Virginia Department of Corrections

Mental Health and Wellness Services

Operating Procedure 730.5

Mental Health and Wellness Services: Behavior Management

Authority:
Directive 730, *Mental Health and Wellness Services*

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REVIEW

The Content Owner will review this operating procedure annually and re-write it no later than three years after the effective date.

The content owner reviewed this operating procedure in December 2023 and necessary changes are being drafted.
The content owner reviewed this operating procedure in January 2025 and necessary changes are being drafted.

COMPLIANCE

This operating procedure applies to all units operated by the Virginia Department of Corrections (DOC). Practices and procedures must comply with applicable State and Federal laws and regulations, American Correctional Association (ACA) standards, Prison Rape Elimination Act (PREA) standards, and DOC directives and operating procedures.

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DEFINITIONS

Ambulatory Restraints - Utilization of handcuffs, leg irons, handcuff cover, and either a waist chain or a chain connecting the handcuff cover on the handcuffs to the leg irons or clinically approved ambulatory restraints; this is generally the first level of restraints utilized in physical management of inmate disruptive behavior.

"At Risk" Inmate - An inmate who meets criteria for being "at risk" for deterioration, self-harm, and/or being a danger to others in a Restorative Housing Unit as determined by a Mental Health Clinician; see *Mental Health and Wellness Services Screening* 730_F12.

Cell with Restrictions - A housing assignment where specified items have been removed to reduce the likelihood of self-injury; such items may include clothing, linens, personal care items, etc.. Typically a Mental Health Clinician will identify the items to be removed from a cell, however, in an emergency or when a Mental Health Clinician is unavailable, the determination may be made by the Facility Unit Head, Administrative Duty Officer, or Shift Commander.

Clinically Approved Restraints - Soft restraints approved by the Chief of Mental Health and Wellness Services and/or Health Services Unit for use at DOC institutions.

Community Corrections Alternative Program (CCAP) - A system of residential facilities operated by the Department of Corrections to provide evidence-based programming as a diversionary alternative to incarceration in accordance with COV §53.1-67.9, *Establishment of community corrections alternative program; supervision upon completion.*

Facility - Any institution or Community Corrections Alternative Program.

Five Point Restraints - A method of restraining an inmate where the inmate is placed face up on the bed with both arms and legs restrained. A chest strap is placed over the inmate's chest.

Four Point Restraints - A method of restraining an inmate where the inmate is placed face up on the bed with both arms and legs restrained.

Health-Trained Staff - Correctional Officers or other correctional staff who are trained and appropriately supervised to carry out specific duties regarding the administration of health care.

High Risk Sexual Aggressor (HRSA) - As identified by the *Classification Assessment* and Mental Health Clinician assessment, any inmate/probationer/parolee at high risk of being sexually abusive.

High Risk Sexual Victim (HRSV) - As identified by the *Classification Assessment* and Mental Health Clinician assessment, any inmate/probationer/parolee confirmed as a sexual victim or identified as being at high risk of being sexually victimized.

Hunger Strike - The voluntary refusal of food by an inmate possessing the capacity to make such decision, for the purpose of negotiating conditions of confinement or other changes.

Hunger Strike Consultation Team (HSCT) - An interdisciplinary team designated to review a hunger strike event with the local interdisciplinary team when inmate has reached a set threshold of 15 missed meals or consultation is requested for care and case planning purposes.

Hunger Strike Local Interdisciplinary Team - Facility participants in the Hunger Strike Consultation Team include: Regional Operations Chief or Regional Administrator, Warden or Assistant Warden, Health Authority, Chief of Housing and Programs, Building Lieutenant, Major, Senior Mental Health Clinician, and the Regional Mental Health Clinical Supervisor or their designees.

Institution - A prison facility operated by the Department of Corrections; includes major institutions, field units, and work centers.

Medical Practitioner - A Physician, Nurse Practitioner, or Physician's Assistant.

Mental Health Classification Code - A numeric code assigned to an inmate by a Mental Health Clinician that reflects the inmate's current mental health status and mental health and wellness service needs; the coding system is hierarchical, ranging from MH-0 representing no current need for mental health and wellness services to MH-4S representing the greatest need for mental health and wellness services.

Mental Health Clinician - An individual with at least a master's degree in psychology, social work, or relevant human services field with knowledge, training, and skills in the diagnosis and treatment of mental disorders, which may include a Psychiatric Provider, Social Worker, or Registered Nurse.

Mental Health Treatment Team (MHTT) - An interdisciplinary team typically comprised of a Psychiatrist, Psychologist or Mental Health Clinician, clinical Social Worker, and Nurse who has a psychiatric background; the team works in conjunction with other support staff, including medical and security staff, for the purpose of assessing the mental health status and services needs of the inmate and developing and implementing treatment, management, and aftercare plans.

Mid-level Practitioner - Nurse Practitioner and Physician Assistant.

Multi-Disciplinary Team (MDT) - MDT members are responsible to review individual inmates related to restorative housing and step-down statuses and act as the Institutional Classification Authority to make recommendations for housing status, transfer, security level, good time class, etc.; decisions are the responsibilities of the Facility Unit Head and Regional Administrator.

Precautions - Level of care status which may include conditions under which an inmate who is considered by a Mental Health Clinician to be at significant risk for deterioration, suicide, self-injury, harm to others due to mental health reasons, is closely observed by an assigned Corrections Officer, or other designated person and whose access to potentially harmful items may be restricted while they are at risk.

Qualified Health Care Personnel - A Licensed Practical Nurse, Registered Nurse, Physician Assistant, Nurse Practitioner, or Physician.

Qualified Mental Health Professional (QMHP)-Adult - An individual employed in a designated mental health and wellness services position who meets Department of Health Professions (DHP) Board of Counseling regulatory standards including at least a bachelor's degree in human services or a related field, supervised experience, registration with DHP as a QMHP, and ongoing education in mental health topics.

Restorative Housing Unit - A general term for special purpose bed assignments including restorative housing, and step-down statuses; usually a housing unit or area separated from full privilege general population.

- Alt-GP Status - General population bed assignments operated with increased privileges above RHU status but more control than full privilege general population for inmates making an informed voluntary request for placement and inmates assigned to the restorative housing unit for their own protection.
- RHU-Restorative Housing (RHU) Status - Special purpose bed assignments operated under maximum security regulations and procedures, and utilized under proper administrative process, for inmates requesting placement with informed voluntary consent, inmates needing confinement for their own protection, when there is a need to prevent imminent threat of physical harm to the inmate or another person, or the inmate's behavior threatens the orderly operation of the facility.
- RH Step-Down 1 (SD-1), RH Step-Down 2 (SD-2) Status - General population bed assignments operated with increased privileges above RHU status but more control than full privilege general population.

Safety Cell - A designated cell that is outfitted as closely as possible with approved equipment to minimize risk of self harm or suicide.

Safety Status – A VACORIS internal status that identifies inmates at risk for deterioration, suicide, self-injury, harm to others due to mental health reasons, whose management includes a specific placement within the facility.

Serious Mental Illness (SMI) - Psychotic Disorders, Bipolar Disorders, and Major Depressive Disorder; any diagnosed mental disorder (excluding substance use disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified Mental Health Clinician.

Psychological - *as relating to the mental and emotional state of an individual.*

Cognitive - *as relating to cognitive or intellectual abilities.*

Behavioral - *as relating to actions or reactions in response to external or internal stimuli that is observable*

and measurable.

Special Management Instructions - Instructions provided by a Mental Health Clinician as to how an inmate is to be managed by security and other staff including, for example, items the inmate is allowed or not allowed to have as documented on the *"At Risk" Inmate Notification* 730_F13.

Stripped Cell - A housing assignment in which every item, including clothing, mattress, and bedding; but excluding fixtures that are attached to the floor, ceiling and walls has been removed. In a Modified Stripped Cell, some items are removed and other items remain in the cell.

PURPOSE

This operating procedure provides strategies to assist facility staff in managing the behavior of an inmate or CCAP probationer/parolee in a Department of Corrections (DOC) facility when there is substantial danger of self-injury, suicide, or injury to others as a result of a mental disorder or who may be at risk for deterioration, self-harm, or harm to others when placed in a Restorative Housing Unit.

PROCEDURE

I. Behavior Management

A. General

1. Correctional facilities must control and manage inmate and Community Corrections Alternative Program (CCAP) probationer/parolee behaviors for the safety of the public, employees, and inmates and CCAP probationers/parolees.
2. Unusual or problematic behaviors include but are not limited to: self-injury, threats to persons or property, assaults on others, hunger strike, throwing or smearing urine and excrement, flooding, and setting fires.
3. Facility staff must provide appropriate intervention and control as needed to protect the inmate or CCAP probationer/parolee, staff, and other inmates or CCAP probationers/parolees, and to maintain a sanitary, safe, and secure environment.
4. Because unusual or problematic behavior may occur as the result of physical or mental illness, personality disorder, or may be deliberately manipulative to gain desired ends, facility administration, security, mental health and wellness services, and health services staff must work together closely to determine the appropriate level and duration of controls imposed on each inmate and CCAP probationer/parolee.
5. The control measures authorized in this operating procedure must be appropriately matched to the seriousness of the behaviors they are intended to control.
   a. Inmates and CCAP probationers/parolees will be protected from personal abuse, corporal punishment, personal injury, disease, property damage, and harassment. (5-ACI-3D-08)
   b. The controls must not be applied any longer than necessary to manage the targeted behaviors.
   c. The use of excessive controls measures is equated to the use of excessive force.

B. Identification of inmates with mental health service needs

1. Intake to the DOC
   a. On intake to the DOC, all new inmates receive an initial mental health screening to evaluate suicide risks in accordance with Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*. Based upon their findings, staff may make an emergency referral, a routine referral, or no referral to mental health and wellness services staff.
   b. In addition to the mental health screening, all new inmates in DOC institutions will also undergo a mental health appraisal by a Mental Health Clinician within 14 days of admission in accordance with Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification.* The mental health appraisal includes an assessment of current suicidal potential and person-specific circumstances that increase suicidal potential, review of inpatient and/or outpatient psychiatric treatment, review of treatment with psychotropic medications, etc.
2. All intra-system (within the DOC) transfer inmates will receive an initial mental health screening by designated trained staff at the time of admission to the new facility to evaluate suicide risks in accordance with Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*. Based upon their findings, staff may make an emergency referral, a routine referral, or no referral to mental health and wellness services staff.

3. All inmates that have significant mental health needs as determined by a Mental Health Clinician, when housed at a facility with a Mental Health Clinician, will receive an annual review of their mental health status and classification.
4. Staff (Security staff, Case Management Counselors, work supervisors, Teachers, etc.) may refer inmates for a mental health assessment at any time they are concerned that they may be a danger to themselves or others.
5. Inmates identified with mental health and wellness services needs are provided appropriate care in accordance with Operating Procedure 730.3, *Mental Health Services: Levels of Service*.
6. This operating procedure provides strategies and techniques for crisis intervention when there is substantial danger of self-injury, suicide, or injury to others as a result of a mental disorder, as determined by a Mental Health Clinician.
7. For challenging cases, Mental Health Clinicians will seek consultation, supervision, and when warranted refer the inmate for an evaluation.

C. Safety Status and *Precautions*

1. Any inmate who requires a specific placement within the facility to assist in management due to being at risk for deterioration, suicide, self-injury, or harm to others due to mental health reasons will be considered to be on the internal status of Safety Status and will be entered into VACORIS by a Mental Health Clinician until no longer deemed necessary, at which time a Mental Health Clinician will revise inmate's internal status in VACORIS (i.e., placement in medical for purpose of *Precautions*)
2. *Precautions* may be ordered by a Mental Health Clinician, or if the Mental Health Clinician is not available, by the Facility Unit Head or Administrative Duty Officer (ADO). Authorization and conditions of the *Precautions* will be documented by the Mental Health Clinician on the "At Risk" Inmate Notification 730_F13.
   a. A building supervisor where the inmate is housed will countersign the "*At Risk" Inmate Notification* 730_F13 to confirm receipt of any Special Management Instructions.
   b. Special Management Instructions must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
3. An inmate placed on *Precautions* will be strip searched by a Corrections Officer for potentially harmful objects and initially will be provided only an approved safety smock.
   a. All other property will be removed from the cell.
   b. The safety smock may be removed by order of a Mental Health Clinician if warranted by the inmate's clinical condition or, in an emergency situation, when the Mental Health Clinician is unavailable, upon the order of the Shift Commander of the facility.
4. Corrections Officers at their discretion or as ordered by a Mental Health Clinician will strip search inmates on *Precautions* for potentially harmful objects. Corrections Officers must search the inmates' cells on a random basis, or more often as specified by the Mental Health Clinician, for contraband and other materials that could be used for self-harm on the *"At Risk" Inmate Notification* 730_F13.
5. For inmates placed on *Precautions* with 15 minute Watch, a Corrections Officer will check the status of the inmate at variable intervals, but not less than once every 15 minutes. (5-ACI-4A-11)
   a. At a minimum, the Corrections Officer will observe that the inmate is breathing (e.g., seeing movement of the chest up and down, and hearing snoring or other sounds coming from the inmate's nose or mouth).
   b. If it is not evident that the inmate is breathing, the Corrections Officer will elicit a response from the inmate. For example, the Corrections Officer will ask the inmate a question such as, "How are you doing?" and the inmate will respond verbally and/or behaviorally (e.g., by raising a hand in response).
   c. Documentation of the status checks, behaviors, etc., will be made on the *Special Watch Log* 425_F5.

6. For inmates placed on *Precautions* with one-to-one supervision (Constant Watch), a Corrections Officer will physically observe the inmate on a continuous and uninterrupted basis and will maintain a clear and unobstructed view of the inmate at all times. The assigned individual will document observations of the inmate's behaviors and responses on the *Special Watch Log* 425_F5. (5-ACI-4A-11)
7. If there does not appear to be any sound or movement by the inmate, the Corrections Officer(s) will summon assistance and enter the cell as soon as it is safe to do so, usually only after arrival of a second staff person. If, upon assessment by the first responder, the inmate is determined to not be breathing, cardiopulmonary resuscitation (CPR) will be initiated immediately; see the *Suicide Prevention and Intervention* section of this operating procedure.
8. On every workday that the inmate remains on *Precautions*, a Mental Health Clinician will interview the inmate and document their findings utilizing the *Mental Health Monitoring Report* 730_F14. If a Mental Health Clinician is not available, health services staff will interview the inmate.
9. Typically, an inmate who is removed from *Precautions* with one-to-one supervision (Constant Watch) will be placed on *Precautions* with 15 minute Watch.
10. An inmate on *Precautions* may be offered items/privileges/property as determined by the Mental Health Clinician based upon an assessment and evaluation of their clinical condition. The Mental Health Clinician will document changes in *Precautions*, interventions, property and privileges using the *"At Risk" Inmate Notification* 730_F13.
    a. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any Special Management Instructions.
    b. Special Management Instructions must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
11. Discontinuation of *Precautions* will be determined only by a Mental Health Clinician (after consultation with other Clinicians) based upon an interview to assess and evaluate the inmate's mental status, behavior and overall level of functioning.
    a. The Mental Health Clinician will complete a *Suicide Risk Assessment* 730_F15 indicating that the inmate appears to no longer present a significant risk of suicide.
    b. Discontinuation of *Precautions* will be documented on the *"At Risk" Inmate Notification* 730_F13 and the *Mental Health Monitoring Report* 730_F14.
12. Based on the Mental Health Clinician's assessment, an inmate who has been placed on *Precautions* will typically go through a step-down process before being completely released from *Precautions*.
    a. Generally, this will occur over the course of several days, with the Mental Health Clinician authorizing the gradual return of clothing, linens, etc., to the inmate.
    b. If the Mental Health Clinician determines that the inmate continues to be at risk for self-harm, the inmate will remain on *Precautions* until the Mental Health Clinician determines otherwise.
    c. An inmate may be continued on *Precautions* for as long as is considered necessary by the Mental Health Clinician.
    d. If appropriate, the Mental Health Clinician can consider involuntary commitment to an acute care setting as provided in Operating Procedure 730.3, *Mental Health Services: Levels of Service*.
13. All treatment staff members who check on the inmate's status will note these contacts in the *Special Watch Log* 425_F5.

D. "At risk" inmates in a Restorative Housing Unit

1. Each institution will systematically identify, monitor, and manage inmates considered "at risk" for deterioration, self-harm, or harm to others when placed in a Restorative Housing Unit.
    a. All inmates must have an initial mental health screening on intake into the DOC in accordance with Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and*

Classification.

b. Qualified health care personnel or health-trained staff will screen all inmates transferring from one institution to another on the day of arrival, or no later than the next working day if the inmate arrives when nursing staff is not on duty in accordance with Operating Procedure 720.2, *Medical Screening, Classification, and Levels of Care*.

c. Any noted mental health concerns will be forwarded to a Mental Health Clinician.

2. Health screening will be conducted by qualified health care personnel or health-trained staff when qualified health care personnel are absent.

a. Health screenings must be conducted when the inmate arrives at the institution (as noted above) and whenever qualified health care personnel determine that a screening is needed.

b. A health screening conducted by staff other than a Mental Health Clinician will be documented in the inmate's health record. Qualified health care personnel will utilize the *Intra-system Transfer Medical Review, DOC 726-B* 720_F9*;* health-trained staff will utilize the *Health Screening - Health-Trained Staff* 720_F10.

c. At the completion of the health screening, the screener will immediately contact a Mental Health Clinician designated to provide services to that institution if:

i. The inmate expresses or evidences current suicidal ideation, plan, or intent, or

ii. The inmate expresses or evidences acute psychotic symptoms or behaviors, or

iii. There is documentation of or the inmate reports suicidal behavior within the last three months, or

iv. The inmate is designated as or scores as a High Risk Sexual Victim (HRSV) or a High Risk Sexual Aggressor (HRSA)

v. A routine referral is needed for other mental health related issues

3. A Mental Health Clinician may complete a *Mental Health and Wellness Services Screening* 730_F12 on any inmate at an institution at any time. If the inmate is not considered "at risk", the completed *Mental Health and Wellness Services Screening* is valid for one year from the completion date, if there is no change in the inmate's mental health status or service needs.

4. The Mental Health Clinician will maintain a list of inmates who meet the criteria for "at risk" in a Restorative Housing Unit. This list may be provided to the Shift Commander and/or Restorative Housing Unit Supervisor and the Health Authority to ensure that "at risk" inmates receive proper supervision and care.

5. On the first working day after an initial assignment to a Restorative Housing Unit, the Mental Health Clinician will complete a *Mental Health and Wellness Services Screening* 730_F12 and *Mental Health Monitoring Report* 730_F14; COV §53.1-39.2, Restorative housing; restrictions on use. (5-ACI-4B-10, 5-ACI-4B-28)

a. A *Mental Health and Wellness Services Screening* 730_F12 must be completed for any inmate upon initial assignment to RHU who has not previously been screened within the last seven days as a result of RHU assignment.

b. A *Mental Health Monitoring Report* 730_F14 must be completed for any inmate upon initial assignment to RHU by a Mental Health Clinician with at least a QMHP qualification. This review will include a mental status assessment of the inmate, and will address the following:

i. Is the inmate oriented to time/place/person and to the current situation?

ii. Does the inmate appear to be a danger to self or others?

iii. What are the current behaviors and/or symptoms displayed by the inmate?

iv. Any recommendations to the staff for managing the inmate will be stated on the *"At Risk" Inmate Notification* 730_F13.

c. At institutions with no Mental Health Clinician, qualified health care personnel, or health-trained staff must interview the inmate within one working day after placement in a Restorative Housing Unit using the *Restorative Housing Review* section of the *Health Screening - Health-Trained Staff*

720_F10 to identify if there is any indication the inmate may be "at risk" and in need of transfer to an institution with a Mental Health Clinician.

6. The Mental Health Clinician will complete a *Mental Health Monitoring Report* 730_F14 weekly, or more if warranted, for every inmate assigned to RH.
7. If the Mental Health Clinician determines an inmate assigned to a RHU status to be "at risk," they will complete an *"At Risk" Inmate Notification* 730_F13 to communicate relevant management information to security staff.
   a. A building supervisor (e.g., Unit Manager, Watch Commander, Building Lieutenant, or Building Sergeant) where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.
   b. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
8. If the Mental Health Clinician determines that placement in a Restorative Housing Unit may have a detrimental effect on an inmate's mental health, the Mental Health Clinician will notify the Facility Unit Head that placement in the Restorative Housing Unit is not recommended. (5-ACI-6C-06)
   a. The Mental Health Clinician will offer alternatives for mental health care such as commitment to an acute care setting, transfer to another institution, or strategies for management within the general population.
   b. The Facility Unit Head's signature is required on the *"At Risk" Inmate Notification* 730_F13 for placement of an "at risk" inmate in the Restorative Housing Unit against Mental Health Clinician recommendations.
9. A Mental Health Clinician will screen "at risk" inmates in the Restorative Housing Unit at a minimum of every seven days to assess the level of risk and complete a *Mental Health Serious Mental Illness (SMI) Determination* 730_F34, when warranted. The Mental Health Clinician will determine the frequency of observation based upon the inmate's mental health status, mental health and wellness service needs, and the institution's mental health and wellness services procedures. (5-ACI-4B-11)
   a. The Mental Health Clinician will see the inmate as soon as possible but no later than the first working day after the inmate enters the Restorative Housing Unit. This review, documented on a *Mental Health Monitoring Report* 730_F14, will include a mental status assessment of the inmate.
   b. The Mental Health Clinician will provide Restorative Housing Unit security staff documentation of the inmate's current mental health issues and any special management instructions via *"At Risk" Inmate Notification* 730_F13.
      i. Security staff must enter pertinent information from the *"At Risk" Inmate Notification* 730_F13 in the Special Conditions section on the inmate's *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
      ii. Each time a Mental Health Clinician sees an inmate in a Restorative Housing Unit, that contact will be logged on the inmate's *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5 by the Mental Health Clinician's initials or documented by other means.
   c. Based on the initial assessment considering the inmate's current mental status service's needs, level of behavioral functioning, clinical history, and mental health procedures, the Mental Health Clinician will determine how often a Mental Health Clinician is to see an "at risk" inmate in the Restorative Housing Unit.
   d. Before a *Disciplinary Offense Report* is served on an inmate housed in the Restorative Housing Unit for a mental health reason (e.g., suicide watch); an inmate who may be cognitively or mentally impaired in general population; or an inmate with a Mental Health Classification Code of MH-2S, MH-3S, or MH-4S the Mental Health Clinician will assess the inmate in accordance with Operating Procedure 861.1, *Inmate Discipline,* and complete the *Disciplinary Offense Mental Health Screening* 861_F2.
10. Any identified "at risk" inmate placed in a RHU status will receive a physical screening (i.e., weight

and vital signs taken and recorded, checked for symptoms of possible side effects to prescribed medication) by a qualified health care professional (i.e., RN, LPN/CNT, or CHA) no less than once every 14 days.

11. Unless mental health attention is needed more frequently, each inmate on RHU status will receive a weekly visit from mental health and wellness services staff. (5-ACI-4B-28)
    a. The visit ensures that inmates have access to mental health and wellness services.
    b. The presence of mental health and wellness services staff in the Restorative Housing Unit is announced and recorded in the Restorative Housing Unit logbook.
    c. Mental Health Clinician weekly visits will be recorded on the inmate's *Individual Inmate Log* 425_F4 and *Special Watch Log* 425_F5.
    d. When doing rounds, a Mental Health Clinician will review the inmate's *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5 during weekly visits to review the entries logged by security staff. The Mental Health Clinician will note if the inmate has participated in activities of daily living such as out of cell activities, interacting with staff, engaging in recreation, attending Multi-Disciplinary Team (MDT) hearings, accepting and consuming meals, taking showers, etc. If the log documents that this inmate has not been engaging in activities of daily living for a period of 21 calendar days, the Mental Health Clinician may have the inmate escorted to a secure location for an out-of-cell assessment.
    e. The Senior Mental Health Clinician determines the frequency of Psychiatrist or Psychiatric Provider visits to Restorative Housing Units.
12. A Mental Health Clinician will personally interview and prepare a *Mental Health Monitoring Report* 730_F14 on any inmate who remains on RHU status for more than seven days. (5-ACI-4A-10, 5-ACI-4B-10)
    a. If assignment on RHU status continues beyond seven days, a Mental Health Clinician must conduct a mental health screening using the *Mental Health Monitoring Report* 730_F14 every seven days thereafter or more frequently if clinically indicated.
    b. Any mental health interaction will be documented on a *Mental Health Monitoring Report* 730_F14.
    c. The mental health assessment will be conducted in a manner that ensures confidentiality.
13. When any inmate is placed in restraints for clinical purposes within a cell, a Mental Health Clinician will visit the cell and assess the inmate within the first 24-hours that the inmate is restrained.
    a. This assessment will be documented on the *"At Risk" Inmate Notification* 730_F13.
        i. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.
        ii. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
    b. The Mental Health Clinician will determine the extent and frequency of any additional mental health monitoring and/or services.

E. Staff training (5-ACI-6A-30, 5-ACI-6A-35; 4-ACRS-4C-16)

1. Training of non-mental health and wellness services staff to recognize warning signs of a mental health crisis is a critical component of a successful suicide prevention and crisis intervention program. All staff with responsibility for supervision (including security staff) will be trained on suicide prevention and intervention during their first year of employment and annually thereafter.
2. All training on suicide prevention and crisis intervention will be approved by the Chief of Mental Health and Wellness Services and the Academy for Staff Development and will be provided by a Mental Health Clinician. The training will include but is not be limited to the following:
    a. Identifying the warning signs and symptoms of suicidal behavior.
    b. Understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations of precipitating factors.

c. Responding to suicidal, depressed, and self-injurious inmates.
d. Communication between security and mental health and wellness services staff.
e. Referral procedures.
f. Precautions and procedures.
g. Housing observation and safety watch level procedures.
h. Follow-up monitoring of suicidal and self-injurious inmates.
i. Reporting and documentation.
j. Recognition of signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal.
k. Methods for accessing health/mental health and wellness services staff during a mental health crisis.
l. Procedures for placement of an inmate patient in a level of care in accordance with their mental health needs.
m. Population specific factors, pertaining to suicide risk in the facility.

3. Staff training requirements:
   a. All staff with inmate contact in DOC facilities are required to complete the four-hour training entitled "*Inmates with Mental Disorders and High Risk Behaviors*." This must occur during the first year of employment and annually thereafter.
   b. The Basic Skills classes for Corrections Officers, Nurses, P&P Officers, and Case Management Counselors will include the *Basic Skills in Mental Health Issues* training. On an annual basis thereafter, a minimum of four hours of training on mental health issues is required.
4. Security staff and health care personnel are trained to respond to health-related situations within a four-minute response time in accordance with Operating Procedure 720.7, *Emergency Medical Equipment and Care*.

F. Observe, act, report, and document

1. All staff with inmate contact whether direct (face-to-face) or indirect (requests, complaints, or grievances) must be alert to warning signs and behaviors that indicate an inmate is in danger of self-injury, suicide, or injury to others.
2. If security or other staff observes an incident of self-injurious, suicidal, or dangerous behavior, the following will immediately occur:
   a. Remove any materials by which the individual has harmed or may harm self or others.
   b. Inmate or CCAP probationer/parolee must remain in sight of staff until otherwise directed by Mental Health Clinician.
   c. Notify the Shift Commander of the inmate's or CCAP probationer's/parolee's behavior.
   d. Notify the medical department.
   e. Notify a Mental Health Clinician or on call Mental Health Clinician when the incident occurs.
3. An *Internal Incident Report* in VACORIS must be completed with a copy of the *Report* documenting self-injurious and/or suicidal behavior forwarded to the Senior Mental Health Clinician. If such an incident occurs at a facility with no Mental Health Clinician, the *Report* will be forwarded to the Health Authority

G. Respond

1. Any Mental Health Clinician who observes or receives a report of an inmate or CCAP probationer/parolee exhibiting suicidal, self-injurious (e.g., cutting) or other problematic (e.g., feces smearing) behavior will assess the inmate or CCAP probationer/parolee as soon as possible to determine the need for direct intervention and develop a treatment plan and/or a *Self-Management Housing Plan* 730_F32, if needed.

2. The approved interventions to manage suicidal, self-injurious (e.g., cutting), or other problematic (e.g., feces smearing) behaviors are provided in this operating procedure.
3. The Mental Health Clinician will reduce the level of intervention as the inmate or CCAP probationer/parolee demonstrates appropriate behaviors with the goal of reintegrating the inmate or CCAP probationer/parolee into the general population or, if necessary, providing the appropriate mental health and wellness services in accordance with Operating Procedure 730.3, *Mental Health Services: Levels of Service*.
4. Reporting and after action review
   a. Staff and, when appropriate, inmates or CCAP probationers/parolees involved in an incident will be debriefed to gather the information needed to report and review the incident.
   b. Incidents will be reported in accordance with Operating Procedure 038.1, *Reporting Serious or Unusual Incidents.* When applicable, the type of restraints, e.g., handcuffs, ambulatory, four/five point, etc. used during a reportable incident will be documented in the incident report on the participant page under *Use of Restraints*.
   c. A documented internal review will be conducted of suicides, suicide attempts, and use of clinical restraints. (5-ACI-6A-35, 5-ACI-6D-02) The Chief of Mental Health and Wellness Services or the facility administration may initiate reviews of other incidents as necessary to improve responses to future incidents.

H. Any in-person assessment of an inmate in a Restorative Housing Unit by a Mental Health Clinician or other qualified health care professional will be accomplished in the following manner:

1. The inmate will be restrained by handcuffs behind the back; use of leg irons is optional dependent on security level and the inmate's behavior pattern.
2. The inmate will be instructed to sit on their bunk.
3. Two certified Corrections Officers and the Mental Health Clinician/qualified health care professional will enter the cell to perform the assessment.
4. If the assessment cannot be successfully completed with the hands cuffed behind the inmate's back, the qualified health care professional will step back and allow the Corrections Officers to move the handcuffs to the front of the inmate.
5. If the assessment cannot be successfully completed in the cell, the inmate must be removed from the cell and escorted in appropriate restraints to an area where the assessment or examination can be completed.
6. Treatment chairs or modules may be used, if available.
7. In-person mental health interviews and assessments will be conducted in a manner that ensures confidentiality and provides for a therapeutic atmosphere as deemed appropriate by mental health and wellness services staff.

II. Interventions

A. General

1. The Mental Health Clinician may authorize the use of interventions including restraints for mental health management purposes using the *"At Risk" Inmate Notification* 730_F13.
   a. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.
   b. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5
2. If the inmate is removed from a general population and placed in the Restorative Housing Unit or requires an internal move to a *Safety Cell*, *Medical Cell*, or other compatible location, the review and classification requirements of Operating Procedure 425.4, *Management of Bed and Cell Assignments*

(Restricted), will apply.

3. If the Mental Health Clinician is unavailable, the Shift Commander, with the approval of the ADO may implement interventions as needed to prevent injury to the inmate or other persons. The inmate will be assessed by the Mental Health Clinician as soon as practical and the Mental Health Clinician will authorize further interventions as appropriate.

B. Self-Management Housing Plan (SMHP)

1. A SMHP is intended to provide enhanced housing protocol for inmates who are displaying acting out behavior that is compromising their daily functioning and significantly interfering with the orderly operation of the institution on a repetitive basis, but the behaviors are not considered to be the result of a severe mental illness. Examples of volitional behavior include swallowing various items, scratching or cutting self, insertion of various items into body orifices, altering or damaging state property in a manner that increases the risk of harm to self or others, and/or smearing feces.
2. A referral is made by an institutional staff member to the Senior Mental Health Clinician. Together, they fill out a *Maladaptive Behavior Screening* 730_F33. Protocols will be prioritized based on points accumulated as approved by the Mental Health Clinician.
3. A *Self-Management Housing Plan* 730_F32 will typically be used for an inmate who is currently in a Restorative Housing Unit, but SMHP's can also be utilized for inmates in other housing situations when indicated (e.g., infirmary, Mental Health Unit, etc.). A SMHP will not be used as punishment, but to minimize the risk of continued acting out by an inmate who has recently displayed such behavior by decreasing exposure to items that they may use for these volitional behaviors.
4. A SMHP will not substitute for *Precautions* but an inmate can be on both.
5. A SMHP will not be used unless it is recommended by a Mental Health Clinician who has assessed the inmate and their needs, and discussed it with the inmate.
   a. The Mental Health Clinician will forward the SMHP for review and approval by the Facility Unit Head, Unit Manager, building supervisor, or their designees.
   b. The Mental Health Clinician will be responsible for taking the approved *Self-Management Housing Plan* 730_F32 to the relevant housing unit where a building supervisor will countersign the SMHP to confirm receipt of any special management instructions.
   c. The housing unit staff is responsible for implementation of the SMHP.
   d. Without a subsequent SMHP renewal received on the housing unit, the SMHP will expire on its indicated expiration date (up to 30 days), and normal housing status procedures will resume.
6. Monitoring inmates on a SMHP:
   a. Security staff's observational checks will be performed and documented in accordance with the inmate's status.
   b. Mental Health Clinicians will monitor and assess the status and needs of the inmate at least weekly or more often as necessary, while on an SMHP, and provide data on progress to Multi-Disciplinary Team (MDT) members.
   c. Qualified health care personnel will monitor the health status of inmates on an SMHP.
   d. A camera may be used as additional monitoring of the inmate, but it will not replace required security observation checks.
7. A SMHP is intended to be used for only as long as is necessary to assist the inmate in controlling their behavior.
   a. The SMHP will only be used for up to 30 days at a time, after which it may be renewed in 30-day increments.
   b. After assessing the inmate's status, with agreement between a Mental Health Clinician and an ADO, the SMHP may be terminated whenever it has been demonstrated that the inmate will refrain from acting out behaviors and is behaving in a more prosocial manner.

8. Any SMHP in effect will be automatically terminated once the inmate achieves all the goals in the SMHP. While this plan is in place, all classification actions are suspended unless first approved by the Senior Mental Health Clinician, with appeals decided by the Facility Unit Head.
9. An electronic copy of the SMHP will be kept in a shared folder at the facility and forwarded to the Mental Health Clinical Supervisor (MHCS).

C. Housing

1. An inmate considered at imminent risk, threatening, or exhibiting self-injurious, suicidal, or dangerous behavior will be placed in an area where they can be closely monitored and that promotes staff observation and interaction with the inmate.
2. With approval of the Facility Unit Head, an inmate who is at a Field Unit or Work Center and who is considered at imminent risk, threatening or exhibiting self-injurious, suicidal, or dangerous behavior will be transferred as soon as possible to a major institution for monitoring and assessment. The transfer will occur in accordance with *Emergency Transfers* as defined in Operating Procedure 830.5, *Transfers, Institution Reassignments*.
3. With approval of the Facility Unit Head, a CCAP probationer/parolee who is at a CCAP and who is considered at imminent risk, threatening or exhibiting self-injurious, suicidal, or dangerous behavior will be transferred as soon as possible to a hospital; see Operating Procedure 720.7, *Emergency Medical Equipment and Care*; or jail; see Operating Procedure 940.4, *Community Corrections Alternative Program*.
4. Each major institution will designate *Safety Cell(s)* or areas to monitor suicidal, self-injurious, or potentially harmful inmates. The cells or areas must permit easy access and an unobstructed view of the inmate at all times and will minimize the inmate's opportunity for self-harm.
    a. Beds and other items approved for use in designated *Safety Cell(s)* or areas are listed on Attachment 1, *Clinically Approved Restraints and Safety Cell Equipment* (Restricted).
        i. Items not included on Attachment 1, *Clinically Approved Restraints and Safety Cell Equipment* (Restricted), must be reviewed by the Mental Health and Wellness Services Steering Committee (MHWSSC) and approved by the Regional Administrator and the Chief of Mental Health and Wellness Services.
        ii. To the extent possible, other elements of the designated cells or areas will be designed and constructed in accordance with the *Safety Cell – Safety Inspection*730_F3.
    b. The MHCS, Assistant Facility Unit Head, Building and Grounds Superintendent, and Senior Mental Health Clinician will jointly inspect the designated cells, safety equipment, and areas at least once per year, or as warranted, for possible fixtures or architectural features that could be used for self-harm.
    c. The inspection will be documented by the MHCS on the *Safety Cell – Safety Inspection* 730_F3.
    d. The MHCS will provide the completed checklist electronically, including any recommended modifications to the Facility Unit Head, Regional Administrator, and Chief of Mental and Wellness Health Services.
    e. Within 30 days, the MHCS will follow up with the Facility Unit Head regarding the status of recommended modifications. The MHCS will report the status of each recommended modification via an e-mail to the Facility Unit Head, the Regional Administrator, and the Chief of Mental Health and Wellness Services.
        i. For completed modifications, the MHCS will state what the modification was and when it was completed.
        ii. For modifications in process but not yet completed, the MHCS will note the expected completion date and will follow up with the Facility Unit Head at that time. A subsequent status report will be emailed to the Facility Unit Head, the Regional Administrator, and the Chief of Mental Health and Wellness Services. If the modification is not made by the expected completion date, the MHCS will confer with the Facility Unit Head and with the Regional

Administrator, if necessary, to address the delay.

iii. The Regional Administrator may determine that a recommended modification cannot reasonably be made (e.g., is considered to be cost prohibitive) and will provide written notification of this via email to the Facility Unit Head, the MHCS, and the Chief of Mental Health and Wellness Services as soon as the determination is made. The recommended modification, if still considered an issue by the MHCS, will be noted again no later than during the next inspection.

5. Prior to the inmate being placed in the *Safety Cell* or area, both the inmate and the cell will be searched for materials that can be used for self-harm. In addition, security staff will search the cells daily or more often, as indicated by the Mental Health Clinician, to prevent inmate access to potentially harmful objects.

6. Under emergency conditions, a suicidal/self-injurious/dangerous inmate may be placed temporarily within a cell or area other than the institution's designated *Safety Cells* or areas. The inmate must be moved to a designated *Safety Cell* or area as soon as possible.

D. Property

1. Property may be restricted while an inmate is on *Special Management Instructions* to help ensure the safety of the inmate when they are at risk for deterioration, self-harm, or harm to others.

2. The Mental Health Clinician will determine what items or privileges will be provided to the inmate. The Mental Health Clinician will document and authorize these precautions and interventions on the *"At Risk" Inmate Notification* 730_F13.

   a. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.

   b. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.

3. In lieu of or in addition to restraints, an inmate may be placed in a cell with restrictions. In cases where personal property is removed, the Facility Unit Head will ensure proper inventory and storage of the items in accordance with Operating Procedure 802.1, *Inmate and CCAP Probationer/Parolee Property*, until the property is returned to the inmate.

4. Stripping the inmate of all clothing will be avoided and used only as a last resort. When standard issue clothing presents a security or health risk (e.g., suicide prevention observation), provisions will be made to supply the inmate with an approved safety smock and/or safety blanket that promotes safety in a way that is designed to prevent humiliation and degradation. (5-ACI-6E-01)

5. Inmates placed on *Precautions* will be allowed the approved safety smock and/or safety blanket only, except in situations in which the Mental Health Clinician documents justification that the use of a paper garment provides a safer management option (e.g., when managing an inmate who engages in self-mutilating behavior and the use of the paper gown allows for better monitoring of newly self-inflicted injuries, including the removal of stitches or when environmental concerns are a factor (high temperatures, poor ventilation, etc.).

6. Inmates placed on *Precautions* will be assessed and evaluated by the Mental Health Clinician who will determine the items/privileges/property that the inmate may be offered. Authorization and conditions of the *Precautions* will be documented by the Mental Health Clinician on the *"At Risk" Inmate Notification* 730_F13.

   a. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.

   b. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.

E. Safety Diet

1. The safety diet is designed to be eaten without utensils and is served using containers that minimize

the possibility of injury to the inmate and others.

2. The Mental Health Clinician may order the safety diet in accordance with the Food Service Manual Chapter 3, *Menu Planning*. The order will be reviewed at least weekly to determine if it will be continued.

F. Clinical use of restraints (5-ACI-6C-13)

1. This operating procedure provides guidance whereby inmates may be restrained within a cell for clinical reasons as determined and authorized by a Mental Health Clinician or Medical Practitioner after reaching the conclusion that less restrictive measures would not be successful.
   a. A Mental Health Clinician's clinical restraint authorization will be documented on the *"At Risk" Inmate Notification* 730_F13.
      i. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.
      ii. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
   b. A Medical Practitioner's order providing medical clearance for clinical restraints will be documented in the inmate's health record.
   c. Initial authorization is for up to 24-hours, but the inmate may be released earlier based on the recommendation of the Mental Health Clinician or Medical Practitioner.
   d. When an inmate is approved to be restrained within a cell for clinical reasons, the Facility Unit Head and Mental Health Clinician will be responsible to submit an *Incident Report* in VACORIS documenting the reasons for use of restraints and the appropriate approvals and notifications in accordance with Operating Procedure 038.1, *Reporting Serious or Unusual Incidents*.
   e. Inmates may be restrained within a cell for control and security purposes in accordance with Operating Procedure 420.2, *Use of Restraints and Management of Inmate Behavior* (Restricted). However, within designated Mental Health Units, no in-cell restraints will be utilized without a Mental Health Clinician's authorization.
2. Prior to the utilization of clinical restraints, the Mental Health Clinician, in consultation as necessary with facility administrators, health services staff, and security staff, will determine if an inmate can be managed safely and the behavior be controlled effectively and humanely utilizing less restrictive measures, e.g., a safety smock, placing the inmate in a cell with restrictions, etc. The least restrictive means of control will be used.
3. Restraints will be applied only when necessary and for the least amount of time required to gain control of disruptive or self-injurious behavior.
   a. Every effort will be made to work with the inmate to assist in the management of their behavior prior to the utilization of restraints.
   b. When an inmate continues to harm or threatens self-harm, the least restrictive interventions must be considered first. These include, for example, removing items from the inmate's cell, placing the inmate in a safety smock, placing the inmate in ambulatory restraints, etc.
   c. In addition, the facility Mental Health Clinicians are encouraged to confer with peers, co-workers and supervisors regarding strategies for the management and treatment of the inmate, including the development and implementation of a *Self-Management Housing Plan* 730_F32 or other behavioral plan.
4. Restraints will be utilized for safety purposes only, never as punishment.
5. When contact with a Mental Health Clinician or Medical Practitioner is not possible, the Facility Unit Head or ADO may determine that an emergency exists and authorize the temporary restraint of an inmate within a cell until a Mental Health Clinician or Medical Practitioner can be contacted.
6. When the Mental Health Clinician or Medical Practitioner considers it necessary for an inmate to be restrained beyond 24-hours, the clinician will advise the Facility Unit Head.

a. If the Facility Unit Head agrees with the recommendation, no further approval is necessary.
b. If the Facility Unit Head does not agree with the clinician's recommendation, the Facility Unit Head will contact the Regional Administrator to discuss the circumstances; the Mental Health Clinician (as well the Regional MHCS, if available) will be included in the discussion.
c. The Regional Administrator will approve or disapprove the clinician's recommendation.
d. The Mental Health Clinician or Medical Practitioner will document the decision in Section IV of the inmate health record.

7. At the 24-hour mark, an *Incident Report Addendum* in VACORIS will be completed by the Facility Unit Head documenting either approval for continued restraints or disapproval and the inmate's release from restraints.
8. If the clinician recommends that restraints be continued beyond 48-hours, the Facility Unit Head will be advised and will contact the Regional Administrator for approval. If the Regional Administrator approves the request, they will notify the Regional Operations Chief.
9. At the 48-hour mark, an *Incident Report Addendum* in VACORIS will be completed by the Facility Unit Head documenting either the approval to continue restraints or disapproval and the inmate's release from restraints.
10. When an inmate is to be restrained in excess of 48-hours the Senior Mental Health Clinician will:
    a. Notify the Regional MHCS via telephone and via e-mail, attaching the most recent *Mental Health Monitoring Report* 730_F14, progress notes, and any other related documentation as to why the inmate was initially placed in restraints and why restraints are recommended beyond 48-hours.
    b. Update the MHCS every day that the inmate remains in restraints.
11. When an inmate is clinically restrained in excess of 48-hours, the MHCS will notify the Chief of Mental Health and Wellness Services and provide an update every day that the inmate remains in restraints.
12. An inmate may not be clinically restrained beyond 72-hours without approval by the Regional Administrator, then the Regional Operations Chief, and then the Chief of Corrections Operations in consultation with the Chief of Mental Health and Wellness Services.
13. Approved restraints
    a. Restraints ordered by medical and mental health and wellness services staff are limited to clinically approved restraints.
        i. This requirement does not preclude the use of metal restraints by security when Humane restraints have proven ineffective due to an inmate's behavior or prior history.
        ii. The inmate's wrists and/or ankles will be wrapped in gauze or adhesive tape by health services staff prior to metal restraints being applied.
    b. The only clinically approved restraints authorized for purchase and use in DOC institutions are listed on Attachment 1, *Clinically Approved Restraints and Safety Cell Equipment* (Restricted), examples include:
        i. Leather or Humane (poly) ambulatory restraints (wrist to waist, ankle).
        ii. Leather or Humane (poly) locking bed restraints (wrist, ankle, torso) - inmates will be placed in a "four or five point" restraint position, face up on the bed.
        iii. Safety helmet - to be used only on an inmate who bangs their head or attempts to bite themselves or others.
        iv. Safety smock and safety blanket.
    c. The MHWSSC will coordinate the review and approval of all new clinically approved restraints for use in the DOC.
    d. All purchases of restraint equipment must be reviewed and approved by the Director of Security and Correctional Enforcement.
    e. Other restraining devices, such as body wraps, blankets, specially designed chairs, etc. may not be

used without a review by the MHWSSC and approval of the Chief of Mental Health and Wellness Services and the Director of Security and Correctional Enforcement.

f. Staff are not authorized to use this equipment until they have successfully completed the required training approved by the Training Director.

14. Inmates may be clinically restrained to a restraint bed or bunk within a cell. Inmates will not be restrained to the cell bars, or any other cell fixture or equipment except the bed. If a Mental Health Clinician or Medical Practitioner considers it necessary, the inmate may be observed and interviewed prior to authorizing the use of restraints.

15. Pregnant inmates and inmates in postpartum recovery will not be restrained unless an individualized determination is made that the inmate poses a danger to themselves, the fetus, or others. (5-ACI-3A-17)

    a. The use of any restraints on pregnant inmates and inmates in postpartum recovery will be based on a serious security risk or imminent risk of injury to the mother or fetus and must be approved by the Facility Unit Head or Assistant Facility Unit Head.

        i. Any restraints applied in addition to the handcuffs must be applied in a manner to ensure safety and security for all parties.

        ii. Handcuffs applied in the front of the inmate are the only restraints authorized without Medical Practitioner or mid-level practitioner approval.

        iii. Prior to applying handcuffs, health care staff must be consulted to determine if the use of handcuffs present a threat to the health or life of the pregnant inmate or fetus.

    b. If handcuffs are not adequate to protect the inmate, the fetus, and others; the Facility Unit Head or Assistant Facility Unit Head, Medical Practitioner or mid-level practitioner, and Mental Health Clinician must be notified of the reason for applying additional clinical restraints and must approve the application of additional clinical restraints and the restraint methods.

        i. When the Facility Unit Head/Assistant Facility Unit Head, Medical Practitioner/mid-level practitioner, and Mental Health Clinician are not in agreement, the Regional Operations Chief, Regional Health Administrator, and RMHC will be consulted.

        ii. If a decision still cannot be reached, the decision will be escalated to the Chief of Corrections Operations, Health Services Director, and Chief of Mental Health and Wellness Services.

    c. A written *Incident Report* documenting the restraints applied and reason for applying the restraints will be submitted in VACORIS in accordance to Operating Procedure 038.1, *Reporting Serious or Unusual Incidents.*

16. Qualified health care personnel, when on duty at the institution, will examine the inmate as soon as possible after restraints have been initially applied, and any time they are reapplied, to ensure that circulation is adequate.

    a. Qualified health care personnel must advise as to whether an inmate has a condition that alters the general application of the restraints.

    b. Qualified health care personnel will assure that the inmate has adequate hydration, release for toileting, and release of limbs to prevent the development of blood clots.

    c. In situations where no qualified health care personnel are on duty at the institution, the inmate will be checked as early as possible during the first shift in which such staff are back on duty.

    d. The examination and subsequent examinations will be documented on the *Special Watch Log* 425_F5.

17. Observation and care of inmates placed in restraints within a cell

    a. An inmate who is placed in restraints will be partially or completely released from the restraints at mealtimes and for toilet use, a minimum of seven times during each twenty-four hour period, and documented on the *Restraints Break Log* 420_F27. Three of the seven breaks will occur one half hour prior to each meal.

    b. Security staff will directly observe the inmate in restraints at least every 15 minutes, and more often

if necessary, as directed by the Mental Health Clinician or Medical Practitioner. Documentation of the status checks, behaviors, etc., will be made on the *Special Watch Log* 425_F5.

c. A Mental Health Clinician will interview the inmate at least once per workday and determine if the inmate may be stepped down to a less restrictive alternative. If a less restrictive alternative is considered appropriate, the Mental Health Clinician will update the *Special Management Instructions* in *"At Risk" Inmate Notification* 730_F13.
   i. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.
   ii. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.

d. The Mental Health Clinician's visit will be documented on the *Special Watch Log* 425_F5.

e. When a Mental Health Clinician is not on duty at the institution, the necessity for the Mental Health Clinician to come into the institution to assess the inmate face-to-face is a clinical decision made on a case-by-case basis. This decision will be made in consultation with health services staff on duty and may include, as needed, input from the Mental Health Clinician's immediate supervisor, the Facility Unit Head, relevant security staff (Shift Commander, etc.), and/or the ADO.

18. No inmate will be released from clinical restraints or *Precautions* without a face-to-face interview, assessment, and review of the incident by the Mental Health Clinician. (5-ACI-6C-13)

a. Results of each interview and assessment will be documented on the *Mental Health Monitoring Report* 730_F14.

b. The Mental Health Clinician will make referral for further clinical or management services as warranted.

c. Release from clinical restraints must be reported on an *Incident Report Addendum* in VACORIS with the *Restraints Break Log* 420_F27 uploaded as an external document.

G. Communication/Reporting

1. For each inmate on *Precautions* or in-cell restraints, the Mental Health Clinician will provide the following information electronically to the Facility Unit Head, Assistant Facility Unit Head, Shift Commander on current shift, and Shift Commander for following shift, Restorative Housing Unit or other building supervisor, and Health Authority at the end of each workday:

a. Inmate name and DOC number.

b. Housing and cell assignment.

c. The status of all precautions, including but not limited to: level of watch, restrictions on property and other items, and type of meals to be provided.

d. Date and time precautions were put in place.

2. The Shift Commander or designee provides the information on watches and restraints to relevant administration and security staff at muster and on the *Supervisor's Daily Activity Report* provided in Operating Procedure 401.1, *Development and Maintenance of Post Orders* (Restricted).

III. Suicide Prevention and Intervention

A. Suicide Prevention and Intervention Program

1. This operating procedure has been approved by the Chief of Mental Health and Wellness Services and the Chief of Corrections Operations to serve as a written suicide prevention plan for each facility. (5-ACI-6A-35; 4-ACRS-4C-16)

a. Any additions or changes due to the facility mission will be incorporated into an Implementation Memorandum, mental health and wellness services operating protocol or other document that is approved by the Senior Mental Health Clinician and reviewed and approved by the Facility Unit Head, MHCS, and Chief of Mental Health and Wellness Services.

b. This operating procedure includes staff and inmate/probationer/parolee critical incident debriefing

and reporting that covers the management of suicidal incidents and safety watches.

2. Each Facility Unit Head will ensure that a Suicide Prevention and Intervention Program is implemented at the facility in accordance with this operating procedure.
3. The Senior Mental Health Clinician will be responsible for directing the management and treatment of suicidal inmates and for ensuring that the facility's program conforms to the guidelines for training, identification, referral, assessment/intervention, and debriefing/reporting as outlined in this procedure.

B. Warning Signs and Suicide Threats

1. Corrections Officers and other staff who have frequent contact with inmates are often the first to become aware of an inmate making a suicide threat. Such threats may include but are not limited to statements such as, "I wish I was dead," "My family would be better off without me," "I'm going to kill myself," or "I'm leaving this place tomorrow one way or another." Warning signs may include but are not limited to the following:
   a. Preoccupation with death, dying, or suicide;
   b. Possession of sharp objects, fabric or other material made into a noose; saving pills;
   c. Changes in sleep patterns, eating habits, energy level, and/or ability to concentrate;
   d. Setting of affairs in order (e.g., the inmate may have stacks of letters in their cell addressed to each family member); or
   e. Giving away possessions (e.g., the inmate may send home or to friends items previously valued).
2. Initial response to suicidal threats
   a. Any staff aware of an inmate making a suicide threat will immediately notify the security staff in the area, their immediate supervisor, the Shift Commander, and the Mental Health Clinician (if available).
   b. Reporting staff will make every effort to maintain constant observation of the inmate during the notification process and until appropriate staff arrive or *Special Management Instructions* are implemented.
   c. The Shift Commander will ensure that the Mental Health Clinician and appropriate levels of supervision have been notified. If there is no Mental Health Clinician on duty, the Shift Commander will notify the on-call Mental Health Clinician for that facility or the facility that provides Mental Health Clinician services.
   d. The Shift Commander may place the inmate on *Precautions* with one-to-one supervision (Constant Watch), if needed, pending implementation of *Special Management Instructions* as provided by the Mental Health Clinician.
   e. Staff will document on an *Internal Incident Report* in VACORIS what the inmate said or did and the actions taken (e.g., watched the inmate constantly and notified supervisors) as provided in Operating Procedure 038.1, *Reporting Serious or Unusual Incidents*.

C. Suicidal behavior or suicide-in-progress - Staff will take immediate action when suicidal behavior is observed. Any available person, including inmates, and non-security staff, may be asked to assist during an emergency.

1. First person on the scene will:
   a. Immediately notify other staff of the need for assistance.
   b. Survey and secure the scene for safety (e.g., the situation could be a diversionary tactic or an attempt to assault staff or to escape).
   c. If the suicidal behavior occurs in a cell in general population, the first Corrections Officer on the scene may use their discretion in entering the cell alone. If they consider it necessary, they may postpone entering the cell until after the arrival of a second Corrections Officer.
   d. If the suicidal behavior occurs in a cell other than in general population, enter the cell only after the arrival of a second Corrections Officer.

e. If an inmate is found hanging, staff will take measures to remove pressure from the inmate's neck, including removal of the object from around the neck and/or lifting the inmate's legs to remove pressure on the neck. It is important to get pressure off the inmate's neck immediately.

f. If needed, retrieve the seatbelt cutter tool from its secure location and cut the material from around the inmate's neck. Each Restorative Housing Unit control room is equipped with the seatbelt cutter tool as part of their standard emergency equipment.

g. If the inmate is non-responsive, is bleeding, or is in obvious physical distress, initiate and continue first aid/CPR until health services staff or qualified staff arrive to take over.

2. Second Corrections Officer on scene will:
   a. Assist with first aid/CPR as necessary.
   b. Maintain security and preserve the scene as much as possible.
3. Building supervisor will:
   a. Ensure that health services staff and the Shift Commander have been notified.
   b. Supervise and assist with first aid/CPR as needed.
   c. Maintain security and preserve the scene as much as possible.
   d. Coordinate health services staff timely entry into the area.
4. Health services staff will:
   a. Determine the appropriate level of medical care.
   b. Initiate or take over life support measures, as needed.
   c. Call for an ambulance if needed.
   d. Advise the Shift Commander if an ambulance is called.
   e. After providing appropriate treatment for physical injuries, health services staff will facilitate transfer of the inmate to another medical facility if required, in accordance with Operating Procedure 720.2, *Medical Screening, Classification, and Levels of Care*, Operating Procedure 720.7, *Emergency Medical Equipment and Care*, and Operating Procedure 830.5, *Transfers, Institution Reassignments*.
5. Shift Commander will:
   a. As advised by health services staff, ensure that an ambulance has been called and is en route.
   b. Prepare the facility for safe and timely entry and exit of external ambulance/emergency medical personnel.
   c. Notify duty officer and the Mental Health Clinician. The Shift Commander will ensure that the *Special Management Instructions* provided by the Mental Health Clinician are implemented.
   d. In the event of a suicide, notify the Institutional Investigator.
6. The ADO will:
   a. Ensure that other appropriate facility and departmental staff are notified in accordance with Operating Procedure 038.1, *Reporting Serious or Unusual Incidents.*
   b. Ensure that all necessary documentation is completed, including the *Incident Report* in VACORIS in accordance with Operating Procedure 038.1, *Reporting Serious or Unusual Incidents*.
7. Security and other staff will communicate any information regarding the inmate's mental and behavioral status to the Mental Health Clinician.
8. The on-site or on-call Mental Health Clinician will review all available information in order to determine if the inmate's intent was to commit suicide.
   a. If the Mental Health Clinician determines that the incident was an attempted suicide, the Mental Health Clinician will gather all relevant *Internal Incident Reports* in VACORIS and complete the *Incident Report* for "Attempted Suicide" in VACORIS by noon of the day following the incident.
   b. If the Mental Health Clinician determines that the incident was not an attempted suicide, the Mental

Health Clinician will then decide which, if any, additional actions are warranted to address the behavior.

D. Mental health and wellness services staff response to a suicide threat, suicidal behaviors, or suicide attempt

1. Upon notification by the Shift Commander, the Mental Health Clinician will provide initial *Special Management Instructions* using *"At Risk" Inmate Notification* 730_F13 to safeguard the inmate until they can be assessed.
   a. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.
   b. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
2. If a Mental Health Clinician is on site at the facility when an inmate displays suicidal behaviors or is placed on *Precautions* by other staff, the Mental Health Clinician will see the inmate that day to assess and evaluate their clinical condition (i.e., mental status, behaviors, overall level of functioning, risk for suicide).
3. Following this initial assessment interview, the Mental Health Clinician will determine and document the level of precautions and interventions using *"At Risk" Inmate Notification* 730_F13.
   a. A building supervisor where the inmate is housed will countersign the *"At Risk" Inmate Notification* 730_F13 to confirm receipt of any *Special Management Instructions*.
   b. *Special Management Instructions* must be entered on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
4. The Mental Health Clinician will perform follow-up assessment interviews of the inmate as needed, generally within 48-hours of the initial assessment interview or the next working day. Results of each follow-up interview will be documented on the *Mental Health Monitoring Report* 730_F14.
5. Any Mental Health Clinician directing that an inmate be placed on *Precautions* will verbally inform the Shift Commander or designee of this need immediately.
6. Each day that an inmate is on *Precautions*, the Mental Health Clinician will review the *Special Management Instructions* for renewal and/or updates based on the inmate's clinical needs; see *"At Risk" Inmate Notification* 730_F13.
7. In cases where an inmate's self-injurious and/or suicidal behavior is acute and imminently life-threatening, and determined to be secondary to or symptomatic of a mental illness, mental health and wellness services staff will initiate the transfer of the inmate to an acute care setting as soon as the inmates physical condition has stabilized, per Operating Procedure 730.3, *Mental Health Services: Levels of Service*.
8. If a Mental Health Clinician is not on duty at the facility (after hours, weekend/holiday):
   a. Inmates placed on *Precautions* at the facility will be seen by Mental Health Clinician staff no later than the next working day. The necessity for the on-call Mental Health Clinician to come into the facility to assess the inmate face-to-face is a clinical decision made on a case-by-case basis. This decision will be made in consultation with the health services staff on duty and may include, as needed, input from the Mental Health Clinician's immediate supervisor, the Facility Unit Head, relevant security staff (Shift Commander, etc.), and/or the ADO.
   b. Inmates already on *Precautions* will be monitored by the on-call Mental Health Clinician at least once every 24-hours via a telephone consultation with the health services staff on duty.
   c. The on-call Mental Health Clinician will discuss and assess with the health services staff on duty, the inmate' observed behavior and mental status.
   d. If the inmate is not exhibiting any significant clinical change, then the current *Special Management Instructions* may continue unchanged.

e. If the inmate's behavior or mental status warrants a change in the *Special Management Instructions*, the on-call Mental Health Clinician will have the changes documented by the health services staff on duty in Section VI of their health record. Immediately following the conversation with the health services staff on duty, the Mental Health Clinician will communicate the changes in the *Special Management Instructions* to the Shift Commander and other appropriate staff.

f. Upon arrival at the facility on the next business day, the on-call Mental Health Clinician will document the telephone consultation with the health services staff on duty and with the Shift Commander, et al, on a mental health and wellness services document (e.g., *Mental Health and Wellness Services Progress Note* 730_F30, *Mental Health Monitoring Report* 730_F14, or *Health Services Complaint and Treatment Form* 720_F17) to be filed in Section IV of their health record. The on-call Mental Health Clinician will also sign/initial the *Special Management Instructions* documented by the health services staff on duty in Section VI of their health record. In addition, the Mental Health Clinician will complete an updated *"At Risk" Inmate Notification* 730_F13.

9. If the inmate is at a facility without full time Mental Health Clinician staff, contact with a Mental Health Clinician will be made in accordance with the *Guidelines to Access Emergency Mental Health Services* attachment to Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*. Mental Health Clinician recommendations may include, but are not limited to, transfer to a facility with full time Mental Health Clinicians for further assessment, placement on *Precautions*, or management of the inmate at the current facility with follow-up provided by the Mental Health Clinician.

10. If the inmate remains in the housing unit after being interviewed by the Mental Health Clinician, staff involved with the inmate will continue to monitor the inmate's behavior. Staff will notify their supervisor and the Mental Health Clinician of any concerns or other relevant information.

11. No inmate will be released from *Precautions* or clinical restraints without a face-to-face interview and assessment by the Mental Health Clinician. Results of each follow-up interview and assessment will be documented on a mental health and wellness services document (e.g., *Mental Health and Wellness Services Progress Note* 730_F30 or *Mental Health Monitoring Report* 730_F14).

12. In the event of a suicide, the Mental Health Clinician will immediately notify the Senior Mental Health Clinician or designee who will immediately notify the MHCS and the Chief of Mental Health and Wellness Services. Licensed mental health units will make additional notifications as required by the licensing agency.

E. Suicide Risk Assessment

1. The Mental Health Clinician who is evaluating an inmate's risk of self-injury or suicide will interview the inmate and will consider as much of the following information as is available:
   a. History of suicide attempts or self-injurious behavior.
   b. Presence and extent of depression or hopelessness.
   c. Presence of impulsivity or attention-seeking behavior.
   d. Suicidal or self-injurious behavior or ideation, if present.
   e. Evidence of preparation for suicidal behavior.
   f. Presence or extent of inhibitions/deterrents to such behavior.

2. The Mental Health Clinician will conduct an interview and complete a *Suicide Risk Assessment* 730_F15 at the time that the Mental Health Clinician is considering the release of the inmate from *Precautions*.

F. Debriefing - The DOC *Critical Incident Peer Support* Team is available to provide support to staff following any suicide.

G. Administrative Review (5-ACI-6A-35; 4-ACRS-4C-16)

1. For each confirmed suicide, the Mental Health Clinician or designee will prepare an *Administrative*

Review - Suicide 730_F16.

2. The report will be reviewed with the MHCS, Facility Unit Head, Regional Health Administrator, and others as appropriate.
3. Following a completed suicide, a Regional MHCS will convene and facilitate a multidisciplinary review of the event, including security, mental health and wellness services, health services, treatment, and Special Investigations Unit staff who were involved.
   a. This Regional MHCS or authorized designee is empowered to look into all aspects of the inmates' incarceration and is authorized by this procedure to review all relevant records and interview facility staff.
   b. A review of all available and pertinent incident reports, log entries, and other data and information will be conducted in order to ascertain individual, interpersonal, site, and systemic issues that may have influenced the outcome.
   c. This team will serve as a forum to review relevant data, beneficial changes to procedure or processes, recognize components that functioned well, and generate recommendations for improving safety.
   d. Within seven working days, a Regional MHCS will prepare a written review, including root cause analysis, findings of fact, recommendations, and the rationale behind the recommendations and submit the report to the Chief of Corrections Operations and the Chief of Mental Health and Wellness Services for their review and response. (5-ACI-6A-36)

IV. Hunger Strike (5-ACI-3B-14)

A. Philosophy

1. As legally appointed custodians of inmates, the DOC has a responsibility to provide for their health and safety. An inmate who chooses to go on a hunger strike (i.e., refuses food intake) presents a unique challenge to the orderly operation of a correctional facility due to extra demands placed on security staff, the necessary medical assessments and daily evaluations, increased psychological monitoring and administrative review.
2. An inmate who is acting out by engaging in a hunger strike may be attempting to gain something (such as a transfer, attention, access to tangibles, avoidance, or sensory stimulation).
3. Depending upon the length of time and severity of the hunger strike, the inmate may be regarded as "at risk" for self-harm in accordance with Operating Procedure 420.2, *Use of Restraints and Management of Inmate Behavior* (Restricted), and this operating procedure.
4. As time progresses, the negative effects of a lack of nutrition may pose a serious threat to the physical health of the inmate and, at the extreme, can become life threatening. The techniques described below to intervene with and manage an inmate who is on a hunger strike are intended to serve as incentives for the inmate to resume consumption of fluids and/or nutrition.
5. These techniques are separate from those used to prevent imminent self-harm (e.g., threatening to or actually harming self, etc.) and are designed to prevent or minimize potential "at risk" behaviors and to end the hunger strike as soon as possible.
6. Security staff, health services staff, treatment staff, and mental health and wellness services staff play key roles in working with an inmate who is on a hunger strike. Working jointly with security and administrative staff, the health services and mental health and wellness services staff will address the hunger strike behavior in a structured and consistent manner, with the goal of maintaining the inmate's health and well-being.
7. All staff will seek to enlist the inmate's cooperation for evaluation and will try to determine the reason(s) for the hunger strike and resolve any reasonable complaints. All staff will encourage appropriate drinking and eating behavior and will report and document any observations of fluids and/or food consumption, especially fluid consumption.

8. If necessary, a petition for involuntary treatment as authorized in COV §53.1-40.1, *Medical and mental health treatment of prisoners incapable of giving consent*, may be initiated.
9. At 21 missed meals, the Facility Unit Head will inform the Regional Operations Chief who will notify the Chief of Corrections Operations (CCO) about the hunger strike.
    a. After notifying the CCO, the Regional Operations Chief will notify the Operations and Logistics Unit Operations Center for inclusion in the Daily Briefing Report.
    b. The CCO may choose to meet with the Hunger Strike Consultation Team (HSCT), and the local interdisciplinary team to determine if a petition to the Court using COV §37.2-1101, *Judicial authorization of treatment*, is warranted. DOC administrative staff will then petition the Court.

B. Report and Initial Response

1. The Shift Commander will immediately notify the Senior Mental Health Clinician or designee and the Health Authority after the inmate's sixth consecutive missed meal as documented via routine security checks.
2. After an inmate misses their ninth consecutive meal, as documented via routine security checks, the Shift Commander will notify the ADO, health services staff, and update the Senior Mental Health Clinician.
3. After an inmate misses their ninth consecutive meal, mental health and wellness services staff will complete a *Mental Health Provider Assessment of Inmate on Hunger Strike* 730_F48. Health services staff will then complete a *Medical Notification of Ninth Missed Meal* 730_F50. Thereafter, a *Daily Nursing Hunger Strike Assessment* 730_F49 will be completed. On the next working day, the Medical Provider will complete a *Medical Provider Assessment of Inmate on Hunger Strike* 730_F51. The Medical Provider will complete this *Assessment* initially and at least weekly thereafter.
4. The Shift Commander and mental health and wellness services staff will jointly assess the proper housing assignment.
5. An *Incident Report* in VACORIS and *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5 will be initiated immediately. An *Incident Report* in VACORIS is required after the ninth consecutive missed meal as documented via the routine security checks in accordance with Operating Procedure 038.1, *Reporting Serious or Unusual Incidents*.
6. All commissary and food items will be removed.
7. The immediate institution of a 'Hunger Strike Tray'
    a. Hunger Strike Tray will
        i. Replace milk with one serving of dairy
        ii. Replace juice with one serving of fruit
        iii. Water will be offered with meals
    b. Mental health and wellness services staff will notify the Food Services Director when a Hunger Strike Tray is warranted.
8. Mental health and wellness services staff will complete a *Hunger Strike – Root Cause Analysis* 730_F43 indicating the function of the strike and the immediate staff response. *Hunger Strike – Root Cause Analysis* forms will be submitted to the Regional MHCS and Hunger Strike Data Collector no later than the next business day after the ninth missed meal.
9. Security staff may turn off plumbing for the cell and flush the toilet once before meal times to ensure the inmate does not flush the meal to give the appearance of consuming them.
10. A Mental Health Clinician will assess the inmate for imminent risk of self-harm and, if indicated, place the inmate on "at-risk" monitoring, establishing the frequency of monitoring by mental health and wellness services staff for each working day.
11. Facilities without a Mental Health Clinician will immediately contact the Mental Health Clinician at the designated major institution with mental health and wellness services staff or the MHCS to consult

regarding possible interventions. Facilities without 24-hour medical coverage may initiate procedures to transfer the inmate to a facility with 24-hour medical care.

12. Within 24-hours of hunger strike notification, the inmate will be seen by qualified health care personnel who will:
    a. Obtain a history.
    b. Attempt to conduct a physical examination.
    c. Attempt to obtain and record vital signs.
    d. Attempt to obtain the inmate's weight (noting the presence of any handcuffs, etc., the weight of which must be subtracted).
    e. Provide the inmate with a copy of Attachment 2, *Hunger Strike Fact Sheet,* with information on the effects of prolonged fasting, and have the inmate review and sign *Inmate Education/Self-Management Prolonged Fasting* 730_F31.
    f. A Nurse and Medical Provider will provide the inmate with a medical explanation of the possible impact of prolonged fasting on them as an individual, given the inmate's specific physical condition.
    g. Begin documenting physical status and relevant notes on a *Health Services Complaint and Treatment Form* 720_F17 in inmate's medical record, providing relevant updates regarding compliance and medical status to the local interdisciplinary team.
13. No later than the next working day, the inmate will be seen by a Medical Practitioner who will attempt to conduct a complete physical examination and who will order the following laboratory tests: CBC, CMP, Magnesium, Phosphate, and U/A. If the Medical Practitioner finds the inmate's health is in jeopardy, the inmate will be transferred to an appropriate medical facility.
14. Health services staff will visit the inmate on a hunger strike daily to monitor for any signs of serious illness or change in the inmate's physiological condition, and will measure and record the inmate's weight and vital signs. Health services staff will notify a Medical Practitioner if the inmate is losing weight or less oriented to surroundings, unsteady when ambulating, exhibiting any signs of decompensation, or concerning features/presentations.
15. *Standard Treatment Guidelines* will be utilized and referenced. Liquid nutrition will not be utilized unless the inmates' condition suggests it is medically necessary, in very rare situations.

C. *Hunger Strike Protocol*

1. If a hunger strike has not been resolved within 15 meals after the last known meal, a local interdisciplinary team or a Mental Health Treatment Team if the inmate is in a designated Mental Health Unit will be convened to develop a *Hunger Strike Protocol*. If the 120-hour threshold would be reached during an upcoming weekend or holiday, the meeting and *Hunger Strike Protocol* 730_F44 must be completed prior to the close of business on the last work day before the weekend/holiday.
    a. This local interdisciplinary team will be comprised of the Assistant Facility Unit Head, the Senior Mental Health Clinician or designee, the Chief of Security or designee, the Medical Doctor, the Health Authority or designee, the building supervisor or designated security staff for the unit in which the inmate is housed, and the inmate's Case Management Counselor.
    b. The Senior Mental Health Clinician will facilitate this committee and take a primary role in gathering input for, designing, implementing, and monitoring of the intervention and management techniques used in the committee's *Hunger Strike Protocol*.
    c. The plan will be designed to:
        i. Determine how and when the daily assessment and monitoring of the inmate's physical and mental status will occur.
        ii. Outline general strategies and specific incentives to encourage the inmate to demonstrate appropriate eating/drinking behavior.
    d. All staff involved with the inmate on a hunger strike will carry out the *Hunger Strike Protocol* in a

consistent manner. Any questions or issues regarding the *Hunger Strike Protocol* will be directed to mental health and wellness services staff.

e. Review of documentation of the *Hunger Strike Protocol*, including initiation, updates, or cessation of the *Hunger Strike Protocol* will still be completed by the Facility Unit Head, with copies to plan participants, the Regional Administrator, the Regional Health Administrator, and the Regional MHCS.

f. If an alternative approach to a *Hunger Strike Protocol* is warranted, the multidisciplinary group must meet and the reasons for not writing the *Hunger Strike Protocol* must be documented.

i. For example, a *Hunger Strike Protocol* would not be implemented when an inmate has self-reported they are engaged in a religious fast or is eating commissary items.

ii. Documentation of exceptions to a *Hunger Strike Protocol* must be submitted to the Chief Physician, Chief of Mental Health and Wellness Services, Chief Nurse or designee, and Regional Administrator.

g. Sites with formal treatment plans will include hunger strike as a treatment plan problem.

2. Examples of general strategies of the *Hunger Strike Protocol* may include, but are not limited to the following:

a. The inmate being placed on 15-minute watch in a cell with restrictions:

i. Lights on

ii. Blanket and pillow only at night time

iii. Toilet paper as appropriate

iv. No phone calls except for legal emergencies

b. The inmate will be allowed to have their legal materials unless the facility administration has determined that having such is a threat to the safe and secure operation of the facility or a threat to the physical well-being of the inmate.

3. Examples of incentives the inmate may earn include, but are not limited to the following:

a. If the inmate drinks a full cup of water/fluids, the inmate will receive an approved safety blanket for the next four hours, or in addition to the four hours the inmate has already earned if they meet the criteria.

b. Incentives that appear likely to result in the inmate's cooperation with the daily assessments and/or with increased eating behavior will be implemented.

i. It is recommended that incentives be designed so that the inmate has to earn them on a daily basis.

ii. Any suspicion that meals are disposed of versus consumed will disqualify that meal from earning incentives for that day.

c. Incentives will not include, e.g., nutritional supplements, intravenous fluids, etc.

4. The Facility Unit Head will review the committee's *Hunger Strike Protocol* and copies will be provided to the plan participants, the Regional Administrator, the Regional Health Administrator, and the MHCS. Documentation of observations of inmate behavior, inmate responses to interventions, the initiation and discontinuance of medical and mental health orders, will occur per the direction of the facility administration.

5. Termination of hunger strike

a. The decision to terminate the *Hunger Strike Protocol* will be made by the local interdisciplinary team once the inmate has expressed a willingness to eat and is consuming normal meals.

b. Termination of a hunger strike must be reported on an *Incident Report Addendum* in VACORIS documenting when the inmate began consuming meals in accordance with Operating Procedure 038.1, *Reporting Serious or Unusual Incidents.*

c. When the hunger strike is declared over the by the local interdisciplinary team, health services staff will continue to actively monitor the inmate on a daily basis until the treating Medical Practitioner

determines that the inmate is medically stable.

d. If the inmate refuses to eat after being determined to be medically stable, it will be managed as a new hunger strike in accordance with this operating procedure.

D. Management

1. Security staff will ensure that any medical and mental health orders are strictly followed so that the inmate's behavior is monitored and managed consistently via the individually developed *Hunger Strike Protocol*.
2. Security staff will assign one designated staff member per shift to be responsible for the delivery and visual monitoring of food/fluid intake so that accurate documentation of what is consumed can occur. Observations regarding the amount of food and fluid intake will be documented on the *Individual Inmate Log* 425_F4 or *Special Watch Log* 425_F5.
3. The inmate will be offered three meals per day according to the facility's normal meal schedule unless otherwise ordered by the Medical Practitioner. The inmate will be allowed 15 minutes to consume a meal (30 minutes if the inmate is making efforts to consume the meal). Each refused meal will be removed from the inmate's tray slot to maintain an accurate record of food intake.
4. If determined necessary by health services staff to augment regular meals, an inmate may be offered liquids at regular intervals provided in a measured cup or container. An adequate daily intake of fluid for a normal adult is approximately 13 cups (104 ounces) for men and nine cups (72 ounces) for women. The inmate will be allowed five minutes to consume the fluids separate from a meal (Ten minutes if the inmate is making efforts to consume the fluids).
5. The inmate's condition will be monitored daily by health services staff with weight and skin turgor checked and recorded. Health services staff will document assessment findings in the inmate's health record.
6. The inmate will be seen by a Medical Practitioner at least once a week and laboratory tests ordered on at least weekly intervals, or sooner, as the Medical Practitioner deems appropriate.
7. Health services staff will attempt to enlist the inmate's cooperation for regular medical assessments. Refusal to cooperate with any requested medical evaluations will be recorded as potentially threatening to the inmate's wellbeing. Security staff's assistance may be requested to physically position the inmate for necessary medical observation of their health status (e.g., to have the inmate sit up).
8. Mental health and wellness services staff will be responsible for chairing the *Hunger Strike Protocol* meeting, writing, and updating the *Hunger Strike Protocol* 730_F44 as needed. Health services staff will actively monitor health status, manage the inmate's physical condition, and provide updates to the local interdisciplinary team and the Facility Unit Head.
9. The local interdisciplinary team will assess the inmate and their complaints and, when possible, attempt to obtain reasonable resolution. This may necessitate the involvement of another department or resource (e.g., the inmate's Case Management Counselor, medical, etc.). If such efforts do not result in the cessation of the hunger strike, then other techniques may be utilized to encourage the inmate to cease the hunger strike and to cooperate in consuming food/liquids.
10. The local interdisciplinary team will continue to monitor the inmate and update the *Hunger Strike Protocol* as necessary.
11. The *Hunger Strike Protocol* will be continued until health services staff determines that the inmate's physiological condition has improved to a medically satisfactory level as indicated by weight, blood studies, vital signs, etc., and recommends to the local interdisciplinary team that it be discontinued. Health services and mental health and wellness services staff will then confer with the facility administration.
12. The specific conditions of the *Hunger Strike Protocol*, including when the *Hunger Strike Protocol* will be discontinued, will be recorded by the mental health and wellness services staff in the P Section of a SOAP Note. It will be placed in Section IV of the inmate's health record.

13. The local interdisciplinary team will evaluate all of the information available about the case, discuss alternatives, and make intervention recommendations.
14. The local interdisciplinary team will meet at least once per week to review the case and make further recommendations as necessary. The local interdisciplinary team will determine the need for further weekly meetings based upon the actions and progress of the inmate in response to intervention strategies.
15. Updates to or discontinuation of the *Hunger Strike Protocol* will be forwarded to the plan participants, the Regional Administrator, the Regional Health Administrator, and the MHCS.
16. Based on the inmate's condition, health services staff will seek guidance on the inmate's care from the DOC Chief Medical Officer.
17. The local interdisciplinary team will meet with the HSCT weekly when the inmate has missed 15 meals, or can request additional consults as they or the HSCT deem necessary. The HSCT may also request an outside evaluation of the inmate's mental health functioning.
18. If health services staff determines that closer monitoring of the inmate's medical condition or judicial intervention is warranted, the inmate will be brought from the Restorative Housing Unit to a medical isolation cell. Otherwise, the hunger strike can be treated as a behavioral issue and will be managed in the Restorative Housing Unit.
19. At the discretion of the facility Medical Practitioner, the inmate will be admitted to a DOC Medical Infirmary or to an outside acute care facility if their condition deteriorates.
20. If and when, it is deemed necessary by the facility Medical and/or Mental Health Practitioner, depending on the underlying catalyst for the hunger strike, a Court order will be sought to treat the inmate-over their objection, if necessary.
    a. The procedures as outlined in the COV §53.1-40.1, *Medical and mental health treatment of prisoners incapable of giving consent*, regarding court-ordered medical treatment of inmates are to be followed.
    b. After 21 missed meals, the CCO may choose to meet with the Hunger Strike Consultation Team (HSCT) and the local interdisciplinary team to determine if a petition to the Court using COV §37.2-1101, *Judicial authorization of treatment*, is warranted. If directed, the DOC administrative staff will then petition the Court.
    c. Please note that involuntary treatment can be sought only if it has been determined that the inmate is incompetent or incapable of giving consent and the treatment is in the best interests of the inmate in accordance with Operating Procedures and the COV.
21. If a judicial order for medical treatment is obtained, health services staff will implement the order(s) according to appropriate medical practices.
22. If the inmate begins to eat, health services staff will determine how fluids and food or other sources of nutrition will be provided to the inmate (e.g., how much at a time, whether solid food or liquid supplements, etc.). This information will be communicated per institutional procedures to food services staff and to security staff.
23. The *Standard Treatment Guidelines - Hunger Strike Intervention and Management Guidelines* provides specific information for the management of Re-feeding Syndrome.

V. Food Abuse and Disrupting Food Service Operations

A. Mental health and wellness services staff may be asked to consult with other staff to employ the following behavior management strategies when an inmate deliberately disrupts the food service operation by misuse or abuse of food service utensils or equipment, or throws food or drink at any staff member.

1. Place the inmate in a stripped or modified stripped cell removing any items that may be used as containers.
2. Restricted feeding procedures may be used for an inmate assigned to the Restorative Housing Unit

who uses food or food service equipment that is hazardous to staff, self, or other inmates.

3. Inmates who are on stripped or modified stripped cell and on restricted feeding procedures may obtain drinking water from their cell tap.

B. See Operating Procedure 420.2, *Use of Restraints and Management of Inmate Behavior* (Restricted) for further guidance.

VI. Smearing/Manipulation of Feces

A. Philosophy

1. The DOC is responsible for the health and safety of inmates and staff. An inmate who smears, throws, and/or manipulates fecal material presents a challenge to the safe, sanitary, and orderly operation of a correctional facility. Such a situation requires strategies for effective interventions and control.
2. The presence of fecal material in a housing unit can pose serious health risks. Feces may contain bacteria, parasites, blood, and other potentially hazardous contaminants. The presence of infectious materials in feces or other substances is not readily identifiable and represents a significant health risk for the inmate and staff who are exposed to these materials.
3. The inmate who manipulates feces puts themselves and others at risk. Inmates who exhibit feces smearing behaviors have been known to smear feces into vents that circulate the air throughout the housing unit. The fecal material dries in these vents and can circulate the particles throughout the housing unit. This presents a significant health risk as feces may attract rodents or insects that could spread infections and diseases to others.
4. While it is possible for inmates who are mentally disordered to decompensate and regress to the point where they will engage in such behaviors, some cases of feces smearing/manipulation are not related to mental illness. In these cases, the inmate's behaviors are often goal-directed and intended to produce some secondary gain (such as a transfer, attention, power, and control over staff, etc.). These situations are considered behavioral problems as the inmate chooses to act out in an attempt to manipulate the system or staff.
5. Security staff, mental health and wellness services staff, and health services staff will work together in a structured and consistent manner. All staff will encourage the inmate to exhibit appropriate behaviors while discouraging further feces smearing/manipulation behaviors.
6. Security staff must notify the facilities Senior Mental Health Clinician or designee of any incident of feces throwing, smearing and/or manipulation. Facilities without a Mental Health Clinician will contact the Mental Health Clinician at the designated major institution or MHCS.

B. General guidelines for staff interactions

1. When dealing with inmates who engage in feces smearing/manipulation, staff will be aware that emotional responses to the inmate's behaviors do not help to resolve the issue.
   a. These reactions may only strengthen the inmate's resolve and put them in the "power" position. One of the secondary gains the inmate may be striving for is the negative attention and emotional upset they may perceive from staff reactions to their behavior.
   b. Staff will present themselves professionally and try not to react emotionally to the inmate's behavior. This professional manner combined with a "matter of fact" attitude helps to remove one of the inmate's desired responses from staff.
2. Inmates who engage in these types of behaviors will be encouraged to use positive alternative behaviors that are designed to replace the unwanted behaviors. First, the inmate will be encouraged to use the approved complaint/grievance system to resolve any problems they may be experiencing. The inmate may be given cleaning supplies and encouraged to focus their efforts on cleaning up the cell.
3. It is important that staff realize that inmates who engage in feces smearing or other manipulation of

bodily wastes are likely engaging in this behavior to garner some form of secondary gain. From a management perspective, it would be helpful to know what secondary gain the inmate expects. Therefore, everyone who has contact with the inmate will be observant and attentive to the inmate's communications. Timely and accurate documentation and communication of the inmate's behaviors to all staff involved is important to the success of the recommended interventions and strategies.

C. Interdisciplinary Intervention/Management Plan

1. Security staff will notify the institution's senior Mental Health Clinician of any incident of feces smearing/manipulation. The senior Mental Health Clinician will then determine if an assessment of the inmate is warranted.
2. If the senior Mental Health Clinician determines that an assessment is warranted, the designated Mental Health Clinician will assess the inmate and their complaints, and when possible, attempt to obtain a reasonable resolution. This may necessitate the involvement of other staff (e.g., the inmate's Case Management Counselor, health services, security, etc.). If such efforts do not result in the cessation of the feces smearing/manipulation, then other techniques may be utilized to address these behaviors.
3. The inmate must receive a disciplinary offense for such violations, in accordance with Operating Procedure 861.1, *Offender Discipline, Institutions*, unless a Mental Health Clinician determines that they are not responsible for their actions because of a mental disorder.
4. If the Mental Health Clinician determines the incident to be a behavioral problem (as opposed to a mental disorder), the Mental Health Clinician may initiate a meeting of the local interdisciplinary team or a MHTT if the inmate is in a designated Mental Health Unit; see Operating Procedure 730.3, *Mental Health Services: Levels of Service*. This local interdisciplinary team will be comprised of the following individuals: Mental Health Clinician acting as Chair, the Assistant Facility Unit Head, the Chief of Security or designee, the building supervisor or designated security staff for the unit in which the inmate is housed, the Medical Practitioner, the Health Authority or designee, and the inmate's Case Management Counselor.
5. The local interdisciplinary team will evaluate all of the information available about the case, discuss alternatives, and make intervention recommendations.
   a. The local interdisciplinary team will meet at least once per week to review the case and make further recommendations as necessary.
   b. The local interdisciplinary team will determine the need for further weekly meetings based upon the actions and progress of the inmate in response to intervention strategies.
6. All recommendations made by the local interdisciplinary team will be subject to the Facility Unit Head's review and approval.

   Updates to or discontinuation of the *Interdisciplinary Intervention/Management Plan* will be forwarded to the plan participants, the Regional Administrator, MHCS, and the Regional Health Administrator.
7. The recommendations of the local interdisciplinary team will be documented by the Health Authority or designee and entered into the inmate's health record. Progress notes will be maintained by each discipline in the appropriate sections of the health record or other place of documentation.
8. Intervention strategies may include but are not limited to the following:
   a. The inmate may be subject to disciplinary action per Operating Procedure 861.1, *Offender Discipline, Institutions*.
   b. The Mental Health Clinician will determine what items or privileges will be provided to the inmate. The Mental Health Clinician will document and authorize these precautions and interventions on the *"At Risk" Inmate Notification* 730_F13.
   c. In cases where personal property is removed, the Facility Unit Head will ensure proper inventory and storage of the items in accordance with Operating Procedure 802.1, *Inmate and CCAP*

Probationer/Parolee Property, until the property is returned to the inmate.

d. If the inmate is using the water in their toilet or sink to dilute the fecal material for smearing, the water may be turned off and turned back on for legitimate purposes as determined by security staff.

e. The inmate may be placed on restricted feeding procedures in accordance with Operating Procedure 420.2, *Use of Restraints and Management of Inmate Behavior* (Restricted).

f. If no other intervention strategies are deemed effective, restraints may be used to prevent the continuation of the feces smearing/manipulation behavior.

g. As incentives to exhibit appropriate behaviors, the items or privileges that have been removed from the inmate may be reinstated gradually. If the inmate continues to exhibit appropriate behaviors, they will earn other items leading to a gradual reintroduction of all items and privileges. However, if the inmate resumes the feces-smearing behavior, all items will be removed and the process will begin again.

9. Mental health and wellness services staff will continue to provide staff consultation, support, and offer recommendations throughout this process. Mental health and wellness services staff will provide input for and monitor the intervention and management techniques used.

10. Security staff will consistently implement all interventions and strategies recommended by the local interdisciplinary team.

REFERENCES

COV §37.2-1101, *Judicial authorization of treatment.*

COV §53.1-39.2, *Restorative housing; restrictions on use.*

COV §53.1-40.1, *Medical and mental health treatment of prisoners incapable of giving consent.*

Operating Procedure 038.1, *Reporting Serious or Unusual Incidents*

Operating Procedure 401.1, *Development and Maintenance of Post Orders* (Restricted)

Operating Procedure 420.2, *Use of Restraints and Management of Inmate Behavior* (Restricted)

Operating Procedure 425.4, *Management of Bed and Cell Assignments* (Restricted)

Operating Procedure 720.2, *Medical Screening, Classification, and Levels of Care*

Operating Procedure 720.7, *Emergency Medical Equipment and Care*

Operating Procedure 730.2, *Mental Health and Wellness Services: Screening, Assessment, and Classification*

Operating Procedure 730.3, *Mental Health Services: Levels of Service*

Operating Procedure 802.1, *Inmate and CCAP Probationer/Parolee Property*

Operating Procedure 830.5, *Transfers, Institution Reassignments*

Operating Procedure 861.1, *Inmate Discipline*

Operating Procedure 940.4, *Community Corrections Alternative Program*

Standard Treatment Guidelines

ATTACHMENTS

Attachment 1, *Clinically Approved Restraints and Safety Cell Equipment* (Restricted)

Attachment 2, *Hunger Strike Fact Sheet*

FORM CITATIONS

Restraints Break Log 420_F27

Individual Inmate Log 425_F4

Special Watch Log 425_F5

Intra-system Transfer Medical Review, DOC 726-B 720_F9

Health Screening - Health-Trained Staff 720_F10

Health Services Complaint and Treatment Form 720_F17
Safety Cell – Safety Inspection 730_F3
Mental Health and Wellness Services Screening 730_F12
"At Risk" Inmate Notification 730_F13
Mental Health Monitoring Report 730_F14
Suicide Risk Assessment 730_F15
Administrative Review - Suicide 730_F16
Mental Health and Wellness Services Progress Note 730_F30
Inmate Education/Self-Management Prolonged Fasting 730_F31
Self-Management Housing Plan 730_F32
Maladaptive Behavior Screening 730_F33
Mental Health Serious Mental Illness (SMI) Determination 730_F34
Hunger Strike – Root Cause Analysis 730_F43
Hunger Strike Protocol 730_F44
Mental Health Provider Assessment of Inmate on Hunger Strike 730_F48
Daily Nursing Hunger Strike Assessment 730_F49
Medical Notification of Ninth Missed Meal 730_F50
Medical Provider Assessment of Inmate on Hunger Strike 730_F51
Disciplinary Offense Mental Health Screening 861_F2