SUICIDE PREVENTION PROGRAM

Standard

The facility staff identifies suicidal juveniles and intervenes appropriately.

Compliance Indicators

1. A suicide prevention program includes the following:
   a. Facility staff identify suicidal juveniles and immediately initiate precautions.
   b. Suicidal juveniles are evaluated promptly by the designated health professional, who directs the intervention and ensures follow-up as needed.
   c. Acutely suicidal juveniles are placed on constant observation.
   d. Nonacutely suicidal juveniles are monitored on an unpredictable schedule with no more than 15 minutes between two checks. If, however, the nonacutely suicidal juvenile is placed in isolation, constant monitoring and observation is required.

2. Key components of a suicide prevention program include the following:
   a. Training
   b. Identification
   c. Referral
   d. Evaluation
   e. Treatment
   f. Housing and monitoring
   g. Communication
   h. Intervention
   i. Notification
   j. Review
   k. Debriefing

3. The use of other juveniles in any way (e.g., companions, suicide-prevention aides) is not a substitute for staff supervision.

4. Treatment plans addressing suicidal ideation and its reoccurrence are developed, and patient follow-up occurs as clinically indicated.

5. The responsible health authority approves the suicide prevention plan; training curriculum for staff, including intake screening for suicide potential and referral protocols; and training for staff conducting the suicide screening at intake.

6. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

Acutely suicidal (active) juveniles are those who engage in self-injurious behavior
or threaten suicide with a specific plan, or express a state of an immediate thought of completing suicide associated with imminent risk. These juveniles should be placed on constant observation.

Nonacutely suicidal (potential or inactive) juveniles are those who express current suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent prior history of self-destructive behavior. In addition, juveniles who deny suicidal ideation or do not threaten suicide but demonstrate other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury should be placed on suicide precautions and observed at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes).

Discussion

The intent of this standard is to ensure that suicides are prevented if at all possible. When suicides do occur, appropriate corrective action is identified and implemented to prevent future suicides.

While juveniles may become suicidal at any point during their stay, high-risk periods include immediately upon admission, after adjudication, after return to a facility from court, after the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one), prolonged stays in juvenile detention facilities, or after suffering humiliation (e.g., sexual assault) or rejection. Juveniles entering or unable to cope with segregation, other specialized single-room housing assignments, or room confinements (e.g., time-out, quiet time, separation) are at high risk for suicide. Youth placed in a room alone after an emotional outburst should be constantly monitored. In addition, juveniles who are in the early stages of recovery from severe depression may be at risk.

A treatment plan should be developed or revised for any juvenile expressing suicidal ideation. This treatment plan should be developed by the mental health staff in conjunction with the patient to address relapse prevention and initiate a risk management plan. The risk management plan should describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions the patient or staff can take if suicidal thoughts do occur.

Key components of a suicide prevention program include the following:
1. Training. All staff members who work with juveniles are trained to recognize verbal and behavioral cues that indicate potential suicide and how to respond appropriately. Initial and at least biennial training are provided, although annual training is highly recommended.
2. Identification. The receiving screening form contains observation and interview items related to potential suicide risk. If a staff member identifies someone who is potentially suicidal, the juvenile is placed on suicide precautions and is referred immediately to mental health staff.

3. Referral. There are procedures for referring potentially suicidal juveniles and those who have attempted suicide to mental health care clinicians or facilities. The procedures specify a time frame for response to the referral.

4. Evaluation. An evaluation, conducted by a qualified mental health professional, determines the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any change in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individual’s discharge from suicide precautions.

5. Treatment. Strategies and services to address the underlying reasons (e.g., depression, auditory commands) for the juvenile’s suicide ideation are to be considered. The strategies include treatment needs when the patient is at heightened risk to suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.

6. Housing. Unless constant supervision is maintained, a suicidal juvenile is not isolated but is housed in the general population, mental health unit, or medical infirmary, and located in close proximity to staff. All cells or rooms housing suicidal juveniles are as suicide-resistant as possible (e.g., without protrusions that would enable hanging).

7. Monitoring. There are procedures for monitoring a juvenile identified as potentially suicidal. Unpredictable, documented supervision is maintained, with intervals no more than 15 minutes apart. Although several protocols exist for monitoring suicidal juveniles, an actively suicidal juvenile (either threatening or engaging in self-injurious behavior) should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television) can be used as a supplement to, but never as a substitute for, staff monitoring.

8. Communication. Procedures for communication between mental health care, health care, and child care staff regarding juvenile status are in place to provide clear and current information. These procedures include communication between transferring authorities (e.g., local court system, county facility, medical/psychiatric facility) and facility child care staff.

9. Intervention. There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures.

10. Notification. Procedures state when correctional administrators, outside authorities, and family members are notified of potential, attempted, or completed suicides.
11. Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides are detailed, as are procedures for reporting a completed suicide.

12. Review. There are procedures for mental health, medical, and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) occurs. See Y-A-10 Procedure in the Event of a Juvenile Death for details.

13. Debriefing. There are procedures for offering timely debriefing to all affected personnel and juveniles. Debriefing is a process whereby individuals are given an opportunity to express their thoughts and feelings about an incident (e.g., suicide or attempt), develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms. Debriefing can be done by an in-house response team or outside consultants prepared to handle these highly stressful situations. There are different approaches to the debriefing process, including some highly confrontational or “forced interventions” methods. Such methods are not intended under this standard.

A psychological autopsy for each suicide should be completed within 30 days. The typical psychological autopsy is based on a detailed review of all file information on the juvenile; a careful examination of the suicide site; and interviews with staff, juveniles, and family members familiar with the deceased. (See Y-A-10 Procedure in the Event of a Juvenile Death; also see additional resources in the Standards and Resources section at www.ncchc.org.)

An active approach to the management of suicidal juveniles is recommended. In facilities where 24-hour mental health staff coverage is not present, designated health and/or child care staff should be able to initiate suicide precautions until the mental health clinician on call can be contacted for further orders. On the other hand, only designated qualified mental health professionals should be authorized to remove a juvenile from suicide precautionary measures.

A suicide or serious suicide attempt can be a stressful event for staff and other juveniles. Where feasible, persons trained in debriefing procedures should be used. Practical guidelines on the debriefing process are available from organizations such as the International Critical Incident Stress Foundation.

It is recommended that “cutting tools” be routinely issued to all staff or at least be readily available in all areas of the facility. These devices have been designed to be safe but effective instruments for interrupting a suicide by hanging.