, see also Policy 500.304, "Mental Health Unit Transfers").

C. Razor restriction
   1. Initial placement of offenders/residents on razor restriction
      a) Mental health staff is responsible for the placement of an offender/resident on razor restriction, due to a pattern of self-injury with a razor or other sharp object, to decrease the risk of further self-injurious behavior.

      b) Mental health staff must write a management plan that includes the reason for placement on razor restriction, provisions for periodic review of the restriction, and provisions for removal of the restriction. Mental health staff must place the plan in the offender's/resident's mental health file, and must note the placement and removal dates in COMS in the mental health profile text box.

   2. Once an offender/resident is placed on razor restriction, security staff must confiscate any razors in their possession, and prohibit them from purchasing a razor from the canteen.
      a) If the offender/resident resides in a multi-occupancy room, all the offenders/residents in that room must also be subject to razor restriction.

      b) Offenders/residents on razor restrictions are not placed in dormitory settings.

   3. Shaving/grooming for offenders/residents on razor restriction
      Facilities must have operational procedures to allow offenders/residents the opportunity to shave at least three times per week. These procedures may include such examples as:

a) Providing electric razors;

b) Allowing offenders/residents to shave under the observation of staff;

c) Having staff pass out razors during a designated time period and then collecting them; or

d) Other measures preventing offenders/residents from using razors for self-injury.

4. Facilities may develop operations procedures for imposing razor restrictions for all offenders/residents in a living unit.

5. Transfer of offenders/residents on razor restriction
Security staff are responsible to check the COMS mental health profile to identify offenders/residents on razor restrictions prior to transferring them to another unit or facility, and notifying the new unit or facility of the restriction prior to the transfer.

D. Prevention and education
All new DOC employees receive instruction related to the identification and management of suicidal and self-injurious offenders/residents.

1. Department staff are trained to recognize verbal and behavioral cues that indicate the potential for suicide or self-injury, and how to appropriately respond to these cues. Even when staff suspect that an offender/resident is being manipulative, suicide/self-injury statements or behaviors must be taken seriously and reported appropriately.

2. Volunteers and contractors who have significant offender/resident contact also receive training on suicide and self-injury. The DOC employee development unit is responsible for curriculum development and implementation.

3. All staff training must be documented and retained in the agency-approved electronic training management system.

E. Documentation

1. Non-mental health staff must document their observations and concerns regarding suicide and self-injury in an incident report, and make a mental health referral if appropriate – in addition to making immediate telephone notification to mental health services staff and/or the watch commander.

2. Clinical notes regarding suicide and self-injury must be written as soon as possible. In addition to the date, notes must reflect the time of day. If retrospective notes are necessary, they must be clearly identified as such. Notes include:
   a) How the risk of suicide or self-harm came to the provider's attention;

   b) An assessment including risk-factors, protective-factors, significant questions asked and responses, consultations with other professionals, how the provider's clinical judgment and decisions were derived from this information;

   c) A chronological listing of all actions taken; and

d) When precautions (e.g., COS) are being withdrawn, the provider's reasoning for that decision must be clearly described. The rationale must include a description of the offender's/resident's change in behavior and attitude, and how and why the offender's/resident's perspective on life, suicide motivation, etc. has changed to reduce risk. Although contracting for safety may be useful in establishing a therapeutic alliance, such a contract is not to be relied upon when assessing suicide risk.

3. Suicide or self-injury concerns must be entered into the correctional operations management system (COMS) and the iShare mental health significant incident log.

4. Incidents of completed or attempted suicide are reviewed in accordance with Policy 500.700, "Health Services Quality Assurance Program."

INTERNAL CONTROLS:

A. Suicide Risk and Protective Factors forms and other clinical documentation are stored in offender/resident mental health charts.

B. Suicide or self-injury concerns must be entered into the correctional operations management system (COMS) and the iShare mental health significant incident log.

C. Clinical documentation supporting the placement of an offender/resident on razor restriction, and the removal from razor restriction, is stored in the offender's/resident's mental health chart.

D. Placement and removal dates for razor restriction are noted in COMS in the mental health profile text box.

E. All staff training is documented and retained in the agency-approved electronic training management system.

ACA STANDARDS: 4-4257, 4-4262, 4-4276, 4-4267, 4-4342, 4-4373, 4-4374, 4-4416, 1-ABC-4E-42, 2-CO-4F-01, 4-JCF-4B-01

REFERENCES: Minn. Stat. §§ 244.03; 253B; 244.03; 241.01 subd. 3a(a); and 241.021 subd. 4
Policy 202.040 "Offender Intake Screening and Processing"
Division Directive 202.041, "Juvenile Facility Admissions"
Policy 500.303, "Mental Health Assessment"
Policy 500.300, "Mental Health Observation"
Policy 500.305, "Mental Health Services On-Call"
Policy 500.304, "Mental Health Unit Transfers"
Policy 500.050, "Health Screenings and Full Health Appraisals"
Policy 500.700, "Health Service Quality Assurance Program"

REPLACES: Policy 500.306, "Suicide and Self-Injury Prevention," 2/20/18.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: Suicide Risk and Protective Factors (See the behavioral health private iShare site)
Continuing Observation Order form (See the behavioral health general iShare site)

APPROVED BY:
Deputy Commissioner, Community Services
Deputy Commissioner, Organizational Services
Assistant Commissioner, Facility Services
Assistant Commissioner, Office of Strategic Planning, Implementation, and Employee Development

Instructions
500.306RW, "Suicide Prevention and Intervention Plan"