

# Guide to Developing and Revising Suicide Prevention Protocols within Juvenile Facilities

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*All juvenile facilities, regardless of size, should have a comprehensive suicide prevention program that addresses several key components.*

## **Training**

The essential component to any suicide prevention program is properly trained direct care staff, who form the backbone of any juvenile facility. Very few suicides are actually prevented by mental health, medical or other professional staff because suicides are usually attempted in housing units, and often during late afternoon/early evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by direct care staff who have been trained in suicide prevention and have developed an intuitive sense about suicidal youth. Direct care staff are often the only personnel available 24 hours a day; thus, they form the front line of defense in preventing suicides.

All direct care, medical, and mental health personnel, as well as any staff who have regular contact with youth, should receive eight (8) hours of initial suicide prevention training, followed by two (2) 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 factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal youth despite the denial of risk, components of the facility's suicide prevention policy, and liability issues associated with juvenile suicide. The two-hour refresher training should include administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts; review of predisposing risk factors, warning signs and symptoms, identifying suicidal youth despite the denial of risk, and review of any changes to the facility's suicide prevention plan. The annual training should also include general discussion of any recent suicides and/or suicide attempts in the facility.

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

## **Identification/Referral/Evaluation**

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

In addition, although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, 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 any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.

Intake screening for suicide risk may be contained within the medical screening form or as a separate form. The screening process should include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting/transporting officer(s) belief that the youth is currently at risk. Specifically, inquiry 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?
- Have you ever attempted suicide?
- Have you ever considered suicide?
- Are you now or have you ever been treated for mental health or emotional problems?
- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Are you thinking of hurting and/or killing yourself?

Although an individual's 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 that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.

The process should also include referral procedures to mental health and/or medical personnel for a more thorough and complete assessment.

The intake screening process should be viewed as similar to taking your temperature, it can identify a current fever, but not a future cold. Therefore, following the intake screening process, should any staff hear a youth verbalize a desire or intent to commit suicide, observe a youth engaging in any self-harm, or otherwise believe the youth is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the individual 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.

The screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in juveniles. This process, coupled with staff training, will only be successful if an effective method of communication is in place at the facility.

### **Communication**

Certain behavioral signs exhibited by a juvenile may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most suicides can be prevented by direct care staff who establish trust and rapport with youth, gather pertinent information, and take action. There are essentially three levels of communication in preventing juvenile suicides: between the arresting/transporting officer and direct care staff; between and among facility staff (including direct care, medical and mental health personnel); and between facility staff and the suicidal juvenile.

In many ways, suicide prevention begins at the point of arrest. At *Stage 1*, what a youth says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting and/or transporting officers should pay close attention to the 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. Any pertinent information regarding the youth's well-being must be communicated by the arresting/transporting officer to direct care staff. It is also critically important for direct care staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of youth.

At *Stage 2*, effective management of suicidal youth is based on communication among direct care personnel and other professional staff in the facility. Because youth can become suicidal at any point during confinement, direct care staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate direct care staff are 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, the 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.

At *Stage 3*, facility staff must use various communication skills with the suicidal youth, including active listening, staying with the youth if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Direct care staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

Poor communication between and among direct care, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, 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. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

## **Housing**

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. These responses might be more convenient for all staff, but they are detrimental to the youth since the use of isolation escalates the sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal youth should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of a youth's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, straitjackets) 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. These rooms or cells should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In addition, the rooms or cells should not contain any live electrical switches or outlets, bunks with open bottoms, 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. 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.

## **Levels of Observation/Follow-up/Treatment Planning**

In regard to suicide attempts in juvenile facilities, the promptness of the response is often driven by the level of supervision afforded the youth. Medical evidence suggests that brain damage from strangulation caused by a suicide attempt can occur within 4 minutes, and death often within 5 to 6 minutes. Two levels of supervision are generally recommended for suicidal juvenile: close observation and constant observation.

*Close Observation* is reserved for the youth who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. In addition, a youth who denies suicidal ideation or does not threaten suicide, but demonstrates 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 a youth in a protrusion-free room at staggered intervals not to exceed every 10 minutes (e.g., 5, 10, 7 minutes).

*Constant Observation* is reserved for the youth who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such a 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 5 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, mental health staff should assess and interact with (not just observe) the suicidal youth on a daily basis. The daily assessment should focus on the 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?” etc.)

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 correctional personnel. The treatment plan should describe 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 not any nationally-acceptable schedule for follow-up, a suggested assessment schedule following discharge from suicide precautions might be: daily for five days, once a week for two weeks, and then once a month until release.

## **Intervention**

Following a suicide attempt, the degree and promptness of the staff's intervention often foretells whether the victim will survive. National correctional standards and practices generally acknowledge that a facility's policy regarding intervention should be threefold. *First*, all staff who come into routine contact with juveniles should be trained in standard first aid procedures and CPR. *Second*, any staff member who discovers a youth engaging in self-harm 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 cell without backup support, the first responding staff member should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the room or cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool). *Third*, direct care should never presume that the victim is dead, but rather should 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.

Finally, although not all suicide attempts require emergency medical intervention, *all* suicide attempts should result in immediate intervention and assessment by mental health staff.

## **Reporting/Notification**

In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff 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.

## **Critical Incident Staff Debriefing/Mortality-Morbidity Review**

A juvenile suicide is extremely stressful for both staff and other youth. Staff may also feel ostracized by fellow personnel and administration officials. Following a suicide, misplaced guilt is sometimes displayed by a staff member who wonders: "What if I had made my room check earlier?" Youth are often traumatized by critical events occurring within a facility. Such trauma may lead to suicide contagion. When crises occur in which staff and youth are affected by the traumatic event, they should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, comprised of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, mental health personnel), provides affected staff and youth an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment and/or hospitalization), should be examined through a mortality-morbidity review process. 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: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.