



POSITION STATEMENT

Suicide Prevention and Management in Juvenile Correctional Settings

Introduction

Adolescent suicide in the general population is a national tragedy and a major public health problem (Carmona, 2005). For youth between the ages of 10 and 24, suicide is the second leading cause of death, resulting in more than 6,100 lives lost each year (Centers for Disease Control and Prevention, 2016). Youth involved in the juvenile justice system have high rates of exposure to trauma and adverse childhood experiences; they are at higher risk than the general population for suicidal ideation and attempts (Stokes, McCoy, Abram, Byck, & Teplin, 2015).

This position statement highlights the key components of a successful suicide prevention program in the juvenile correctional setting. A more comprehensive description can be found in NCCHC's *Standards for Health Services in Juvenile Detention and Confinement Facilities* (2015), standard Y-G-05 Suicide Prevention Program.

Position Statement

NCCHC recommends that all juvenile correctional facilities—including pre- and postadjudication, small and large, public and private—develop and implement a comprehensive suicide prevention program that takes into consideration the unique characteristics of adolescent suicide. The suicide prevention program should include all of the following key components:

1. Staff training in suicide prevention:
 - a. Includes all staff working directly with juveniles in the facility
 - b. Consists of an initial training as well as regular follow-up trainings at least every two years
 - c. Covers risk factors and red flags for adolescent suicide behaviors
 - d. Reviews the specific screening tool, resources, and policies of the facility
2. Identification of risk:
 - a. Uses a standardized suicide risk screening tool that clearly indicates a suggested level of monitoring
 - b. Takes place at the time of admission initially
 - c. Is continuously assessed throughout a juvenile's period of incarceration
 - d. Takes into consideration any acute changes in legal status or individual behaviors (e.g., fights, outbursts) that might impact risk acutely
 - e. Includes review, documentation, and communication of risk factors (especially history of past suicide attempts and history of trauma)
3. Communication about suicide risk and behaviors:
 - a. Is clearly outlined in any written policies and procedures
 - b. Takes place between youth, direct care staff, and clinical staff on an ongoing basis
 - c. Is documented clearly in staff logs and clinical notes
 - d. Must be passed on between shifts
4. Housing status:
 - a. Must be considered when reviewing suicide risk, including increased risk for youth on confinement status who are alone in their rooms and who require additional clinical monitoring
 - b. Considers potential safety risks inside the room, including available means for hanging, in particular, but also access to sharps, strings, linens, hygiene products, or other chemicals

5. Monitoring level system:
 - a. Consists of at least three levels based on suicide risk:
 - i. Constant observation with 1:1 staff supervision – associated with highest risk
 - ii. Close observation with frequent checks by staff at 5- to 10-minute intervals – associated with moderate risk
 - iii. Routine observation with checks by staff at 15- to 20-minute intervals – associated with low risk
 - b. May include supplemental monitoring through video cameras, which must not replace the above in-person checks by staff
 - c. Includes a process for monitoring with an open door for patients at the highest risk
 - d. Is determined and reevaluated by clinical staff at least daily, including review by a psychiatrist when appropriate to consider inpatient psychiatric hospitalization or medication trials
 - e. Is clearly communicated to staff in terms of both individual status and facility protocols
 - f. May never be used as punishment or retaliation, nor include unnecessary isolation or removal of comfort measures unless determined necessary for safety reasons by clinical staff
6. Intervention strategies:
 - a. Make tools, such as cutting tools, immediately available to staff for use if they find a youth engaging in hanging behavior
 - b. Train clinical staff in evidence-based treatment approaches for working with suicidal and self-injurious adolescents
 - c. Incorporate short-term and long-term treatment planning, in the form of a multidisciplinary treatment plan, by clinical staff
 - d. Require clinical evaluation and recommendations prior to the removal of any standard privileges (e.g., clothing, hygiene, school or recreational activities)
 - e. Document roles and strategies for multidisciplinary team members, including direct line staff, in addressing the suicidal or self-injurious thoughts and behaviors while the patient is being stabilized
7. Postincident review process:
 - a. Takes place as soon as possible after any suicide or near-miss event
 - b. Includes a formal, multidisciplinary sentinel event review that takes a root-cause analysis approach to understanding the factors that contributed to the event and identifying potential systemwide improvements that might prevent future events
 - c. Incorporates appropriate debriefing for all staff involved in the incident
 - d. Considers any potential impact of the incident on other youth in the facility

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October 2012 — reaffirmed with revision

October 2019 — reaffirmed with revision

Note: Earlier versions of this statement were titled Prevention of Juvenile Suicide in Correctional Settings.

References and Resources

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