Authorization for Release of Protected Health Information

Inmate/Resident Name _____ Date of Birth_____

Inmate/Resident # _____

Facility Name_____

I authorize Corrections Corporation of America to use or disclosure of PHI to:

_____
(Name)

_____
(Address)

Specific description of the information to be used or disclosed to include treatment dates:

_____

_____

—

For the following purpose:

_____

_____

_____

including the following portions of the record(s):

☐ All Records ☐ Lab Tests Only ☐ Addiction Treatment ☐ Psychiatric Records ☐ All HIV Information

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the Federal privacy regulations.

I understand that I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Corrections Corporation of America in reliance on it before I revoked it.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand this authorization will expire on (check and complete one):

☐ 120 days from the date below and covers only treatment prior to that date.

☐ On the happening of the following event that relates to me or the purpose of the use of disclosure:

_____

CCA is released and discharged of any liability, and the undersigned will hold the company, its employees, agents, and contractors harmless for complying with this information request.

I understand that CCA may assess a charge for photocopying of records which I may be required to pay prior to receipt of the records.

_____
Signature of Inmate or Personal Representative
(If Personal Representative, please attach proof of such)

_____ _____
Print Name Date

NOTICE to person or agency receiving information: Federal laws and regulations prohibit further disclosure of the information whose confidentiality is protected in the absence of specific authorization of the inmate or his/her personal representative.

Employee Authorization for Release of Protected Health Information

Name of Employee _____

Social Security Number (for identification purposes only) _____

Facility Name _____

I authorize the disclosure of the following protected health information:

- Post-offer employment physical
- TB Screening Information
- Hepatitis B Vaccine Information
- Treatment for on-the-job injury
- PPE-respirator screening
- SORT Team evaluations
- Other (please describe) _____

During my employment with CCA, I may receive medical treatment from CCA's health services providers to include the following: post-offer employment physical, TB screening, Hepatitis B Vaccines, and/or treatment for on-the-job injuries.

I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and may no longer be protected by the Federal privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. However, my refusal to sign the authorization may affect my employment with CCA in that the release of this information is necessary for employment-related purposes.

I understand that I may revoke this authorization by written notification to the person or department designated by CCA. Any action taken by Corrections Corporation of America in reliance on this authorization will not be affected if I revoke the authorization in the future.

I understand this authorization will expire if the processing of my application does not result in employment with CCA or, if I become employed, upon the termination of my employment with CCA and closure of any related matters that may be pending at that time.

_____ _____

Signature Date

Exhibit B

CORRECTIONS CORPORATION OF AMERICA	POLICY TITLE	Suicide Management/Risk Reduction			
	CHAPTER	13	POLICY NUMBER	13-84	Page 1 of 8
	EFFECTIVE DATE			SUPERSEDES DATE	
	JULY 17, 2006			JANUARY 1, 2005	
SIGNATURE ON FILE AT FACILITY SUPPORT CENTER *Bill Andrade, MD* *Chief Medical Officer* *SIGNATURE ON FILE AT FACILITY SUPPORT CENTER* *Richard P. Seiter* *Executive Vice President/Chief Corrections Officer* *SIGNATURE ON FILE AT FACILITY SUPPORT CENTER* *G.A. Puryear, IV* *Executive Vice President/General Counsel*	FACILITY NAME	LEE ADJUSTMENT CENTER			
	FACILITY EFFECTIVE DATE			FACILITY SUPERSEDES DATE	
	SEPTEMBER 15, 2006			AUGUST 1, 2006	

13-84.1 POLICY:

Every CCA Facility will have a Suicide Management/Risk Reduction Training Program. The program will be implemented by trained qualified Health Services Staff.

13-84.2 AUTHORITY:

CCA Company Policy

13-84.3 DEFINITIONS:

Licensed Independent Practitioners (LIP) – Physicians, Physician's Assistant, Advanced Registered Nurse Practitioner, Dentist, and Psychiatrist. Each LIP shall perform duties according to the state scope of practice guidelines.

Licensed Mental Health Professional (LMHP) – Psychiatrist, Psychologist, Licensed Clinical Social Worker, and other individuals with appropriate mental health licensure in accordance with state scope of practice guidelines.

Qualified Health Services Staff (QHSS) – Includes physicians, physician assistants, nurse practitioners, nurses, dentists, mental health professionals, and others who by virtue of their education, credentials, and experience are permitted by law within the scope of their professional practice acts to evaluate and care for patients.

Self-Injurious Behavior – Actions that result in self-harm.

Suicidal – Pre-occupation with thoughts of self-harm or actively engaging in behavior that is likely to cause serious bodily harm, with the intended and explicit purpose of ending one's life.

Suicidal Gestures – Statements, threats and behavior that suggests thoughts, intent or plan to harm oneself.

Suicide Precautions **with** Constant Observation –Twenty-four (24) hour direct one-on-one observation (per written order of a psychiatrist, physician, or mid-level practitioner) of inmates/residents who are actively suicidal as evidenced by engaging in behavior that is likely to cause death.

Suicide Precautions **without** Constant Observation – Twenty-four (24) hour observation (per written order of a psychiatrist, physician, or mid-level practitioner) of inmates/residents who are engaged in suicidal ideation, verbal threats, self-harm, or who exhibit self-injurious or destructive behavior, or demonstrating other concerning behaviors. This type of observation requires staff to be present, within sight or sound distance, and to perform direct visual observation on a varied schedule of one (1) minute to fifteen (15) minutes but not to exceed fifteen (15) minutes.

13-84.4 PROCEDURES:

PROCEDURES INDEX

SECTION	SUBJECT
A	Suicide Prevention Plan
B	Training
C	Initial Identification/Screening
D	On-Going Identification/Screening
E	Intervention
F	Suicide Precaution Levels
G	Downgrading and Discontinuation
H	Safe Housing
I	Transfer
J	Follow-Up

A. SUICIDE PREVENTION PLAN

1. Each facility will develop a Suicide Prevention Plan that addresses specific facility initiatives and the facility's plan for compliance with this policy. The 13-84AA Suicide Prevention Facility Risk Assessment (Sample) may be used as a guide for the development of the Suicide Prevention Plan. At a minimum, the Suicide Prevention Plan will include:

   a. Facility overview addressing facility size, population, annual intakes, and other facility facts that may be relevant in developing the plan;

   b. Areas of focus needing improvement;

   c. Program structure to include coordinator, facility multi-disciplinary taskforce, meeting schedules, drills, and other structural aspects of the facility program;

   d. Monitoring and quality improvement activities; and

   e. Pre-service and in-service training plans.

2. The facility Suicide Prevention Plan requires review and approval from the FSC Regional Director, Health Services and the Warden/Administrator.

3. Each facility will conduct an annual review of the Suicide Prevention Plan. The plan will be updated as necessary utilizing a risk assessment process to identify areas of potential risk and target the facility plan toward continuous improvement. Revisions to any approved Suicide Prevention Plan require review and approval from the FSC Regional Director, Health Services.

B. TRAINING

All facility personnel receive training during pre-service orientation and at least annually in in-service training on the following:

1. Facility Suicide Prevention Plan;

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

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

4. Responding to suicidal and depressed offenders;

5. Communication between correctional and health services staff;

6. Referral procedures;

7. Housing observation and suicide watch procedures;

8. Follow-up monitoring of inmates/residents who make a suicide attempt; and

9. Avoiding obstacles (negative attitudes) to prevention.

C. INITIAL IDENTIFICATION/SCREENING

1. At the time of receiving inmates/residents, the receiving personnel will make every effort to obtain information from the arresting and/or transporting officer(s) regarding their assessment of the inmate/resident's medical, mental health, or suicide risk to include any observed behavior. The type of information requested should include:

   a. Whether the inmate/resident appeared to be under the influence of alcohol or drugs;

   b. Whether the inmate/resident or other individual was making any comments that would be cause for concern;

   c. Whether the inmate/resident appeared to be overly ashamed, embarrassed, scared, depressed, or exhibiting bizarre behavior;

   d. Whether there were any facts or circumstances surrounding the arrest and/or alleged crime that would suggest the inmate/resident to be a suicide risk;

   e. Whether the inmate/resident received a sentence; and

   f. Any other information that may be helpful.

   NOTE: The 13-84BB Arresting/Transporting Officer Questionnaire may be used as a guide for obtaining and documenting appropriate medical, mental health, or suicide risk information.

   In the event the assessment reflects medical, mental health, or suicide risk, the receiving officer will notify the health service department immediately.

2. An initial mental health screening will be performed by health trained or qualified health services staff upon inmate/resident arrival to the facility.

   a. Inmates/residents will be screened utilizing the 13-50B Intake Mental Health Screening Form. Screening will include inquiry regarding past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; and suicide risk during prior confinement.

   b. The 13-50B Intake Mental Health Screening form is a screening inventory and **IS NOT** the only guide for referral to mental health services.

   c. The inmate/resident's prior medical, mental health, and suicide risk during prior confinement will be verified through either manual or management information system review.

3. During the full health appraisal, the LIP will evaluate any signs, symptoms, or information received by the inmate/resident that may necessitate a referral to mental health staff.

4. A comprehensive mental health evaluation will be completed in accordance with CCA Policy 13-61 Mental Health Services.

D. ON-GOING IDENTIFICATION/SCREENING

1. Any staff member identifying an inmate/resident who appears to be potentially suicidal will complete a 13-61B Referral for Mental Health or Chemical Dependency Services form and immediately forward it to health services staff.

2. Correctional Officers or other personnel are to immediately advise the Unit Manager and/or Shift Supervisor of any potentially self-destructive behavior (related to potential suicide) displayed by the inmate/resident. Health Services staff will receive immediate notification of such behavior.

3. If an inmate/resident declares a Psychological Emergency, the Shift Supervisor will be advised. The Shift Supervisor will notify the appropriate QHSS.

4. In **ALL** cases of attempted suicide, security personnel will immediately notify health services staff and the Warden or Administrative Duty Officer.

   AT THIS FACILITY ADDITIONAL NOTIFICATION PROCEDURES ARE AS FOLLOWS:

   1ST Notification:

   Kentucky DOC Duty Officer (for Kentucky inmates only)

   Vermont DOC Out-of State Unit (for Vermont inmates only)

   CCA Facility Support Center (refer to CCA Policy 5-1 for notification requirements)

   2nd Notification OR after regular hours:

   Kentucky DOC Duty Officer (for Kentucky inmates only)

   Vermont DOC Out-of State Unit (for Vermont inmates only)

   CCA Facility Support Center (refer to CCA Policy 5-1 for notification requirements)

5. Due to the strong association between inmate/resident suicide and special management housing assignment (e.g. disciplinary, administrative, or protective custody segregation), any inmate/resident assigned to a special management unit will receive a pre-segregation health evaluation (See CCA Policy 13-42, Health Evaluations for Pre-Segregation/Segregation Access to Health Care) for early detection of potential suicide risk.

E. INTERVENTION

1. In the event information obtained during the initial intake process, observation, history, or interview information suggests that an inmate/resident is potentially suicidal, the QHSS will be immediately notified. The following steps may be directed by the QHSS and implemented by appropriate staff:

a. Inmate/resident may be temporarily held or housed in a cell that is as suicide resistant as is reasonably possible (free of all obvious protrusions and provides full visibility to staff) and placed on Suicide Precautions. Appropriate referral will be made to mental health staff for further evaluation/directions.

2. Procedures Following a Suicide Attempt

a. Any correctional officer or other staff member who discovers an inmate/resident engaging in self-harm shall immediately survey the scene to assess the severity of the emergency, alert other staff to call for health services staff, retrieve the housing unit's first aid kit and cut-down tool; and begin standard first aid and/or CPR as necessary.

b. The first responder shall always enter the cell and initiate appropriate life-saving measures. Further, staff shall never presume that the victim is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel.

c. Although not all suicide attempts require emergency medical intervention, all suicide attempts shall result in immediate intervention and assessment by qualified health services staff.

F. SUICIDE PRECAUTION LEVELS

1. When observation, history, or interview suggests that an inmate/resident is potentially suicidal or following a suicide attempt, the following steps are to be implemented by QHSS. In the absence of QHSS, the Warden/Administrator, Assistant Warden/Administrator, Chief of Security, or Shift Supervisor will implement the following steps:

a. The inmate/resident will be placed on **SUICIDE PRECAUTIONS:**

- In order to provide immediate safety, QHSS will place an inmate/resident on suicide precautions upon recognition of or notification of suicidal ideation/behavior. The appropriate LIP will be notified and an order will be written in the chart with a SOAP note detailing reasons for placement.
- Suicide precautions **with** or **without** constant observation may be authorized by a Licensed Independent Provider who has order-writing privileges. The inmate/resident will be evaluated by an LMHP as soon as reasonably possible but within forty-eight (48) hours of placement. At that time, the LMHP will develop a plan of care for the inmate/resident that will include at least daily assessment by the LMHP or QHSS.
- Initially inmates/residents will be placed in a cell that is as suicide resistant as is reasonably possible (free of all obvious protrusions and provides full visibility to staff). Personal belongings, objects, and clothing that could be used in a suicidal manner are to be initially removed. When clothing is removed from a suicidal inmate/resident, the inmate/resident will be issued a safety garment or other protective clothing that is suicide resistant and prevents humiliation and degradation. Finger foods only, eating utensils will not be permitted
  - Upon assessment from an LMHP, certain personal belongings that could not be used in a suicidal manner may be returned to the inmate/resident.

- The inmate/resident's behavior will be observed and documented by staff on the 13-63A Observation Monitoring form.
    - Inmates/residents under suicide precautions **with** constant observation will have twenty-four (24) hour direct one-on one observation.
    - Inmates/residents under suicide precautions **without** constant observation will have twenty-four (24) hour observation with staff present, within sight or sound distance. Observation will include direct visual observation on a varied schedule of one (1) minute to fifteen (15) minutes but not to exceed fifteen (15) minutes.

b. Use of soft restraints and protective helmets may be authorized by the LIP or by QHSS with verbal approval from the LIP. Written orders must be secured within twenty-four (24) hours. Restraint/Equipment use must be in accordance with CCA Policy 13-69, Personal Restraint. QHSS are to use the least restrictive management orders that are consistent with clinical conditions.

G. DOWNGRADING/DISCONTINUATION

Inmates/residents under suicide precaution **with** or **without** constant observation may not be downgraded or discharged from suicide precautions until an LMHP reviews the inmate/resident's healthcare record, confers with correctional personnel regarding the inmate/resident's behavior, assesses the inmate/resident, writes a progress note, develops and/or updates a written plan of care, and writes an order to remove the inmate/resident from suicide precaution or level of precaution. The LMHP will communicate with the appropriate LIP to confer on the inmate/resident's status. In the event that the state does not permit orders by an LMHP, the LIP will write the order based on the LMHP consultation and recommendation.

H. SAFE HOUSING

Any inmate/resident placed on suicide precaution shall be housed in a cell that is as suicide resistant as is reasonably possible, free of all obvious protrusions, and provides full visibility to staff.

I. TRANSFER

In the event an inmate/resident on suicide precaution is being transferred from the custody of CCA, the inmate/resident's suicide precaution status will be documented on the 13-86A Transfer In/Transfer Out Screening form and the 13-86B Special Instructions for Transporting Officers form to ensure continuity of care.

J. FOLLOW-UP

1. In order to ensure continuity of care for suicidal inmates/resident, all inmates discharged from suicide precautions shall remain on the mental health caseload and receive regularly scheduled follow-up assessments by mental health staff until the inmate/resident is transferred or released from the facility. Unless the inmate/resident's individual treatment plan directs otherwise, the reassessment schedule shall be as follows: daily for the first five (5) days, then once a week for two (2) weeks and then once every month until the inmate/resident is released from treatment by the LMHP. In the absence of an LMHP, follow-up assessments may be performed by an LIP.

2. Mortality and Morbidity Review Process

a. All completed suicides and suicide attempts requiring outside medical treatment shall be examined through a mortality and morbidity review process in accordance with CCA Policy 13-52, Quality Management Program.

b. The review shall be multidisciplinary and include correctional, medical, and mental health personnel.

c. The review process shall include a critical inquiry of the following:

i. Circumstances surrounding the incident;

ii. Facility procedures relevant to the incident;

iii. All relevant training received by involved staff;

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

v. Possible precipitating factors leading to the suicide or serious attempt;

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

3. Critical Incident Debriefing

Health Services staff will participate in critical incident debriefings as described in CCA Policy 5-1, Incident Reporting. The Chaplain, mental health staff or appropriate designee will provide debriefing to staff and inmates/residents who are affected by critical incidents at the facility.

13-84.5 REVIEW:

The Chief Medical Officer or qualified designee will review this policy on an annual basis.

13-84.6 APPLICABILITY:

All CCA Facilities (Provided contractual requirements do not mandate otherwise)

13-84.7 APPENDICES:

13-84AA Suicide Prevention Facility Risk Assessment

13-84BB Arresting/Transporting Officer Questionnaire

13-84.8 ATTACHMENTS:

13-50B Intake Mental Health Screening

13-61B Referral for Mental Health or Chemical Dependency Services

13-63A Observation Monitoring Form

13-86A Transfer In/Transfer Out Screening

13-86B Special Instructions for Transporting Officers

13-84.9 REFERENCES:

CCA Policy 5-1

CCA Policy 13-42

CCA Policy 13-50

CCA Policy 13-52

CCA Policy 13-61

CCA Policy 13-63

CCA Policy 13-69

CCA Policy 13-86

ACA 4-4373M/4-ALDF-4C-32M/3-JTS-4C-37M/3-JCRF-4C-06

4-4416/4-ALDF-4C-33

NCCHC P-G-05E/J-G-05E

JCAHO EC.1.10

EC.1.20

PC.5.60

Suicide Prevention Facility Risk Assessment

Date: _____ Facility: _____

Coordinator: _____ Warden: _____

This tool is intended to assist you in assessing your suicide risk, with the sole purpose of identifying strengths, weakness, threats, and opportunities to improve the capability of the facility to prevent suicides in the correctional setting.

1.0 FACILITY ASSESSMENT OF ISOLATION MANAGEMENT ROOM(S)

1.1 When inmates are placed into suicide precautions, where are they housed?

- ☐ medical observation ☐ Sometimes ☐ Always
- ☐ segregation ☐ Sometimes ☐ Always
- ☐ other _____(specify) ☐ Sometimes ☐ Always

1.2 For each of the locations used (as listed above), please complete the following checklist. (Note: this checklist is consistent with and modified from Florida DC4-527)

CHECKLIST FOR REVIEW OF ISOLATON MANAGEMENT ROOM / OBSERVATION CELL

Location: ☐ Medical Observation ☐ Seg ☐ Other Date: _____

Reviewer (Printed Name/Title): _____ Cell Number: _____

Review Item	Yes	No	N/A	Comments
1. a. The door is made of solid hardwood or metal and has a shatter-resistant observation window (e.g., made of Lexan® vs. glass) that permits easy scanning of the room.				
b. Sliding door cannot be easily blocked or tied shut.				
c. Interior hinges that are >18 inches above the floor are flush-mounted or retractable or have been modified with epoxy (or in some other fashion) in order to keep the patient from utilizing it to securely anchor any kind of noose.				
d. The door lacks features that are higher than 18 inches from the floor to which cloth or other material may be securely hung or tied.				
e. Standard cell doors (with bars) are fully shielded from the inside with Lexan® or wire mesh having holes not larger than 3/16"				
2. The floor and walls are solid, smooth, and high-impact resistant. They also lack metal or other protrusions. Walls lack features that are higher than 18 inches above the floor to which cloth or other material may be securely hung/tied.				
3. Tile and baseboards, when present, are securely attached.				
4. The ceiling is solid and lacks features to which cloth or other material can be securely tied/hung or, if present, such features are at least ten (10) feet above the floor.				

Review Item	Yes	No	N/A	Comments
5. Vents are covered with small wire mesh or a metal plate (with holes not larger than 3/16") in a manner that cloth or other material cannot be securely tied to or hung from the vents. Space around the vent frame is sealed with hard epoxy or other suitable substance to prevent placing of cloth or other material between the vent frame and the wall or ceiling. Vents have no exposed sharp edges or, if present, such features are at least ten feet (10') above the floor.				
6. Lighting is recessed and covered with shatter-resistant material or, if not recessed, is contained in a security-rated fixture that is smooth and installed in such a manner that cloth or other material cannot be securely tied to or hung from fixture. No space exists between the fixture and the ceiling/wall. Hard epoxy or other material that cannot be easily removed was used to fill space between fixture and ceiling. The light fixture does not possess features to which cloth or other material can be securely tied or hung or, if present, the fixture is at least ten feet (10') above the floor.				
7. Sprinklers are not within reach of the inmate from floor or are recessed in a cone-shaped housing or other housing to which cloth or other material cannot be securely tied/hung; nonrecessed sprinkler is out of the inmate's reach and is connected to a coupling that would separate under 70 lbs. of weight. No space exists between the base of the housing and the surface to which it is attached. Hard epoxy or other material that cannot be easily removed was used to fill space between fixture and ceiling.				
8. Windows are made of shatter-resistant material or are covered with security-rated screens or other material (e.g., Lexan®) that prevent access to the glass. Holes in security-rated screen are not > 3/16" inch. Window cranks are flush with frame.				
9. Toilet and sink are made of metal. They are also smooth and lack features to which cloth or other material can be securely tied or hung. Fixture(s) is (are) mounted against the wall and water shut-off valve is outside the room.				
10. Smoke detectors, when present, are at least ten (10) feet above the floor or are recessed in wall/ceiling or are enclosed in small wire mesh or other suitable housing that prevents access to the smoke detector. The wire mesh or other enclosure has holes that are not larger than 3/16" and lacks features to which cloth or other material can be securely tied/hung.				
11. Electrical outlets are not present. Electrical switches, e.g., to adjust lighting, are secure to the point that inmate cannot access wiring. Switches do not protrude so far as to be used to inflict serious injury.				
12. Beds, when present, have solid bottoms and are secured to the floor or wall so that inmate cannot stand upright. All other surfaces are smooth so that cloth or other material cannot be securely hung or tied. Beds are not more than 18" above the floor if the beds have features to which cloth or other material can be securely hung or tied.				
13. A plastic-covered or other washable mattress (except cloth) with triple stitching is available for **immediate** use in each room. The mattress is intact, with no tears or loose stitching.				
14. Three (3) triple-stitched, heavy canvas (weight #12) or other tear-resistant blankets are available for **immediate** use in each room. Blankets are intact, with no tears or loose stitching.				

Review Item	Yes	No	N/A	Comments
15. At least three (3) privacy wraps are available for immediate use in each room at institutions where male inmates are housed. Wraps are at least 30 inches wide and made of triple-stitched, heavy canvas, or other tear-resistant material. Wraps are intact, with no tears or loose stitching. At least ten (10) paper gowns or three (3) gowns made of canvas or other tear-resistant material are available per room for immediate use at institutions where female inmates are housed.				
16. The institution has a written procedure ensuring that blankets and privacy garments are cleaned and treated for fire retardation after each episode of use or after three (3) consecutive days of use. Application of fire retarding chemicals is not required on blankets/garments made of fire-resistant materials (as reported by the manufacturer).				

2.0 FACILITY HISTORY

2.1 Number of suicides at our facility

2002 _____

2003 _____

2004 _____

2005 _____

2006 YTD _____

TOTAL _____

2.2 Number of suicide attempts at our facility requiring transport to an emergency room

2002 _____

2003 _____

2004 _____

2005 _____

2006 YTD _____

TOTAL _____

2.3 Location of prior year suicides and attempts requiring transport to an emergency room

_____ in medical observation

_____ in segregation

_____ in GP

_____ in other _____(specify)

2.4 Major findings from the past year in the "after action" and Mortality and Morbidity Reviews

a)_____

b)_____

c). _____

d) _____

2.5 Corrective Actions (List)

Actions	Completed	
	Yes	No
a) _____	☐	☐
b) _____	☐	☐
c) _____	☐	☐
d) _____	☐	☐

3.0 STAFFING

3.1 Total Staff by category

	Correctional	Non-correctional	Total
# of FTE's – Budgeted	_____	_____	_____
# of FTE's – Filled	_____	_____	_____
Variance	_____	_____	_____

3.2 Turnover Rate

Correctional	Non-correctional	Total
_____	_____	_____

3.3 Mental Health Staff

	Budgeted Hrs.	Filled Hrs.	Variance
Psychiatrist	_____	_____	_____
Psychologist	_____	_____	_____
Mental Health Coordinator	_____	_____	_____
Mental Health Counselor	_____	_____	_____

3.4 Mental Health Coverage

a) At our facility, we have mental health coverage 7 days/week ☐ Yes ☐ No

b) At our facility, we have mental health coverage 5 days/week ☐ Yes ☐ No

c) If A & B are no, describe the mental health coverage_____

3.5 Do you have Unit Management at your facility? ☐ Yes ☐ No

If yes, describe_____

4.0 FACILITY GENERAL INFORMATION

4.1 Capacity and count

Category	# of Beds	
	G.P.	SEG
Jail	_____	_____
Prison	_____	_____
Detention Center	_____	_____
Total	_____	_____

4.2 Intake turnover

a) At our facility we have _____ intakes and _____ releases per month

b) At our facility inmates intake to the facility:

☐ On regularly scheduled days (Specify) _____

☐ 24/7

☐ During the week but not holidays and weekends

4.3 Transportation

a) We average _____ court runs/week. Averaging _____ inmates per run

5.0 MEDICAL

5.1 All intra-system transfers have completed transfer information including an assessment of mental health status. ☐ Yes ☐ No

5.2 Pre-seg evaluation includes a documented review of mental health history and mental health history. ☐ Yes ☐ No

5.3 a) There is a call-out system for mental health ☐ Yes ☐ No

b) Mental health call-out is completed and/or inmate counseled ☐ Yes ☐ No

5.4 Psychotropic medication use

a) _____% of inmates on psychotropic meds

b) _____% compliant

Arresting/Transporting Officer Questionnaire

Facility: _____

Inmate/Resident Name: _____ **Inmate/Resident Number:** _____

☐ **New Inmate** ☐ **Return from Court**

☐ **Return from Medical Consult** ☐ **Return from Special Appointment**

1. Does the inmate appear to be under the influence of alcohol or drugs? ☐ Yes ☐ No

2. Has the inmate made *any* comments (e.g., "I'm going to kill myself," "I want to die," "I have nothing to live for," "Everyone would be better off without me around") or engaged in *any* behavior that would be cause for concern? ☐ Yes ☐ No

3. Has another individual with knowledge of inmate informed you and/or made comments that suggest that inmate is potentially suicidal and/or has a history of suicidal behavior, has a history of mental illness, has medical problems, or is under the influence of alcohol and/or drugs? ☐ Yes ☐ No

4. Does the inmate appear to be overly ashamed, embarrassed, scared, depressed, or exhibiting bizarre behavior? ☐ Yes ☐ No

5. Are there any facts or circumstances surrounding the arrest and/or alleged crime that may suggest the inmate is potentially suicidal? ☐ Yes ☐ No

6. Was inmate sentenced? ☐ Yes ☐ No
   If yes, sentence_____

7. Do you have any other information that would be helpful to us while the inmate is confined in this facility? ☐ Yes ☐ No

8. Comments: _____
   _____
   _____
   _____

_____ _____
Completed by Date

If answer is yes to any of the above, please notify the Health Services department immediately.

Intake Mental Health Screening

Inmate/Resident Name: _____ **Inmate/Resident #** _____

Facility: _____ **Date of Birth:** _____

Instructions:

- Explain to the inmate/resident that you need to ask questions regarding their mental health history.
- All items must be read to the inmate/resident. Do not allow inmate/resident to self-administer.
- For questions 3 through 8, ask about both past and current symptoms.
- Circle the appropriate answer.

- **If the inmate/resident gives a "YES" response to ANY of questions 2-12, you MUST refer the inmate/resident to mental health staff for assessment. <u>There are no exceptions to this procedure.</u>**
- If the inmate/resident gives a **"YES" response to question 10 or 11, make an immediate referral** to mental health staff and make sure continuous observation (suicide) watch is provided until seen by the mental health staff.

1.	Orientation (person, place, time) – if disoriented, **please refer immediately.**	Oriented	**Disoriented**

		PAST		CURRENT	
2.	Have you ever been admitted to a state or private mental hospital by a psychiatrist or other mental health professional for emotional problems/ nerves? If yes, when and where?	No	**Yes**		
3.	Have you ever taken medication for emotional problems, head trauma or seizures, for mental illness, or for "nerves"? If yes, when and where?	No	**Yes**	No	**Yes**
4.	Have you ever heard or seen things that other people said they couldn't ?	No	**Yes**	No	**Yes**
5.	Have you ever felt that other people could read your mind or could control your mind Put thoughts into your head or take thoughts out of your head? That you were being plotted against, poisoned or spied upon by others?	No	**Yes**	No	**Yes**
6.	At times have you had so much energy (without drinking or taking drugs) that you could go for days without sleep and your thoughts just seemed to race in your head?	No	**Yes**	No	**Yes**
7.	When in school, were you ever enrolled in special education classes?	No	**Yes**	No	**Yes**
8.	Have you ever been charged with a sex offense or been the victim of a sex offense?	No	**Yes**	No	**Yes**
9.	Have you ever felt so bad, so depressed, that you tried to take your own life? If yes, when?_____ *If the inmate/resident has considered but not TRIED suicide, note this in the COMMENT section.*	No	**Yes**		
10.	**Are you now thinking about harming or killing yourself?** *"Yes" is an immediate placement on suicide precaution and referral to mental health*			No	**Yes**
11.	**Are you now thinking about harming someone else?** *"Yes" is an immediate referral to mental health*			No	**Yes**
12.	Are you now experiencing any serious problems that you would like to talk over with one of the mental health staff?			No	**Yes**

Comments/Observations (e.g., emotional response to incarceration): _____

_____

This is a *screening inventory* and IS NOT your only guide for referral to mental health services. You may still refer the inmate/resident in the following circumstances:

- if you suspect that, in spite of the answers, this inmate/resident is experiencing some emotional difficulties;
- if you need additional mental health information on an inmate/resident prior to classification;
- or for reasons not listed here that you feel are important.

Referred to Mental Health?	No	**Yes**		**Placed on suicide precaution?**	No	**Yes**

Interviewer: _____ **Title** _____ **Date/Time** _____

Referral for Mental Health or Chemical Dependency Services

Date: _____

Inmate/Resident Name: _____

Inmate/Resident No.: _____

Briefly describe reason for referral: _____

_____

_____

_____

_____

_____

Prior mental health treatment or chemical dependency (if known): _____

_____

_____

_____

Current medication (if referred by Health Services staff):

Drug: _____ Dose: _____

_____ _____

_____ _____

Compliant ❑ Yes ❑ No

Priority: Emergency ❑
ASAP ❑
As time permits ❑

Referred by: _____

Observation Monitoring Form

Date: ____________________

Inmate/Resident Name: ____________________ Inmate/Resident # __________ Cell Location ______________

Reason for Observation/Seclusion: _________________________ Ordered by: _________________________

Time and Date Placed on Observation/Seclusion: _______________ Date Renewed: _________________________

On Medications? ____ Yes ____ No

Frequency of checks: ☐ 15 minutes ☐ 30 minutes ☐ other____

Items Allowed (Check Appropriate Line)

YES	NO	
___	___	Suicide Garment
___	___	Undergarments
___	___	Suicidal Blanket
___	___	Mattress
___	___	Pillow
___	___	One Book
___	___	Smoking Materials

Notify Health Services Staff For:

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

CODE EXPLANATION

1. Beating on door/wall
2. Yelling or screaming
3. Crying
4. Cursing
5. Laughing
6. Singing
7. Mumbling incoherently
8. Standing still
9. Walking
10. Lying or sitting
11. Quiet
12. Sleeping
13. Meals served/eaten
14. Fluids served/taken
15. Bath/shower
16. Toilet
17. Smoking
18.
19.

Staff Signatures	Initials

Primary Therapist

Psychiatrist/Physician

TIME	CODE	INT'S	TIME	CODE	INT'S	TIME	CODE	INT'S

Code and signature are required on the above time lines. INT's = Initials

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MAR 2006

Transfer In/Transfer Out Screening

Date: _____ **Time:** _____ **Primary Language:** _____

Inmate/Resident Last Name: _____ **Inmate/Resident First Name:** _____

DOB: _____ **Inmate/Resident Number:** _____

Diabetic: ☐ **Yes** ☐ **No** **BS:** _____

1. Does inmate/resident have any conditions that would prevent him/her from travel at this time? ☐ Yes ☐ No ☐ N/A (Transfer In)
   If yes, describe: _____
2. Will inmate/resident require any medications or treatment during transport? ☐ Yes ☐ No ☐ N/A (Transfer In)
   If yes, describe: _____
3. Are there any special needs or instructions for transport personnel? ☐ Yes ☐ No ☐ N/A (Transfer In)
   If yes, describe: _____
   ***NOTE: Complete the 13-86B**
4. Have all records pertinent to the transfer of medical care accompanied the inmate/resident? ☐ Yes ☐ No
   If yes, list documents: _____
5. Does the inmate/resident have a medical condition that could or does pose a health/ safety threat to him/herself or others? ☐ Yes ☐ No
   If yes, describe: _____
6. Current medications and dosage: ☐ Yes ☐ No
   (Write "none" or list below) Medications sent with instructions:
   1. _____
   2. _____
   3. _____
7. Does the inmate/resident require immediate medical attention? ☐ Yes ☐ No
8. Is the inmate/resident allergic to any medications? ☐ Yes ☐ No
   If yes, list: _____
9. Date of last TB skin test: _____ Results _____ mm
   Action taken: _____
10. Are there any identified nutritional risks? ☐ Yes ☐ No
11. Current medical conditions: check all that apply

____ allergies	____ asthma	____ ulcers	____ epilepsy	____ hepatitis
____ HIV	____ diabetes	____ heart condition	____ gynecological problems	
____ weight loss	____ tuberculosis	____ high blood pressure	____ mental illness or treatment	

12. Current plan of care instituted by transferring facility: _____
    _____
    _____
13. Pending medical appointments and/or surgery: _____

Disposition: ☐ Cleared for transport (Transfer Out) ☐ Cleared for general population (Transfer In) ☐ Hold for medical

Examiner's Signature: _____ **Title:** _____ **Date:** _____

Special Instructions for Transporting Officers

Date: _____ Time: _____ Primary Language: _____

Inmate/Resident Last Name: _____ Inmate/Resident First Name: _____

DOB:_____ Inmate/Resident Number:_____

Special Instructions to Transporting Officer:_____

Original: Transporting Officer Copy: Medical Department