COMMISSIONER'S DIRECTIVE 843	In Effect: 2013-09-23 Last Review: 2013-09-23 Due for Review: 2015-09-01

Management of Inmate Self-Injurious and Suicidal Behaviour

PROGRAM ALIGNMENT	Custody
OFFICE(S) OF PRIMARY INTEREST	Health Services Sector
ONLINE @	• http://infonet/cds/cds/843-cd-eng.pdf • http://infonet/cds/cds/843-cd-fra.pdf • http://www.csc-scc.gc.ca/text/plcy/cdshtm/843-cde-eng.shtml • http://www.csc-scc.gc.ca/text/plcy/cdshtm/843-cde-fra.shtml
AUTHORITIES	• *Corrections and Conditional Release Act* (CCRA), sections 85 to 88 • Provincial mental health legislation and regulations
PURPOSE	• To ensure the safety of inmates who are self-injurious or suicidal using the least restrictive measures for the purpose of preserving life and preventing serious bodily injury, while maintaining the dignity of the inmate in a safe and secure environment • To encourage and support an interdisciplinary approach so that the inmate can resume regular activities as soon as possible
APPLICATION	Applies to staff members who contribute to efforts to ensure the safety of inmates in institutions (including Regional Treatment Centres) and excludes those working in Community Correctional Centres

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RESPONSIBILITIES

1. The Institutional Head will ensure that:

   a. staff receive suicide prevention training and training on the use of the Pinel Restraint System, as per the National Training Standards

   b. a bed, or an appropriate chair or stretcher, to accommodate the Pinel Restraint System is available in their institution (except minimum security institutions and Healing Lodges)

   c. for cases in which the inmate is engaged in self-injury:

      i. he/she, or his/her delegate, as determined by a Standing Order, authorizes the application of the Pinel Restraint System and in accordance with the Situation Management Model

      ii. he/she, or his/her delegate as determined by a Standing Order, authorizes the reduction of

use, or removal of the Pinel Restraint System

d. an inmate is transferred, as soon as practicable, to a Regional Treatment Centre or an appropriate health care facility if any of the required assessments cannot be facilitated (i.e. mental health or health assessment) while in the Pinel Restraint System

e. he/she decides whether to use the Interdisciplinary Mental Health Team (IMHT) or the Correctional Intervention Board (CIB) for overseeing the management of an inmate who is suicidal or self-injurious. Should the CIB be used, minimum membership will be the same as the IMHT, as outlined in CD 850 – Mental Health Services. The Team/Board will follow the Process for Self-Injury Intervention (Annex B)

f. all behavioural indications, threats and actual situations of self-injury and attempted suicide are documented by those responsible for any aspect of the case

g. a communication process is in place so that staff who have regular interaction with the inmate are informed, in a timely fashion, when an inmate has been placed in the Pinel Restraint System, on High Suicide Watch, Modified Suicide Watch, Mental Health Monitoring or when the observation level has been changed

h. the Process for Self-Injury Intervention (Annex B) is communicated to staff and adhered to

i. the Inmate Suicide Awareness and Prevention Workshop is available on a regular basis and inmates have access.

2. Staff will:

a. intervene immediately when an inmate is discovered in the act of self-injury or suicide. Interventions must be in accordance with the Situation Management Model described in CD 567 – Management of Security Incidents

b. ensure that interventions with a self-injurious or suicidal inmate are communicated to staff and contractors who have regular interactions with inmates.

3. A mental health professional may authorize the use of the Pinel Restraint System in cases where the inmate is not engaged in self-injury if it is part of the inmate's Treatment Plan. In this case, the mental health professional must seek input from the Duty Correctional Manager regarding the application, removal, or reduction of the Pinel Restraint System.

4. Any of the monitoring and/or assessments required in this policy may be overridden by a licensed mental health professional practicing within his/her scope of practice, with input from the Duty Correctional Manager. This directive must be written, dated and signed.

5. Unlicensed mental health professionals may provide any of the required monitoring or assessment

under the supervision of a licensed mental health professional.

PROCEDURES FOR ASSIGNING A SUICIDE WATCH OBSERVATION LEVEL

Screening for Suicide Risk

6. All inmates will be screened using the Immediate Needs Checklist – Suicide Risk pursuant to CD 705-3 – Immediate Needs and Admission Interviews.

7. In addition to the requirements in CD 705-3 – Immediate Needs and Admission Interviews, the Immediate Needs Checklist – Suicide Risk will be used:

    a. within 24 hours of arrival to a new institution

    b. upon admission to administrative segregation

    c. by any non-health care staff interacting with the inmate when there is reason to believe that the inmate may present some risk for suicide and a mental health professional is not immediately available. This would include when returning from outside court or when the reason for placement in administrative segregation is changed.

8. If there is reason to believe that the inmate may be at imminent risk to attempt suicide, the staff member will immediately contact a mental health professional and the Duty Correctional Manager. The mental health professional will assign an observation level based on an in-person assessment. If no mental health professional is available, the Duty Correctional Manager will immediately place the inmate on High Watch and the inmate will be assessed by a mental health professional as soon as reasonably possible, but within 24 hours.

9. Referral to a mental health professional (use Referral Form Psychology/Institutional Mental Health Services, CSC/SCC 0450) must be documented in a Casework Record.

Suicide Watch Observation Levels (High Suicide Watch, Modified Suicide Watch and Mental Health Monitoring)

10. An inmate assessed as requiring High or Modified Suicide Watch will:

    a. be placed in a suicide watch cell

    b. have a mental health assessment, in person, by a mental health professional within 24 hours; the frequency of subsequent assessments will be determined by a mental health professional. The mental health professional will review and initial the Seclusion and Restraint Observation Report (CSC/SCC 1006) and incorporate any relevant information into the assessment

    c. be visited daily by a Nurse, pursuant to CD 800 – Health Services (section on Administrative Segregation).

11. Inmates on High Suicide Watch will be under constant, direct observation by a Correctional Officer/Primary Worker (or it may be a mental health professional in Regional Treatment Centres). Monitoring via camera only is not permitted.

12. Inmates on Modified Suicide Watch will be monitored as noted above, or under constant observation via Closed Circuit Television (CCTV). If constant observation takes place via CCTV, the CCTV monitor is not to be located in the Main Communications Control Post (MCCP). For women inmates, CCTV monitoring will be done in accordance with CD 577 – Operational Requirements for Cross-Gender Staffing in Women Offender Institutions.

13. The Correctional Officer/Primary Worker (or the mental health professional, if applicable) will document the inmate's activities on a Seclusion and Restraint Observation Report (CSC/SCC 1006), as required, but at least every 15 minutes.

14. When an inmate has been assigned to an observation level, the Nurse will consult with the Psychiatrist, or the institutional Physician, within 24 hours, to conduct a review of the inmate's medication profile. The review will include the method of medication administration, taking into account the inmate's level of risk for self-injurious or suicidal behaviour.

15. The mental health professional will complete the High Suicide Watch Observation Form (CSC/SCC 1434), the Modified Suicide Watch Observation Form (CSC/SCC 1435) or the Mental Health Monitoring Form (CSC/SCC 1436). A copy will be given to the Duty Correctional Manager, who will ensure that it is accessible to staff who have regular interaction with the inmate on all shifts. If the inmate has an active Interdisciplinary Management Plan (CSC/SCC 1432), the Suicide Watch Observation Forms are not required.

16. At shift briefings, the Duty Correctional Manager will advise Correctional Officers/Primary Workers of any inmates who are currently assigned an observation level and the conditions of the observation level.

High Suicide Watch

17. An inmate who is at imminent risk for suicidal or self-injurious behaviour is placed on High Suicide Watch.

18. An inmate placed on High Suicide Watch will be provided with, at minimum:

    a. a security gown, at all times

    b. a security blanket and mattress unless the inmate attempts to use these items in a manner that is self-injurious or affects staff's ability to monitor the inmate. In this case, the items can be removed from the cell, with the intention of returning the item as soon as safely possible

    c. food and fluids that can be easily consumed without cutlery or tableware (finger foods)

d. hygiene items (the mental health professional, with input from the Duty Correctional Manager, will determine when to provide hygiene items if these items are associated with any risk for suicidal or self-injurious behaviour).

Modified Suicide Watch

19. An inmate who is at elevated risk for suicidal or self-injurious behaviour is placed on Modified Suicide Watch.

20. In addition to the items listed for an inmate placed on High Suicide Watch, an inmate placed on Modified Suicide Watch, at the discretion of the mental health professional and with input from the Duty Correctional Manager, will be provided with:

    a. personal items, including but not limited to clothing, books, writing materials, and hygiene products (see 22 d, above)

    b. cutlery and/or tableware, and regular institutional meals.

21. This access is given in order to move towards normalizing the inmate's environment to the extent that is possible. It also affords the mental health professional the opportunity to evaluate the inmate's response to a reduction of restrictions while the inmate is under continuous observation.

Mental Health Monitoring

22. An inmate who is at risk for suicide or self-injury, typically following removal of High or Modified Suicide Watch status, will be placed on Mental Health Monitoring.

23. An inmate placed on Mental Health Monitoring will remain under the care of a mental health professional, who will determine the frequency and intensity of Mental Health Monitoring. The inmate may remain in his/her regular cell or be placed in another appropriate cell following consultation between the mental health professional and the Duty Correctional Manager.

Modifications to Observation Levels

24. If there is an increase in perceived risk of self-injurious or suicidal behaviour, staff will immediately notify a mental health professional and the Duty Correctional Manager. If no mental health professional is available, the Duty Correctional Manager will increase the observation level to High Suicide Watch. Any change will be documented on the appropriate Observation Form (1434, 1435, or 1436).

25. The observation level will be reduced and/or discontinued only when a mental health professional completes an in-person assessment, consults with the Duty Correctional Manager, and determines that the inmate's risk can be managed on a lower observation level. The observation level will normally only be reduced one level at a time.

PROCEDURES FOR THE APPLICATION OF RESTRAINT EQUIPMENT

26. The Pinel Restraint System is the only restraint system to be used for self-injurious behaviour in maximum and medium security institutions, women's institutions, and Regional Treatment Centres. Minimum security institutions and Healing Lodges may use the Pinel Restraint System, if available.

27. The use of the Pinel Restraint System, in response to self-injury or as a component of an Interdisciplinary Management Plan, does not replace efforts to understand and address the causes of the behaviour, nor is it intended to be the principal intervention.

28. The Pinel Restraint System will only be applied by trained staff.

29. Inmates will be appropriately clothed or covered while restrained.

30. To avoid positional asphyxia, at no time will a restrained inmate be placed lying face down. An inmate restrained to a bed or an appropriate stretcher will be placed either in the recovery position (side lying) or on his/her back with his/her head elevated. See section below for pregnant inmates.

Pregnant Inmates

31. Restraints should only be used as a last resort with pregnant inmates. If the Pinel Restraint System is being considered for application on a pregnant inmate, approval by a Physician will be sought if time and circumstances permit (or the Physician will be contacted immediately thereafter).

32. If restraints are applied, extreme caution will be exercised to ensure that both the inmate and fetus are protected from injury (e.g. supported by staff on each side while walking).

33. Pregnant inmates who are restrained in bed will be tilted on their left side. They will not be positioned flat on their back at any time. Approval will be given by the attending Physician for any other position.

Reporting the Use of the Pinel Restraint System

34. The use of the Pinel Restraint System for a situation in which an inmate is engaged in self-injury is:

    a. a reportable use of force if the inmate is engaged in self-injury and is physically uncooperative. The Use of Force Report (CSC/SCC 0754) will be completed

    b. a non-reportable use of force if the inmate cooperates and/or requests the application of the Pinel Restraint System. If at any point before the removal of the Pinel Restraint System the inmate is uncooperative, it becomes a reportable use of force.

35. Where use of the Pinel Restraint System is part of a treatment plan and the inmate consents, it is neither a reportable incident nor a reportable use of force.

Assessment and Monitoring of the Use of the Pinel Restraint System

36. When the application of the Pinel Restraint System is a reportable use of force, the use of force will be considered complete once the inmate is secured in the Pinel Restraint System and the Nurse has completed the post-use of force physical assessment pursuant to CD 567-1 – Use of Force. At this time, video-recording will cease.

37. When a Nurse is present during the application of the Pinel Restraint System, he/she will conduct an initial assessment of the inmate's physical and mental health upon completion of the application of the restraints. This assessment will include at a minimum:

    a. ability to breathe without restriction

    b. heart rate, respiratory rate and oxygen saturation

    c. circulation to the hands and feet

    d. general mental health assessment

    e. referral to another health care professional, as required.

38. When there is no Nurse present during the application of the Pinel Restraint System:

    a. a Nurse will be called to attend the institution and complete the health assessment within two hours of its application. If this is not possible, arrangements have to be made to ensure this assessment is completed within the two-hour timeframe

    b. while waiting for the Nurse to arrive, a first aid/CPR certified staff member will immediately complete a first aid assessment, take action as appropriate and notify the Duty Correctional Manager once the assessment is completed and if there are any concerns. For any concerns regarding the inmate's physical health, the Duty Correctional Manager will refer to the section on "Response to Medical Emergencies" in CD 800 – Health Services.

39. If the inmate refuses a post-use of force or health assessment, the Nurse may perform the assessment based only on observation and interview data. The Nurse will observe the inmate to ascertain whether or not there are any signs of physical distress which require immediate intervention. If no signs of physical distress are present, the Nurse will document the refusal and return at the next designated time to re-offer the appropriate assessment.

40. At a minimum, an inmate placed in the Pinel restraint equipment will be under constant observation by a Correctional Officer/Primary Worker (or it may be a mental health professional in Regional Treatment Centres), either by CCTV or in direct view. If constant observation takes place via CCTV, the CCTV monitor is not to be located in the Main Communications Control Post (MCCP).

41. In situations where the inmate is restrained in the supine position (i.e. laying face up), he/she will be constantly monitored, in person, by a Correctional Officer/Primary Worker (or it may be a mental health professional in Regional Treatment Centres).

42. The Correctional Officer/Primary Worker (or mental health professional, if applicable) will ensure the inmate's safety as well as record the inmate's general appearance and behaviour. Situations that are to be reported to the Nurse on duty (or to the Duty Correctional Manager when the Nurse has not yet arrived) include, but are not limited to the following:

    a. excessive sweating

    b. difficulty breathing

    c. complaints of pain

    d. increase in thirst

    e. increase in restlessness, agitation, or change in level of consciousness, or

    f. soiling of clothes.

43. The Correctional Officer/Primary Worker (or the mental health professional in Regional Treatment Centres) will record all observations on the Seclusion and Restraint Observation Report (CSC/SCC 1006), as required, but at least every 15 minutes.

44. After the initial health assessment, a Nurse will perform an additional health assessment:

    a. every 15 minutes for the first hour (or more frequently, based on clinical need)

    b. once every hour thereafter (or more frequently, based on clinical need)

    c. following the removal of the Pinel Restraint System.

45. Following the first hour of the application of the Pinel Restraint System, range of motion exercises will normally be completed as part of each health assessment. If the inmate refuses or is too agitated for the restraints to be removed from individual extremities, this will be documented.

46. A mental health professional will complete a mental health assessment, in person, as soon as reasonably possible. This assessment will normally take place within six hours of the application of the restraints.

47. In situations of continuous or repeated application of the Pinel Restraint System in a 24-hour period, the mental health assessment by the mental health professional will be completed at least once every 24 hours, following the initial assessment.

48. The health assessment completed in response to the application of the Pinel Restraint System will replace any other health assessment that is required as per the levels of observation.

49. Where the requirements with respect to mental health and physical health assessments cannot be met, the inmate will be transported to an appropriate health care facility for assessment.

50. The mental health and physical health assessments must be done by professionals operating within their scope of practice and competence.

Activities of Daily Living While in the Pinel Restraint System

51. The inmate placed in the Pinel Restraint System will be offered:

    a. the opportunity to attend to activities of daily living to the extent possible

    b. food at regular meal delivery times (if this is not feasible, accommodations will be made to ensure that no meals are missed)

    c. fluids at least every two hours while the inmate is awake

    d. the opportunity to meet his/her elimination needs at least hourly while awake. Supervision will be provided by Correctional Officers/Primary Workers and Nurses of the same gender. Nursing assistance will be provided when required.

Pinel Restraint System: Follow-Up and Review Procedures

52. If the continuous use of restraint equipment exceeds an eight-hour period, the Interdisciplinary Mental Health Team (IMHT) or Correctional Intervention Board (CIB) will develop an intervention strategy to reduce and eliminate the use of restraints. The strategy must be in place no later than 36 hours from the application of the Pinel Restraint System.

53. If the continuous use of restraints exceeds 24 hours, a review of the use of the restraints will be completed as soon as possible, but no later than 48 hours from the IMHT/CIB discussion. The IMHT/CIB will task a mental health professional, who is not a member of the intervening team, to complete the review. The IMHT/CIB members will refer to the Regional Suicide/Self-Injury Management Committee if they need assistance in finding a mental health professional.

54. The review will, at a minimum, look at the following areas with respect to the use of the Pinel Restraint System:

    a. whether a treatment plan is in place

    b. consideration of all alternatives to the Pinel Restraint System

c. a strategy to prevent future use of the Pinel Restraint System

d. whether a plan to remove the restraints is in place

e. the need for additional reviews.

55. The IMHT/CIB will continue to meet at least every two working days to evaluate the intervention strategy if the use of the Pinel Restraint System continues.

REMOVAL OF THE PINEL RESTRAINT SYSTEM

56. Following the removal of the Pinel Restraint System, the inmate will be assessed by:

a. a Nurse who will complete a post-removal health assessment

b. a mental health professional who will assign or modify an observation level.

SUPPORT FOR INMATES

57. Support for inmates following self-injurious or suicidal behaviour will be provided pursuant to CD 567 – Management of Security Incidents and CD 840 – Psychological Services.

TRANSFER OF INMATES

58. For any transfer of inmate at risk for suicide/self-injury, see CD 710-2 – Transfer of Offenders.

ENQUIRIES

59. Strategic Policy Division
National Headquarters
Email: Gen-NHQPolicy-Politi@csc-scc.gc.ca

Commissioner,

Original Signed by:
Don Head

ANNEX A

CROSS-REFERENCES AND DEFINITIONS

CROSS-REFERENCES

CD 567 – Management of Security Incidents
CD 567-1 – Use of Force
CD 567-3 – Use of Restraint Equipment for Security Purposes
CD 568-1 – Reporting and Recording of Security Incidents
CD 577 – Operational Requirements for Cross-Gender Staffing in Women Offender Institutions
CD 705 – Intake Assessment Process
Immediate Needs Checklist – Suicide Risk as per CD 705-3 – Immediate Needs and Admission Interviews
CD 709 – Administrative Segregation
CD 710-2 – Transfer of Offenders
CD 800 – Health Services
CD 803 – Consent to Health Service Assessment, Treatment and Release of Information
CD 805 – Administration of Medication
CD 835 – Health Care Records
CD 840 – Psychological Services
CD 850 – Mental Health Services

Security Bulletin – Positional Asphyxia and Excited Delirium (2008-03-12)
Security Bulletin – Head Banging (2009-10-28)

DEFINITIONS

Activities of daily living: normal daily activities such as eating, bathing, dressing, and grooming.

Appropriate chair/stretcher: a chair/stretcher that can be immobilized in a secured area, and is suitable to the inmate's weight and height.

Cooperative: when there is no verbal or physical resistance and the inmate responds to staff presence, verbal communication and complies voluntarily with verbal commands or orders.

Health care facility: community hospital, Regional Treatment Centre, Regional Psychiatric Centre or CSC regional hospital.

High Suicide Watch: an observation status for inmates who are at imminent risk for suicidal or self-injurious behaviour, during which the inmate is under continuous direct observation.

Interdisciplinary Mental Health Team (IMHT): a team chaired by the Chief Psychologist/Psychiatrist, Clinical Manager or delegate, with team members that may include mental health staff, health care

staff, Parole Officers, Correctional Managers, Elders, and ad hoc members as required. The IMHT discusses current clinical, operational and case management issues/concerns, short-term/long-term goals, and the roles and responsibilities of all staff intervening with the inmate, in order to respond effectively, and provide advice and support to the inmate.

Mental health assessment: an observation and description of an inmate's current state of mind, under the domains of appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgement.

Mental Health Monitoring: an observation status for inmates who are at risk for suicide or self-injury that typically follows removal of High or Modified Suicide Watch status.

Mental health professional: CSC staff and contractors who offer services for the purposes of improving an offender's mental health and are registered or licensed in Canada, preferably in the province/territory of practice. Individuals will operate within their scope of practice and competence. Examples include Psychologists, Psychiatrists, Physicians, Nurses, and Clinical Social Workers.

Modified Suicide Watch: an observation status for inmates who are at elevated risk for suicidal or self-injurious behaviour, during which the inmate is under continuous observation.

Physically uncooperative: when the inmate refuses to comply with staff directions or orders (e.g. refuses to move from an area or leave a cell). The inmate may offer active physical, but not assaultive resistance by pulling or running away or resisting staff attempts to move him/her to a standing position.

Positional asphyxia: asphyxia results when oxygen is reduced or elevated carbon dioxide levels are created in the body. Placing an inmate in restraints in certain positions or placing an officer's body weight on an inmate to subdue him/her can lead to positional asphyxia.

Restraint equipment: an approved device listed in the Security Equipment Manual intended to temporarily restrict or limit free movement.

Self-injury/self-injurious behaviour: the intentional, direct injuring of body tissue without suicidal intent.

Suicidal behaviour: a behaviour that intentionally puts life at risk and may result in death, done with the intention to end life.

Suicide: an intentional act to end one's life that results in death.

ANNEX B

PROCESS FOR SELF-INJURY INTERVENTION

1. OBJECTIVE

To outline a two-pronged method for intervening with inmates who self-injure: i) short-term response – Critical Response and Incident Management Plan, which concentrates on the immediate intervention needs for an inmate following a self-injurious incident; and ii) long-term response – Interdisciplinary Management Plan, which is a comprehensive approach to intervening with inmates who self-injure **repetitively and whose ongoing behaviour is posing significant challenges to the institution**.

2. CRITICAL RESPONSE AND INCIDENT MANAGEMENT PLAN

Purpose: A Critical Response and Incident Management Plan (CRIMP) is a review of an inmate's behaviour subsequent to an incident of self-injury.

Responsibility/Timeframes

- The CRIMP is normally completed within 24 hours of the incident, by a mental health professional, at the institution where the incident occurred. The CRIMP must be completed after every incident of self-injury.
- An in-person interview of the inmate is required to complete the CRIMP.

Content/Details

- The review includes: reasons for self-injury, level of risk for further self-injury or suicide, level of intervention required, as well as recommendations for further mental health care.
- The Institutional Head will determine which group will review completed CRIMPs and manage the inmate's case, either the institution's Correctional Intervention Board (CIB) or the Interdisciplinary Mental Health Team (IMHT).
- As reasons for self-injuring may be different on each occasion, all incidents need to be considered and a CRIMP must be completed in response to each occurrence.
- In the event that multiple self-injurious situations occur in a 24-hour period, by the same inmate, or when an Interdisciplinary Management Plan is in place, an **addendum** to the CRIMP can be completed, substituting the need for a CRIMP for each self-injurious situation. In these exceptions, each incident of self-injury must be documented and the situation assessed, in keeping with professional standards.
- The CRIMP and the inmate's case are reviewed by the CIB/IMHT, at the next scheduled meeting. If the mental health professional believes the review should be completed sooner, a meeting will be convened.
- If the decision is made for an Interdisciplinary Management Plan, an interim management plan will be developed as soon as possible, normally within three to five working days.
- The objective is to encourage and support an interdisciplinary approach in order for the inmate to resume usual activities as soon as possible.

Documentation

- The CRIMP will not include any confidential health information.
- The individual completing the CRIMP will ensure activation of the OMS Alert "Current Suicide/Self-Injury Risk", if relevant, and notification of the appropriate personnel. Completion of the CRIMP will be documented as a "Memo to File" on OMS.
- Critical Response and Incident Management Plan (CSC/SCC 1430).

3. COMPREHENSIVE PSYCHOLOGICAL/PSYCHIATRIC ASSESSMENT

Purpose: A Comprehensive Psychological Assessment (CPA) is a mandatory assessment for all inmates who require an Interdisciplinary Management Plan. Treatment Centres have the option of completing a Comprehensive Psychiatric Assessment, in place of the Comprehensive Psychological Assessment. A comprehensive assessment is imperative for understanding the inmate and formulating appropriate clinical care.

Responsibility/Timeframes

- The CPA is completed by either an institutional or contract Psychologist/Psychiatrist if one has not been completed within two years.
- If a CPA has been completed within two years, the decision to complete a second CPA would be determined by case specifics and at the discretion of the Chief of Psychology/Attending Psychiatrist.
- As the CPA is an integral part of the Interdisciplinary Management Plan, it will normally be completed four weeks from the date it is assigned to a Psychologist/Psychiatrist.

Content/Details

- The comprehensiveness of the psychological assessment and psychometric evaluation(s) is guided by case specifics such as complexity of inmate need (clinical profile), pattern of self-injurious behaviour and clinical judgement. The Chief of Psychology/Attending Psychiatrist will determine the content of the CPA.
- Every effort should be made to ensure the consent and participation of the inmate (via informed consent).
- In the event that an inmate is unwilling to provide consent, a comprehensive file review will be done to the fullest extent possible.

Documentation

- Due to the presence of confidential health information, the CPA will be placed on the Psychology File.
- If the inmate does not provide consent, this must be clearly documented in the introduction of the comprehensive file review.

4. COMPREHENSIVE SUICIDE/SELF-INJURIOUS ASSESSMENT

Purpose: The Comprehensive Suicide/Self-Injurious Assessment (CSSIA) is a detailed self-injury assessment, focused on triggers (past, present and changes), factors affecting risk, offender goals and

treatment targets. It provides an overall analysis and synthesis of self-injury and suicidal behaviour over time (e.g. changes in mood, lethality, risk, areas of increased/decreased clinical concern, etc.).

Responsibility/Timeframe

- The CSSIA is completed by either an institutional or contract Psychologist/Psychiatrist.
- The request for a CSSIA is made at the discretion of the Chief of Psychology/Attending Psychiatrist. The CSSIA is not mandatory.

Content/Details

- The CSSIA is completed to obtain additional information related to the inmate's history of self-injury and to guide the identification of interventions. It may also be used as a part of the Comprehensive Psychological/Psychiatric Assessment.
- It may be completed as a step in the process to determine the need for an Interdisciplinary Management Plan.
- Completed CRIMPs contribute to the CSSIA and in turn the CSSIA contributes to the content of the Interdisciplinary Management Plan.

Documentation

- Due to the presence of confidential health information, the CSSIA will be placed on the Psychology File.
- In the event that an inmate is unwilling to provide consent, information will be obtained via a comprehensive file review, done to the fullest extent possible. This must be clearly documented in the introduction of the CSSIA.
- Comprehensive Suicide/Self-Injury Assessment (CSC/SCC 1438).

5. ALTERNATIVES/AVOIDING USE OF RESTRAINTS

Purpose: The Alternatives/Avoiding Use of Restraints is a tool to identify the causes of agitation. It also assists in the subsequent development of measures and/or interventions to avoid the use of restraints. The Alternatives/Avoiding Use of Restraints form is not mandatory.

Responsibility

The tool is completed by a mental health professional during an in-person interview with the inmate.

Content/Details

- Questions provide an opportunity for the inmate to contribute to the identification and development of interventions.
- It can be used in response to a single incident of self-injury or as part of the assessment process in the development of an Interdisciplinary Management Plan.

Documentation

- Alternatives/Avoiding Use of Restraints (CSC/SCC 1437).

6. CLINICAL OPINION AND BEHAVIOURAL SUMMARY

Purpose: The Clinical Opinion and Behavioural Summary (COBS) provides a synthesis of the information identified by the clinical team via the clinical file review and a synopsis of the information contained in the CPA. The COBS helps to complete the Interdisciplinary Management Plan.

Responsibility/Timeframes

- A Psychologist/Psychiatrist will normally complete the COBS within ten working days from the date of the completion of the CPA. The Psychologist/Psychiatrist responsible for drafting the COBS should seek input from other health care disciplines.

Content/Details

- The focus is to identify specific responsivity issues and behavioural concerns that impact the clinical and operational interventions for the inmate.
- The COBS also contains behavioural cues that are linked to an increase in risk of suicide/self-injury and integrated behavioural patterns, which will assist in the development of the Interdisciplinary Management Plan.
- Information obtained from Alternatives/Avoiding Use of Restraints (CSC/SCC 1437) may be included in the synthesis.
- The amount of personal health information in the COBS will be minimized.
- COBS will be shared with all members of the CIB/IMHT.

Documentation

- Clinical Opinion and Behavioural Summary (CSC/SCC 1431).

7. INTERDISCIPLINARY MANAGEMENT PLAN

Purpose: The Interdisciplinary Management Plan (IMP) is an integrated clinical, case management and security intervention plan to assist staff with the effective management of inmates with complex self-injury needs in order for the inmate to resume usual activities as soon as possible.

Responsibility/Timeframes

- The interim Interdisciplinary Management Plan will normally be completed within three to five working days following the decision to develop the plan.
- The CIB/IMHT will normally complete the Interdisciplinary Management Plan within ten working days from the date of completion of the COBS.
- All interim, current and updated Interdisciplinary Management Plans will be provided to the Institutional Head.
- All staff involved with the inmate must have access to the Interdisciplinary Management Plan.
- The CIB/IMHT is responsible for a weekly, formal review of the Interdisciplinary Management Plan.
- The Interdisciplinary Management Plan will be discontinued when the inmate has achieved a sustained level of stability, as determined by the CIB/IMHT. IMHT follow-up will continue as outlined in the Institutional Mental Health Service (Primary Care) Guidelines.

Content/Details

An Interdisciplinary Management Plan must be completed for those atypical inmates who repeatedly exhibit behaviour that endanger their life or physical integrity, who are often the subject of special incident reports, and for whom known standard intervention practices do not seem to produce the desired results.

- The Interdisciplinary Management Plan outlines the current intervention guidelines and activities, based on the inmate's observation level (i.e. High Suicide Watch, Modified Suicide Watch and Mental Health Monitoring). The plan outlines the appropriate environment to ensure the safety of staff and inmates, during the crisis, as well as a return, as quickly as possible, while incorporating the less restrictive level of care. The Plan will identify behaviours and moods associated with vulnerability, methods to engage the inmate and identification of the process involved, as well as specific staff.
- The Interdisciplinary Management Plan will be enhanced through the participation of the inmate (via informed consent). In the event that an inmate is unwilling to provide consent, the Interdisciplinary Management Plan will be developed through secondary sources. Every effort should be made to encourage the inmate's participation. All efforts must be documented on OMS/Casework Record.
- The inmate's Parole Officer will update the Correctional Plan as required (please refer to CD 710-1 – Progress Against the Correctional Plan).

Documentation

- Storage/filing of the Interdisciplinary Management Plan must be in a secure area (i.e. unit office, Correctional Manager's office).
- Interdisciplinary Management Plan (Daily Routine) (CSC/SCC 1432).

ANNEX C

FLOW CHART OF THE KEY STEPS FOR SELF-INJURY INTERVENTION IN INSTITUTIONS

The following flow chart depicts key steps for self-injury intervention in institutions.