IN THE DISTRICT COURT OF THE UNITED STATES FOR THE

MIDDLE DISTRICT OF ALABAMA, NORTHERN DIVISION

EDWARD BRAGGS, et al.,	)	
	)	
Plaintiffs,	)	
	)	CIVIL ACTION NO.
v.	)	2:14cv601-MHT
	)	(WO)
JEFFERSON S. DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections, et al.,	)	
	)	
Defendants.	)	

PHASE 2A ORDER AND INJUNCTION ON MENTAL-HEALTH IDENTIFICATION AND CLASSIFICATION REMEDY (INTAKE)

On April 23, 2018, the parties submitted stipulations to the court regarding Mental Health Intake. In open court on April 24 and 25, 2018, they agreed that the stipulations should be reduced to an enforceable order and further agreed to some clarifications of the stipulations. Accordingly, it is the ORDER, JUDGMENT and DECREE of the court as follows:

(1) The stipulations (doc. no. 1780), as clarified in open court on April 24 and 25, 2018, are approved.

(2) Defendants Jefferson Dunn and Ruth Naglich are ENJOINED and RESTRAINED from failing to comply with the attached provisions, as clarified in open court on April 24 and 25, 2018.

DONE, this the 25th day of April, 2018.

/s/ Myron H. Thompson
UNITED STATES DISTRICT JUDGE

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ATTACHMENT

Unless otherwise specified below, the processes and procedures outlined below will be implemented by the ADOC within sixty (60) days of the date of the recitation of these stipulations to the court.

I. Intake Mental Health Assessment

An RN with mental health training will conduct a mental health receiving screening as soon as possible, and no later than twelve (12) hours, upon an inmate’s arrival in the ADOC.

The RN will document the mental health receiving screening on ADOC Form MH-011, Reception Mental Health Screening Evaluation.

The mental health RN conducting the screening shall conduct a mental health receiving screening in accordance with the National Commission on Correctional Healthcare ("NCCHC") standard M-E-02.

All mental health staff should report suspected abuse of an inmate to the appropriate authority. Inmates arriving with signs of recent trauma should be referred immediately for medical observation and treatment.

At a minimum, mental health receiving screening staff should be trained on how to make the required observations, how to determine the appropriate disposition of an inmate based on responses to questions and observations, and how to document findings on the receiving screening form.

The mental health RN will refer the inmate for a psychiatric evaluation if the inmate reports, at a minimum:

(1) Current prescription for psychiatric medications;

(2) Any in-patient mental health hospitalization;

(3) Mental health treatment within the last year;

(4) Past or current suicidal acts or ideation;

(5) Trauma (history of victimization or abuse);

(6) Head injuries (with or without loss of consciousness);

(7) Gender dysphoria;

(8) Hallucinations or delusions or;

(9) When the inmate's presentation suggests the need for psychiatric evaluation.

If the inmate reports a current prescription for psychiatric medications, ADOC will attempt to verify with the prescriber or pharmacy within twelve (12) hours of the intake screening and ensure continuity of medication.

If the prescription cannot be verified within twelve (12) hours, the inmate shall be seen by a psychiatrist or CRNP within twenty-four (24) hours of intake screening during regular working hours. Weekend and holiday response can be via Tele-health when necessary, to ensure appropriate medication.

If the inmate reports receiving mental health services, and can correctly report the prior mental health provider, a records request from the prior provider will be made within seventy-two (72) hours of the intake screening.

All health records from the prior facility of incarceration should be requested within the seventy-two (72) hour time frame, if they are not presented at intake.

If the inmate reports receiving mental health services and cannot remember or correctly identify the prior mental health provider, the mental health staff will reasonably attempt to locate his prior records.

The mental health RN performing the intake screening will triage the mental healthcare needs of the inmate. When a referral is indicated the mental health nurse shall designate if the need is emergent, urgent or routine.

(1) Emergent need - the mental health RN conducting the intake screening believes there is an imminent risk of injury to the inmate or others or that the need for mental health services is otherwise emergent.

(2) Urgent need - the mental health RN conducting the intake screening believes the mental health services should be provided in the near future, but not immediately.

(3) Routine need - the mental health RN conducting the intake screening believes that the inmate requires assessment on a routine basis.

The on-site or on-call psychiatrist shall be contacted immediately to evaluate an inmate when the RN determines that the mental health screening suggests

that an inmate may be at risk for harm to self or others or may be experiencing acute psychosis (emergent).

If the on-site psychiatrist is not available, the inmate will be placed on watch status until the evaluation can be completed. The on-call psychiatrist will be contacted for additional instructions.

The mental health staff of the ADOC vendor will:

(1) Be trained in identifying inmates at risk for self-harm or potentially in need of immediate mental health assistance when conducting the reception mental health screenings;

(2) Conduct the reception mental health screening when an inmate is admitted to the ADOC and before the inmate is placed in a housing area that does not provide constant correctional officer observation;

(3) Review transfer medical documentation prior to conducting the reception mental health screening to

optimize available information about the inmate's mental status or treatment;

(4) Conduct the mental health screening in an area permitting inmate confidentiality and encouraging inmate self-reporting;

(5) Provide the inmate an initial description of the mental health services available in the ADOC, how to access these services and the grievance process for mental health related complaints;

(6) Document the initial mental health screening on ADOC Form MH-011, Reception Mental Health Screening Evaluation; and

(7) File original forms in the inmate's Healthcare record and forward a copy to the ADOC Psychologist responsible for reception mental health evaluations.

II. Social History Assessment, Suicide Risk Assessment, and Testing

A Psychologist or licensed mental health professional within fourteen (14) days of the intake

screening, will conduct a Social History Assessment (SHA) of every inmate. The mental health professional will utilize a standardized mental health screening form and SHA within the OHS module. In addition, a Suicide Risk Assessment (SRA) will be completed consistent with attached Exhibit A. The completed SRA will be placed in the inmate health record.

The OHS approved SRA items shall be in accordance with NCCHC Standard M-E-04.

The standardized mental health screening form, Social History Assessment and Suicide Risk Assessment shall, be utilized by the psychologist or licensed mental health professional in assessing the need for a referral to the psychiatrist for evaluation for placement on the mental health caseload.

A licensed psychologist, psychiatrist or CRNP collaborating with a psychiatrist will assign a mental health code. The licensed professional will review the required completed intake screening and assessment results prior to assigning a mental health code.

These designated professionals will complete and sign the ADOC Mental Health Coding form in accordance with AR 613. The mental health clerk or other trained support staff may enter the assigned mental health code into the OHS module as transcribed by the licensed professional on the coding form.

Before an inmate is transferred from Kilby Correctional Facility or Tutwiler Prison for Women after his or her initial intake or before an inmate is placed in a segregation unit at Kilby Correctional Facility or Tutwiler Prison for Women immediately following his or her initial intake, the Social History Assessment Suicide Risk Assessment, Testing and if referred, the Reception Psychiatric Evaluation must be completed. If ADOC seeks to place an incoming prisoner into segregation immediately, the prisoner must be placed on mental health observation until such time as the inmate is evaluated by mental health staff qualified to diagnose mental health conditions to determine if the prisoner has a serious mental illness

as defined in the Stipulations of the parties reflected in Doc. No. 1720.

III. Reception Psychiatric Evaluation

A psychiatrist will evaluate referred inmates within seven (7) working days of the referral (except in cases where it is determined in the receiving screening or reception mental health evaluation that an immediate psychiatric evaluation is required).

If immediate psychiatric evaluation is ordered, the psychiatrist will evaluate the inmate within twenty-four (24) hours of the referral.

The evaluations shall include review of the inmate's health record and direct examination of the inmate. The evaluation will include, but is not limited to, the following:

(1) Current complaint

(2) Psychiatric history

(3) Prior mental health treatment

(4) Prior use of psychotropic medication

(5) Pertinent medical history (including history of head injuries with or without loss of consciousness)

(6) Substance abuse history

(7) Pertinent personal history (including education, victimization, history of trauma or abuse)

(8) Pertinent family history including family history of mental illness

(9) Mental status examination

(10) Risk for suicide and violence

(11) Brief social history

(12) DSM 5 diagnosis

(13) Psychiatric input for treatment plan

Any mental health or intellectual disability test results that are not available at the time of the psychiatric evaluation shall be reviewed by the psychiatrist within fourteen (14) days of the complete battery of test results becoming available. If, in the psychiatrist's clinical judgment, the test results are

clinically significant and may indicate a different assessment than the initial psychiatric evaluation, the psychiatrist shall re-evaluate the inmate within fourteen (14) days of reviewing the tests.

If the inmate has been transferred to another facility the need for a reevaluation by the receiving facility psychiatrist, psychologist or collaborating CRNP will document on the ADOC Intra-system Inmate Healthcare Communication Form. The receiving facility healthcare staff shall review, sign and schedule the required follow-up.

IV. Assignment of a Mental Health Code

At intake, all inmates entering the system will be assigned a mental health code, as outlined in ADOC AR 613, by a psychologist, psychiatrist or CRNP in collaboration with a psychiatrist. Mental Health Coding is captured in the OHS Healthcare module and documented in the inmate Healthcare record.

Mental health professionals are responsible for providing pertinent mental health status information to the ADOC Classification Supervisor. ADOC Classification personnel consider and utilize the inmate's mental health code in the institutional assignment of the inmate. The mental health coding process is a HIPAA compliant process.

V. Miscellaneous Provisions

Each of the steps listed above must be conducted in a location and manner that provides for confidentiality.

Nothing in this agreement supersedes or eliminates any mental health testing requirements of the ADA Consent Decree to include administration of appropriate tests for Intellectual Deficits or Learning Disabilities.

EXHIBIT A

MHM CLINICAL GUIDELINES
PSYCHOLOGICAL SERVICES

Suicide/Self-Injury Risk Assessment

Suicide/Self-Injury Risk Assessments are conducted as an essential aspect of mental health care and as part of MHM's suicide prevention program. The intent of a Suicide/Self-Injury Risk Assessment is not to predict suicidal behavior but to prevent suicidal behavior through early identification and intervention. Suicide/Self-Injury Risk Assessments may need to be completed at any time during the course of the inmate's care and custody. Monitoring for elevated risk of dangerous behaviors should be part of every clinical encounter. Formal Suicide/Self-Injury Risk Assessments should take place under the following circumstances and when clinically indicated:

- Initial screening for reception inmates
- When suicidal ideation or impulses are identified and/or upon referral for potential suicidal behavior
- When implementing or discontinuing suicide precautions
- When transitioning caseload inmates to different levels of mental health care
- As part of mental health evaluations for placement or continued stay in segregated housing

Placement of an inmate on suicide precautions should not be deferred until a Suicide/Self-Injury Risk Assessment can be completed. Inmates need not be on the mental health caseload to require a Suicide/Self-Injury Risk Assessment. Conversely, provision of such assessment does not result in automatic placement on the mental health caseload. If mental illness is detected for the first time during the course of a Suicide/Self-Injury Risk Assessment, placement of the inmate on the mental health caseload is warranted.

These Guidelines are not intended to replace clinical judgment. The Guidelines and accompanying Suicide/Self-Injury Risk Assessment templates cannot anticipate risk factors that are unique to individual inmates. When risk or protective factors are identified through clinical inquiry but not covered by these Guidelines, clinical judgment should be exercised. Clinical judgment is also essential in integrating findings, drawing conclusions regarding inmates' current suicide risk and making recommendations regarding interventions. Some factors that are protective for many inmates may be risk factors for others. Overall risk is not determined by a single factor but is based on clinical judgment determined by consideration of all risk and protective factors.

The Guidelines do not "force" a particular clinical decision.

The Suicide/Self-Injury Risk Assessment forms accompanying these Guidelines are not actuarial tools. The Assessment forms are not meant to predict outcome, but rather to assist staff in identifying and managing specific clinical risks. Neither the Suicide/Self-Injury Risk Assessment forms nor these Guidelines establish requirements or standards. Requirements and standards are established by local policy, applicable law and regulatory/accreditation agencies. These Guidelines are not intended to supplant local policies and procedures. When these Guidelines conflict with client policy and procedures with regard to scope or content, staff should be guided by the client's policy and procedures. Ethical concerns regarding the inmate's care and custody should be addressed and resolved through consultation with supervisors and facility administration.

MHM staff completing Suicide/Self-Injury Risk Assessments should be independently licensed and have experience providing mental health services in correctional environments. Whenever possible, mental health staff who are already involved in the treatment of the inmate should complete Suicide/Self-Injury Risk Assessments, due to their greater knowledge of the inmate's treatment needs and history.

SUICIDE/SELF-INJURY RISK ASSESSMENT CLINICAL GUIDELINES – PSYCHOLOGICAL SERVICES

This document was created to serve as a guideline for completion of suicide and self-injury risk assessments. It is not an actuarial tool. These Clinical Guidelines do not establish standards or requirements. Instead, they are intended as tools to assist staff who are engaged in assessing suicide/self-injury risk. MHM staff complete suicide/self-injury risk assessments as an essential aspect of mental health care and to meet standards set by the client and/or accreditation agencies. If these guidelines conflict with local policy or expectations, staff should be guided by local policy. No risk assessment guidelines can be exhaustive, and clinical judgment should be used when risk factors or clinical issues not covered by these guidelines are identified during the course of the assessment

DEFINITION

A Suicide/Self-Injury Risk Assessment is a specialized mental health evaluation that identifies risks for suicidal and/or self-injurious behaviors for a particular inmate, protective factors and skills or strengths exhibited by the inmate that can be used to help reduce risk, an overall clinical judgment of the degree of risk posed at the time of the assessment, and the interventions that are needed to restore or maintain safety. The type and degree of risk, and the type and degree of safety interventions needed to reduce this risk, are expected to vary across time and circumstance. As such, assessment of risk is an ongoing task and is never "final." The primary goals of Suicide/Self-Injury Risk Assessments are 1) to estimate the inmate's overall level of risk for suicide and/or self-injury; 2) identify specific risk factors or pressures that raise the inmate's risk; 3) identify specific protective factors and coping skills that lower the inmate's risk; and 4) provide recommendations for safety interventions.

LIMITS OF SCOPE AND INTENT

Suicide/Self-Injury Risk Assessments are not actuarial tools intended to predict suicidal or self-injurious behavior. Suicide Risk Assessments provide an empirically grounded, structured review of risk and protective factors that can be utilized to inform clinical decision-making. Their purpose is prevention and intervention, not prediction.

These Guidelines do not require staff to distinguish between suicidal and other types of self-injurious behavior. While determined suicide plans should always be taken seriously, lack of such plans does not necessarily lower risk. Inferred or self-reported "intent" may not be reliable. The degree of harm caused by self-injurious behavior may be much greater than the inmate intended. In terms of consequences and implications, unintended death resulting from self-injury is suicide.

These Guidelines are not intended to expand the scope of contractually required mental health services or to replace clinical judgment. Instead, they are intended to provide structured guidance to mental health staff when conducting formal assessment of inmates for risk of self-harm and suicide. Monitoring risk for dangerous behaviors, including suicide, self-injury, homicide and assault should be part of every clinical encounter. When elevated risks are identified through routine monitoring, completion of a formal Suicide/Self-Injury Risk Assessment may not be needed. These Guidelines are not exhaustive, and the identification of just one risk factor, whether covered by the Guidelines or not, may be sufficient to warrant immediate intervention. Clinical judgment is required to integrate findings, draw conclusions regarding inmates' current suicide risk and make recommendations regarding interventions. The Guidelines do not "force" a particular clinical decision.

PROCEDURE

Recommendations: Suicide/Self-Injury Risk Assessments should be completed by independently licensed mental health staff. These staff should be trained in completing these assessments and in suicide prevention, experienced in providing correctional mental health care, and aware of the risks of self-injury and suicide that are specific to correctional settings. As with all assessments, Suicide Risk Assessments should be completed in as objective, balanced and nonjudgmental manner as possible.

Suicide/Self-Injury Risk Assessments may need to be completed at any time during the course of an inmate's care and custody. Circumstances in which Suicide/Self-Injury Risk Assessments should be completed include but are not limited to the following:

- Initial screening for reception inmates
- When suicidal ideation or impulses are identified and/or upon referral for potential suicidal behavior
- When implementing or discontinuing suicide precautions
- When transitioning caseload inmates to different levels of mental health care
- As part of mental health evaluations for placement or continued stay in segregated housing

A Suicide/Self-Injury Risk Assessment does not need to be completed prior to placing an inmate on suicide precautions, but should be completed as soon as practical thereafter. When discontinuing suicide precautions, completion of a comprehensive Suicide/Self-Injury Risk Assessment may not be necessary. However, structured review of dynamic risk factors and protective factors should be undertaken to ensure the inmate's risk management and treatment needs have been met. A modified form has been included with these Guidelines for this purpose.

I. **Sources of Information.** Staff should utilize all relevant available sources in gathering data for the Suicide Risk Assessment. A face-to-face interview with the inmate is essential but not sufficient. Relevant sources include the inmate's health record, incident reports, any referral information, and knowledge of the inmate based upon providing mental health treatment (if available). Review of documentation prior to interviewing the inmate is recommended. Whenever possible, Suicide Risk Assessments should be completed through multidisciplinary consultation.

II. **Record Review.** Thorough record review can be time-consuming. Prior suicide risk assessments, psychiatric or other mental health evaluations, psychosocial histories, treatment plans and discharge summaries are among the best sources of information relevant to the risk assessment. Information available from the record may be sparse when inmates are newly received (e.g., jail detainees or reception inmates in state facilities) or have not received prior mental health services. When records are available, examine them for the following:

- Historical (static) risk factors (e.g., history of prior suicidal or self-injurious behavior)
- Clinical (dynamic) risk factors (e.g., current/recent suicidal ideation, behavioral impulsivity or social alienation)
- Institutional/situational risk factors (e.g., segregation status, enemies, recent bad news)
- Protective factors and coping skills (e.g., positive and supportive relationships with family and/or peers, treatment compliance, realistic future orientation and plans)

Knowledge of these risk and protective factors prior to meeting with the inmate can be helpful in guiding the interview. During record review, be alert to indications regarding the inmate's reliability and suggestibility. Conflicting data from the record should be documented and resolved.

Completion of the modified assessment at the time of discharge from suicide precautions should include a detailed review of risk assessments and planned intervention strategies developed at the time of the initiation of suicide precautions.

III. **Interview.** Face-to-face interviews with inmates are required to complete Suicide/Self-Injury Risk Assessments. These interviews should take place in a private interview setting with adequate time to avoid being rushed. Inmates should be informed about the nature of the interview and limits of confidentiality.

a. **General Approach.** Suicidal inmates may be motivated to deny suicidal ideation and plans, and it should be assumed that "there is more than first meets the eye" when conducting Suicide/Self Injury Risk Assessments. Initial denials of suicidality should not be accepted at face value. It is essential to stay attuned to pauses, hesitancies or other nonverbal signs on the part of the inmate that may indicate undisclosed suicidal ideation. It is also essential to attend to the quality of rapport, the inmate's suggestibility, and the reliability of the inmate's self-report.

Staff should be comfortable discussing suicidal feelings and fantasies. A persistent, inquisitive, confident and calm stance is recommended. An "alarmist," nervous, judgmental or reactive approach to the interview is likely to elicit shame, hostility and/or defensiveness on the part of the inmate, thereby shutting down the inmate's self-disclosure and collaboration. The following approaches[1] can help maximize rapport and self-disclosure:

- Ask for specific descriptions of behavioral incidents, not the inmate's opinions.
- Avoid judgmental or shame-inducing questions by framing questions in a manner that is consistent with the inmate's experience.
- Assume the existence of suicidal/self-injurious impulses and ask about them directly, in a matter-of-fact tone.
- Frame questions regarding frequency of behavior and ideation, in a manner that over-estimates their true frequency, so that the inmate will respond with a more accurate estimation of their frequency (rather than simply minimizing them).

[1] From S. C. Shea (2002). *The practical art of suicide assessment.* NY: Wiley.

- Avoid blanket questions. Instead, ask about specific types of suicidal/self-injurious behavior and ideation separately (e.g., "Have you ever taken an overdose?" "Have you ever cut yourself?").

b. Content Areas for Risk. The scope of the interview should extend beyond simple exploration of current suicidal or self-injurious ideas. Whenever possible, content areas of the interview should be built upon and extend findings from the record review. However, if risk and protective factors have been identified through record review or during prior Suicide Risk Assessments, it may not be necessary to inquire exhaustively regarding each of these factors. A complete mental status exam should always be part of the interview. Use of the accompanying Suicide/Self-Injury Risk Assessment Template can assist in structuring inquiry and promoting a thorough assessment. Beyond historical and clinical risk factors, content areas for the interview should include:

- Recent behavioral changes
- Environmental stressors
- Expressed suicidal ideation
- Suicidal and self-injurious behavior
- Previous suicide attempts
- Previous incidents of self-harm
- Consequences of prior suicide attempts or self-injury

Special attention should be paid to the inmate's

- Hopelessness, helplessness, despair and/or worthlessness
- Agitation, depression and/or severe anxiety
- Persistent insomnia
- Extreme guilt or shame
- Reality testing (e.g., presence of fatalistic delusions or fantasies)
- Future oriented thinking and cognitive flexibility
- Attitudes toward death/injury (e.g., fearlessness, fixation)
- Treatment compliance
- Insight into his/her own emotions and impulses

c. Content Areas for Protective Factors. Part of the interview should include a discussion with the inmate about coping strategies and other factors that may protect against suicidal and self-injurious behavior. Areas of potential inquiry include the inmate's:

- In-cell activities
- Distress tolerance skills
- Emotion regulation skills
- Long-term goal orientation
- Relationships with cell mates or other inmates on the tier
- Relationships with supports in the community
- Ability to ward off suicidal/self-injurious impulses
- Ability to ask for help
- How the inmate has handled similar situations in the past

IV. Determinations and Recommendations. Clinical judgment is required to make a determination regarding the inmate's current risk for suicidal and self-injurious behavior. Balancing protective factors against risk factors is a complex task. The ability to rely on the inmate's coping and survival skills should be carefully established rather than assumed. In general, it is recommended that behavior and nonverbal indicators be weighted more strongly than the inmate's self-report. For example, the inmate's denial of suicidal ideation should carry less weight if it is given in the presence of nonverbal signs of agitation, anger, despair and alienation than if it is given in the presence of hopeful and flexible thinking and calm, engaged, open interpersonal rapport.

"Safety contracting" is not recommended. Safety contracting is not supported by research and may provide false reassurance of safety due to lack of reliability in inmate self-report. Safety contracting may also preempt the assessment process by avoiding making a final determination as to the inmate's risk.

It is recommended that the inmate's current risk for suicidal and/or self-injurious behavior be rated globally as low, medium or high. Global ratings of risk take into account historical, clinical and situational/environmental risk factors as well as the inmate's strengths. Data regarding historical risk factors are often unavailable for jail detainees and new reception state inmates. When this is the case, historical risk factors should be assumed to be present until proven otherwise. The presence of high numbers of historical risk factors,

whether assumed or verified, does not require a determination that the inmate is at high current risk. Inmates with multiple historical risk factors may still be found at low current risk for suicide.

There is no "formula" for determining low, moderate or high risk. However, the following five elements, when present, greatly raise the likelihood that the inmate is at high risk for suicidal/self-injurious behavior:

- Elevated hostility, anger, antagonism and alienation
- Psychological turmoil (anguish, despair, unbearable anxiety, agitation)
- Cognitive "tunnel vision," or rigid, extreme thinking that is trapped in a single perspective
- Belief that suicide or self-injury is a solution (the inmate's belief that he or she will feel better if she/he engages in the behavior)
- History of suicide attempts and/or serious self-injury

Treatment considerations associated with each of the three global levels of risk include but are not limited to the following:

a. **Low Risk:** No specialized treatment interventions are needed. Treatment should continue as usual if the inmate is on caseload.
b. **Moderate Risk:** Enhanced treatment interventions are needed. Additional evaluation, contacts and programming are likely to be warranted. Placement in specialized housing for treatment or monitoring may need to be considered. Individual planning focusing on supporting the inmate's strengths and coping skills that reduce risk is needed. In the case of recurrent self-injurious behavior, consideration of behavioral interventions is likely to be warranted.
c. **High Risk:** Crisis interventions are needed. The inmate is likely to require suicide precautions and a crisis treatment plan addressing the inmate's risks and immediate treatment needs.

Clinical judgment should err on the side of caution. Although consideration should be given to the least restrictive alternative principle, the possible harm caused by placing an inmate on suicide precautions who is not actually at risk is significantly less than that of failing to place an inmate on suicide precautions who is actually at risk.

V. Documentation. In most cases, correctional systems have already developed templates to be used for documenting a suicide risk assessment. Where such templates are lacking, the accompanying templates can be utilized. Explicit documentation of the rationale for reaching global ratings of risk is strongly recommended. Additional narrative can be provided in progress notes.

The **Suicide/Self-injury Risk Assessment** template is intended for most situations. It constitutes a comprehensive assessment of risk.

The **Abbreviated Suicide/Self-Injury Risk Assessment** template focuses on re-assessment of dynamic factors that were identified during an earlier comprehensive risk assessment and are believed to have changed over the course of treatment. This form is most appropriate for use when discontinuing suicide precautions.

CONFIDENTIAL

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MHM Services, Inc.

Suicide/Self-Injury Risk Assessment

Inmate Name:	Inmate #:	Inmate DOB:
Institution:	Date of Assessment:	

Reason for Suicide/Self-Injury Risk Assessment			
☐ Initial Intake Screening	☐ Emergent Referral	☐ Initiation of Precautions	☐ Admission to Mental Health Unit
☐ Other Encounter	☐ Urgent Referral	☐ Discontinuation of Precautions	☐ Discharge from Mental Health Unit

Health Record Reviewed	☐ Yes ☐ Not Available	Prior Suicide/Self-Injury Risk Assessment Reviewed	☐ Yes ☐ Not Available

Historical (Static) Risk Factors				Review all items. Provide description, details and dates:
Family/close friends history of suicide	☐ Y	☐ N	☐ ?	
Prior suicidal/self-injurious behavior	☐ Y	☐ N	☐ ?	
Prior suicidal/self-injurious ideation	☐ Y	☐ N	☐ ?	
History of substance abuse	☐ Y	☐ N	☐ ?	
History of physical or sexual abuse	☐ Y	☐ N	☐ ?	
History of severe impulsivity	☐ Y	☐ N	☐ ?	
History of mental illness/psychiatric treatment	☐ Y	☐ N	☐ ?	
Cluster B Personality Traits	☐ Y	☐ N	☐ ?	

Other/Additional Narrative:

Clinical (Current, Dynamic) Risk Factors				Review each item and check all that apply.			
Recent suicidal/self-injurious behavior	☐ Y	☐ N	☐ ?	Auditory hallucinations: persecutory/commands to self-harm	☐ Y	☐ N	☐ ?
Fixed determination to harm/kill self	☐ Y	☐ N	☐ ?				
Premeditated, lethal plan/behavior	☐ Y	☐ N	☐ ?	Hopelessness and/or helplessness	☐ Y	☐ N	☐ ?
Recent suicidal/self-injurious ideation	☐ Y	☐ N	☐ ?	Feelings of worthlessness	☐ Y	☐ N	☐ ?
Suicide notes/giving belongings away	☐ Y	☐ N	☐ ?	Current insomnia	☐ Y	☐ N	☐ ?
Fearlessness about death	☐ Y	☐ N	☐ ?	Social withdrawal atypical for inmate	☐ Y	☐ N	☐ ?
Belief that death will bring relief	☐ Y	☐ N	☐ ?	Shame, threat to self-esteem, or guilt	☐ Y	☐ N	☐ ?
Lack of future orientation or plans	☐ Y	☐ N	☐ ?	Intense turmoil, agitation, anxiety, anguish or despair	☐ Y	☐ N	☐ ?
Fatalistic delusions or fantasies	☐ Y	☐ N	☐ ?				
Recent assaultive/violent behavior	☐ Y	☐ N	☐ ?	Elevated anger, hostility or alienation	☐ Y	☐ N	☐ ?
Recent/current impulsivity	☐ Y	☐ N	☐ ?	Sudden calm following suicide attempt	☐ Y	☐ N	☐ ?
Treatment noncompliance	☐ Y	☐ N	☐ ?	Affective instability or lability	☐ Y	☐ N	☐ ?
Rigid, all-or-nothing thinking	☐ Y	☐ N	☐ ?	Fearfulness regarding safety	☐ Y	☐ N	☐ ?

Other/Additional Narrative:

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MHM Services, Inc.

Suicide/Self-Injury Risk Assessment

Inmate Name:	Inmate #:	Inmate DOB:

Situational (Current, Dynamic) Risk Factors			*Review all items. Provide description, details and dates:*
Signs of withdrawal/detoxification	☐ Yes	☐ No	
Chronic, serious or terminal illness	☐ Yes	☐ No	
New disciplinary charge or sanctions	☐ Yes	☐ No	
Single cell placement	☐ Yes	☐ No	
Administrative/disciplinary segregation	☐ Yes	☐ No	
High profile/heinous/shocking crime	☐ Yes	☐ No	
Potential for long/life sentence	☐ Yes	☐ No	
Recent parole violation/new charge	☐ Yes	☐ No	
First jail/prison sentence	☐ Yes	☐ No	
Recent loss, rejection or separation	☐ Yes	☐ No	
Other recent bad news	☐ Yes	☐ No	
Trauma or sexual/physical abuse in facility	☐ Yes	☐ No	
Conflicts with peers/officers	☐ Yes	☐ No	
Other/Additional Narrative:			

Protective Factors			*Review each item and check all that apply.*		
Family support	☐ Yes	☐ No	Realistic future orientation and plans	☐ Yes	☐ No
Support from spouse/significant other	☐ Yes	☐ No	Positive goal orientation	☐ Yes	☐ No
Role in caring for children or dependents	☐ Yes	☐ No	High school or greater level of education	☐ Yes	☐ No
Positive, supportive peer relations	☐ Yes	☐ No	Treatment compliance	☐ Yes	☐ No
Strong protective spiritual/religious beliefs	☐ Yes	☐ No	Positive coping skills *(describe below)*	☐ Yes	☐ No
Other/Additional Narrative:					

Assessment of Current Risk:	☐ Low	☐ **Moderate**	☐ **High**
Comments/Discussion of Rationale:			

Recommendations:	☐ Initiate/change/maintain watch status as follows:	
☐ No acute interventions needed	☐ Refer for psychiatric evaluation	☐ Refer for specialized housing
☐ Develop/modify treatment plan to address risks	☐ Refer for behavioral planning	☐ Increase programming/contacts
☐ Develop/modify crisis treatment plan	☐ Provide debriefing to inmate	☐ *Other:*

Staff Name (printed) with Credentials	Staff Signature	Date and Time

Braggs v. Dunn
MHM Services, Inc.

Abbreviated Suicide/Self-Injury Risk Assessment
For Use with Discontinuation of Suicide Precautions Only

Inmate Name:	Inmate #:	Inmate DOB:
Institution:	Date of Assessment:	

☐ Yes	Suicide/Self-Injury Risk Assessment from initiation of suicide precautions reviewed *If no prior Suicide/Self-Injury Risk Assessment available from initiation of suicide precautions, do not use this form and complete full Suicide/Self-Injury Risk Assessment*
☐ Yes	Static (historic) risk factors from previous assessment remain unchanged *If not, describe changes in detail below:*
Changes/new information regarding static risk factors:	
☐ Yes	Current situational risk factors from previous assessment remain unchanged *If not, describe changes in detail below.*
Changes/new information regarding current situational risk factors:	

Review of Current Clinical Risk Factors				*Re-assess each item and check all that apply.*			
Recent suicidal/self-injurious behavior	☐ Y	☐ N	☐ ?	Auditory hallucinations: persecutory/commands to self-harm	☐ Y	☐ N	☐ ?
Fixed determination to harm/kill self	☐ Y	☐ N	☐ ?				
Premeditated, lethal plan/behavior	☐ Y	☐ N	☐ ?	Hopelessness and/or helplessness	☐ Y	☐ N	☐ ?
Recent suicidal/self-injurious ideation	☐ Y	☐ N	☐ ?	Feelings of worthlessness	☐ Y	☐ N	☐ ?
Suicide notes/giving belongings away	☐ Y	☐ N	☐ ?	Current insomnia	☐ Y	☐ N	☐ ?
Fearlessness about death	☐ Y	☐ N	☐ ?	Social withdrawal atypical for inmate	☐ Y	☐ N	☐ ?
Belief that death will bring relief	☐ Y	☐ N	☐ ?	Shame, threat to self-esteem, or guilt	☐ Y	☐ N	☐ ?
Lack of future orientation or plans	☐ Y	☐ N	☐ ?	Intense turmoil, agitation, anxiety, anguish or despair	☐ Y	☐ N	☐ ?
Fatalistic delusions or fantasies	☐ Y	☐ N	☐ ?				
Recent assaultive/violent behavior	☐ Y	☐ N	☐ ?	Elevated anger, hostility or alienation	☐ Y	☐ N	☐ ?
Recent/current impulsivity	☐ Y	☐ N	☐ ?	Sudden calm following suicide attempt	☐ Y	☐ N	☐ ?
Treatment noncompliance	☐ Y	☐ N	☐ ?	Affective instability or lability	☐ Y	☐ N	☐ ?
Rigid, all-or-nothing thinking	☐ Y	☐ N	☐ ?	Fearfulness regarding safety	☐ Y	☐ N	☐ ?

If any of these risk factors are still present, describe how they are being addressed. If other risk factors are present, identify and address here:

Assessment of Current Risk:	☐ Low	☐ Moderate	☐ High

Comments/Discussion of Rationale:

Recommendations: ☐ Risk remains too high to discontinue precautions at this time

☐ Risk has been adequately addressed and precautions may be discontinued.
☐ Treatment Plan/progress notes updated to include planned treatment interventions to reduce future risk.

Staff Name (printed) with Credentials	Staff Signature	Date and Time

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Updated March 2014