STATE OF LOUISIANA
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS
CORRECTIONS SERVICES

Health Care Policy
No. HCP30

15 March 2019

INSTITUTIONAL SERVICES / HEALTH CARE POLICIES
Mental Health and Substance Use Services
Suicide Prevention, Suicide Intervention, and Post Suicide Management and Training

1. **OBJECTIVE:** To establish a written suicide prevention plan for the Department of Public Safety and Corrections concerning the management of offenders who display suicidal tendencies or behavior and to establish a formal procedure for staff and offender critical incident debriefing that covers the management of suicidal incidents.

2. **REFERENCES:** La. R.S. 28:171; ACA Standards 5-1D-4082, 5-1D-4084, 5-4A-4257, 5-6A-4368-1, 5-6A-4370, 5-6A-4371, 5-6A-4373, 5-6A-4373-1, 5-6B-4389, 5-6B-4393, 5-6B-4393-1, 5-6D-4410, 5-6E-4416, 5-2A-4425 (Adult Correctional Institutions); Department Regulation Nos. AM-F-41 "Critical Incident Stress Management Program," and HCP28 "Mental Health Screening, Appraisal, and Evaluation."

3. **POLICY:** It is the policy of the Secretary that each institution shall have a written suicide prevention plan that is approved by the Health Authority and reviewed by the institution or program administrator. Management of self-injurious and suicidal offenders is conducted under the supervision and direction of a qualified medical person or a qualified mental health staff so as to enhance each institution's ability to prevent suicides.

4. **APPLICABILITY**: Deputy Secretary, Chief of Operations, Department's Medical/Mental Health–Director, Department's Chief Nursing Officer, Unit Medical Director, Unit Mental Health Director, Regional Wardens, Wardens, and Sheriffs or Administrators of local jail facilities where state offenders are housed. Each Unit Head shall be responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this policy.

5. **DEFINITIONS:**

   A. **Completed Suicide**: A self-injurious behavior that resulted in death of an individual.

   B. **Extreme Suicide Watch**: Observation method employed only for the management of offenders who present a clear and continual risk of self-injurious behavior(s).

   C. **Health Care Practitioner/Provider**: Clinicians trained to diagnose and treat patients, such as physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners, and physician assistants.

NOTE: This shall be in accordance with each health care practitioner/provider's scope of training and applicable licensing, registration, certification, and regulatory requirements.

D. **Intake Clinician**: Clinician who evaluates offenders upon intake to a correctional facility.

E. **Mental Health Care Practitioner/Provider/Professional**: Mental health staff who are qualified to diagnose and treat patients with a mental illness, (for example, physicians, physician extenders, psychologists, licensed professional counselors, and social workers) in accordance with each health care professional's scope of training and applicable licensing, registration, certification, and regulatory requirements.

F. **Mental Health Observation**: Observation method employed for the management of an offender who is not suicidal, but exhibits symptoms that need frequent monitoring.

G. **Mental Health Staff:** Individuals whose primary duty is to provide mental health services to offenders commensurate with their respective levels of education, experience, training, and credentials.

H. **Non-suicidal Self-Injurious Behavior**: Refers to the intentional destruction of one's own body tissue without suicidal intent. Common examples including cutting, burning, scratching, and banging or hitting, and most who self-injure have used multiple methods.

I. **Standard Suicide Watch**: Observation method employed for the management of offenders who are at risk for suicide, but do not present a clear and continual risk of self-injurious behavior(s).

J. **Suicide Attempt**: A self-injurious behavior that could have resulted in death and/or a permanent incapacitating physical disability if no intervention occurred.

K. **Suicide Evaluation**: A retrospective reconstruction of the individual's life with an emphasis on the risk factors that may have contributed to the individual's death.

L. **Suicide Gesture**: A self-injurious behavior that would not have resulted in death and/or a permanent incapacitating physical disability if no intervention occurred.

M. **Tier Walker**: An offender screened by Classification, Medical and Mental Health and trained by mental health staff on the warning signs and symptoms of suicide.

6. PROCEDURES

A. Screening for Suicide Risk

1) All intersystem transfer and intra-system transfer offenders shall receive a Mental Health Screening (Form HCP28-a) at the time of admission to a DPS&C facility by mental health–staff that includes screening for suicide risk. (See Department Regulation No. HCP28 "Mental Health Screening, Appraisal, and Evaluation" for more information.)

2) For after-hours suicide assessments may be completed by an on duty nurse and recorded on the Medical Intake Screen Form (intake nursing form). The mental health director/designee shall ensure that such information is timely recorded in the offender's Mental Health Screening, Appraisal and Evaluation.

B. Offenders Identified as Suicide Risk

If an offender is scheduled, transferred, and identified as a significant risk for suicide, the institution to which the offender is transferred shall be notified of this in a written note in the Medical Transfer Summary. Other measures of notification shall be taken as deemed necessary by the Unit Mental Health Director or designee (i.e. telephone contact, email, facsimile) and documented in the offender's medical record.

C. Assessment of Suicide Risk During Incarceration

1) While screening for potentially suicidal offenders is a routine function of mental health staff a potential suicide may also be tentatively identified by other direct care staff at any institution based on their interactions with and observations of offenders. If a Correctional Security Officer believes an offender is a potential suicide risk, that person must communicate this to their immediate supervisor.

2) If it is determined that the offender is being transferred to the receiving facility after an escape attempt or recapture after an escape, the offender shall be considered at high risk for suicide. The Unit Mental Health Director or designee shall ensure that the offender is placed on standard suicide watch and evaluated by a psychiatrist, psychologist, or physician prior to discontinuing the mental health management order. (See Section 6.D. below for more information on mental health management orders.)

D. Mental Health Management Orders

1) A Mental Health Management Order is issued for an offender requiring Mental Health Observation or Suicide Watch (Standard or Extreme).

2) The Instruction on the Mental Health Management Order (Form HCP30-b) shall describe which techniques are to be used for the individual offender and shall specify items permitted and not permitted while on this level of supervision. Examples of such are: "Paper Gown"; "Paper Sheet"; "Suicide

Mattress"; "No Razor"; "Toothbrush controlled by C.S.O./Use of toothbrush monitored"; "No pens, pencils, or sharp objects"). If an offender is placed in a single man cell, frequent conversation with the offender shall be attempted by security to reduce possible detrimental effects of social isolation.

3) In instances where it is determined that standard issue clothing presents a security or medical risk for an offender under a Mental Health Management Order, the mental health staff shall determine the appropriate security garment(s) that, to the extent possible, promote the offender's safety in a way that is designed to prevent humiliation and degradation. The Unit head or designee shall ensure that these garments are supplied to the offender.

4) Once the Mental Health Management Order is completed and a copy is given to the security supervisor, observation begins using the Mental Health Management Order Log Sheet (Form HCP30-c). Appropriate institutional personnel, as designated by the Unit Head, shall then be notified of the watch.

5) After a mental health management order has been discontinued, a follow-up contact with the offender by mental health staff shall be conducted within seven days to assess the offender's current mental status.

E. Types of Mental Health Management Orders

1) Mental Health Observation

a. Mental Health Observation is intended for psychologically impaired or disturbed offenders who show an acute exacerbation of symptoms, which is considered temporary and which may resolve or improve with closer management than can be provided to the offender in general population.

b. Offenders appropriate for Mental Health Observation may include, but not limited to those who are psychotic, in acute distress, noncompliant with psychotropic medication, or otherwise psychologically impaired to a significant degree, but who are not considered a high risk for suicidal or self-injurious behavior. This designation and pertinent observation measures shall be relayed to security personnel.

c. When clinically indicated, the mental health staff or security staff may request or seek to examine parts of the offender's property, such as correspondence, to assess the offender's potential risk for self-injury.

2) Suicide Watch: General Requirements

a. Generally, offenders who are suicidal should be placed in the least restrictive setting possible and should not be isolated unless their behavior indicates otherwise (e.g., an offender has access to items that can be used to cause harm and refuses to refrain from using these items.

b. There are two levels of suicide watch: standard and extreme. When an offender is identified as in need of suicide watch precautions, on-site staff shall maintain continuous observation of the offender until either standard or extreme watch procedure is implemented. (See below Section 6.E.2)h.i. for watch requirements specific to each level).

c. For all suicide watch settings, frequency of observation shall be included in the management instructions and shall vary from continual observation to intervals of 15 minutes or less. Within the prescribed interval, irregular additional observations shall be made on an occasional, random basis to frustrate the planning of self-injurious acts.

NOTE: In addition to observation by security staff at prescribed intervals, the institution may utilize selected offenders as tier walkers to supplement staff observation. However, use of tier walkers shall not relieve security officers of their obligation to observe and document offender behaviors at regular intervals. Utilization of tier walkers is strictly discretionary and must be in accordance with ACA Standard 5-6B-4393. (See below Section 6.E.2)j. "Use of Tier Walkers for Observation of Offenders on Suicide Watch.")

d. Whenever possible, suicide watches shall be implemented by a mental health staff via in-person or via through the facility's mental health on-call schedule. In the absence of mental health staff, another health care practitioner/provider or nurse may implement a standard suicide watch. In all such instances mental health shall be notified immediately, and the offender shall be assessed at the earliest possible time.

e. When clinically indicated, the mental health staff or security staff may request or seek to examine parts of the offender's property, such as correspondence, to assess offender's potential risk for self-injury.

f. After a suicide watch has been discontinued, a follow-up contact with the offender by a mental health staff shall be conducted within seven days to assess the offender's current mental status and suicide intent.

g. Prior to releasing an offender from any suicide watch, the security staff assigned to the offender's housing area shall be notified of the pending release.

h. Standard Suicide Watch Requirements:

i. In standard suicide watches, the attending mental health staff shall be responsible for utilizing the least restrictive management necessary to prevent an offender's self-harm.

ii. An offender who has been placed on a standard suicide watch shall be evaluated by mental health (or nursing staff in the absence of mental health staff) at a minimum of every 24 hours. Upon initiation of extreme suicide watch, offenders shall be evaluated at intervals no longer than 12 hours.

iii. A standard suicide watch shall be discontinued or down-graded only by a physician, mental health staff, or nurse practitioner in collaboration with a physician.

i. Extreme Suicide Watch Requirements

i. Extreme Suicide Watch shall only be ordered for the management of an offender who presents a clear and continual risk of significant self-injurious behavior, which includes behaviors deemed life threatening/suicidal as well as those deemed as non-suicidal self-injurious behaviors.

ii. Extreme Suicide Watch requires the authorization of the Medical Director or designee, (qualified medical staff).

iii. In Extreme Suicide Watches, the attending healthcare practitioner/provider who ordered the restraints (if ordered) shall be responsible for utilizing the least restrictive management necessary to prevent an offender's self-harm.

iv. Extreme Suicide Watch shall be stepped down to a Standard Suicide Watch for a length of time sufficient to assess the offender's stability prior to removing the offender from a Mental Health Management Order requiring suicide watch.

v. An Extreme Suicide Watch may only be modified (modified or downgraded) by a health care practitioner/provider. Notification of watch discontinuance or modification shall be sent to the Unit Medical Director or Designee.

vi. The Medical Director or designee (Mental Health Director) shall conduct an after incident review on each use of restraints for medical or mental health purposes utilizing the Utilization of Medical/Mental Health Restraints After Incident Review (Form HCP40-a.)

j. Use of Tier Walkers for Observation of Offenders on Suicide Watch

i. Treatment staff and designees such as "Tier Walkers" may be used to augment the observation of an offender on suicide watch. The "Tier Walker's" job is to observe the offender(s) on suicide watch and report any self-injurious or unusual activity.

ii. It is important to note that a "Tier Walker" is not equivalent to a fellow cell mate for the offender on suicide watch in a shared cell.

iii. Classification staff and unit security head or designee shall identify eligible offenders for tier walker positions based on disciplinary history, education, and personal knowledge of the offender.

iv. Mental health staff shall review the mental health records of potential tier walkers to ensure they meet the following criteria for selection:

a) Mental Health Level of Care 4 or 5; and

b) No mental health management orders within a three-year period, unless an exception is granted by Unit Mental Health Director or designee

v. A medical professional shall review the medical record of potential candidates to ensure that they have an appropriate medical duty status.

vi. Those offenders selected to be a tier walker shall be trained by a mental health staff utilizing a formal lesson plan developed by the Unit Mental Health Director and approved by the Health Care Authority. Offenders selected to be a tier walker shall also be trained by nursing staff in infection control issues and procedures for cleaning precautionary body fluids.

F. Suicide: Attempt or Completion

1) Duties of the first officer on the scene:

a. Notify other staff (call for help, activate beeper, etc.);

b. Get the victim down if hanging (using C-spine stabilization) (IMMEDIATE ACTION IS REQUIRED! SECONDS MAY SAVE A LIFE!!). *Policy permits single officer cell entry to save a life;

c. Initiate first aid (control bleed, begin CPR, etc.).

2) Duties of the second officer on the scene (*if second officer present*):

a. Request ambulance or medical assistance;

b. Assist with first aid and CPR as necessary;

c. Maintain security and preserve scene as much as possible;

d. Assist with evacuation of offender.

3) Duties of the Security Supervisor:

a. Ensure that ambulance or medical response team has been called; supervise and assist with first aid/CPR, as necessary, until medical assistance arrives or until evacuation to a medical area occurs;

b. Ensure that staff cooperates with medical team's speedy entry of area and evacuation of victim;

c. Ensure that scene is preserved as much as possible;

d. Notify unit manager/duty officer, institution's investigator, and mental health treatment staff so that the supervisor then can focus his full attention on the suicide incident. The unit manager/duty officer is then to be responsible for notifying other appropriate institutional personnel.

4) Duties of the EMT's, Paramedics, or Initial Response Team:

a. Initiate advanced life support care, resuscitation, or other necessary life recovery treatment commensurate with their training level;

b. Arrange transportation for the victim to the appropriate medical facility.

5) Equipment: The Unit shall be responsible to have the following equipment immediately available to the officers on duty to be used in responding to suicide events in designated areas throughout the prison:

a. Airway protection device;

b. Surgical gloves;

c. Blood stopper compression bandages;

d. Large paramedic shears;

e. Hoffman design 911 rescue tool;

f. Pocket mask.

6) If death occurs, the Health Authority shall notify the medical examiner or coroner of the offender's death and request that an autopsy be performed.

G. Post-Suicide Incident

1) Suicide Evaluation After a Suicide Attempt or Completed Suicide

a. The Warden and/or designee shall ensure the Classification Director and/or designee, Unit Mental Health Director and/or designee and the Unit Medical Director and/or designee work together to gather the necessary information to complete a suicide evaluation after a suicide attempt or a completed suicide. Suicide evaluations shall be completed on the Suicide Evaluation (Form HCP30-d).

b. The Unit Mental Health Director shall be responsible for submitting each Suicide Evaluation (Form HCP30-d) to the Treatment Projects Coordinator and the Department Medical/Mental Health Director within 3 business days of the suicide attempt or completed suicide.

2) Investigation by the Institution's Suicide Investigative Team

a. The Warden and or/designee shall ensure there is a suicide investigative team, which consists of a mental health staff member, an Institutional Correctional Investigator, administration, the security supervisor from the area where the incident occurred, and a medical staff member (physician, registered nurse, or paramedic).

b. The Warden and/or designee shall ensure that after a suicide attempt or a completed suicide, the suicide investigative team conducts an in-depth investigation and considers intensifying efforts to increase observation in high-risk areas. The suicide investigative team shall:

i. Interview witnesses, associates of the victim, and staff members in an effort to determine if any recent events in the

victim's life may have served as a "trigger" to motivate the suicide, and

ii. Evaluate the event to determine if structural or procedural changes could prevent reoccurrences.

c. The Warden and/or his designee shall ensure the suicide investigative team completes a Suicide Evaluation (Form HCP30-d) that includes their findings and submits this to the Secretary, The Dept. Medical/Mental Health Director, Unit Head, and Treatment Projects Coordinator.

3) Suicide Reviews by the Department's Suicide Review Committee

a. The Department Suicide Review Committee shall consist of the Department's Chief of Operations, the Department's Nursing Director and the Department's Medical and Mental Health Director.

b. The Department's Medical/Mental Health Director shall ensure that on a quarterly basis, the Suicide Review Committee meets to review all suicide attempts, all completed suicides, and suicide prevention procedures and to make necessary proposed adjustments to this regulation as needed.

c. The Treatment Projects Coordinator or designee shall serve as chairperson for the committee and shall determine the time, date and location of meetings.

d. Institutions presenting reports of a completed suicide or suicide attempt shall send a mental health representative and security staff to the Suicide Review Committee meeting to discuss the case.

e. Each Unit Head shall ensure that copies of all Investigations and Unusual Occurrence Reports concerning completed suicides and suicide attempts are forwarded to the Treatment Projects Coordinator.

f. The Treatment Projects Coordinator shall ensure the Committee compiles a report for each Suicide Review Committee meeting making recommendations for changes to the existing training program as necessary and submits to the Secretary, Chief of Operations and Unit Heads.

4) Site Review by the Department's Suicide Review Team

a. The Department's Suicide Review Team shall consist of the Unit's Mental Health Director, the unit's Medical Director, the Department's

Chief of Operations or designee and the Department's Medical/Mental Health Director or designee.

b. When the Department Suicide Review Committee deems necessary, the Department's Medical/ Mental Health Director shall ensure that suicide team conducts an in-depth site review after a suicide attempt or completed suicide.

c. The Warden and/or his designee shall ensure the suicide investigative team prepares and provides the Department Suicide Review team with a report of their findings that includes, but is not limited to:

i. Suicide Evaluation (Form HCP30-d)

ii. Facility procedures relevant to the incident;

iii. All relevant training that involved staff had received;

iv. Pertinent medical and mental health services and reports on the victim;

v. Possible precipitating factors leading to incident; and

vi. Recommendations, if any, for changes in policy or Department Regulations, training, physical plant, medical or mental health services, and operational procedures.

5) Critical Incident Stress Management

Critical Incident Stress Management debriefing shall be afforded to offenders and staff following a critical incident, pursuant to Department Regulation No. AM-F-41 "Critical Incident Stress Management Program."

H. Training

1) All staff with the responsibility for offender supervision are trained on an annual basis in the implementation of suicide prevention and intervention. Training shall include but is not limited to:

a. Identifying the warning signs and symptoms of impending suicidal behavior;

b. Understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors;

c. Responding to suicidal and depressed offenders;

d. Communication between correctional staff and health care staff;

e. Referral procedures;

f. Housing observation and suicide watch level procedures;

g. Follow-up monitoring of offenders who make a suicide attempt; and

h. Population specific factors pertaining to suicide risk in the facility.

2) All new correctional officers shall receive 120 hours of training during their first year of employment which includes suicide intervention/prevention.

3) Designated correctional staff and all health care staff shall be trained to respond to a health-related situation within a four-minute response time and the training shall include instruction on suicide intervention. (See Department Regulation No. AM-F-22 Training and Staff Development.)

4) All mental health staff shall receive 12 hours of continuing professional education or staff development in clinical skills annually and mental health staff is encouraged to include suicide/self-injury prevention in that annual training.

5) In addition to regular yearly training, the clinical staff at each institution is encouraged to seek ongoing continuing education specific to suicide prevention.

6) Yearly Refresher: suicide prevention training review

a. Identifying the warning signs and symptoms of impending suicidal behavior.

b. Understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors.

c. Responding to suicidal and depressed offenders.

d. Communication between correctional and health care personnel.

e. Referral procedures.

f. Housing observation and suicide watch procedures.

g. Follow-up monitoring of offenders who make a suicide attempt.

h. Use of emergency equipment, standard first aid, and CPR.

7) The Unit Head shall ensure all correctional officers complete the Mental Health First Aid Training by a certified facilitator. The training teaches staff how to identify, understand and respond to signs of mental illness and substance use disorders.

7. MONITORING REQUIREMENTS/ REPORTS

The Unit Mental Health Director shall ensure that data relative to suicides is submitted in accordance with Department Regulation No. AM-I-4 "Activity Reports/Unusual Occurrence Reports Operational Units."

s/James M. Le Blanc
Secretary

Forms:	HCP30-a	Mental Health Behavioral Checklist
	HCP30-b	Mental Health Management Order
	HCP30-c	Mental Health Management Order Log Sheet
	HCP30-d	Suicide Evaluation
	HCP40-a	Utilization of Medical/Mental Health Restraints After Incident Review

This Health Care Policy supersedes Health Care Policy No. HC-38 dated 01 August 2002.

Reviewed as of: October 1, 2019

Form HCP40-a
07 October 2011

LOUISIANA DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS
Utilization of Medical/Mental Health Restraints After Incident Review

Offender's Name: _____ DOC #: _____

- ☐ Initial assessment made by a licensed nurse or mental health care practitioner.
- ☐ Use of restraints approved in writing by Medical Director or designee.
- ☐ Medical/mental health progress note justifies reason for use of restraints.

Date and time medical/mental health restraints initiated: _____

Date and time medical/mental health restraints discontinued: _____

Medical record/mental health management order documents orders for:

- ☐ Type (i.e., four or five point) and location of restraints ordered.
- ☐ Observation frequency no greater than 15 minutes.
- ☐ Length of time restraints ordered.

Medical record has the following information documented:

- ☐ Health care staff assessed application of restraints upon initiation of restraints.
- ☐ Health care and/or mental health staff assessed medical and mental health status of offender at least every 12 hours.
- ☐ Above assessments documented in offender's medical record.
- ☐ Correctional Security Officers observed offender at ordered intervals and documented on the Mental Health Management Order Log Sheet.
- ☐ Approximate consumption of solids and liquids and hours of sleep documented on the Mental Health Management Order Log Sheet.
- ☐ Health care or trained staff member (which may include a Correctional Security Officer) examined the offender every two hours and documented the presence or absence of swelling and/or discoloration of extremities, the adequacy of blood circulation and any other potential risk to the offender's health.
- ☐ Release from restraint for toilet, sanitation and nourishment functions made available and documented on the Mental Health Management Order Log Sheet at intervals no greater than two hours while the offender is awake.
- ☐ Mental Health Management Orders document progressive down grade to the least restrictive level of care.

_____ _____

Medical Director or designee Date/Time

Form HCP30-b
01 August 2002

MENTAL HEALTH MANAGEMENT ORDER

Name:_____ DOC#:_____ Location:_____

Begin _____

Discontinue _____

Continue _____

Change to _____

Check One: ☐ Standard ☐ Extreme ☐ Other _____

Management instructions:_____

_____

Housing:_____ Able to be doubled? ☐ Yes ☐ No

Property:_____

_____

_____

Observation frequency:_____

Other:_____

_____

Date and time examined:_____

Date and time of order:_____

Ordered by:_____ _____
Signature Title

If an extreme mental health management is ordered a physician signature is required.

Verbal order received by:_____ Date/Time:_____

Any changes requires a new Mental Health Management Order

Copy: Original to Mental Health
Medical Records
Security

Form HCP30-a
01 August 2002

MENTAL HEALTH BEHAVIORAL CHECKLIST

Name:_____ DOC#:_____ Date:_____ Time:_____

Location of Observation:_____

		Yes	Comment
1.*	Self-destructive act	☐	_____
2.*	Suicide ideation	☐	_____
3.	Critical changes in situation	☐	_____
4.	Depressed	☐	_____
5.	Mood changes	☐	_____
6.	Agitated	☐	_____
7.	Hostile	☐	_____
8.	Insomnia/hypersomnia	☐	_____
9.*	Gives away property	☐	_____
10.*	Bizarre behavior	☐	_____
11.	Homicidal ideation	☐	_____
12.	Other	☐	_____

* If any of these items are checked, suicide precautions should be initiated.

Mental Health Notified: (Name)_____ Date/Time:_____

Action Taken:_____

Supervisor's Signature:_____ Date/Time:_____

Reporting Officer:_____ Date/Time:_____

Definitions:

1. **Self-destructive acts** - cuts self, hangs, makes noose, bashes head against wall.
2. **Suicide ideation** - talks of suicide, indirectly talks of suicide (the world would be a better place without me).
3. **Critical changes** - death of a loved one, major change in health status, change in loved one's health, change in marital or significant relationship, additional sentence, appeal denied, dropped from IMPACT or other special program.
4. **Depression** - cries, emotionally flat, apathetic, withdrawn, uncommunicative, verbalize hopelessness worthlessness, moves/speaks slowly, difficulty carrying out routine tasks.
5. **Mood changes** - severe changes in mood from sad to happy or happy to sad.
6. **Agitation** - offender begins pacing, has excessive body movements or excessive speech.
7. **Hostility** - out of character hostility; offender normally cooperative becomes hostile.
8. **Insomnia/hypersomnia** - sleeps too little or too much (not one sleepless night or one period of sleeping too much).
9. **Gives away personal possessions** - pay debts, says goodbye to friends.
10. **Bizarre behavior** - speaks in nonsensical manner, expresses bizarre ideas, inattentive to surroundings (appears to be attending to only his/her own thoughts, appears "lost"), rapid speaking with overflow of ideas, talks to self, appears to be hallucinating.
11. **Homicidal ideation** - talks of homicide; indirectly talks of homicide; threatens to hurt or kill someone.
12. **Other** - any observation that reporter feels significant; describe briefly.

Copy: Medical Records
Security

Form HCP30-c
01 August 2002

MENTAL HEALTH MANAGEMENT ORDER LOG SHEET
(To be completed at least every 15 minutes)

Offender's Name:_____ DOC#:_____ Date:_____

Check One: ☐ Extreme
☐ Standard

Name of therapist:_____

Please record the time of the observation, check the behavior you observe or write in the appropriate space the behavior you observe, and sign.

	acting out (racking down, yelling, throwing things, flooding cell, etc.)	sitting quietly or standing at bars	sleeping	using bathroom	talking to others	laughing or crying to self	self-stimulating (rocking, masturbating, talking to self, singing)	
Time								**Officer's Signature**

Please check if the offender ate his/her meals and record the time of each meal. Also record the time of his/her shower.

Breakfast: Time_____ Lunch: Time_____ Dinner: Time_____ Shower: Time_____

Form HCP30-d

Suicide Evaluation

Facility:

Attempt ☐ Completed ☐

Name:

DOC:

Age/DOB:

Sex:

Race:

Level of Care at the time of Incident:

Date of Incident:

DOC Admission date:

Sentence:

Length of stay at institution prior:

Description of Incident:

1st Response: Initial Action taken

2nd Response: What was done after

Disposition: Transfer/kept in house after incident

Observation Status: LOC history, Prior MHO SSW ESW dates

Medical History: meds, etc.

Profile: Kids, marital status, visitation history, family support, etc.

Criminological Facts: cell, history of bullying? Criminal history

Form HCP30-d
Page Three

Mental Health History: Major depressive disorder, history of self-mutilation, drug misuse, psychosis, self-reporting, childhood history

Signature Date

Evaluations:

Facility

Medical
