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EXECUTIVE SUMMARY

A Process Action Team was chartered in December 2007 to examine offender suicides within the Oklahoma Department of Corrections due to an unprecedented increase in suicides reported during Fiscal Year 2006 and Fiscal Year 2007.

This report outlines the process used by the Process Action Team in examining this critical problem and presents findings and recommendations resulting from this comprehensive examination. Recommendations are as follows:

- **Recommendation #1:** Charter a multi-disciplinary work group to develop a standardized training program for staff based on core competency levels outlined in OP-140129 entitled “Suicide Prevention,” and customize training for each work location to address facility physical plant, field memoranda, etc.

The training will incorporate the risk factors identified in the survey of corrections departments nationally (refer to page 21) as well as the Department of Corrections precipitants and behavior changes identified (refer to page 20) as a suicide prevention handout for staff training materials.

The training plan, when developed, will be reviewed by stakeholders from multiple disciplines (i.e., security, mental health, medical, etc.).

Prior to work assignment on the Mental Health Units at Mabel Bassett Correctional Center, Joseph Harp Correctional Center, and Oklahoma State Penitentiary, all security staff will receive specialized mental health training as developed by this work group.

- **Recommendation #2:** Examine the use of video conferencing as a method of training delivery for staff.
- **Recommendation #3:** Standardize the suicide prevention segment of the offender orientation and offer it at every facility. The offender orientation will include the risk factors, precipitants, and behaviors as identified in Recommendation #1 above.
- **Recommendation #4:** Standardize the definitions of “suicide attempt” and “self-mutilation.”
- **Recommendation #5:** Initiate policy changes that require the initial mental health screening to include screening for appropriate placement of offenders in high risk jobs such as jobs in the kitchen, maintenance, Oklahoma Correctional Industries, etc. At minimum security, these high risk jobs would also include Department of Transportation crews and prisoner public works projects crews.
- **Recommendation #6:** Establish a multi-disciplinary work group to develop an implementation plan for an Offender Observer Program to aid in offender observation during suicide watch. The plan will include selection criteria, training curriculum, and recommended pilot sites.

- **Recommendation #7:** Designate security positions assigned to Mental Health Units at Mabel Bassett Correctional Center, Joseph Harp Correctional Center, and Oklahoma State Penitentiary as specialized, nonrotation positions due to the level of training (refer to Recommendation #1).

Prior to work assignment on the Mental Health Units at Mabel Bassett Correctional Center, Joseph Harp Correctional Center, and Oklahoma State Penitentiary, all security staff will be screened by senior security staff, unit management, and mental health staff for motivation and capability.

- **Recommendation #8:** Set aside funding for 36 additional safe cells at locations identified on Page 9.
- **Recommendation #9:** Explore options for providing suicide watch for female offenders in need of suicide watch while housed at Altus Community Work Center.
- **Recommendation #10:** Require the mental health authority, in conjunction with security staff, to develop a policy and a field memorandum addressing maintenance and inspection schedules for suicide smocks and blankets, as well as cell searches for Levels I and II.
- **Recommendation #11:** Initiate annual recertification of safe cells to be conducted by Safety Administration based on guidelines set forth in OP-140141.
- **Recommendation #12:** Revise OP-140129 to incorporate the National Commission on Correctional Health Care (NCCHC) Standard MA-A-10 (Procedure in the Event of an Inmate Death) to include clarifying the content, goals, and communication of results of the review process and requiring a psychological autopsy on every offender suicide.
- **Recommendation #13:** Revise OP-140129 to require an individualized treatment plan containing, at a minimum, relapse prevention and risk management protocol (to include signs, symptoms, and the circumstances under which the risk of suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur) for every offender with a history of suicidal ideation and/or action to ensure compliance with NCCHC Standard MH-G-03 (Treatment Plans).
- **Recommendation #14:** Revise OP-140129 to ensure compliance with NCCHC Standard MH-G-04 (Suicide Prevention Program. Specifically, revise OP-140120 to ensure that:

“Evaluation” includes “procedures for periodic follow-up assessment after the individual’s discharge from suicide precautions.”

“Treatment” strategies and services address “the underlying reasons for the offender’s suicide ideology . . .”

“Strategies” include “treatment needs when the patient is at a heightened risk of suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.”

“Monitoring” includes “other supervision aids (i.e., closed circuit television, offender companions or watchers) can be used as a supplement to, but never as a substitute for, staff monitoring.”

INTRODUCTION

On December 17, 2007, Debbie G. Mahaffey, deputy director of Treatment and Rehabilitative Services, chartered a Process Action Team to examine offender suicides within the Oklahoma Department of Corrections. The Process Action Team followed the process shown in Appendix A in conducting this examination.

Process Action Team Leader

Dr. Bill Ellington, Mental Health Services, Oklahoma State Penitentiary

Process Action Team Members

Courtney Charish, Evaluation and Analysis
Karen Collins, Eddie Warrior Correctional Center
Katryna Frech, James Crabtree Correctional Center
Ron Guthrie, Joseph Harp Correctional Center
Jay Hodges, Training and Staff Development
Brian Holden, Oklahoma State Penitentiary
Stephanie Howard, Lexington Assessment and Reception Center
Dr. Gale Joslin, Joseph Harp Correctional Center
Lynn Martinez, Eddie Warrior Correctional Center
Steve Moles, Dick Conner Correctional Center
Dr. Laura Pitman, Female Offender Operations
Jack Pogue, Oklahoma State Penitentiary
Shawn Price, Dick Conner Correctional Center
Patrick Scychosz, Oklahoma State Penitentiary
Dr. James A. Smash, James Crabtree Correctional Center
Pat Sorrels, Institutions
Dr. Doyle Stewart, Oklahoma State Penitentiary
Amy Thomas, Oklahoma State Penitentiary
Etta Thomas, Training and Staff Development
Bruce White, Oklahoma State Penitentiary
Randy Workman, Oklahoma State Penitentiary

Facilitator

Debbie Boyer, Quality Assurance

Administrative Support

Cindy Gill, Quality Assurance
Liz Janway, Mental Health Services

OVERVIEW OF THE PROBLEM

The Oklahoma Department of Corrections was fortunate to have been well below the national average for prison suicides, as well as below the Oklahoma suicide rate for the general public since 1999.

However, within the first few months of Fiscal Year 2006, the Department of Corrections chief mental health officer noted an unprecedented increase in offender suicides.

Immediate action was taken at that time to produce an intensive training suicide risk management workshop that resulted in policy changes and may have accounted for a reduction of suicides for the remainder of Calendar Year 2006.

However, during Fiscal Year 2007, another increase was identified. As a result of this increase, the Suicide Prevention Process Action Team was chartered.

STEP 1: IDENTIFY AND SELECT THE PROBLEM

The team's objective for **Step 1: Identify and Select the Problem** was to ensure the "As Is" statement of the problem and the "Desired" statement identified on the Charter Agreement were clearly understood by all team members.

"As Is" Statement:

For the past two years, the Oklahoma Department of Corrections has been above the national average for prison suicides. Numerous factors contribute to the suicide rate within the Oklahoma Department of Corrections including specialized staff training, staffing levels, lack of designated housing, and a lack of updated research including risk indicators.

"Desired" Statement:

There will be no suicides within the Oklahoma Department of Corrections.

STEP 2: ANALYZE THE PROBLEM

The team's objective for **Step 2. Analyze the Problem** was to identify the gaps between the "As Is" and "Desired" states and collect the data necessary to analyze the problem.

The Process Action Team met on April 10, 2008. The team used brainstorming to identify gaps and modified affinity to categorize those gaps into six areas:

Cell Design:

- Facilities that deter suicide;
- Cell design "anchor points" for hanging;
- Availability of observation cells (housing);
- Safe cells;
- Conditions of confinement (logistical issues);
- Better technology to observe;
- Devote resources;
- Secure electrical outlets and lighting;
- Make shift cells when placements are not available;
- Lack of cells.

Housing Utilization:

- Lack of appropriate housing;
- Housing assignments—together or not;
- Facility assignments;
- Mechanism to make moves (Department of Corrections is bed driven);
- Mechanism for security/medical documentation to make appropriate placements;
- Communication is lacking between Department of Corrections, private prisons, and counties bringing offenders into Lexington Assessment and Reception Center and Mabel Bassett Correctional Center.

Staffing:

- Lack of money;
- Necessary staff to fend off suicides;
- More staff;
- Lack of quality staff;
- Inadequate supervision of offenders in crisis;
- Specific staff (officers) on non-rotating assignments;
- Security training;
- Staffing—officer and mental health;
- Selection of staff (officers) on MHU;

- Upper management at facility level must “buy into” mental health issues and understand they are real;
- Staff overwhelmed with workload which decreases patient care—leads to mistakes; goes for medical and non-medical.

Training:

- New employee orientation—signs/response (i.e., mental health block with mental health involvement and officer input);
- Response cards to individual employees with supervisor follow-up;
- Inadequate training about suicide warning signs (obvious and those not so obvious i.e., facial expressions);
- Health issues and understanding that they are real;
- Failure to recognize potential suicide situations;
- Offender orientation (PREA);
- Lack of standardized suicide prevention training;
- Line staff do not follow plan of care;
- Training of understanding causes;
- Legal training, legal verification;
- Communication skills.

Data/Lessons Learned:

- National statistics;
- Classification and evaluation of real incidents and contributing factors communicated to all facilities;
- Lack of knowledge about offender characteristics related to suicide attempts and completions;
- Lack of data regarding suicide attempts;
- Treatment in past, outside Department of Corrections and inside Department of Corrections, conditions of confinement, precipitants, life factors, home life, outlook, physical health, length of sentence, offense, behavior, situations in life, IQ, race, educational level, length of time in the Department of Corrections, the number of times incarcerated, mental health level;
- Other state data i.e., movement of offenders from mental health facilities that are closing to corrections.

Policies and Procedures Issues:

- Defined process of utilization of isolation cells/processes;
- Strategic housing placement of inmates/criteria;
- Maintaining the environmental dynamics;
- Availability of high risk information to case management/unit management team (HIPAA);
- More guidance for the suicide committees at the facility level;
- Established suicide prevention committees with meeting times and purpose;
- Inadequate communication about high risk offenders;
- Security requirements to provide programs;
- Critical information communicated to new facility when offender transfers;
- Communication (in all directions);
- Jobs with restrictions/criteria;
- Brother Keeper Program with support from team, security, mental health, etc.;
- Inmate observers in policy but do they exist;
- Offender suicide prevention training;
- Lack of pathways to divert suicide and seek help;
- Job placement for inmates with job description, criteria, etc.;
- Old school philosophy, specific officer on specific units, maintaining the environmental dynamics;
- Training;
- Inconsistent forms and logs—suicide risk information communicated to next shift and other staff.

The Process Action Team met on April 25, 2008, and reviewed the results of the brainstorming.

Revisions were made and are included in the brainstorming results above.

Additionally, the Process Action Team identified specific data that needed to be collected, the person responsible for collecting the data, and the due date for the data collection.

Data Analysis and Findings~Cell Design

The Process Action Team surveyed Oklahoma Department of Corrections facilities regarding the number of existing safe cells and the number of additional safe cells needed. Following are the results of that survey:

Oklahoma Department of Corrections Facility	Number of Existing Safe Cells	Additional Safe Cells Needed
Charles E. "Bill" Johnson Correctional Center	1	0
Dick Conner Correctional Center	2	0
Eddie Warrior Correctional Center	1	0
Howard McLeod Correctional Center	1	0
Jackie Brannon Correctional Center	0	0
James Crabtree Correctional Center	1	2
Jess Dunn Correctional Center	1	1
Jim E. Hamilton Correctional Center	1*	0
Joseph Harp Correctional Center	11 10*****	20
John Lilley Correctional Center	1	0
Lexington Assessment and Reception Center	2 (A&R) 1 (LCC)	2
Mack Alford Correctional Center	2**	2
Mabel Bassett Correctional Center	1 (Medical) 4 (MHU) 1 (SHU but does not meet the full criteria)	2***
Northeast Oklahoma Correctional Center	1	1
Oklahoma State Penitentiary	2	2
Oklahoma State Reformatory	1	2
Oklahoma State Reformatory		1****
William S. Key Correctional Center	1	2

Notes:

*Does not meet criteria;

**Another safe cell is needed;

***Warden Embry's preference was to direct the question to Mr. Boone based on issues of cost and bed space;

****Dr. Wallace requested one safe cell for use with the work center female offenders.

*****Construction of ten safe cells is in progress.

Findings:

Thirty-six additional safe cells are needed at various locations across the agency.

Data Analysis and Findings~Housing Utilization

A suicide prevention survey was e-mailed to 40 of the 50 state Departments of Corrections. Eighteen states responded (Alabama, Arizona, Arkansas, Delaware, Florida, Idaho, Illinois, Maryland, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New York, North Carolina, Ohio, Oregon, and Wisconsin).

The survey asked questions regarding official suicide resistant cell design standards, how officers and other frontline staff are assigned to high risk areas, whether such staff receive specialized training, and if their department uses an offender observer program to assist with suicide prevention.

Findings:

Official Suicide Resistant Cell Design Standards: Only one state, Florida, had a cell design standard as specific as Oklahoma's standard. Oklahoma's safe cell design standard appears to be more comprehensive than most states.

Other Potential Policy Additions: Florida includes in their observation cell policy a maintenance schedule of mattresses, blankets, and suicide prevention garments. Every 24 hours all items are inspected for tears, loose stitching, and if defective, are replaced immediately. Staff also replace blankets and privacy apparel when soiled, after three consecutive days of use, and/or as requested by medical/mental health staff. Institutions ensure blankets and privacy garments are cleaned and treated for fire retardation after each episode of use or after three consecutive days. Florida also includes annual certification requirements. Each isolation cell is inspected and certified at least yearly and at any time damage or a structural change occurs that affects one or more of the certification criteria. If a cell is decertified, the room may be used with self-injurious inmates as approved by the chief mental health officer.

Assignment of Officers and Staff to High Risk Areas: Most states had no formal policy. Two were based on labor contracts; two were based on seniority bid; and in one state (Idaho) officers were selected by the deputy warden.

Oregon was the only state with selection criteria stated in policy. Oregon's policy specifies that in order to be selected to work in the Mental Health Unit, the employee must: (1) Successfully complete trial service; (2) be interviewed and receive a satisfactory appraisal by the Mental Health Unit lieutenant and members of the Mental Health Unit treatment team, (3) express an interest in working with Mental Health Unit offenders; (4) demonstrate the ability to work with Mental Health Unit offenders through conflict-reducing and conflict-control skills; and (5) demonstrate the ability to use good judgment.

Rotation versus Permanent Placement: The states were split on this issue. Nine states used permanent placements. Most of the states noted that officers can request transfers and/or breaks, and temporary officers may need to be assigned for security reasons. Five states have mandatory rotation; however, the rotation period varied from six months to 18 months. Wisconsin allows each institution to determine its policy on the issue. Three states did not respond to this question.

Specialized Training for Officers and Staff in High-Risk Areas: Half of the states have specialized training, ranging from annual refreshers on self-injury and suicide prevention to five extra days of pre-service/in-service training. Three additional states use on-the-job training. Four states have no specialized training. Two states did not respond to this question. Ohio provided a copy of their specialized training outline.

Offender Observer Programs: Twelve of the 18 states do not use offender observer programs. Four of the 12 indicated this is a staff responsibility. One indicated that such a practice was condemned by the ACLU in 1994. Most of the remaining states that do not use offender observer programs responded that they would not have an issue with such a program and/or they had not considered such a program. Ohio is currently collecting data to pilot an offender observer program modeled after the federal system. Oregon began a pilot program eight months ago called Crisis Companions which uses trained volunteer offenders to provide additional support for offenders on suicide watch. Three other states have fully implemented programs (Arizona, Idaho, and Maryland). Each of these states sent their policies for review. Arizona's program takes the approach one step further using offender observers in high-risk areas at all times (not just for suicide watches). Some of these programs rely on volunteers; others are institutional jobs held by offenders. One state did not respond to this question.

Data Analysis and Findings~Staffing

There is a need to continuously review staffing levels to ensure appropriate staffing at each work location.

Data Analysis and Findings~Employee Training

The Process Action Team reviewed OP-140129 entitled “Suicide Prevention,” dated June 17, 2008.

OP-140129 requires training consist of standardized lesson plans enhanced with content specific to each facility and the entire contents approved by the chief mental health officer.

OP-140129 outlines the following training components:

Core Competency Level I Suicide Prevention Training: All Department of Corrections staff who interact with offenders receive training in understanding, identifying, and managing suicidal offenders. This training is provided in person by a qualified mental health professional and is given in pre-service and annual training.

Core Competency Level II Suicide Prevention Training: Those personnel designated in the facility Suicide Prevention Plan as having authority to initiate a suicide watch are required to complete more specialized training provided by a licensed qualified mental health professional. This training includes the Level I Suicide Prevention Training and a minimum of four additional hours of more in-depth experiential training in assessing suicide risk and procedures for initiating a suicide watch developed by the facility’s Suicide Prevention Team.

Core Competency Level III Suicide Prevention Training: All Suicide Prevention Team members are required to complete a minimum of four hours of advanced training provided by a licensed qualified mental health professional. This training addresses the philosophy behind suicide prevention and management issued involved in continuous quality improvement of the facility’s suicide prevention plan.

A review of the Oklahoma Department of Corrections current training revealed the following:

Type of Training	Material Covered	Format and Credit Hours
Pre-Service Training	Suicide Prevention and Intervention	Blended Learning 1.5 Credit Hours
In-Service Training	The New Asylums	Online Course 1 Credit Hour
	Mental Illness: A Guide for Correctional Employees	Online Course 1 Credit Hour
	Suicide Prevention and Intervention	Online Course 2 Credit Hours

Findings:

Suicide prevention training is currently delivered via blended learning and self-paced online courses.

There is a gap between agency policy OP-140129 and actual practice related to employee suicide prevention training.

Data Analysis and Findings~Offender Training

The Process Action Team surveyed facilities with regard to whether suicide prevention information was included in new offender orientation.

Oklahoma Department of Corrections Facility	Was Suicide Prevention Information Included in New Offender Orientation?
Charles E. "Bill" Johnson Correctional Center	No
Dick Conner Correctional Center	No
Eddie Warrior Correctional Center	No (There is information about how to contact mental health services.)
Howard McLeod Correctional Center	Yes (Available programs and services)
Jackie Brannon Correctional Center	Yes (General information about suicide watch/therapeutic seclusion is provided; Orientation information is provided for self-referral per mental health assistance.)
James Crabtree Correctional Center	No
Jess Dunn Correctional Center	No
Jim E. Hamilton Correctional Center	No
Joseph Harp Correctional Center	Yes (Suicide prevention is mentioned in new arrival orientation both for themselves and any other offender they meet. They are advised they can go to any staff member.)
John Lilley Correctional Center	Yes (The qualified mental health provider attends a weekly scheduled orientation meeting with all new arrivals and presents information about access to mental health services.)
Lexington Assessment and Reception Center	Yes (The presentation is informal and includes a general description of the signs and symptoms that one might experience prior to contemplating suicide. The emphasis is on the availability of mental health services and support services in general.)
Mack Alford Correctional Center	No (It is not included in the orientation; however, offenders are made aware of the availability of mental health services and how to request those services).
Mabel Bassett Correctional Center	Yes (Offenders are informed about mental health services. Crisis intervention is included in that discussion as well as general information about suicide watch/therapeutic seclusion, etc.).
Northeast Oklahoma Correctional Center	No
Oklahoma State Penitentiary	No
Oklahoma State Reformatory	Yes (We include how to access mental health services staff for appointments. We encourage wellness, and we teach coping skills to new arrivals. If necessary, mental health services staff may place the offender on suicide watch).
William S. Key Correctional Center	No

Findings:

There is a wide variation related to suicide prevention information included in facility offender orientation materials.

Nine of the 17 facilities surveyed, do offer some type of information on offender suicide; the others do not. The information that is offered varies from location to location.

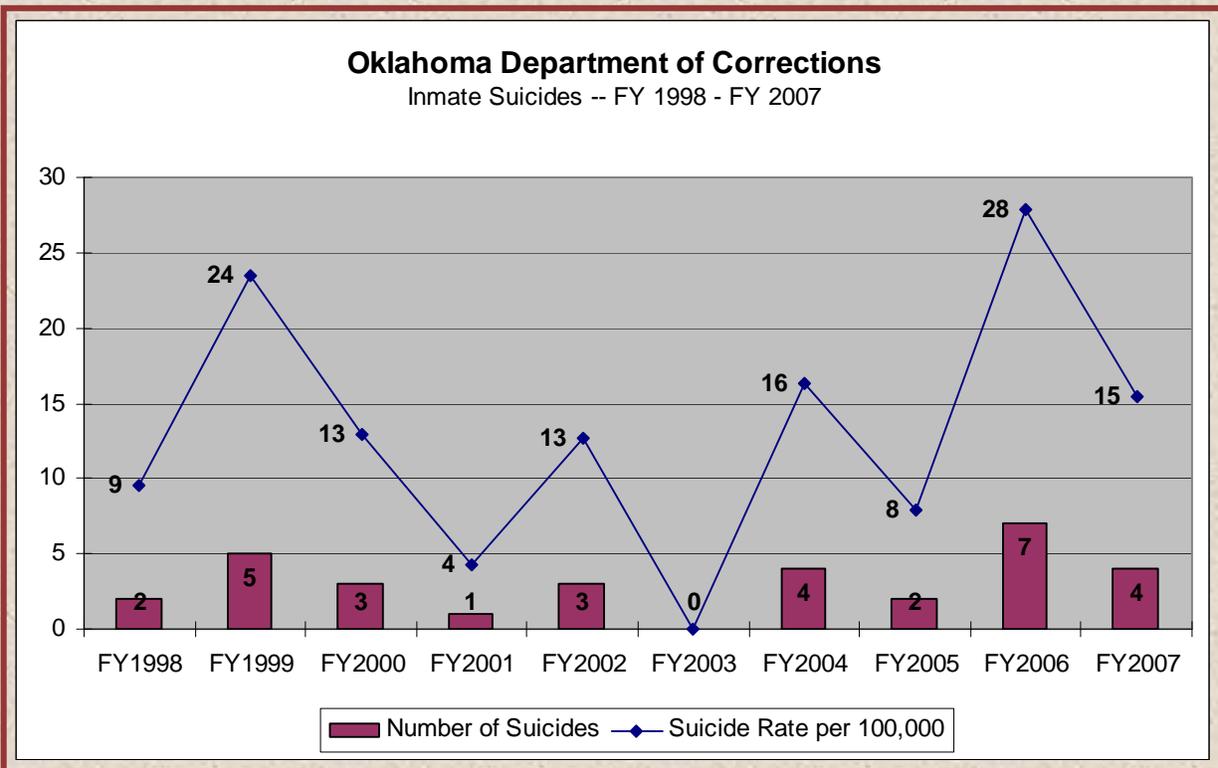
Data Analysis and Findings~Data/Lessons Learned— Analysis of Suicides in Oklahoma Prisons

A retrospective analysis of offender suicides in Oklahoma prisons was completed for the period of Fiscal Year 1998 through Fiscal Year 2007.

According to the most recent BJS data, the national average annual mortality rate due to inmate suicide is 15 per 100,000 inmates (2001 – 2004).

The Oklahoma Department of Corrections rate in that period was 7 per 100,000.

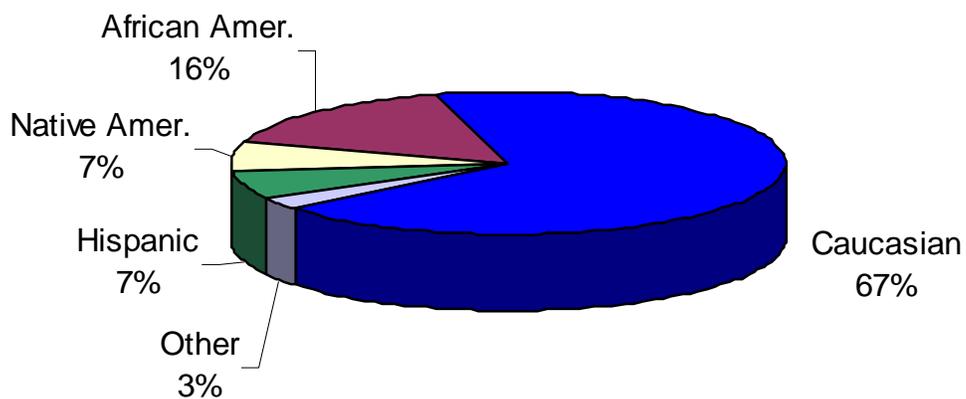
The Oklahoma Department of Corrections mortality rate due to inmate suicide has fluctuated greatly over the past 10 years (see table below), with the suicide rate peaking at an all time high of 28 per 100,000 inmates in Fiscal Year 2006, with 7 inmates committing suicide.



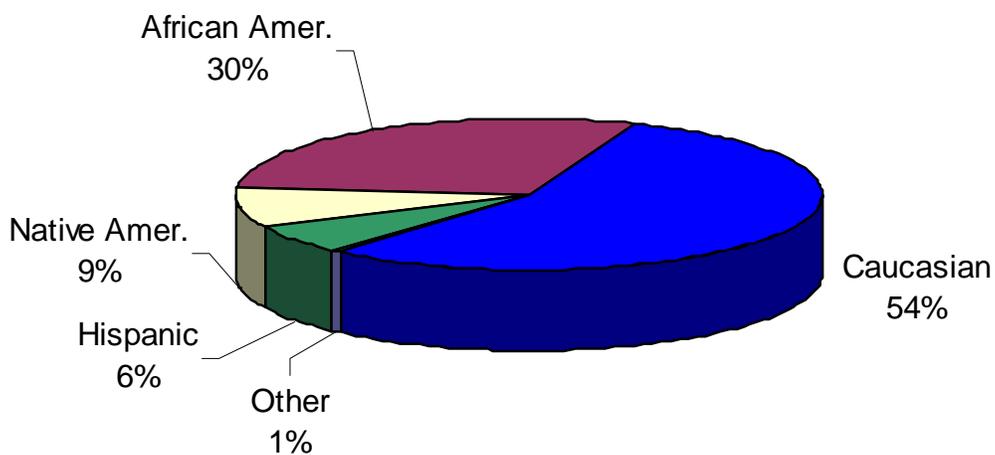
Note: The rate was calculated using the Total Sentenced Population as of fiscal year end, which includes the Out Count and Jail Backup.

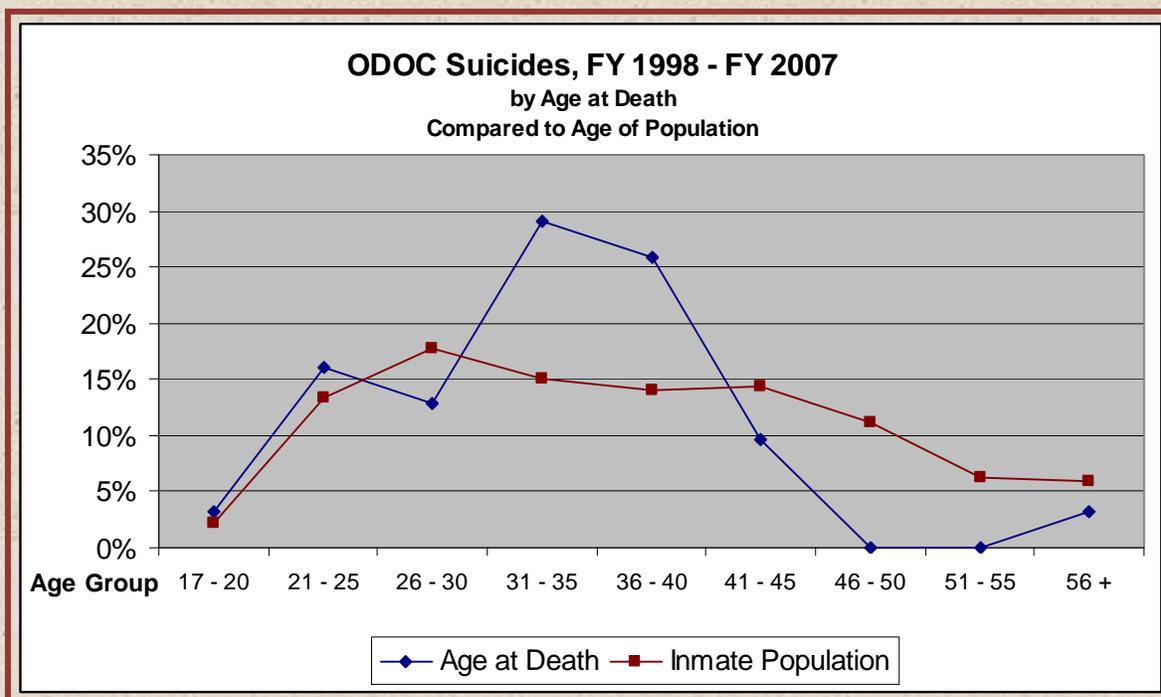
Compared to the inmate population, inmates who commit suicide are more likely to be white (67 percent compared to 54 percent of the inmate population), male (97 percent versus 90 percent), and currently serving time for a violent offense (81 percent versus 48 percent).

ODOC Suicides, FY 1998 - FY 2007 by Race/Ethnicity



ODOC Inmate Population by Race/Ethnicity June 29, 2007





ODOC Inmate Population as of June 29, 2007.

The age distribution of inmate suicides is also distinctly different compared to the inmate population, with most suicides occurring between the ages of 31 and 40.

A retrospective qualitative analysis of facility records was completed in order to gather data on the 31 offenders who committed suicide during the study period. The following results are based on this analysis.

Twenty-eight of the 31 offenders had a mental health record within ODOC. Of those 28 offenders, 26 (or 93 percent) had received mental health treatment while in ODOC custody.

Twenty-two of the 31 offenders had a record of previous suicide attempts. Of those 22 offenders, 19 (or 86 percent) had previously attempted suicide at least once, with 11 of the 19 attempting suicide multiple times.

Sixteen of the 31 offenders had a record of self-inflicted violence. Of those 16 offenders, 13 (or 81 percent) had previously self-injured at least once, with 5 of the 13 self-injuring multiple times.

Twenty-two of the 31 offenders had an identifiable suicide precipitant (71 percent), and 15 of the 31 offenders had identifiable behavioral changes (48 percent). Please keep in mind that these numbers are based on a retrospective review of facility records, which may not reflect information identified as actionable prior to the offender's suicide. It is also possible that more offenders in this study displayed behavioral changes prior to their suicide but these changes were not noted in facility records.

During the study period, 32 percent of ODOC suicides occurred at Oklahoma State Penitentiary (10 suicides), 16 percent at Dick Connor Correctional Center (5), and 13 percent at Joseph Harp Correctional Center (4). Eighty-one percent of suicides during the study period were by hanging/asphyxiation (25), 16 percent by overdose (5), and 3 percent by self-inflicted violence (1).

Data on mental health levels are complete for FY 2002 – FY 2007. Twenty offenders committed suicide during this period, and of these 20 offenders, six offenders were classified as a mental health level B (MHL B), four offenders MHL D, four offenders MHL C1, four offenders MHL A, one offender MHL C2, and one offender MHL 0.

The following were identified as precipitants (which may not reflect information identified as actionable prior to the offender’s suicide) and behavior changes.

Precipitants	Behavior Changes
<ul style="list-style-type: none"> • Informed of impending transfer the month prior • Gastroenteritis • Transfer to Oklahoma State Penitentiary two days prior • Received at Lexington Assessment and Reception Center on December 8, 1999; date of death was December 17, 1999—threatened suicide upon reception; letters from wife saying she would take everything he owned; wrote suicide letter to wife • Health problems • Could not bear to serve the 24 year sentence • Dear John letter on Thursday before death on Saturday; wife did not visit as usual • To Restrictive Housing Unit • Assaulted within two weeks prior • Depressed about incarceration • Decreasing staff attention; decreasing family attention • Depressed about incarceration; family refused phone calls; spoke with dad evening before death • Altercation the day before • Imminent fears INS detainer return to Mexico; estranged from family; homeless prior to incarceration • Friday previous court denied custody of daughter to parents • Two days prior to SHU for cigarettes; three days prior “accidental” human bite on elbow • Holiday stress; guilt about separation from children • Health • No English—Spanish only • Parents died • Debt (fear of assault; request/refusal of money; marriage of mom day after) • Assaulted within 6 weeks prior (suicide attempt six weeks prior; gang persecution) 	<ul style="list-style-type: none"> • Requested priest, made confession, suicidal statement to priest; requested doctor to intervene in transfer; suicide notes • Four to five weeks prior made comment “death may be a better alternative to being incarcerated.” • Acting inappropriate (verbalized paranoia) • Actively psychotic • In “funk,” then angry the day before the suicide (started giving away property the day before the suicide; happy the day of the suicide) • Saying goodbye • Withdrawn • Increasing frequency of self-injury (increasing frequency of seizure reports) • Asked cell mate whether he would see loved ones in afterlife (wrote letter about death) • Fearful • Picking fights hoping others would fight with him • Nervous (upset and depressed) • Escalation in self-injury frequency/intensity in months preceding death • Suicidal thoughts report to volunteer • Attempted suicide six weeks prior (stated intention to try again when returned to prison)

Additionally, a suicide prevention survey was e-mailed to 40 of the 50 state Departments of Corrections. Eighteen states responded including Alabama, Arizona, Arkansas, Delaware, Florida, Idaho, Illinois, Maryland, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New York, North Carolina, Ohio, Oregon, and Wisconsin.

The following risk factors and signs and symptoms of suicide are a collaboration of lists from six of the survey state’s policies and/or training materials.

Risk Factors	Signs and Symptoms
<ul style="list-style-type: none"> • Has a history of suicide attempts • History of suicide in the family • Pending disciplinary time, placed in segregation or protective custody (increased hours of isolation) • Institutional problems (i.e., classification, unwanted transfers, etc.) • Recent death or serious illness of a family member • Loss of family support due to divorce or family relocation • Denied parole, convicted of a new crime, facing detention time • Has a long sentence • Will be leaving soon after serving a lengthy sentence • Recently sexually assaulted or threats of such in the future • Other inmate conflicts, assaults, victimizations • Has been having problems with his peer group/friends • Has a serious mental illness such as depression or schizophrenia • Self-injury or self-destructive behavior • Has a language barrier or disability resulting in being isolated • Progressive health problems—chronic or terminal illness • Has a significant anniversary date approaching 	<ul style="list-style-type: none"> • Seems extremely sad or is crying • Loses interest in or almost all people and activities (stopped attending groups, work assignments, mental health sessions, medical appointments, refusing visitors) • Withdrawn and noncommunicative • Sudden drastic changes in eating or sleeping habits (loss of appetite, weight loss, sleeping difficulties, irregular sleeping hours, insomnia, sleeping all the time) • Neglect of personal hygiene • Seems to be in slow motion, no energy • Is tense, agitated, and cannot seem to relax; emotional outbursts and sudden anger • Expresses pessimism, hopelessness, and helplessness • Talks about suicide or verbalized thoughts of wanting to be dead • Asks questions about death; talks about death or afterlife • Packs up and/or gives possessions to others, pays off debts • Appears calm, elated, or carefree after a period of agitation or depression

Data Analysis and Findings~Data/Lessons Learned— Self-Mutilation and Attempted Suicide

The Process Action Team surveyed Oklahoma Department of Corrections facilities regarding the basis for distinguishing between “self-mutilations” and “attempted suicides.”

Oklahoma Department of Corrections Facility	Basis Used to Distinguish Between Self- Mutilation and Attempted Suicide
Charles E. “Bill” Johnson Correctional Center	Verbal assessment, historical information, type of wound, findings with risk management interview worksheet OP-140129B.
Dick Conner Correctional Center	Intent of individual as can be ascertained.
Eddie Warrior Correctional Center	Self-mutilation is defined as the intention to alleviate (emotional) pain. Attempted suicide is defined as the intent to die.
Howard McLeod Correctional Center	This is determined by the history, previous diagnosis, current behaviors and the conclusions drawn from the most recent session. Also the extent of the harm/attempt is a small consideration. I do not trust what they tell me usually, especially if they are in an unstable state. In my opinion, so much is determined on an individual basis. This is a difficult question to respond to.
Jackie Brannon Correctional Center	Clinical judgment as to perceived intent and projected degree of lethality.
James Crabtree Correctional Center	Differentiate between self-injurious behavior, parasuicidal behavior and attempt. Use offender mental health history for information on attempts, gestures, methods, psychiatric hospitalizations, and Oklahoma Department of Corrections history of watch/seclusion. Interview the offender to determine purpose, secondary gain, intent. Is borderline personality disorder supported based on history? There has only been one attempt recently, and that was in February.
Jess Dunn Correctional Center	Attempted suicide is the result of the behavior/action, carries a high probability of death, and there is clear evidence of intent/desire for death. With self-mutilation, there is no clear evidence of desired/intent for death, and the behavior/action is not life threatening.
Jim E. Hamilton Correctional Center	Determined by interview, client report.
Joseph Harp Correctional Center	We treat all self-injurious behaviors as serious incidents. Over the years we have seen many offenders who most would call self-mutilators eventually kill themselves. Therefore, in practice,

Oklahoma Department of Corrections Facility	Basis Used to Distinguish Between Self-Mutilation and Attempted Suicide
	we do not make a distinction between self-mutilation and suicide attempts. Both are maladaptive methods of dealing with life's stressors.
John Lilley Correctional Center	There have been no self-mutilation events at John Lilley in the year that I have been here. In the future, any event that included self-mutilation will most likely initially be designated as a suicide attempt with self-mutilation.
Lexington Assessment and Reception Center	Primarily severity of injury, circumstances surrounding the event, etc. Good question—one we have touched on briefly in the past at mental health meetings. We may need further discussion.
Mack Alford Correctional Center	Clinical judgment.
Mabel Bassett Correctional Center	Differentiating between self-mutilations and suicide attempts is a judgment call. Generally speaking, the severity of the injury, the potential for lethality, and the individual history of the offender are considerations.
Northeast Oklahoma Correctional Center	This determination is made if a serious incident report is processed. If the warden determines that suicide was attempted, then a serious incident report is generated.
Oklahoma State Penitentiary	Self-mutilation is separated from suicide attempts by determining the type of cut or abrasion as well as the area which is mutilated and by counseling the offender about his intent and his manner of preparation, as well as determining the availability of a means of committing suicide.
Oklahoma State Reformatory	Distinction between self-mutilation and a genuine suicide attempt is made by the cut. If a patient is a borderline pd with a wound such as cutting on their legs which is not visible unless they tell us or show us. In a suicide attempt the expression of depression make take the form of a cut that is vertical and deep on the forearm. Self-mutilation and suicide attempts are distinguishable by diagnosis and the intention of these acts. Self-mutilation may be for attention. Suicide attempts are done to avoid psychological pain and the loss of hope and meaning in life.
William S. Key Correctional Center	Intent of offender's actions.

Findings:

There are inconsistencies across the system related to the criteria used to distinguish between a suicide attempt and self-mutilation.

Three facilities distinguish a suicide attempt from self-mutilation based on intent; two facilities based the difference on lethality; seven base the difference on both; and four facilities use other criteria.

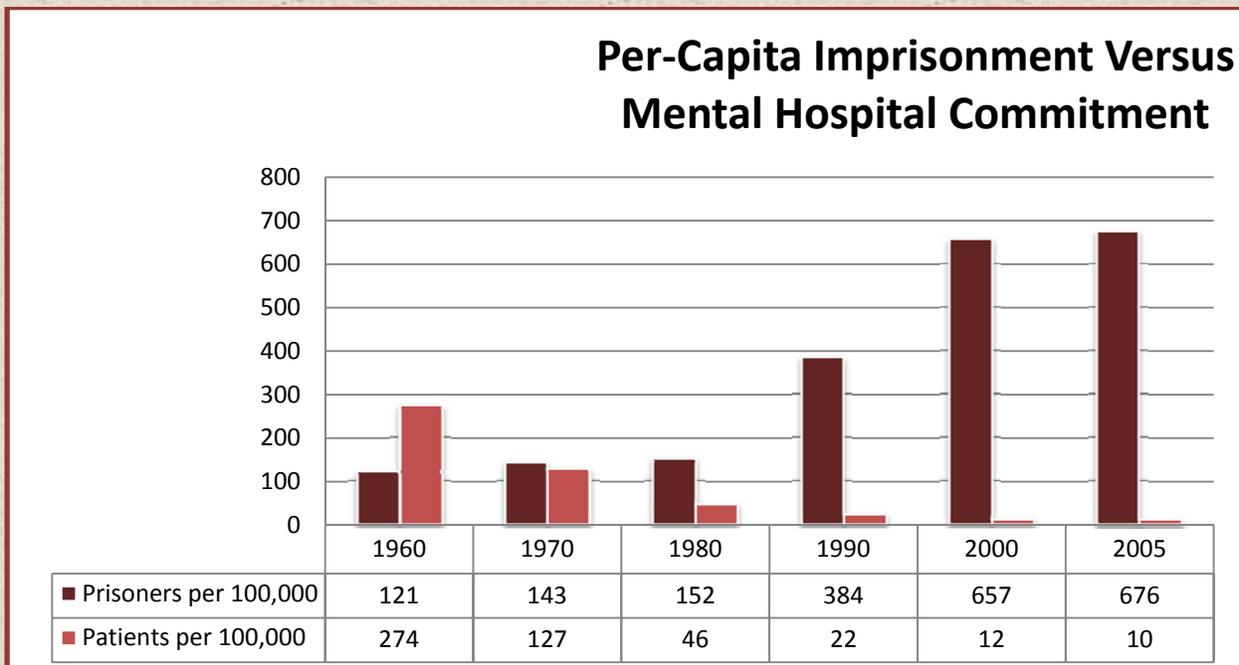
Data Analysis and Findings~Data/Lessons Learned— Closure of Mental Health Facilities and Resulting Impact

The Process Action Team examined the closure of mental health facilities and the resulting impact on corrections.

A report entitled, “The Shortage of Public Hospital Beds for Mentally Ill Persons,” issued by the Treatment Advocacy Center, states, “Since the 1960s there has been a mass exodus of patients from public psychiatric hospitals. Data are available on the number of patients in such hospitals in 1955 and in 2004-2005. The data show that:

“In 2005 there were 17 public psychiatric beds available per 100,000 population compared to 340 per 100,000 in 1955. Thus, 95 percent of the beds available in 1955 were no longer available in 2005” . . . “The consequences of the severe shortage of public psychiatric beds include increased homelessness; the incarceration of mentally ill individuals in jails and prisons; emergency rooms being overrun with patients waiting for a psychiatric bed; and an increase in violent behavior including homicides, in communities across the nation.”

The following chart, generated by the Oklahoma Criminal Justice Resource Center, compares the number of prisons per 100,000 and the number of mental health patients per 100,000 and illustrates the increase in prisoners and the decrease in mental health patients.



Findings:

The closure of several state mental health facilities has impacted the number of offenders with mental health problems who enter state prison facilities. The numbers of prisoners per 100,000 have continued to increase while the number of patients per 100,000 has declined.

Data Analysis and Findings~Policies and Procedures— High Risk Jobs

The Process Action Team examined agency policy with regard to the criteria for high risk offender jobs and learned that the restrictions governing the release of mental health and drug abuse histories are more stringent than HIPPA. The agency's general counsel does not support release of this information.

Data Analysis and Findings~Policies and Procedures— Offender Observer Program

The Process Action Team gathered information regarding the Brothers Keeper Program operated at San Quentin Prison.

On February 17, 2005, inmate Robert Dubner of the San Quentin prison in California hung himself with a bed sheet shortly after breakfast. Inmate Dubner was a well-known and respected “shot caller” or leader by the inmates at the facility. After this incident, the inmates of San Quentin went to the Men’s Advisory Committee of the prison requesting something be implemented to deter future incidents.

The Brothers Keeper Program was an inmate-initiated program through the Inside Prison Project group. Counselors from the Bay Area Women Against Rape (BAWAR) based in Oakland, California, were brought in to instruct inmates as a type of crisis intervention peer. The instruction was not based solely on suicidal tendencies but crisis intervention as a whole. The BAWAR organization conducted approximately 85 hours of training of the inmates chosen for the program and followed up with monthly case conferencing.

The first group selected for training consisted of nine inmates from the facility. The first requirement was that the inmate had to volunteer to become involved with the training and then pass a selection committee. Inmates who completed the training were identified at the facility by a black rubber wrist band. This enabled any inmate who felt he was in need of help to identify the inmates in his unit or cellblock that had been trained.

The nine inmates trained at San Quentin are located only in the north cell block at this time. Another group of nine is in the process of being trained to be dispersed to other areas of the facility. The initial nine were also involved in the selection process of the new trainees. Other prisons throughout the country have taken this program and adapted it to their needs utilizing inmates in various roles depending on the facility security level and other factors.

Findings:

Offenders must volunteer for the program to receive the training.

Offenders are not given any special privileges or compensation for completing the training. They do receive a certificate of training placed in their offender file.

Offenders are not given any authority for decision making in reference to offenders in crisis.

Offenders do not approach staff about inmates in crisis. They are there to talk with the offender through crisis or convince the offender to seek assistance on their own.

The training agenda includes:

Orientation;
Counseling Skills I and II;
Gender Roles/Family Systems;
Tough Guise DVD;
Post Trauma Stress Disorder
California Department of Corrections and Rehabilitation Video;
Role Plays;
Suicide; The training agenda includes:

Orientation;
Counseling Skills I and II;
Gender Roles/Family Systems;
Tough Guise;
Post-Trauma Stress Disorder;
California Department of Corrections and Rehabilitation Video;
Role Plays;
Suicide;
Grief, Loss, and Healing;
Sexual Assault;
Carolyn Craven Video;
Medical and Legal Issues;
Role Plays;
Child Abuse Overview;
Sexual Abuse;
Physical Abuse;
Neglect;
Teen Issues;
Adults Abused as Children Breaking Silence Video;
Male Victimization;
Shame;
Role Plays;
Domestic Violence;
Significant Others;
Role Plays;
Diversity;
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning;
Disabilities;
Substance Abuse;
Difficult Callers;
Role Plays;
Protocols and Procedures;
Competency, Written Test, Skills Assessment, Role Play Exam and Graduation

Grief, Loss, and Healing;
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Medical and Legal Issues;
Role Plays;
Child Abuse Overview;
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Role Plays;
Diversity;
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning;
Disabilities;
Substance Abuse;
Difficult Callers;
Role Plays;
Protocols and Procedures;
Competency, Written Test, Skills Assessment, Role Play Exam and Graduation

Data Analysis and Findings~Policies and Procedures— ACA Accreditation

The team examined Department of Corrections Operations Memorandum No. OP-140129 entitled, “Suicide Prevention,” as it relates to American Correctional Association (ACA) Standards. Following are the results of this review:

ACA Standard 4-4373: Suicide Prevention and Intervention: (MANDATORY) There is a written suicide prevention plan that is approved by the health authority and reviewed by the facility or program administrator. The plan includes staff and offender critical incident debriefing that covers the management of suicidal incidents, suicide watch, assaults, prolonged threats, and death of an offender or staff member. It ensures a review of critical incidents by administration, security, and health services. All staff with responsibility for offender supervision are trained on an annual basis in the implementation of the program. Training should include, but is not limited to:

- Identifying the warning signs and symptoms of impending suicidal behavior;
- Understanding the demographics and cultural parameters of suicidal behavior, including incidence and variation in precipitation factors
- Responding to suicidal and depressed offenders
- Communication between correctional and health care personnel
- Referral procedures
- Housing observation and suicide watch level procedures
- Follow-up of monitoring of offenders who make a suicide attempt

Finding:

OP-140129 entitled, “Suicide Prevention,” contains all of the elements listed in American Correctional Association Standards 4-4373.

ACA Standard 4-1084: Correctional Officers: Written policy, procedure, and practice provide that all new correctional officers receive an added 120 hours of training during their first year of employment and an added 40 hours of training each subsequent year of employment. At a minimum, this training covers the following area: Signs of suicide risks; suicide precautions.

Finding:

The training outlined in OP-140129 is applicable to all correctional officers and contains the elements listed in American Correctional Association Standard 4-4084.

ACA Standard 4-4410: Internal Review and Quality Assurance: (MANDATORY) A system of documented internal review will be developed and implemented by the health authority. The necessary elements of the system will include: Reviewing all deaths in custody, suicides, or suicide attempts, and illness outbreaks.

Finding:

OP-140129 provides for an “Administrative Review” in Section XIII. and, if requested by the chief mental health officer, a “Psychological Autopsy.” In addition, a “Mortality Review” (Section II.C.) is conducted on all offender deaths pursuant to OP-140111 entitled, “Offender Death, Injury, and Illness Notification Procedures.”

ACA Standard 4-4257: Supervision: Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuing observation.

Finding:

OP-140129 specifies three levels of suicide watch in Section V.C. Suicide Watch Level I is continuous; Suicide Watch Level II requires observation at staggered intervals at least once every 15 minutes. Suicide Watch Level III requires observation at staggered intervals at least every 30 minutes. This strategy meets American Correctional Association Standard 4-4257.

ACA Standard 4-4389: Emergency Response: (MANDATORY) Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program is conducted on an annual basis and is established by the responsibility health authority in cooperation with the facility or program administration and includes instruction on the following: Suicide intervention.

Finding:

Section VIII. of OP-140129 (Suicide Attempt Response) provides guidelines for responding when an offender makes a suicide attempt. Section II.B. indicates this will be included in the pre-service and annual suicide prevention training. This meets American Correctional Association Standard 4-4389.

ACA Standard 4-4393: Offender Assistants: Unless prohibited by state law, offenders (under staff supervision) may perform familial duties commensurate with their level of training. These duties may include the following: Serving as a suicide companion or buddy if qualified and trained through a formal program that is part of a suicide prevention plan.

Finding:

Section IX. of OP-140129 provides guidelines for the selection and training of offender observers/orderlies. These guidelines meet the requirements of American Correctional Association Standard 4-4393.

Data Analysis and Findings~Policies and Procedures— NCCHC Accreditation

The team examined Department of Corrections Operations Memorandum No. OP-140129 entitled, “Suicide Prevention,” as it relates to National Commission on Correctional Health Care (NCCHC) Standards (2008 Draft). Following are the results of this review:

NCCHC Standard MA-A-10: Procedure in the Event of an Inmate Death: Deaths of mental health patients and those who commit suicide are reviewed to determine the appropriateness of mental health care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

Findings:

The NCCHC standard recommends an “administrative review,” “clinical mortality review,” and a “psychological autopsy” for every offender suicide.

The administrative review outlined in OP-140129 incorporates elements of the “administrative” and “clinical mortality” review as defined by the NCCHC.

OP-050108 entitled, “Use of Force Standards and Reportable Incidents,” Section XII., discusses the review of serious incidents and appears focused on what NCCHC defines as an “administrative review.”

OP-140129 provides for a psychological autopsy only if requested by the chief mental health officer.

OP-140129 should be revised to incorporate the NCCHC Standard MA-A-10. This would include clarifying the content, goals, and communication of results of the review process and requiring a psychological autopsy on every offender suicide.

NCCHC Standard MH-C-04: Mental Health Training for Correctional Officers: All correctional officers who work with inmates receive mental health related training. Correctional officers assigned to mental health areas including mental health programs, residential units, or segregated housing units must receive additional training from mental health staff in order to fulfill their specific roles.

Findings:

In the discussion section of the standard, the authors state that “correction officers permanently assigned to special mental health housing areas . . . need advanced training and routine refresher training the recognition and management of inmates with significant mental illness.

The Oklahoma Department of Corrections should implement advanced mental health training for correctional officers assigned to mental health and segregated housing units.

NCCHC Standard MH-G-03: Treatment Plans: Mental health services are provided according to individual treatment plans.

With respect to suicide prevention, this standard recommends that “mental health clinicians develop an individual treatment plan for any inmate expressing suicidal ideation. The plan addresses relapse prevention and initiates a risk management protocol. The risk management protocol plan describes signs, symptoms, and the circumstances under which the risk of suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur.” This standard requires development of an individualized suicide prevention plan for use with each offender with a history of suicide ideation and/or actions.

Finding:

This standard is not met within OP-140129. OP-140129 should be modified to require an individualized treatment plan containing, at a minimum, the elements listed above for every offender with a history of suicidal ideation and/or action.

NCCHC Standard MH-G-04: Suicide Prevention Program: The facility identifies suicidal inmates and intervenes appropriately.

Findings:

Several of the key components addressed under this standard were not continued in Department of Corrections policy and should be included:

“Evaluation” should include “procedures for periodic follow-up assessment after the individual’s discharge from suicide precautions.”

“Treatment” strategies and services should address “the underlying reasons for the offender’s suicide ideology . . .”

“Strategies” should include “treatment needs when the patient is at a heightened risk to suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.”

“Monitoring” should include “other supervision aids (i.e., closed circuit television, offender companions or watchers) can be used as supplement to, but never as a substitute for, staff monitoring.”

STEP 3: GENERATE POTENTIAL SOLUTIONS

During their June 20, 2008, meeting, the Process Action Team moved to **Step 3. Generate Potential Solutions.**

The objective of **Step 3. Generate Potential Solutions** was for the team to review the data collected in order to determine if the data confirms that a problem actually exists; identify potential causes/hindering forces that contribute to the problem; analyze the data to identify the most significant causes; identify any helping forces that can be leveraged; collect any additional information; and then generate potential solutions.

Potential solutions were identified and are presented under Step 4: Select and Plan the Recommended Solutions.

STEP 4: SELECT AND PLAN THE SOLUTION

The team's objective for **Step 4. Select and Plan the Solution** was to determine the optimum solutions and plan for implementation.

The following were identified by the Process Action Team as final recommendations:

- **Recommendation #1:** Charter a multi-disciplinary work group to develop a standardized training program for staff based on core competency levels outlined in OP-140129 entitled "Suicide Prevention," and customize training for each work location to address facility physical plant, field memoranda, etc.

The training will incorporate the risk factors identified in the survey of corrections departments nationally (refer to page 21) as well as the Department of Corrections precipitants and behavior changes identified (refer to page 20) as a suicide prevention handout for staff training materials.

The training plan, when developed, will be reviewed by stakeholders from multiple disciplines (i.e., security, mental health, medical, etc.).

Prior to work assignment on the Mental Health Units at Mabel Bassett Correctional Center, Joseph Harp Correctional Center, and Oklahoma State Penitentiary, all security staff will receive specialized mental health training as developed by this work group.

Responsibility for Implementation: Team Member Ron Guthrie, Etta Thomas, Jay Hodges, Courtney Charish, and Dr. Laura Pitman.

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #2:** Examine the use of video conferencing as a method of training delivery for staff.

Responsibility for Implementation: Team Member Jay Hodges

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #3:** Standardize the suicide prevention segment of the offender orientation and offer it at every facility. The offender orientation will include the risk factors, precipitants, and behaviors as identified in Recommendation #1 above.

Responsibility for Implementation: Team Member Ron Guthrie

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #4:** Standardize the definitions of "suicide attempt" and "self-mutilation."

Responsibility for Implementation: Team Members Dr. Gale Joslin and Dr. Laura Pitman

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #5:** Initiate policy changes that require the initial mental health screening to include screening for appropriate placement of offenders in high risk jobs such as jobs in the kitchen, maintenance, Oklahoma Correctional Industries, etc. At minimum security, these high risk jobs would also include Department of Transportation crews and prisoner public works projects crews.

Responsibility for Implementation:

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #6:** Establish a multi-disciplinary work group to develop an implementation plan for an Offender Observer Program to aid in offender observation during suicide watch. The plan will include selection criteria, training curriculum, and recommended pilot sites.

Responsibility for Implementation: Team Members Warden Randy Workman, Jay Hodges, and James Smash.

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #7:** Designate security positions assigned to Mental Health Units at Mabel Bassett Correctional Center, Joseph Harp Correctional Center, and Oklahoma State Penitentiary as specialized, nonrotation positions due to the level of training (refer to Recommendation #1).

Prior to work assignment on the Mental Health Units at Mabel Bassett Correctional Center, Joseph Harp Correctional Center, and Oklahoma State Penitentiary, all security staff will be screened by senior security staff, unit management, and mental health staff for motivation and capability.

Responsibility for Implementation: Team Members Ron Guthrie and Gale Joslin

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #8:** Set aside funding for 36 additional safe cells at locations identified on page 9.

Responsibility for Implementation: Team Member Randy Workman

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #9:** Explore options for providing suicide watch for female offenders in need of suicide watch while housed at Altus Community Work Center.

Responsibility for Implementation: Team Member Dr. Laura Pitman

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #10:** Require the mental health authority, in conjunction with security staff, to develop a policy and a field memorandum addressing maintenance and inspection schedules for suicide smocks and blankets, as well as cell searches for Levels I and II.

Responsibility for Implementation: Team Members Ron Guthrie and James Smash

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #11:** Initiate annual recertification of safe cells to be conducted by Safety Administration based on guidelines set forth in OP-140141.

Responsibility for Implementation: Jonathan Roberts, Safety Administration

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #12:** Revise OP-140129 to incorporate the National Commission on Correctional Health Care (NCCHC) Standard MA-A-10 (Procedure in the Event of an Inmate Death) to include clarifying the content, goals, and communication of results of the review process and requiring a psychological autopsy on every offender suicide.

Responsibility for Implementation:

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #13:** Revise OP-140129 to require an individualized treatment plan containing, at a minimum, relapse prevention and risk management protocol (to include signs, symptoms, and the circumstances under which the risk of suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur) for every offender with a history of suicidal ideation and/or action to ensure compliance with NCCHC Standard MH-G-03 (Treatment Plans).

Responsibility for Implementation:

Decision: Approved Disapproved Needs Further Discussion

- **Recommendation #14:** Revise OP-140129 to ensure compliance with NCCHC Standard MH-G-04 (Suicide Prevention Program. Specifically, revise OP-140120 to ensure that:

“Evaluation” includes “procedures for periodic follow-up assessment after the individual’s discharge from suicide precautions.”

“Treatment” strategies and services address “the underlying reasons for the offender’s suicide ideology . . .”

“Strategies” include “treatment needs when the patient is at a heightened risk of suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.”

“Monitoring” includes “other supervision aids (i.e., closed circuit television, offender companions or watchers) can be used as a supplement to, but never as a substitute for, staff monitoring.”

Responsibility for Implementation:

Decision: Approved

Disapproved

Needs Further Discussion

The Process Action Team's first step in planning for implementation is to seek approval on the recommendations listed above.

STEP 5: IMPLEMENT THE SOLUTION

Once the proposed recommendations have been approved, the responsible division will be asked to submit specific action steps and timetables for completion.

As part of the implementation process, the Process Action Team members identified the data needed to evaluate the effectiveness of the recommendations as indicated below:

- Number of offender suicides
- If an offender observer program is developed, data would also be gathered on self-mutiliations, crisis interventions, suicides interventions, and number of offenders participating in the program.

STEP 6: EVALUATE THE SOLUTION

Data will be collected according to the implementation plan.

The Process Action Team will review the data collected and compare the new “As Is” state to the “Desired” state to evaluate effectiveness of the implemented solutions and conduct further analysis to address additional problems as needed.