

Suicide Prevention Protocols for Juvenile Justice Youth

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Introduction

Youth who come into contact with the juvenile justice system, especially those in residential facilities, have higher rates of suicide than their non-system-involved peers (Gallagher & Dobrin 2006). Suicide prevention efforts by this system should begin at the initial point of entry and be coordinated to protect youth at every step along the way. This guide, developed by the Youth in Contact with the Juvenile Justice System Task Force (<http://actionallianceforsuicideprevention.org/task-force/juvenilejustice>) of the National Action Alliance for Suicide Prevention (Action Alliance) (<http://actionallianceforsuicideprevention.org>), discusses suicide prevention practice components across the following points of contact:

- Referral/Arrest
- Courts
- Probation
- Detention and Secure/Non-Secure Care Facilities
- Aftercare

The task force's Suicide Prevention Programming and Training Workgroup was charged with developing a guide for implementing accepted suicide prevention guidelines at each point of contact. To do so, the group turned to *Suicide Prevention in Juvenile Correction and Detention Facilities* (Hayes, 1999), which was produced by the Council of Juvenile Correctional Administrators (CJCA) with support from the Office of Juvenile Justice and Delinquency Prevention. This report addresses performance-based standards for juvenile correction and detention facilities and describes a comprehensive suicide prevention program for juvenile facilities that involves the following components:

- Training
- Identification; Referral; Evaluation
- Communication
- Housing (Safe Environment)
- Levels of Observation; Follow-Up; Treatment Planning
- Intervention (Emergency Response)
- Reporting and Notification
- Mortality-Morbidity Review

Background

Envisioning a nation free from the tragic experience of suicide, the Action Alliance was launched in 2010 by U.S. Department of Health and Human Services Secretary Kathleen Sebelius and former U.S. Department of Defense Secretary Robert Gates. This public-private partnership advances the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance's Youth in Contact with the Juvenile Justice System Task Force was established to focus attention on the needs of youth in the juvenile justice system. The task force was co-lead by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Juvenile Justice
- Joseph J. Coccozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration. Each workgroup developed products specific to its respective task.

Suicide Prevention Programming and Training Workgroup Members and Staff

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For this document, the workgroup tailored and extended these original key components to points of contact beyond detention and secure/non-secure care facilities.

Because of the intense level of daily interaction, it may be argued that suicide prevention lies primarily in the domain of detention and other secure/non-secure settings. However, suicide prevention must be a priority for providers at *all* points of contact within the system. Correspondingly, this guide builds on a foundation established for detention and other secure/non-secure care settings to address the other points of contact: referral/arrest, courts, probation, and aftercare.

Suicide Prevention in Juvenile Correctional Facilities (<http://www.sprc.org/training-institute/juvenile-correctional-curriculum>) is a two-hour curriculum to help state juvenile correctional administrators and facility, training, and mental health directors develop and implement comprehensive suicide prevention policies. This course was developed by the Suicide Prevention Resource Center (SPRC), in partnership with CJCA, for all states, Puerto Rico, and major metropolitan counties. SPRC and CJCA also developed a two-part webinar series (housed on the same website as the course) titled *Suicide Prevention in Juvenile Detention and Correctional Facilities*, in partnership with the National Center on Institutions and Alternatives, to complement the course.

Component 1: Training

In considering the breadth of the juvenile justice processing continuum, it is not difficult to overlook that the “system” is composed of individuals, with varying levels of education, experience, and responsibilities. These providers, at every level of contact, must be equipped with the skills necessary to properly address the needs of youth, particularly those youth at risk of suicide.

Detention and Secure/Non-Secure Care Facilities

The essential component to any suicide prevention program is properly trained direct care staff, members of which form the backbone of any juvenile detention and secure/non-secure care facility (including training schools and residential treatment). As suicides often occur during late afternoon/early evening or on weekends – generally outside the purview of program staff and when direct care staff are often the only personnel available – these staff members form the front-line defense against suicide and must therefore be trained to thwart these incidents.

All direct care, medical, and mental health personnel, as well as any staff who has regular contact with youth, should receive eight hours of initial suicide prevention training, followed by two hours of refresher training each year. The initial training should include:

- administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts
- why the environments of juvenile facilities are conducive to suicidal behavior
- potential predisposing risk and protective factors related to suicide
- high-risk suicide periods
- juvenile suicide research
- warning signs of suicide
- identification of suicidal youth despite the denial of risk
- components of the facility’s suicide prevention policy
- liability issues associated with juvenile suicide

The two-hour annual refresher training should include:

- administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts
- review of predisposing risk and protective factors related to suicide
- warning signs of suicide
- identification of suicidal youth despite the denial of risk
- review of any changes to the facility's suicide prevention policy
- general discussion of any recent suicides and/or suicide attempts in the facility

To ensure an efficient emergency response to suicide attempts, “mock drills” should be incorporated into both initial and refresher training for all staff. All staff should be trained in the use of emergency equipment located in each housing unit. In addition, all staff who have routine contact with youth should receive standard first-aid and cardiopulmonary resuscitation (CPR) training.

Referral/Arrest

Local jurisdictions should embrace and train law enforcement officers in the Crisis Intervention Team concept, a nationally-recognized program known as the “Memphis Model” of pre-arrest jail diversion for individuals in a mental illness crisis. This program provides law enforcement-based crisis intervention training for helping individuals, including youth, with mental illness. By preventing more youth with mental health needs from penetrating deeper into the system, the overall likelihood of suicide by youth within the system at large is decreased.

Courts

Judges, prosecutors, public defenders, and allied juvenile court professionals should be trained to (1) understand that justice-involved youth are at higher risk for suicide, (2) understand risk and protective factors for suicidal behavior in justice-involved youth, and (3) recognize and respond to warning signs of suicide in justice-involved youth, particularly at key decision points (e.g., detention, disposition). Court hearings are a rare occasion for juvenile justice stakeholders and youth and families to be in mutual contact, and a shared understanding and appreciation of suicide dynamics are critical for coordinated case processing and maintained well-being of system-involved youth.

Brief (i.e., one-hour) training in suicide awareness should be incorporated into training that is standard for new court personnel (and those new to juvenile cases). Training should also be incorporated into annual conferences of the National Legal Aid and Defender Association or similar organizations via continuing legal education requirements for public defenders.

Probation

All probation staff should be required to complete an initial two-hour suicide prevention training workshop, followed by an annual one-hour refresher course. The workshops should include discussion of topics detailed in the Detention and Secure/Non-Secure Care Facilities section above.

Aftercare

The range of people with whom youth will interact greatly increases following release from a secure setting. Probation/parole officers; parents and other caregivers; teachers, schools administrators, counselors, and other school staff; community-based mental health providers; and peers all become critical partners in preventing suicide during the aftercare process. Suicide prevention training for these individuals will vary in formality and intensity, but all recipients must understand the trauma experienced by youth leaving secure care, the risk of suicide among these youth, and how to prevent it.

Additional training on CPR and other basic life-saving measures should be offered or required to prepare critical partners to respond to an actual suicide and/or self-harm attempt.

Probation and parole officers, school-based mental health and security staff, and community-based mental health providers should all formally receive at least basic-level training on suicide awareness and prevention. Although similar to training offered to detention and secure/non-secure care facility staff, training provided to those associated with aftercare should emphasize warning signs of suicide visible during short and/or sporadic periods of interaction since the time they spend with youth is not constant.

Available Training Resources

There are a variety of suicide prevention training programs available to schools and communities. The Suicide Prevention Resource Center, in collaboration with the American Foundation for Suicide Prevention (AFSP), maintains the SPRC/AFSP Best Practices Registry for Suicide Prevention (BPR) (<http://www.sprc.org/bpr/section-iii-adherence-standards>) that lists programs, practices, policies, protocols, and informational materials whose content has been reviewed according to current program development standards and recommendations. The programs and materials featured on the registry are designed for use in schools, communities, campuses and other settings. Similarly, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) maintains the National Registry of Evidence-based Programs and Practices (NREPP) (<http://www.nrepp.samhsa.gov/>), which is an online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers.

In February 2013, the first suicide prevention training for juvenile justice direct care staff was accepted to the BPR (<http://www.sprc.org/bpr/section-III/shield-care-system-focused-approach-protecting-juvenile-justice-youth-suicide>). Developed by the Tennessee Department of Mental Health and Substance Abuse Services, *Shield of Care* teaches suicide prevention strategies and emphasizes a system-focused model of prevention. Specifically, it: 1) emphasizes that policy, connectedness to youth, and communication between staff are essential system-level elements of prevention; 2) teaches steps of effective suicide intervention and 3) provides opportunities for staff to reflect on internal policies for prevention, discuss strategies for overcoming potential barriers, and plan how to take action in their specific setting. *Shield of Care* materials are available for free download at <http://tn.gov/mental/recovery/shieldcare.shtml>

Schools seeking to train staff may benefit from a document developed by the Prevention Division of the American Association of Suicidology. This document, entitled *Guidelines for School Based Suicide Prevention Programs* (http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf) (1999), provides practical recommendations for the safe and effective implementation of school-based suicide prevention programs. Topics addressed in *Guidelines*, which could be incorporated into community- and home-based trainings as well, include:

- the conceptual basis for prevention programs
- requirements for effective suicide prevention programs and their implementation
- components of comprehensive school-based suicide prevention programs
- institutionalization and sustainability of suicide prevention programs

For parents, other caregivers, siblings, and peers, more informal training may be most appropriate. Training should still focus on the youth's trauma exposure and signs of potential suicidal behavior, but also include skill building in being a caring, observant caregiver and friend. Creating and maintaining a comfortable environment of caring individuals within a home and neighborhood is very important for a youth returning from secure care.

Component 2: Identification, Referral, and Evaluation

There is little disagreement about the value of screening and assessment in preventing suicide. Research consistently reports that approximately two-thirds of all suicide victims communicate their intent some time before death, and that many individuals with a history of one or more suicide attempts are at a greater risk for suicide than those who have never made an attempt. Identification of youth at risk of suicide, then, is paramount to suicide prevention efforts. (The Suicide Research Workgroup of the Youth in Contact with the Juvenile Justice System Task Force addresses risk identification in its paper, *Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification among Juvenile Justice Youth* (<http://actionallianceforsuicideprevention.org/system/files/JJ-6-R2-Screening-Assessment.pdf>). Also, the BPR and NREPP include potential screening instruments to consider. To render identification meaningful, however, it must be followed by appropriate referral and evaluation.

Detention and Secure/Non-Secure Care Facilities

Intake screening and continuous assessment of all juveniles is critical to a facility's suicide prevention efforts. Screening and assessment should not be viewed as a single event, but as an ongoing process. Youth can become suicidal at any point during confinement, including the initial admission into the facility; after adjudication and upon return to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; during confinement in isolation, segregation, and/or "time-out"; and following a prolonged stay in the facility.

Intake screening for suicide risk may be contained within the medical screening form or presented as a separate form. Inquiry during the screening process should determine the following:

- Was the youth a medical, mental health, or suicide risk during any prior contact and/or confinement within this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the youth is a medical, mental health, or suicide risk now?
- Has the youth ever considered suicide?
- Has the youth ever attempted suicide?
- Is the youth now being treated (or ever been treated) for mental health or emotional problems, such as depression or anxiety? Has the youth recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend of the youth ever attempted, or died by, suicide?
- Does the youth feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Is the youth thinking of hurting and/or killing him/herself?

Although verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on a youth's denial of suicidal intent and/or history of mental illness, particularly when behavior or previous confinement in the facility suggests otherwise. For such cases, the screening process must include referral procedures to qualified mental health and/or medical personnel for a more thorough and complete assessment.

As noted earlier, the risk of suicide is ever-present, so vigilance must continue after the intake screening process. Should any staff hear a youth verbalize a desire or intent to kill his/herself, observe a youth engaging in any self-harm, or otherwise believe a youth is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the youth is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

Finally, given the strong association between juvenile suicide and room confinement, any youth assigned to room confinement or any form of isolation/segregation should receive a written assessment for suicide risk by medical or mental health staff upon admission to the placement.

Referral/Arrest

Brief intake screening for suicide risk should be conducted while a youth is being held post-arrest by law enforcement agencies and prior to entry into a juvenile detention facility.

Courts

Juvenile court judges should ensure, to the extent feasible given system variances, that a valid and reliable screening instrument is used at critical points of contact (e.g., intake to juvenile detention).

Probation

Each probation department (and its officers) should be required to complete for each youth a validated trauma exposure/depression screening instrument that also addresses suicide risk.

Aftercare

Screening and assessment for suicide risk should be a vital component of the aftercare process and involve all of the critical partners noted above.

- Formal screening and assessment for suicidal ideation and/or behavior should be a part of continued probation/parole interaction, from the first meeting with a youth and repeated throughout supervision.
- Screening and assessment should be a part of school mental health services, with referral from correctional/detention placement, family members and other caregivers, school personnel, and/or community-based providers.
- Community primary and mental health care providers should provide screening and assessment services for youth exiting secure care.
- Screening should be conducted by parents and other caregivers from the time the youth returns home and continued indefinitely. Training for parents and caregivers can be provided by the secure care facility staff and/or by school-based and community mental health providers and should focus on screening procedures and practices most appropriate for the home setting.

Component 3: Communication

Certain behavioral signs exhibited by juveniles may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. Most suicides can be prevented by providers who establish trust and rapport with youth, gather pertinent information, and take action. Poor communication between and among direct care, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, courts, probation, and family members) is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts, and boundary issues.

Detention and Secure/Non-Secure Care Facilities

There are essentially three layers of communication necessary for preventing juvenile suicides during detention and in secure/non-secure facilities: (1) between the arresting/transporting officer and direct care staff; (2) between and among facility staff (including direct care, medical, and mental health personnel); and (3) between facility staff and the juveniles.

Suicide prevention in the juvenile justice system begins at the point of arrest. What juveniles say and how they behave during arrest, transport to the facility, and at intake are crucial in detecting risk of suicidal behavior. Direct care staff members rely on arresting/transporting officers to brief them on any pertinent information regarding the youth's well-being. It is also critically important for direct care staff to maintain open lines of communication with family members of the youth, who often have pertinent information regarding the mental health status of the youth.

The second layer of communication – among direct care personnel and other professional staff in the facility – directly influences the effectiveness of suicide prevention once youth are in the facility. Because youth can display warning signs at any point during confinement, direct care staff must maintain awareness, share information, and make appropriate referrals to qualified mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate direct care staff is properly informed of the status of each youth placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of all youth on suicide precautions. Multidisciplinary team meetings (to include direct care, medical, and mental health personnel) should occur on a regular basis to discuss the status of youth on suicide precautions. Finally, authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

To communicate with youth at risk of suicide (i.e., the third layer of communication), facility staff must hone skills such as: active sympathetic listening; staying with the youth if they suspect immediate danger; and maintaining contact through conversation, eye contact, and body language to show that they care. Direct care staff should trust their own judgment and observation of risk behavior and avoid being misled by others (e.g. mental health staff, other youth) into ignoring signs of suicidal behavior.

Referral/Arrest

The scene of arrest is often the most volatile and emotional time for the youth. Arresting and/or transporting officers should pay close attention to youth during this time. Suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers, such as family members and friends. Additionally, youth acting aggressively can be a warning sign of being impulsive. Communication of any intent is another warning sign.

The arresting/referring officer should communicate any concerns revealed during the brief intake screening process to the transport officer and detention facility intake staff. In addition, the arresting/referring officer should speak with family members about any concerns before transporting the youth to a detention facility, as well as speak with the youth using Crisis Intervention Team (CIT) training techniques about any suicidal ideas/thoughts or plans.

Courts

Judicially-led stakeholder meetings, held on a regular basis as part of quality enhancement efforts, can assist in improving communication and planning around suicide prevention.

Probation

Probation departments should establish a protocol for the sharing of results from any screening pertinent to suicide risk with the youth's parents/guardians and/or placement settings.

Aftercare

Regular, formalized communication between all agencies and individuals involved in the lives of youth leaving secure care is essential to providing a wraparound approach to suicide prevention during aftercare.

- The primary communication should always be between individuals caring for youth and the youth themselves. This communication should be friendly, supportive, and positive, helping youth overcome past trauma and feel connected to people who care about them.
- Communication between detention/secure care facility staff and probation/parole officers is critical for sharing previous screening and assessment results, past suicide attempts and self-injurious behavior, and any necessary treatment needs.
- Facility staff should communicate with parents and other caregivers to discuss the youth's time within the facility, any relevant screening and assessment results, and warning signs to heed.
- Parents and caregivers should likewise communicate with school- and community-based mental health providers to maintain open dialogue on the home behavior of youth and treatments they are receiving.
- Facility-based mental health staff should communicate with school- and community-based providers so that all are aware of each other and, to the extent possible, be able to communicate with each other about the youth they serve (if only in generalities).

Overall, memoranda of understanding/agreement should be established to create safe and effective information-sharing agreements between agencies, parents/caregivers, schools, and community providers. Youth and family privacy rights must be maintained, and agencies should work with family members to ensure relevant information is shared in an appropriate manner.

Component 4: Housing (Safe Environment)

Providing a safe environment for youth who are at risk for suicide may be the most observable, physical component of a comprehensive suicide prevention program. Special care must be paid to ensuring that opportunities for suicide or self-harm are minimized throughout the juvenile justice-processing continuum.

Detention and Secure/Non-Secure Care Facilities

In determining the most appropriate housing location for a suicidal juvenile, facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and, on occasion, restrain the individual. Such responses might be more convenient for staff, but they are detrimental to the youth because the use of isolation escalates the sense of alienation and further removes the youth from proper staff supervision. To every extent possible, suicidal youth should be housed in the general population, mental health unit, or medical infirmary and located close to staff. Removal of a youth's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, etc.) should be avoided whenever possible and used only as a last resort when the youth is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the youth, not on decisions that heighten depersonalizing aspects of confinement.

All rooms or cells designated to house suicidal youth should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility.

- Rooms or cells should not contain any live electrical switches or outlets; bunks with open bottoms; or any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging.
- Rooms or cells should contain tamper-proof light fixtures, smoke detectors, and ceiling/wall air vents that are protrusion-free.
- Each room or cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior.

Finally, each housing unit in the facility should contain various emergency equipment, including a first-aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Direct care staff should ensure that such equipment is in working order on a daily basis.

Referral/Arrest

Should a youth be held temporarily (including overnight) in a police department lockup or any other temporary facility, the place of confinement should be as safe and suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility (see details above). When a youth is transported to and from facilities and court proceedings, the vehicle should provide a similarly safe environment.

Courts

Juvenile court judges and administrators must remain mindful that system involvement is inherently stressful for youth. Court facilities – including holding cells and interview rooms – must be inspected and modified to ensure the physical safety of all youth (see general recommendations for ensuring a safe environment above).

Probation

Probation departments should inform and train parents and guardians as to the risk factors, protective factors, and warning signs associated with suicidal behaviors. Guidelines for means-restriction activities and descriptions of community resources (e.g., mental health resources, support groups, school-based resources, youth/recreation centers, churches, etc.) should also be provided. As a component of aftercare, probation is further discussed below.

Aftercare

The *home* will represent a major portion of a youth's post-release environment. It is an environment that is extremely difficult for the justice system to affect, though probation and parole officers can play a part by checking to make sure the home environment is as safe and supportive as possible. Parents and caregivers will need training on how to make the home safe and supportive for their children and be vigilant in watching for signs of possible suicidal and self-injurious behavior. A youth's time in isolation within the home should be limited and/or supervised to any extent possible, utilizing friends, family members, and other care providers whenever possible. After-school time is a particularly important time to make sure the youth is supervised and supported (especially in the absence of parents or caregivers).

Assuming they are still of school age, youth exiting secure care will likely spend much time in the *school building*. Compared to homes, most schools are more controlled, but they typically are not as controlled as the facility from which youth were discharged. All school staff should be aware of the risk for suicide

and self-harm in youth exiting secure care and be prepared to maintain a safe and supportive environment for such youth. Any school discipline policies that result in the isolation of youth should be discouraged. Minimally, such policies must take into account the potential for suicide attempts and self-harm and be monitored appropriately.

Youth's post-release life will likely also include time spent in *general community locations* (e.g., playgrounds, "Boys and Girls Clubs", etc.). While the hope is that these settings are safe and supportive, they nonetheless represent spaces in which youth could engage in suicidal or self-injurious behavior. The presence of caring and aware staff or other adults may act as a deterrent for such behavior. Additionally, the extent to which a youth's presence in such places is voluntary (rather than mandatory) might also decrease the likelihood of suicidal or self-injurious behavior. At the very least, all formal community center staff should have a basic awareness of suicide risk for youth exiting secure care and maintain a safe, supportive environment for such youth.

Similarly, *probation and parole offices* should be welcoming environments so as not to re-traumatize youth through continued system involvement. Though suicides within the confines of the office are less likely, youth's experience at the office may residually impact how they feel when they are not with their probation or parole officer. The more these experiences are viewed as positive and supportive, the less likely re-traumatization will occur.

Finally, *mental and medical service provider offices* are much like those of probation/parole officers and should be safe, supportive, and positive places for youth. It may be further traumatizing or stigmatizing to youth to have to report to these facilities for "treatment," so providers should be aware of this and work to mitigate the effects.

Component 5: Levels of Observation, Follow-Up, and Treatment Planning

Supervision of youth involved in the juvenile justice system ranges from constantly observing youth in secure care who are actively suicidal to determining the appropriate level of supervision necessary for youth in aftercare. In all cases, supervision is one aspect of the overall support that youth, particularly those at risk of suicide, need as they progress through the juvenile justice system.

Detention and Secure/Non-Secure Care Facilities

The promptness of response to suicide attempts in juvenile facilities is often driven by the level of supervision afforded the youth. Two levels of supervision are generally recommended for suicidal juveniles.

- **Close observation** is reserved for youth who are not actively suicidal but who express suicidal ideation (i.e., expressing a wish to die without a specific threat or plan) and/or have a recent history of self-destructive behavior. In addition, youth who deny suicidal ideation or do not threaten suicide but who demonstrate other concerning behavior (through actions, current circumstances, or recent history), indicating the potential for self-injury, should be placed under close observation. Staff should observe such youth in a protrusion-free room at staggered intervals not to exceed every ten minutes (e.g., five minutes, ten minutes, seven minutes).
- **Constant observation** is reserved for youth who are actively suicidal, either forming a specific plan or engaging in suicidal behavior. Staff should observe such youth on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every five minutes.

Other aids (e.g., closed-circuit television, roommates) can be used as a supplement to, but never as a substitute for, these observation levels. In addition, because the overwhelming majority of juvenile suicides are by hanging and death by hanging occurs in only a few minutes, observation under these levels will be safe only if the room or cell is suicide-resistant.

In addition to direct observation, mental health staff should assess and interact with suicidal youth on a daily basis. The daily assessment should focus on current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., “What are your current feelings and thoughts?” “Have your feelings and thoughts changed over the past 24 hours?” “What are some of the things you have done or can do to change these thought and feelings?”).

An individualized treatment plan (to include follow-up services) should be developed for each youth on suicide precautions. The plan should be developed by qualified mental health staff in conjunction with not only the youth, but medical and direct care personnel. The treatment plan should describe warning signs, symptoms, and the circumstances under which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the youth and staff will take if suicidal ideation reoccurs.

Finally, due to the strong correlation between suicide and prior suicidal behavior, in order to safeguard the continuity of care for suicidal youth, all youth discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is no nationally acceptable schedule for follow-up, an assessment schedule following discharge from suicide precautions to consider is: 24 hours, 72 hours, one week, and then once a month until release.

Referral/Arrest

Should youth be held temporarily (including overnight) in a police department lockup or any other temporary facility, they should be placed on either close or constant observation, as described above.

Courts

Consistent with the recommendations presented for detention and secure/non-secure care facilities above, juvenile court administrators should develop and maintain policies and procedures for supervising youth while in court facilities to ensure their safety and the safety of the public.

Probation

For a comprehensive approach to providing support to youth preparing to transition to life in the community, probation departments should integrate mental health services into their other services. A “coach” or mentor should be identified as a key player in the crisis response plan.

Aftercare

In supervising youth during the aftercare period, a balance must be struck between keeping youth safe (preventing suicidal behavior) and over-supervising them (possibly re-traumatizing them). Justice system-involvement is in itself traumatizing, and continued involvement with probation and parole officers may contribute to juveniles’ suicidal ideations or activity. Interaction with aftercare providers must be as supportive and positive as it is supervisory.

Parents and other caregivers will play a vital role in watching over, observing, and supporting their youth returning from secure care. It is important that all caregivers be equipped with the skills to do so

without being too overprotective and suffocating. Independence is important to youth and lack thereof could negatively impact their self-perceptions or otherwise contribute to suicidal thoughts and behaviors.

Parents and caregivers will need support from other family members, their child's peers, the school, and community partners to support and protect their child in the proper way and to the appropriate extent. The friends of a juvenile youth are often surprisingly effective in spreading protection and support, as they are typically regarded as allies who care about the youth, rather than authority figures looking to supervise or manage the youth.

Finally, teachers, school administration staff, and school mental health providers should all play a role in the supervision and support of youth during aftercare. Working together is essential to ensure that the school experience for the youth is positive and not too restrictive and/or overprotective. Receiving extra attention from school personnel may be stigmatizing to the youth and so must be mitigated appropriately.

Component 6: Intervention (Emergency Response)

As noted numerous times throughout this paper, a suicide attempt can occur at any of point of contact within the juvenile justice-processing continuum. It is therefore vital that providers from all points of contact be prepared to intervene with an emergency response. The degree and promptness of intervention, coupled with the efficiency of communication among relevant staff, often foretell whether the victim will survive a suicide attempt. Although not all suicide attempts require emergency medical intervention, *all* suicide attempts and other clear displays of intent should result in immediate intervention and assessment by qualified mental health staff.

Detention and Secure/Non-Secure Care Facilities

National correctional standards and practices, such as those published by the Council of Juvenile Correctional Administrators, the National Commission on Correctional Health Care, and the American Correctional Association, generally acknowledge that a facility's policy regarding intervention should be threefold:

- 1) All staff members who come into routine contact with juveniles should be trained in standard first-aid procedures and CPR.
- 2) Any staff member who discovers a youth engaging in a suicide attempt should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits staff from entering a room or cell without back-up support, the first responding staff member should, at a minimum, make the proper notification for back-up support and medical personnel, secure the area outside the room or cell, and retrieve the housing unit's emergency response bag (first-aid kit, pocket mask or face shield, Ambu-bag, and rescue tool).
- 3) Direct care staff should never presume that the victim is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Referral/Arrest

All staff who work in a police department lockup or any other temporary facility that houses youth should be trained in standard first-aid procedures and CPR. Facilities should follow the emergency response procedures described earlier.

Courts

Protocols for responding to a suicide or an attempted suicide on court grounds should be part of a court's emergency response plan. These protocols should include emergency-response procedures described earlier.

Probation

Probation departments should train staff on recognizing and responding to acute-risk situations, as well as chronic-risk situations, within both initial and annual training programs.

Aftercare

All agencies and individuals involved with youth exiting secure care should be versed in the statistics of suicide completion and suicide attempts by youth exiting secure care. Providers should recognize the vital role they play in preventing future suicides and be trained to act upon that responsibility. This preparation should include not only working knowledge of the practical steps to fully interrupt the act and protect the youth, but also awareness of the trauma that the situation may cause.

Component 7: Reporting and Notification

To facilitate more effective suicide prevention efforts in the future, documentation of suicide attempts and suicides must be completed. While the steps of this process are agency-specific, it can be generally stated that this component involves a) reporting to officials through the chain of command and b) notification of the family of the victim.

Detention and Secure/Non-Secure Care Facilities

In the event of a suicide or suicide attempt, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family and appropriate outside authorities should be immediately notified. All staff members who came into contact with the victim before the incident should be required to submit a statement, including their full knowledge of the victim and incident.

Referral/Arrest

In the event of a suicide attempt or a suicide in a police department lockup or any other temporary facility, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family, as well as appropriate outside authorities, should be immediately notified.

Courts

Juvenile court judges and administrators should participate in reporting data on major incidents involving suicide attempts and suicides by youth who are under court jurisdiction (from petition to disposition).

Probation

Probation departments should develop a central collection point for medically serious suicide attempts and suicides at state and national levels which can be evaluated to address acute- and chronic-risk patterns.

Aftercare

All agencies and individuals involved with youth exiting secure care should be trained on how to communicate any suicide or self-injury attempts or completion to the appropriate entities in the appropriate manner. To maintain awareness and promote vigilance, this information should be shared with relevant “stakeholders” to the degree confidentiality laws allow.

Component 8: Mortality-Morbidity Review

Suicide among youth involved with the juvenile justice system is devastating personally and professionally to providers and personally and socially to other youth. Debriefing and review should follow every completed suicide to not only address the extreme stress associated with the incident, but also to identify necessary revisions to policies and protocols.

Detention and Secure/Non-Secure Care Facilities

Juvenile suicide impacts both providers and youth. Direct care staff members who are involved, even indirectly, with a juvenile suicide may display misplaced guilt (e.g. “What if I had made my room check earlier?”). They may also feel ostracized by fellow personnel and administration officials. Youth in the facility can be equally traumatized by such critical events, which may lead to suicide contagion, especially with already vulnerable youth.

When crises occur in which staff and youth are affected by a traumatic event, they should be offered immediate assistance. Every suicide attempt, fatal or non-fatal, should be followed by active crisis management, including efforts to provide comfort and support to those who are affected by the event and to identify those in significant distress and provide them with individualized support or treatment. Assessment of factors leading to the suicide should seek to identify opportunities to improve policies and protocols.

In addition to this immediate attention to staff and youth in the facility, a multidisciplinary mortality-morbidity review process should be initiated for every completed suicide, as well as every serious suicide attempt (i.e., requiring medical treatment and/or hospitalization). Minimally, the review should include direct care, medical, and mental health staff. If resources permit, clinical review through a psychological autopsy is also recommended. Ideally, the mortality-morbidity review should be coordinated by an outside agency to ensure impartiality. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include a critical inquiry of:

- the circumstances surrounding the incident
- facility procedures relevant to the incident
- all relevant training received by involved staff
- pertinent medical and mental health services/reports involving the victim
- possible precipitating factors leading to the suicide or serious suicide attempt
- recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures

Referral/Arrest

All appropriate follow-up procedures should be followed, including the mortality-morbidity review described above.

Courts

Juvenile court judges and administrators should review major incidents of serious suicide attempts and suicides involving youth who are under court jurisdiction (from petition to disposition).

Probation

When youth are identified as engaging in suicidal behaviors, probation departments should conduct an immediate review of possible risk factors. If a crisis response plan was in place, its utilization should be assessed. If a response plan was not in place, reasons for its absence should be identified and discussed.

Aftercare

Ongoing support to all agencies and individuals involved with youth exiting secure care should be provided, especially in circumstances when suicides or self-injury take place within the “jurisdiction” or community. Any trauma experienced by aftercare providers due to such events should be addressed and appropriate backup support for youth should be available in the event that the usual personnel are unable to fulfill roles or obligations.

Conclusion

Due to the risk of suicide at all points of contact with the juvenile justice system, it is imperative that suicide prevention efforts begin at the time of arrest and continue throughout aftercare. The providers with whom youth will interact during this continuum of services are many and varied, but they must all share the goal of suicide prevention. This goal can be achieved by all providers through a comprehensive suicide prevention program involving the eight components described within this document:

- Training
- Identification; Referral; Evaluation
- Communication
- Housing (Safe Environment)
- Levels of Observation; Follow-Up; Treatment Planning
- Intervention (Emergency Response)
- Reporting and Notification
- Mortality-Morbidity Review

While each of these components should be tailored for the specific responsibilities and needs of the respective provider – i.e., staff of detention and secure/non-secure care facilities, referring/arresting officers, courts, parole and probation officers, and the many providers of aftercare – the shared goal of suicide prevention results in much useful overlap conducive to implementing consistent policy.

It should be further noted that, much like the providers of services, the components themselves are interrelated. For example, while the screening and assessment process provides an opportunity to identify suicide risk in juveniles, it can only be successful if the necessary training of staff is in place and communication throughout the facility or program regularly occurs. Simply stated, a multidisciplinary approach is *the* approach to suicide prevention for youth in contact with the juvenile justice system.

Appendix: Terms and Definitions

Close observation

Deliberate focus on a youth in a detention or secure/non-secure care facility who is not actively suicidal but meets one or more of the following: (1) has expressed suicidal ideation, (2) has a recent history of self-destructive behavior, (3) has denied suicidal ideation or threatened suicide but demonstrates other concerning behavior (through actions, current circumstances, or recent history), indicating potential for self-injury. Staff should observe such youth in a protrusion-free room at staggered intervals not to exceed every 10 minutes (e.g., five minutes, 10 minutes, seven minutes).

Constant observation

More intensive than close observation, constant observation is reserved for youth who are actively suicidal, either forming a specific plan or engaging in suicidal behavior. Staff should observe such youth on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every five minutes.

Continuous assessment

Intake screening and additional follow-up assessment of all juveniles that is critical to a facility's suicide prevention efforts. Assessment should not be viewed as a single event, but as an ongoing process. Youth can become suicidal at any point during confinement, including the initial admission into the facility; after adjudication and upon return to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; during confinement in isolation, segregation, and/or "time-out"; and following a prolonged stay in the facility.

Crisis Intervention Team (CIT)

A nationally-recognized program known also as the "Memphis Model" of pre-arrest jail diversion for individuals in a mental illness crisis. This program provides law enforcement-based crisis intervention training for helping individuals, including youth, with mental illness.

Denial of risk

When individuals who are suicidal misrepresent their condition by denying risk factors or attempting to refute what might appear to an observer as a suicide warning sign. Although verbal responses during the intake screening and subsequent screenings are critical for assessing suicide risk, staff should not exclusively rely on a youth's denial of risk, particularly when behavior or previous confinement in the facility suggests otherwise. For such cases, the screening process must include referral procedures to mental health and/or medical personnel for a more thorough assessment.

High-risk suicide periods

Times in which the likelihood of a suicide attempt is greater than normal, whether due simply to time of day or the day of the week, or due to a recent suicide attempt in the facility. Because suicides often occur during late afternoon/early evening hours or on weekends – generally outside the purview of program staff – direct care staff must be trained to thwart these incidents. Direct care staff members are often the only personnel available 24 hours/day; thus, they form the front line of defense in preventing suicides.

Intake screening

Inquiry done with the youth upon intake at a facility or confinement that covers the following questions: (1) Was the youth a medical, mental health, or suicide risk during any prior contact and/or confinement within this facility, (2) Does the arresting and/or transporting officer have any information (e.g. from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates that the youth is a medical, mental health, or suicide risk now, (3) Has the youth ever considered suicide?, (4) Has the youth ever attempted suicide?, (5) Is the youth now being treated (or ever been treated) for mental health or emotional problems, such as depression or anxiety, (6) Is the youth now being treated (or ever been treated) for mental health or emotional problems, such as depression or anxiety?, (7) Has the youth recently experienced a significant loss (relationship, death of family member/close friend, job, etc.), (8) Has a family member/close friend of the youth ever attempted, or died by, suicide, (9) Does the youth feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness?) and (10) Is the youth thinking of hurting and/or killing him/herself? See *Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification among Juvenile Justice Youth* for more information:

<http://actionallianceforsuicideprevention.org/system/files/JJ-6-R2-Screening-Assessment.pdf>.

Mock drills

Rehearsals aimed at increasing the efficiency of an emergency response to a suicide attempt. By incorporating mock drills into both the initial and refresher trainings for all staff, the likelihood that staff members understand how to best respond in the event of a suicide attempt will improve. Mock drills should allow all staff who have routine contact with youth to rehearse what to do in an event where standard first-aid and CPR are required of them.

Protective factors

Characteristics that decrease the likelihood that an individual will consider, attempt, or die by suicide. Examples include effective mental health care; connectedness to individuals, family, community, and social institutions; problem-solving skills, and contacts with caregivers.

Risk factors

Characteristics that increase the likelihood that an individual will consider, attempt, or die by suicide. Examples include prior suicide attempts, substance abuse, mental health disorders, history of trauma, previous system involvement, and access to lethal means (e.g., hanging).

Self-injury

Bodily harm inflicted upon oneself. One commonly seen form of self-injury is the cutting of one's skin. Although self-injury has the potential the result in death, it is often done to produce a numbing effect, rather than to result in death.

Shield of Care

An 8-hour curriculum developed by the Tennessee Department of Mental Health that teaches juvenile justice staff strategies to prevent suicide in their correctional facility environment. It is the first suicide prevention training for juvenile justice direct care staff that has been accepted into the BPR. It: (1) emphasizes that policy, connectedness to youth, and communication between staff are essential system-level elements of suicide prevention; (2) teaches staff specific steps of effective suicide intervention, and (3) provides opportunities for staff to reflect on internal policies

for prevention, discuss strategies for overcoming potential barriers, and plan how to take action in their setting.

Suicidal ideation

Persistent thoughts of, or wishes for, one's own death, without a specific threat or plan. Screening and assessment for suicidal ideation at all stages of contact with the juvenile justice system is a fundamental component of a suicide prevention-informed juvenile justice system.

Suicide contagion

When one suicide provides a model to follow for others who are suicidal. In detention and secure/non-secure care facilities, youth can be traumatized by critical events, including the suicide of another youth, which may lead to suicide contagion, especially among already vulnerable youth.

Suicide precautions

The management of youth identified as being at risk for suicide, to include, but not be limited to, provisions for safe housing, levels of observation, assessment/treatment by qualified mental health professionals, treatment planning, and follow-up treatment.

Suicide prevention training

Initial: An 8-hour training on suicide prevention that should be completed by all direct care, medical, mental health personnel, and any other staff who have regular contact with youth. Staff who have not yet received suicide prevention training should receive education about their role in creating a suicide prevention-informed juvenile justice system. This training should cover: (1) administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, (2) why the environments of juvenile facilities are conducive to suicidal behavior, (3) potential predisposing risk and protective factors related to suicide, (4) high-risk suicide periods, (5) juvenile suicide research, (6) warning signs of suicide, (7) identification of suicidal youth despite the denial of risk, (8) components of the facility's suicide prevention policy, and (9) liability issues associated with juvenile suicide. This training program should be followed each year with a 2-hour suicide prevention refresher training (described below).

Refresher: An annual 2-hour training to remind staff about what they learned during the initial, more in-depth suicide prevention training program. The refresher training covers topics including (1) administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, (2) a review of predisposing risk and protective factors related to suicide, (3) warning signs of suicide, (4) identification of suicidal youth despite the denial of risk, (5) review of any changes to the facility's suicide prevention policy, and (6) general discussion of any recent suicides and/or suicide attempts in the facility.

Treatment plan

A description of the signs and symptoms of suicide; circumstances under which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions that youth and staff will take if suicidal ideation reoccurs

Warning signs

Indications that an individual is at immediate risk of a suicide attempt. Warning signs include threatening to hurt or kill oneself, seeking a means to kill oneself, expressing feelings of hopelessness, increasing alcohol or drug use, and dramatic mood changes.

National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System. Washington, DC: National Action Alliance for Suicide Prevention.

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