Suicide Prevention for Juvenile Justice Populations

Recommended Training Content and Resources for Juvenile Justice Staff in Detention, Courts, and Probation

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Table of Contents

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1. INTRODUCTION

1.1 Purpose and Target Audience

Youth suicide is a **significant, yet preventable, public health issue**. Suicide is the second leading cause of death among young people ages 10-19. Youth involved in the juvenile justice system are at even higher risk – suicide is the leading cause of death for youth in confinement. However, there are steps we can take to help prevent youth suicide. **Public awareness** of the problem is an important catalyst for action. **Education** about suicide risk factors, protective factors, and warning signs can help adults identify youth who may be at risk for suicide. **Training** in suicide prevention skills enables adults to refer youth in crisis to appropriate mental health services or intervene in case of a suicide attempt.

The Illinois Department of Public Health (IDPH) coordinates statewide suicide prevention efforts. IDPH received federal funds through the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement statewide youth suicide prevention and early intervention strategies, grounded in public-private collaboration. The Illinois Suicide Prevention Alliance, a Director-appointed board, provided guidance. One of the grant strategies was to enhance systems capacity to implement suicide prevention strategies within the juvenile justice system. Training and education occurred in three systems of care: higher education, substance use prevention and treatment, and juvenile justice on various prevention measures they can implement within their system. To address the juvenile justice system, IDPH and the Illinois Public Health Institute (IPHI) convened an ad-hoc committee of experts with backgrounds in suicide prevention and/or juvenile justice administration to produce this document.

The purpose of this document is to provide an overview of key content and resources related to suicide prevention in the juvenile justice population. The key content and resources can be integrated into existing staff training and professional development materials to ensure timely access to suicide prevention strategies. Greater awareness, education, and training for staff working with youth are key strategies in suicide prevention.

The National Action Alliance for Suicide Prevention's Youth in Contact with Juvenile Justice System task force identified three target audiences within juvenile justice: **detention**, **courts**, and **probation**. While there are other points of contact in the juvenile justice system (for example, law enforcement) that need suicide prevention training, this project only focused on identifying key content and resources for training juvenile justice staff in detention centers, courts, and probation. Please refer to Appendix A.5 for information on best practice training programs for a variety of other important audiences who work with youth.

This information was compiled based on current resources and ad hoc committee recommendations. Research and best practices, however, evolve and it is necessary to remain current with the growing body of knowledge as it relates to best practices, training, and policy.

Readers are responsible for assessing the relevance and accuracy of the content of this publication. IPHI, IDPH, and the ad hoc committee will not be liable for any loss, damage, cost, or expense incurred or arising by reason of any person using or relying on information in this publication. This content is intended as a resource to supplement training content provided to staff and may also aid management or administration in policy and practice revisions and updates.

Source Documents
While there is good deal of literature related to suicide prevention, this document relies most on three leading resources for suicide prevention specific to juvenile justice populations. **We encourage readers to obtain and reference these documents as they include tools, training activities, and more in-depth content** beyond what is provided in this document.

1) *Shield of Care: A System-Focused Approach to Protecting Juvenile Justice Youth from Suicide*, developed by the Tennessee Department of Mental Health (TDMH).
TDMH Shield of Care Link

2) *Preventing Suicide: Working with Youth Who Are Justice Involved*, developed by the National Action Alliance for Suicide Prevention (NAASP).
NAASP Preventing Suicide Link

3) *Training Curriculum and Program Guide on Suicide Detection and Prevention in Juvenile Detention and Correctional Facilities*, developed by Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives (NCIA).
NCIA Curriculum and Program Guide Link

1.2 Terminology

For effective collaboration and communication, it is important to have a common understanding of the terminology related to suicide prevention. Additional terms are defined throughout the document and provided in Appendix A.1.

Terms to Remember[1]

- **Suicide:** Self-inflicted death with evidence (either explicit or implicit) that the person wanted to die.
- **Suicide Attempt:** Self-injurious behavior with a non-fatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die.
- **Serious Suicide Attempt:** (For morbidity review purposes) Self-injurious behavior that necessitates medical treatment and/or hospitalization outside the facility.

[1] Terminology was adapted from Hayes, L.M. (2013); Massachusetts Coalition for Suicide Prevention; and SAMHSA. (2014).

- **Aborted Suicide Attempt:** Potentially self-injurious behavior with evidence (either explicit or implicit) that the person intended to die but stopped the attempt before physical damage occurred.
- **Suicidal Ideation:** Thoughts of serving as the agent of one's own death. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent.
- **Suicidal Gesture:** Low lethality, self-injurious behavior generally associated with seeking attention and/or sympathy from others. May include intent to die and can become life-threatening if ignored and/or inadequately responded to by others.
- **Suicidal Intent:** Subjective expectation and desire for a self-destruction act to end in death.
- **Lethality of Suicidal Behavior:** Objective danger to life associated with a suicide method or action. Note that lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous.
- **Ligature points:** Elements in an environment that could be used to support a noose or other strangulation devices (especially, for a suicide attempt).
- **Deliberate Self-Harm:** Willful self-infliction of painful, destructive, or injurious acts without intent to die.
- **Suicide Precautions:** Actions taken to ensure the safe management of suicidal youth, includes (but not limited to) observation, housing, and assessment.
- **Suicidality**: A term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.
- **Suicide Attempt Survivors**: Individuals who have survived a prior suicide attempt.
- **Suicide Rate**: A rate of five suicide deaths per 100,000 means that there are five suicides for every 100,000 of that specific population.
- **Suicide Survivors**: Immediate and extended family members, significant others, acquaintances, co-workers, and others who have experienced the loss of a loved one due to suicide.
- **Culturally Appropriate:** The ability of an organization or program to be effective across cultures, including the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.
- **Trauma:** Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

2. SUICIDE FACTS

Suicide among youth is an important social and clinical concern. Rates among incarcerated youth are even higher than the general population and represent a specific area of social importance.[2] The following section provides **awareness** of the scope of the problem, which is an important part of suicide prevention in any setting.

2.1 Youth Suicide in the General Population

From 1999 through 2014, the suicide rate among all ages in the United States increased 24 percent, from 10.5 to 13.0 per 100,000 population, with the pace of increase greater after 2006.[3] Rates among youth and young adults ages 10-24 also increased during this period, with the greatest rate increase among females ages 10-14.

In the United States…	**In Illinois…**
	
Suicide is the **2nd** leading cause of death among youth ages 10–19.[4]	Suicide is the **2nd** leading cause of death among youth ages 10-14, and the **3rd** leading cause of death among youth ages 15-19.[4]
About **9 percent** of high school students attempted suicide in 2014.[5]	About **10 percent** of high school students attempted suicide in 2014.[5]
Nearly **106,000** youth ages 10-18 were treated in emergency rooms for self-harm injuries in 2014.[6]	Over **3,300** youth ages 10-18 were treated in emergency rooms for self-harm injuries in 2014.[7]
Suicide rates among females ages 10-14 have **tripled from 1999 to 2014**.[8]	
Males are more likely to die by suicide and **females** are more likely to attempt suicide.[9]	
Approximately **2 out of 3 of all suicide victims communicate their intent** some time before death, and **prior risk of suicide is strongly related to future risk**.[10]	

[2] NAASP. (2013). *Need to Know: A Fact Sheet Series on Juvenile Suicide.*
[3] Curtin, S.C., Warner, M., & Hedegaard, H. (2016).
[4] CDC, National Center for Injury Prevention and Control. *National Suicide Statistics, 2014*.
[5] CDC. *Youth Risk Behavior Surveillance System (YRBSS), 2015*.
[6] CDC, National Center for Injury Prevention and Control. *Nonfatal Injury Data, 2014*.
[7] IDPH, Division of Patient Safety.
[8] Curtin, S.C., Warner, M., & Hedegaard, H. (2016).
[9] NAASP. (2013). *Need to Know: A Fact Sheet Series on Juvenile Suicide.*
[10] Hayes, L.M. (2013).

Additional At-Risk Populations

The 2012 National Strategy for Suicide Prevention has recognized the following populations as having an increased risk for suicidal behaviors:[11]

- Individuals with mental and/or substance use disorders
- Individuals bereaved by suicide
- **Individuals in justice and child welfare settings**
- Individuals who engage in non-suicidal self-injury
- Individuals who have attempted suicide
- Individuals with medical conditions
- Individuals who are lesbian, gay, bisexual, or transgender (LGBT)
- American Indians/Alaska Natives

In addition, studies suggest that some individuals with intellectual disability may be at higher risk for suicidal ideation and suicide attempts.[12] Individuals with a propensity for violent behavior[13] and those with a history of trauma[14] are also at higher risk for suicide. Section 3 provides information on risk and protective factors.

Youth may be members of more than one group, compounding their risk for suicide. Many members of these groups also become involved in the juvenile justice system. Involvement in the juvenile justice system is, for virtually all youth, a stressful, anxiety-laden experience. This, in turn, can contribute to feelings of hopelessness, depression, and desperation. Recognizing that youth who come to the juvenile justice system often have a range of preexisting vulnerabilities can be helpful in identifying those most at-risk.

2.2 Suicide among Youth Involved with Juvenile Justice

The National Action Alliance for Suicide Prevention (NAASP) provides the following information on youth in the juvenile justice system:[15]

- Suicide is the **leading cause of death for youth in confinement.**
- Youth in residential facilities have nearly **three times the suicide rate of peers** in the general population.
- **Risk factors** for suicide are often **more prevalent among youth in the juvenile justice** system. (For more information on risk factors, see Section 3)

Several studies have examined suicidal ideation and behavior in delinquent youth. Data are limited for some points of contact, with the most data available on youth in confinement. Data suggest, however, that youth who are more deeply involved in the juvenile justice system have

[11] U.S. HHS and NAASP. (2012).
[12] Batty, G. et al. (2010) and Merrick, J. et al. (2005).
[13] Zagar, R.J. et al. (2016).
[14] See Section 3.2.3 for more information on trauma.
[15] NAASP. (2013). *Need to Know: A Fact Sheet Series on Juvenile Suicide*.

higher prevalence rates of suicidal ideation and behavior than youth who are not as deeply involved. A 2015 article in the Journal of Correctional Health Care finds:[16]

- **Suicidal ideation and attempts** are generally **more prevalent among post-adjudicated youth** than pre-adjudicated youth.
- **Suicidal ideation and attempts** tend to be **more prevalent among youth assessed during correctional stays** than those assessed at intake.
- Youth sampled during stays in **post-disposition secure facilities** appear to have the **highest prevalence rates of suicidal ideation and attempts**.

Many misconceptions exist about youth suicide that can impede staff from taking preventative measures. Understanding the facts about youth suicide is an important first step in prevention. The National Center on Institutions and Alternatives (NCIA) curriculum offers the following list of facts to counter common misconceptions about suicide among youth involved with juvenile justice:[17]

- Many youths who die by suicide have made either **direct or indirect statements indicating their suicidal intentions**.
- Although youth can be impulsive, **most suicidal acts represent a carefully thought out strategy for coping with various personal problems.**
- **More than two-thirds** of youth who die by suicide had a history of suicidal behavior, either an attempt, threat, or self-injury.
- **Most suicidal youth have mixed feelings about killing themselves. They are ambivalent about living, not intent on dying.**
- **You cannot make someone suicidal** when you show your interest in his or her welfare by discussing the possibility of suicide.
- Contrary to common belief, youth suicides have an even distribution throughout the year and **not closely associated with a particular holiday.**
- **Interpreting self-injurious behavior as manipulative** does not automatically make such behavior less dangerous or less lethal.
- Most experts agree that once a youth becomes suicidal, their **written or verbal assurances are no longer sufficient to counter suicidal impulses**.
- There are several reasons **why a youth may deny they are suicidal** at the point they are asked the question, and we must be very careful in how we respond to the denial.
    - Examples of why a youth may deny they are suicidal:
        i. How questions are asked (e.g. loaded questions that could be perceived as judgmental such as, “You’re not suicidal, are you?”)
        ii. Situation in which questions are asked (e.g. as they are coming into a facility, not in a private setting, etc.)
        iii. Unable/unwilling to articulate thoughts; overwhelming emotions influence answers
        iv. Previously hospitalized and do not want to go back

[16] Stokes, M.L. et al. (2015).
[17] Hayes, L.M. (2013).

v. Do not want to be ridiculed or ostracized by peers
vi. Want to avoid any punitive aspect of suicide precautions (i.e. hospital gown, suicide smock, etc.)

3. RISK FACTORS AND WARNING SIGNS FOR YOUTH SUICIDE

All individuals who work with justice-involved youth should be able to **identify warning signs** (ideation, terminal statements, etc.), **understand suicide risk factors** (historical, health, and environmental), and **identify signs of depression** (behavioral and physical) to make **informal assessments** of youth at risk for suicide.[18]

3.1 Terminology[19]

- **Cumulative Risk Factors**: A series of risk factors that occur over time or compound. This may heighten the intensity and severity of a youth's risk for suicide. Cumulative risk factors are not always evident and require a life evaluation.
- **Depression:** A mental health status, which identifies a mood impairment or disorder of an individual.
- **Hopelessness:** A feeling in which a youth perceives or believes they have no alternatives or solutions to their life circumstances and are powerless within their life or environment.
- **Mental Illness:** A clinically diagnosed or recognized impairment or disorder of the brain.
- **Protective Factors:** Include internal and external qualities, characteristics, and systems, which provide emotional and physical support to youth and are associated with the reduced potential for suicide.
- **Risk Factors:** Antecedent behaviors, traumatic experiences and/or mental status.
- **Suicidal Behavior:** Any act (talking about, making plans to, or engaging in activities) that demonstrates a youth's intent to die.
- **Suicide Contagion:** A process by which exposure to the suicide or suicidal behavior of one or more persons triggers a cluster of subsequent suicides and/or suicidal behavior.
- **Suicidal Ideation:** Thoughts of serving as the agent of one's own death. Suicidal ideation may vary in seriousness depending on specificity of suicide plans and the degree of suicidal intent. Can be active ("I feel like killing myself") or passive ("I wish I were dead").
- **Suicide Plan:** The design of how a youth intends to kill himself or herself that includes the detail of method, time, and place.
- **Warning Signs:** Warning signs are those signs that indicate the possibility of an imminent suicidal crisis.

3.2 Understanding Youth Development

Adolescence is a time of rapid growth and development. Adult and adolescent brains work differently – the connections between the emotional and decision-making parts of the brain are still developing.[20] This can affect thinking patterns and can play a factor in suicide risk. Additionally, traumatic events that happen in a young person's life can have a profound impact

[18] TDMH. (2012).
[19] Terminology was adapted from Hayes, L.M. (2013) and TDMH. (2012).
[20] University of Rochester Health Encyclopedia.

on their development. Understanding youth development can show us ways to help youth who may be struggling with thoughts of suicide.

3.2.1 Thinking Patterns Associated with Suicidal Youth

Negative thinking patterns can lead a youth to believe that suicide is the only answer to their problems. Below are examples of what these thinking patterns may sound like:[21]

- **Rigid thinking:** This is an all or nothing thinking pattern.
  - Typically, "if…then" statements. If X does or doesn't happen, I will do Y.
  - "If my dad doesn't come see me by my birthday, I'm giving up."
  - "If I don't get out of here, I will go crazy."
- **Overgeneralizing:** Taking an incident, experience, feeling, etc. and extending it to an unreasonable conclusion.
  - "See, she missed the meeting. She doesn't care and no one else does either."
  - "I can't do this. I can't do anything right."
  - "I've been in this stinking place for years, and no one will ever talk to me."
- **Catastrophizing:** Taking something and making it a catastrophe.
  - "I have nothing to look forward to. I might as well be dead."
  - "People don't care about anyone except themselves."
  - "I'll never get out of here."
- **Terminal statements:** Any statement that hints of death or suicide.
  - "I might as well just kill myself,"
  - "I just can't take it anymore."
- **Perfectionism:** Maintaining an unreasonable high standard or expectations.
  - "An A- is the same as an F."
  - "There's no room for error."
- **Minification:** Minimizing strengths or resources.
  - "*Nobody* likes me."
  - "I've got *nothing*, there's no reason *anyone* would like me."
  - "I'm *totally* stupid."
- **Magnification:** A tendency to view problems as larger and more ominous than they actually are.
  - "I can't take this anymore, not one more second."
  - "This has to end!" (View of the situation or problem as intolerable)
  - "This is too much for me", "I can't handle it" (View of oneself as lacking the ability to manage it)
  - "There's no way out", "There's nothing I can do" (Viewing the problem as unsolvable)
  - "I'll *never* get out" (Viewing the problem as unending)

[21] Adapted from TDMH. (2012) and contributions from committee member Mark Reinecke, Director of the Child and Adolescent Mood (CAM) Lab at Northwestern University.

3.2.2 Healthy Attachment to Others

The Shield of Care training states that **a key factor related to a secure identity is healthy attachment**. Attachment means a lasting bond with another characterized by mutual trust, support, and emotional connection.[22] Those with a history of suicidal ideation and attempts have often had unavailable or insensitive caregivers[23] and have not experienced healthy attachment. **Youth who struggle to develop a stable and secure identity are more likely to be poor problem solvers and are at increased risk of suicide**.[24]

Developing supportive relationships with youth makes it easier for them to accept help in a crisis. Adults and peers can help youth build confidence in their ability to solve small problems, which can make it easier to solve larger problems in the future. **Supportive and secure connections are a strong protective factor against suicidal ideation and behavior**.[25]

3.2.3 History of Trauma

Trauma can disrupt normal development in a young person. **Exposure to trauma can increase the risk of depression, suicide attempts, or suicide completion**. Here are some signs that a youth may have been traumatized in the past:[26]

- Youth may overreact (fight/flight) to stress
- Youth may under-react (be paralyzed by fear/go numb) to stress
- Youth may have difficulty trusting others
- Hyperarousal (on edge – waiting for something to go wrong)

[22] Armsden, G.C. & Greenberg, M.T. (1987).
[23] West M.L. et al. (1999).
[24] Stillion, J.M. & McDowell, E.E. (1991).
[25] TDMH. (2012).
[26] TDMH. (2012).

It is important to distinguish between **acute** and **chronic** trauma, also known as Type I, Type II, and Type III. The following table details the differences between each.

Types of Trauma			
Trauma	Type I	Type II	Type III
Definition	Single blow trauma (acute)	Long standing exposure to persistent overwhelming events (chronic)	Multiple & pervasive violent events beginning at an early age & continuing for years (chronic)
Example	A single incident like an accident, witnessing a murder, or some other one-time event.	Multiple occurrences like domestic violence or parental or caretaker physical or sexual abuse, workplace harassment, persistent cyberbullying, or a series of stressors over time.	Stress is many events before the age of four and clearly antecedent to the development of the human brain's capacity to accommodate to stress; this kind of stress often results in dissociative disorders, extreme mental confusion, memory failure to recall the stress, serious mental illness, and other symptoms co-occurring with violence.
Clinical Issue	Victims have full detailed memory and are likely to be recognized because the victim can recount the traumatic incident.	Victims have full detailed memory and are likely to be recognized because the victim can recount the traumatic incident.	Victims are often not even identified as victims; they are likely to be misdiagnosed on the basis of the long-term effects of the experiences they frequently cannot remember with a full and detailed account because of dissociation and their habitual coping tactics.
Adapted from Garbarino, J. (2015). *Listening to Killers*. University of San Francisco Press.			

The Importance of a Trauma-Informed Approach

Research has clearly demonstrated a powerful **correlation between the experiences of trauma** and the development of **serious, chronic behavioral health problems such as mental and substance abuse disorders**.[27] For example, childhood sexual and physical abuse has been linked with negative outcomes later in life such as engaging in risky health behaviors, poor mental health, self-rated unhappiness, and four to five times higher rates of suicide attempts.[28] Additionally, while estimates on prevalence vary, there is strong evidence which indicates **the majority of individuals involved in the criminal justice system have a history and/or are currently enduring traumatic experiences**.[29] For example, in a recent jail diversion study, 96 percent of women and 89 percent of men reported lifetime trauma which was defined as exposure to violence, physical assault, and sexual assault. Additionally, 74 percent of women and 86 percent of men reported experiencing trauma within the past 12 months.[30] The strong relationship between these mental and behavioral disorders, justice involvement, and trauma provides practitioners a centralized explanatory model regarding what is driving such self-destructive behaviors.

Keeping all of this in mind, when working with youth who are involved in the justice system and demonstrate suicidality, a prudent attitude to have is what SAMHSA calls a **universal assumption of trauma**. This assumption anticipates that all who are justice-involved likely have a history of trauma, so criminal justice professionals should take universal precautions to understand how specific behaviors, such as suicidality, may be related to trauma and to respond in ways that promote recovery and avoid potential re-traumatization. This is called a **trauma-informed approach** and is considered best practice. The trauma-informed approach is founded on the "Four R's" of ***realization***, ***recognition***, ***response***, and ***resisting re-traumatization***. SAMHSA describes it as:

> a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[31]

Services and supports should incorporate the six guiding principles on which the trauma-informed approach is based:

- **Safety**: Staff and youth feel physically and psychologically safe
- **Trustworthiness and transparency**: Organizational decisions are transparent and aim to build trust with clients, family members, and staff
- **Peer support**: Peer support builds safety, trust, hope, and promotes healing and recovery
- **Collaboration and mutuality**: Leveling of power differences engenders relationships and shared decision-making
- **Empowerment, voice, and choice**: Recognize individual strengths and experiences and include client in determining the plan of action to heal
- **Cultural, historical, and gender issues**: Incorporate policies, protocols, and processes that are responsive to gender, race, ethnicity, culture, and historical trauma

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[27] SAMHSA. (2014).
[28] Draper, B. et al. (2008).
[29] SAMHSA. (2014).
[30] Cusack, K.J. et al. (2010).
[31] SAMHSA. (2014).

3.3 Risk Factors for Youth Suicide[32]

Risk factors for suicide are a **combination of individual, relational, community, and societal factors** that contribute to the risk of suicide. Risk factors are those characteristics associated with suicide, though they might not be direct causes.[33]

It is important to note that **risk factors and warning signs are different**. Risk factors are **characteristics or conditions** that increase the chance that a person may try to take their life.[34] Warning signs are those **signs that indicate the possibility of an imminent suicidal crisis**.[35] Someone who has many risk factors for suicide may not show warning signs, and someone who shows warning signs may not have any apparent risk factors. In some cases, a youth may not show warning signs or have any apparent risk factors but still be at risk for suicide. Being able to tell the difference between a risk factor and a warning sign is important for communicating about suicide risk.[36]

The concept of risk factors is used across many disciplines, including medicine and criminal justice. Those in the criminal justice field are likely familiar with risk factors for delinquency, which increase the chances a youth will engage in criminal behavior.[37] Risk factors for youth suicide and youth delinquency may overlap, much like physical inactivity may increase your risk for developing various adverse health conditions, such as cardiovascular disease, depression, or cancer.

Most individuals who attempt suicide are *not* violent or aggressive.[38] Many factors which place individuals at-risk for aggression (including early trauma or exposure to violence, and specific genetic or biological vulnerabilities) may also be associated with an increased risk of depression and suicide.[39] Moreover, a subset of suicidal teens are motivated not by feelings of depression or hopelessness, but by a desire for attention or revenge. They are motivated by a desire to "get back at them" and to "make them pay." These individuals frequently show symptoms of both depression and Oppositional-Defiant Disorder or Conduct Disorder and tend to make impulsive suicide attempts.[40]

Regardless, **all suicidal behavior should be taken seriously** no matter the underlying cause.

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[32] Risk factor lists were adapted from AFSP. *Risk Factors and Warning Signs*; Dore, M.M. et al. (2006); Hayes, L.M. (2013); and CDC, National Center for Injury Prevention and Control. *Suicide Risk and Protective Factors*.
[33] CDC, National Center for Injury Prevention and Control. *Suicide Risk and Protective Factors*.
[34] AFSP. *Risk Factors and Warning Signs*.
[35] TDMH. (2012).
[36] SPRC & Rodgers, P. (2011).
[37] Development Services Group, Inc. (2015).
[38] Wilkins, N. et al. (2014).
[39] Gould, M.S. et al. (2009) and Shaffer, D. et al. (1996).
[40] Freeman, A. & Reinecke, M. (1994).

3.3.1 Historical Risk Factors

- Prior suicide behavior (including non-suicidal self-injury)
- Threats to kill himself or herself
- Family history of suicide behavior
- Personal history of abuse and/or trauma (see Section 3.2.3)

3.3.2 Health Risk Factors

- Mental health condition
    - Depression (see "Symptoms of Depression" below)
    - Hopelessness
    - Substance use/addiction
    - Other conditions
        - Substance use disorders
        - Bipolar disorder
        - Schizophrenia and psychosis
        - Personality traits of aggression, mood changes, and poor relationships
        - Conduct disorder
        - Anxiety disorders

Symptoms of Depression

Depression is the most common form of mental illness identified with completed suicides. Signs and symptoms of depression in youth are similar to those in the general population but are often overlooked or misdiagnosed as normal youth behavior or conduct disorder. **The primary indicator for depression is a noticeable change in baseline behavior**. Some possible signs and symptoms of depression include:

- Lack of appetite
- Overeating
- Insomnia
- Hypersomnia
- Lack of energy, fatigue
- Agitation, irritability, or aggression
- Low self-esteem or self-worth
- Poor concentration
- Lack of interest in activities
- Feelings of hopelessness
- Pervasive thoughts of self-harm, suicide, or homicide
- Somatic complaints
- Isolation or withdrawal from normal activity or groups
- Verbal indicators ("I feel…")
- Marked changes in attitude
- Marked changes in performance
- Marked changes in relationships

Adapted from Hayes, L.M. (2013). *Training Curriculum and Program Guide on Suicide Detection and Prevention in Juvenile Detention and Correctional Facilities.*

(3.3.2 Health Risk Factors continued)

- Barriers to accessing mental health treatment
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts
- Sexual orientation[41]
- Personality traits
    - Impulsive
    - Oppositional (manipulation)
    - Impressionable
    - Immediate and/or concrete
    - Rigid
    - Emotionally needy
- Physical illness/complaints
    - Chronic health condition or pain
    - Traumatic brain injury

3.3.3 Environmental Risk Factors

- Cultural prevalence
    - History or increased incidence of suicide within culture can make youth predisposed to the concept of suicide
    - How a culture communicates about suicide will impact a youth's belief system
    - Youth sub-culture – the behavior and communications of friends and peers – can influence youth values, beliefs, and behavior
- Curiosity and/or obsession with death and violence
- Access to lethal means
- Stressful life events or loss (relational, social, work, or financial)
- Exposure to another person's suicide
- Room confinement (specific to detention facilities – discussed more in Section 8.2)
- Primary caregiver suffers from mental health, substance abuse problems, or is involved in intimate partner violence

3.3.4 High Risk Periods in Confinement

- Withdrawal from drugs and/or alcohol
- Court or other legal hearing
- Personally significant date for each youth (like a birthday)
- Return to detention or confinement
- Receipt of bad news
- Impending release and/or transfer

The Lane County Model offers specific tips to front line staff about how to help youth during high risk periods. More information is included in Section 7.1.2 and Appendix A.4.

[41] OJJDP. (2012).

3.4 Warning Signs[42]

Warning signs are those signs that indicate the possibility of an imminent suicidal crisis.[43] All suicidal behavior should be taken seriously. Most people who take their lives **exhibit one or more warning signs**, either through what they say or what they do.[44]

TALK

If a youth talks about:

- Killing themselves
- Feeling hopeless or purposeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain – often as a result of a loss/crisis (death of a loved one, divorce, break-up, peer rejection, or the loss of anything that is of great value to the youth especially in conjunction with depression)
- Terminal statements – "I won't be a problem for you much longer." "I wish I were dead." "I'm going to kill myself." "It's no use."
- Having a suicide plan
- Perceived expendability – belief that no one would miss the youth, the youth's existence doesn't matter, or that people would be better off without him/her
- Perceived lack of resources – internal and external
- Ideation (thoughts of suicide) – can be expressed through talking, gesturing, writing and drawing

BEHAVIOR

Behaviors that may signal risk, especially if related to a painful event, loss, or change include:

- Increased use of alcohol or drugs
- Actively seeking access to suicide means
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too little or too much
- Making final arrangements, saying goodbye as if s/he will not see someone else again
- Giving away prized possessions
- Aggression
- Fatigue
- Refusing help, feeling beyond help

MOOD

People who are considering suicide often display one or more of the following moods.

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[42] Warning sign lists were adapted from AFSP. *Risk Factors and Warning Signs* and TDMH. (2012).
[43] TDMH. (2012).
[44] AFSP. *Risk Factors and Warning Signs*.

- Depression – beware of increased and/or persistent or more pronounced signs of depression
- Becoming suddenly cheerful after a period of depression – this may mean that the youth has already made the decision to escape all problems by ending his/her own life
- Changes in mood due to bullying and/or harassment and/or extreme embarrassment and/or humiliation
- Anxiety
- Loss of interest
- Irritability
- Agitation
- Rage

4. PROTECTIVE FACTORS FOR YOUTH SUICIDE[45]

Protective factors for suicide are a strength-based concept intended to help adults and youth **recognize and/or build emotion and physical support features** and systems which may intervene or keep youth from acting on suicidal ideation.[46] Protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors are, however, equally as important as researching risk factors.[47]

Protective factors against suicide among youth and adult residents include:

- **Availability of mental health services** that are provided **consistently** by qualified, trained, and supportive staff who provide strong community linkages and referrals and **ensure continuity of care**
- **Easy access** to a variety of **clinical interventions** and support for help seeking
- A **sense of control** over one's own destiny
- **Problem-solving** skills
- **Conflict resolution** skills (including nonviolent ways of handling disputes)
- **Adaptable temperament**
- Support from and **connections to family and community**
- **Religious/spiritual/cultural beliefs** that protect against suicide
- **Housing that is suicide-resistant** (i.e. free of protruding objects and means/methods for suicide) and that is **proximal to staff and peers**
- Positive **school or employment** experience
- **Specific plans** for the future

Just as negative attitudes about oneself, others, the world, and the future can contribute to the risk of suicide, the belief that **problems are solvable**, **hope for the future**, **optimistic attitudes**, and a perception of **self-efficacy** ("I can cope with negative feelings and events.") can serve a protective function. Positive, adaptive attitudes and beliefs can help youth cope with loss and stress.[48]

Moreover, protective factors can diminish the occurrence of negative outcomes and increase resiliency.[49] Prevention efforts in one area (violence, substance abuse) can decrease risk in other areas (suicide, delinquency) because protective factors can help buffer youth from a variety of risk factors.

[45] Protective factor list adapted from CDC, National Center for Injury Prevention and Control. *Suicide Risk and Protective Factors* and U.S. HHS and NAASP. (2012).
[46] Hayes, L.M. (2013).
[47] CDC, National Center for Injury Prevention and Control. *Suicide Risk and Protective Factors*.
[48] Reinecke, M. (2006). and Osman, A. et al. (1998).
[49] Development Services Group, Inc. (2015).

5. OBSTACLES TO PREVENTION

Negative attitudes towards suicide and the idea that youth suicide cannot be prevented often impede meaningful prevention efforts. The NCIA curriculum describes these as **obstacles to prevention**, which can be **local** or **universal**. Local obstacles refer to the attitudes of staff in relation to specific facilities or incidents, while universal obstacles refer to the social science and policy approach to youth suicide.[50]

The NCIA curriculum suggests that demonstrating prevention programs that have effectively reduced the incidence of suicide and suicidal behavior within juvenile facilities is one way to overcome these obstacles. Attitude, however, also plays an important role in suicide prevention. Many suicide prevention trainings ask participants to examine their own attitudes about suicide and asks them to **discard or put aside negative perception**s that may impede suicide prevention efforts.

Assessment Tool for Staff: To assess attitudes regarding suicide, please refer to the sample tool from the Shield of Care training in Appendix A.3.

Suicide prevention requires responsible adults to be pro-active instead of re-active. Administrators in any setting with youth at increased risk for suicide should **avoid complacency and prioritize suicide prevention**.[51] Leaders must convey the belief that **one suicide is too many** and that **suicide is preventable** in communications with all staff.

The NAASP developed a framework for developing public messages about suicide. One of the components of the framework is conveying a **positive narrative**. Successful messaging with a positive narrative conveys that:[52]

- there are actions that people can take to help prevent suicide;
- prevention works;
- resilience and recovery are possible;
- effective programs and services exist; and
- help is available.

[50] Hayes, L.M. (2013).
[51] SPRC and CJCA. (2012).
[52] NAASP. *Action Alliance Framework for Successful Messaging: Positive Narrative.*

6. IDENTIFICATION, REFERRAL, AND EVALUATION

To provide perspective for this section, the NAASP gives the following definitions for screening and assessment:

- **Screening** is an evaluation tool used to identify youth who may be at moderate or high risk of suicide. It is a relatively quick evaluation that can be administered by an individual without specialized clinical training.
- **Assessment** is an evaluation tool that identifies individualized needs of youth and is used for intervention. It typically requires more time and expertise to administer.

Screening and assessment are an ongoing process. There is no agreement on a single set of risk factors used to predict suicide, but **there is agreement about the value of screening and assessment in preventing suicide**. Approximately 2 out of 3 of all suicide victims communicate their intent some time before death, and prior risk of suicide is strongly related to future risk.[53]

Ideally, **all youth should be screened during their initial point of contact** (e.g. during the intake probation interview, after a youth's admission to a juvenile pre-trial detention center or a juvenile correctional intake unit). The purpose of screening is to identify youth who are at risk, so they can be referred for a more extensive evaluation by a trained clinician. One study found that facilities that screen all youth within 24 hours of arrival had lower prevalence rates of serious suicide attempts than those that screen only youth considered at risk for suicide.[54]

6.1 Valid and Reliable Screening Tools

The most useful screening and assessment tools share a number of characteristics: [55]

- They are structured or semi-structured,
- Their accompanying manuals are clear and explicit,
- The tools provide norms that allow comparison of a youth's results,
- Research has demonstrated that the instruments perform reliably, and
- More than one research study has shown that the results are related to behaviors or events that the instrument was intended to identify.

There are many available suicide screeners, although most agree that there is still **no gold standard**.[56] The NAASP review of screening and assessment tools points to several reasons why it is difficult to establish validity of suicide risk instruments for youth. There is a wide age span (ages 10-18) and risk factors likely vary at different stages. Youth have less stable mental status than adults; therefore, their risk level changes more rapidly. It is also difficult to determine the validity of suicide screeners because the outcome is so rare and because of the necessity to

[53] Hayes, L.M. (2013).
[54] OJJDP. (2014).
[55] NAASP. (2013). *Screening and assessment for suicide prevention: Tools and procedures for risk identification among juvenile justice youth*.
[56] Peña J.B.& Caine, E.D. (2006) and SPRC and CJCA. (2012).

intervene when risk is identified.[57] Other concerns when screening and assessing youth include deceptive self-presentation, the propensity of persons to conceal or to hide private issues from others.[58]

Few tools used to screen for suicide risk have been used with juvenile justice populations.[59] Moreover, the best way to administer screens is still under debate. Some studies suggest that self-report questionnaires may yield higher prevalence rates of suicidal ideation than face-to-face interviews.[60] Others, however, caution that effectiveness of screeners depends on characteristics of administration[61] and the trust engendered by the screener. The NCIA curriculum, for example, emphasizes that intake screening must be done in private, so youth will feel less reluctant to disclose sensitive medical and mental health information. The NCIA curriculum also cautions that adults should not rely on denial of suicide to assess suicide risk.[62]

Completed suicides are rare, and assessing an individual child or adolescent's risk of suicide is a complex, challenging task. Caution and care are needed when evaluating potentially suicidal youth. Clinical researchers typically recommend using a *combination* of measures and approaches. These can include screening instruments, objective self-report rating scales, structured interviews assessing factors underlying and maintaining the individual's distress, and thoughtful clinical interviewing. Integrating information from a variety of tools and approaches offers the best opportunity of identifying youth at risk for suicide. As risk of suicide tends to ebb and flow over time, repeated, regular screening for the presence of suicidal ideations is recommended.

6.2 Guidelines for Screening Process[63]

The NCIA curriculum does not point to any particular screening tool or way to administer the screen. It provides overall guidelines on the information that should be gathered. The screening process should gather information regarding:

- past suicidal ideation and/or attempts;
- current ideation, threat, and/or 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;
- arresting/transporting officer(s) belief that the youth is currently at risk

[57] NAASP. (2013). *Screening and assessment for suicide prevention: Tools and procedures for risk identification among juvenile justice youth*.
[58] Pope, K.S., Butcher, J.N., & Seelen, J. (2006).
[59] NAASP. (2013). *Suicidal Ideation and Behavior among Youth in the Juvenile Justice System: A Review of the Literature*.
[60] OJJDP. (2014).
[61] Grisso, T. et al. (2012).
[62] Hayes, L.M. (2013).
[63] Guidelines for screening process adapted from Hayes, L.M. (2013).

In addition, the NCIA curriculum suggests the screener should verify the following questions:

- 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 youth is a medical, mental health or suicide risk now?
- Asking the youth: "Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?"
- Asking the youth: "Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?"

6.3 Strategies for Face-to-Face Suicide Assessment[64]

Using reliable and valid instruments and techniques is the foundation of suicide assessment. Quite often, however, suicidal youth are uncomfortable (or unwilling) to discuss their thoughts and feelings with staff. Without accurate information about emotions and suicidal thoughts, it is all but impossible to determine risk. The author proposed several **strategies for eliciting valid information** about suicidal thoughts from clinical patients. Although these strategies were developed for use with adults, they can be helpful when talking with at-risk youth. They include:

1) Behavioral Incident. Simply inquire about behavioral facts and thoughts. Inquire in a direct, matter-of-fact manner. Step through the suicidal incident in a moment-by-moment basis.
2) Shame Attenuation. Assume a non-judgmental, validating stance. Maintain an attitude of unconditional positive regard.
3) Gentle Assumption. Assume that suicidal thoughts are occurring and frame your questions accordingly.
4) Symptom Amplification. To circumvent individual's attempts to downplay disturbing thoughts or behavior, suggest a higher level of the action for them to respond to (e.g., "How much of the day do you think about suicide?" 50 percent 60 percent, 70 percent)
5) Denial of the Specific. Rather than asking open-ended or broad questions, inquire about specifics (e.g. "Have you ever thought about jumping in front of a train? Taking too many pills?")
6) Normalization. Let the individual know that their distress, and thoughts, are understandable, and that others have felt the same way. (e.g. "Many individuals, after a few days here, tell me they don't think they can take it. Does that ever happen to you?")

[64] Shea, S.C. (2002).

6.4 Screeners Used with Juvenile Justice Populations[65]

Below are several screeners that have been used with juvenile justice populations. In each case, the screener serves to identify youth at risk for suicide and who should be referred for a more thorough evaluation by a clinician.

The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is a brief screener used extensively in primary care, clinical practice, research, and institutional settings. It demonstrates strong psychometric properties[66] although there has been little examination of its effectiveness with juvenile justice populations. It can be administered by lay persons. There are no costs associated with its use and free training videos are available through the C-SSRS website.

The **Massachusetts Youth Screening Instrument-Second Version (MAYSI-2)** is the most widely used mental health screener in juvenile justice settings in the United States. It was designed to assist juvenile justice facilities in identifying youth with mental health needs. The overall mental health screener consists of 52 questions; the suicide screening questions contains five questions. A number of studies with juvenile justice samples have established good correlations with other suicide screeners and diagnostic measures and have found good associations with past attempts and independent interview data on current suicidal thoughts. We do not know its impact on suicide prevention, however.[67] Users must register and purchase a manual but there are no further costs to use.

Suicidal Behaviors Questionnaire-Revised (SBQ-R) The 14-item SBQ-R was designed for use with adults but has also been used with youth. The measure has identified youth who were at risk according to other predictors, but its use in juvenile justice settings – and research in those settings – has been limited. The measure is available for use without charge.

Suicidal Ideation Questionnaire (SIQ) The SIQ was developed for use with high school-aged youth (3 questions) youth ages 12–14 years (15 questions). Norms and cutoffs indicating the need for further evaluation are available. Research has documented the ability of the SIQ to identify youth who have histories of suicide attempts or who may make future suicide attempts. It has been used in juvenile justice settings, although research on its use in those settings is limited. The SIQ can be administered via computer or paper-and-pencil. Users must purchase a manual and an answer sheet is required for each administration, creating a per-case cost of about one to two dollars.

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[65] For additional resources, please consult NAASP. (2013). *Screening and assessment for suicide prevention;* Peña J.B. & Caine, E.D. (2006); SPRC and CJCA. (2012); and Grisso, T. & Underwood, L. (2004).
[66] Posner, K. et al. (2011).
[67] Grisso, T. et al. (2012).

6.5 Recommendations for Identification, Referral, and Evaluation in Different Settings

6.5.1 Detention

As described in the NAASP recommendations, the risk of suicide is ever-present, so vigilance must continue after the intake screening process. If 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.[68]

6.5.2 Courts

According to NAASP recommendations, 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).[69]

For youth in immediate crisis, an attentive attorney may be able to identify warning signs and ensure the youth receives mental health care. Attorneys can help youth by meeting in person to get visual cues, asking direct questions, listening carefully to the youth, and sharing their knowledge with other adults when appropriate. Adults should also look for warning signs in younger children (not only teens).[70]

6.5.3 Probation

The NAASP recommends that each probation department (and its officers) should be required to complete a validated trauma exposure/depression screening instrument that also addresses suicide risk for each youth.[71] Individuals who work directly with youth in the juvenile justice system (probation officers, guards, program administrators, etc.) should receive formal training in screening (e.g. QPR).

[68] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[69] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[70] Pilnik, L. (2008).
[71] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

7. COMMUNICATION

7.1 Trust and Rapport

7.1.1 Establishing Trust and Rapport

Certain behavioral signs exhibited by youth may be indicative of suicidal behavior and, if detected and communicated with others, can reduce the likelihood of suicide. The NAASP asserts that adults, who establish trust and rapport with youth, gather pertinent information, and take action can prevent most youth suicide.[72]

The Shield of Care training indicates that sometimes **youth put up barriers to protect themselves**, which can make it hard to connect with them. They may never have had an adult reach out to them, and when this happens, they may shut down. It sometimes takes numerous attempts and numerous people to reach through their barriers. Understanding their perspective can help establish a connection.[73]

7.1.2 Listening Skills

Good listening skills are paramount to suicide prevention. One way to demonstrate listening is to paraphrase what the youth is saying through **reflective listening**. The goal is to reflect back what the adult hears while retaining as much of the youth's original meaning. Another listening strategy is **acknowledgement**, in which the adult tells the youth what they are hearing, in their own words. It does not require the adult to agree with the youth, but it does demonstrate **active listening**.[74]

The Lane County Model describes **strategies for how to talk with youth during high risk periods of confinement** (see Appendix A.4). For example, to reduce stress of a court appearance, adults may encourage youth to role play their appeal to the judge, to help them find the words to clarify their desires for placement, services, etc.[75]

7.2 Bridges and Barriers to Communication with Suicidal Youth

7.2.1 Bridges to Communication with Suicidal Youth

The NCIA curriculum outlines basic "do's and don'ts" when communicating with a youth at risk for suicide. For effective communication, adults working with youth should:[76]

- Listen patiently
- Trust their own judgment (i.e. don't let others mislead you into ignoring suicidal signals)

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[72] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[73] TDMH. (2012).
[74] TDMH. (2012).
[75] Mace, D. et al. (2003).
[76] Hayes, L.M. (2013).

- Maintain contact (through verbalization, eye contact, and body language) and conversation
- Try to keep the youth's sense of the future positive
- Stay with the suicidal youth
- Take all threats seriously and make the immediate referral

If an adult suspects a youth is suicidal, they should ask about suicide directly; **direct questions without judgment will help youth provide a direct answer**. Staff should practice phrasing and asking direct questions without judgment. It would NOT be appropriate to ask, "You're not thinking about killing yourself, are you?" or "You don't have any dumb ideas about trying to kill yourself, do you?" The Shield of Care training provides sample questions that are direct and non-judgmental such as:[77]

- Are you thinking about suicide?
- Are you thinking about killing yourself?
- Sometimes when people (insert warning sign), they might be thinking about suicide. Are you?
- You have a (court date) coming up and (you just said you cannot take it anymore). Are you thinking about suicide?
- **Ask at least twice**, specifically: "Are you thinking of killing yourself? Are you thinking of ending your life? Etc."

If the youth responds "yes" to considering suicide, the adult should tell the youth their safety is a priority and make an immediate referral. Even if a youth denies, the adult should protect the youth until mental health care arrives and they are able to convey their concerns to mental health staff. The Shield of Care training also stresses that staff should not rely on **contracts for safety** or **no suicide contracts** (i.e. an agreement between the patient and clinician whereby the patient agrees not to harm him or herself) because these contracts are **unreliable**.[78]

A contract for safety is not to be mistaken with a **safety plan**. A safety plan is a prevention tool in which an individual works with a counselor or therapist to develop written steps to lead them to safety should they experience suicidal thoughts. The safety plan should be kept in a place where it is easily accessible, so an individual can refer to it if they have thoughts of harming themselves.[79]

7.2.2 Barriers to Communication with Suicidal Youth

The NCIA curriculum offers the following guidance on what **not to do** when communicating with a suicidal youth. Adults working with youth in juvenile justice **should not**:[80]

[77] TDMH. (2012).
[78] TDMH. (2012).
[79] National Suicide Prevention Lifeline. *How Can a Safety Plan Help?*
[80] Hayes, L.M. (2013).

- Offer solutions or give advice
- Become angry, judgmental, or threatening to the youth by telling them that he/she will be sorry for completing suicide or that their feelings are wrong
- Act sarcastic or make jokes about the situation
- Placate the youth by making promises they cannot keep
- Challenge the youth to make good on his/her threat (i.e. the adult says they can prevent the youth from completing suicide no matter what they do)
- Ignore the suicidal risk or threat
- Form a negative attitude (or obstacle to prevention)

The Shield of Care training emphasizes that youth are sensitive to judgment and scrutiny and may face increased scrutiny once involved with the juvenile justice system. Real or imagined, **feelings of scrutiny can contribute to the development of negative feelings and low self-worth** often associated with youth suicidality.[81] Regarding issues that relate to self-consciousness, personal matters, or suicide, responsible adults should **talk to youth in private, if possible.**[82] Although conversations may take place in private, this does not imply confidentiality and the adult should relate relevant information to appropriate professionals if they suspect the youth is suicidal.

7.3 "Manipulation" and Self-Harm

Managing youth that may be viewed by some staff as manipulative is challenging. The word itself has a negative connotation, as does the term attention-seeking. Whatever the motive of the youth, it is important to remember that even what appears as **manipulative behavior** (such as threats of self-harm and/or incongruent statements and behaviors regarding suicide) is still maladaptive. It is indicative of a deeper issue and **should not be ignored** since it could possibly lead to self-harm or even death.

The NCIA curriculum offers some insight into how adults should understand and respond to manipulative behavior and self-harming behavior:[83]

- Often direct care workers (with support of mental health and/or medical staff) dismiss behavior as manipulative and suggest the behavior should be ignored and not reinforced through intervention.
- It is not unusual for mental health professionals to resort to labeling, with youth engaging in deliberate self-harm termed manipulative or attention seeking; and truly suicidal youth seen as serious and crying for help.
- Manipulative and suicidal behavior, although distinguishable, are not mutually exclusive. Both types of behavior can occur (or overlap) in the same individual and can cause serious injury and death.

[81] Stillion, J.M. & McDowell, E.E. (1996).
[82] TDMH. (2012).
[83] Hayes, L.M. (2013).

- Self-harm is a complex, multi-faceted behavior, rather than simply a manipulative behavior motivated by secondary gain. Youth engage in self-harm for a number of reasons, using it to cope with their environment, control and manage pain, and/or manipulate their environment.
- **The appropriate response to manipulative or self-harming behavior is to**:
    - Utilize preventative steps to discourage self-harming behavior
    - Avoid punitive sanctions as a response, which can escalate the behavior and result in more serious injury or death
    - **Determining whether a youth is manipulative or actually suicidal is not the responsibility of non-clinical staff**
    - Refer the youth to mental health/medical personnel for assessment and treatment

7.4 Communication Between Adults Caring for Youth

Poor communication between and among direct care, medical, mental health personnel, arresting or referral agencies, courts, probation, and family members is a common factor found in the reviews of many custodial suicides. The NAASP suggests that **communication problems are often caused by lack of respect, personality conflicts, and boundary issues.**[84]

7.4.1 Communication Amongst Staff

The Shield of Care training teaches staff to understand their role in suicide prevention and advises staff to adopt a team approach to overcome communication problems:[85]

- Staff should **avoid getting stuck in traditional clinical versus custodial roles** when it relates to suicide prevention
- Administrative staff should recognize the concerns of support staff
- Information related to suicide risk at present and in the near future should be shared freely with those working directly with youth
- Multidisciplinary team meetings should occur regularly to discuss the status of youth placed on suicide precautions

The Shield of Care training stresses the importance of open lines of communication between mental health care staff and security staff, and among security staff, **especially during shift changes**. Outgoing staff should document and share behaviors with incoming staff and should provide feedback to each other regarding staff performance or youth behavior.[86]

7.4.2 Collaboration Across the Juvenile Justice System

The 2006 report *Endangered Youth* outlined recommendations for addressing the problem of suicide among youth in the child welfare and juvenile justice systems. Lack of communication

[84] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[85] TDMH. (2012).
[86] TDMH. (2012).

and lack of awareness can result in a youth not getting help in a timely fashion. Administrators and staff should be **communicating across agencies and disciplines** in the best interest of the youth, not operating in silos. The recommendations for interdisciplinary communication included:[87]

- **Creating forums and procedures** where agencies and organizations serving at-risk youth can share information and collaborate to bring the best available care to youth and families; and
- Improving **communication, collaboration and care coordination** with colleagues representing different agencies and professional disciplines.

SAMHSA recommends that collaboration across sectors is built on a **shared understanding of trauma** and principles of a trauma-informed approach. People who have experienced trauma often have complex needs that span various service sectors. Referral to a trauma-insensitive program could undermine the progress of the individual.[88]

7.5 Recommendations for Communication in Different Settings

As youth are transferred between different points of contact in juvenile justice, important information about their physical and mental health status must be communicated. Sometimes this information is not transmitted when a youth has a change in custody. Note that any information that is transmitted **must be consistent with HIPAA guidelines**.

7.5.1 Courts

According to NAASP recommendations, judicially-led stakeholder meetings should be held on a regular basis as part of quality enhancement efforts to assist in improving communication and planning around suicide prevention.[89]

7.5.2 Probation

The NAASP recommends that 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.[90]

In the interest of ensuring youth safety, it is imperative that probation staff authorizing a youth's admittance to detention provide as much of the following information as possible:[91]

- Whether youth is currently or has previously been engaged in counseling and with whom

[87] Dore, M.M. et al. (2006).
[88] SAMHSA. (2014).
[89] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[90] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[91] Prepared by committee member Connie Kaiser, Superintendent - Juvenile Detention in Champaign County.

- Whether youth has ever made suicidal threats or experienced thoughts of self-harm, and if so, when and by what means
- Whether youth has ever attempted suicide, and if so, when and by what means
- Whether youth has given any indication that he/she might be at risk of self-harm
- Whether youth currently or has previously appeared to have symptoms of intoxication or withdrawal due to alcohol or drug use
- Whether youth has history of substance abuse
- Anything that the Probation staff might have knowledge of about the youth that might impair the safety of youth or others
- Youth's social history, psychological and psychiatric evaluations and medical history
- Information regarding any mental health diagnoses and past mental health hospitalizations
- Consent of legal guardian to medical treatment
- Copy of youth's medical card and insurance information
- Whether youth has ever experienced auditory or visual hallucinations
- Whether youth has experienced alteration in state of consciousness or orientation to person, place, or time
- Whether youth is experiencing signs of depression or agitation or abnormal behavior
- Whether youth has previously been depressed, frequently agitated, or demonstrated abnormal behavior
- Any information about youth's mental and cognitive impairment or developmental disabilities
- Must provide youth's medications and information regarding the purpose of the medication, any necessary information regarding youth's medical health care history, and whether there is a need for any follow up treatment or appointments

7.5.3 Law Enforcement

Law enforcement personnel who deliver youth to detention facilities must:[92]

- Inform detention intake officers about whether youth gave any indication that he/she might be at risk of self-harm
- Inform detention intake officers if youth appear to have symptoms of intoxication or withdrawal due to alcohol or drug use
- Convey to detention intake officers anything that has come to their attention that might impair the safety of the youth or others
- Inform detention staff if youth appears to be depressed or agitated or demonstrates abnormal behavior
- Inform detention intake staff if youth demonstrates any obvious mental or cognitive impairment or developmental disabilities
- Present detention intake staff with any medication that the youth has in his/her possession and convey information they have in regard to its purpose

[92] Prepared by Connie Kaiser, Superintendent - Juvenile Detention in Champaign County.

8. HOUSING

8.1 Providing a Safe Environment for Youth

The NAASP suggests that 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. We must take precautions to minimize opportunities for suicide or self-harm at all points of contact in the juvenile justice processing continuum.[93]

Whenever possible, adults must **restrict access to anchors and ligatures** when working with youth at risk for suicide. Be aware of anything that can be used to hang, suffocate, poison, cut, puncture, electrocute, or burn.[94]

The NCIA curriculum states that all rooms designated to house suicidal youth should be as **suicide-resistant** as possible, free of all obvious anchors and providing full visibility to staff. Unless contraindicated, youth on suicide precautions should continue to receive regular privileges. Different colored uniforms should be avoided. Removal of youth's clothing, use of safety smocks, and physical restraints should be avoided and used only as a last resort when youth is engaging self-destructive behavior.[95]

8.2 Room Confinement

The NCIA curriculum tells us that youth need not be locked in their room to be under room confinement. The placement can include either a locked or unlocked door, or even an open door. Room confinement is also known by other names, including time-out, quiet time, restriction, adjustment, conflict resolution, room lock, and off-program.[96]

There is a **strong correlation between room confinement of youth and suicide**. A nationwide survey of suicide by incarcerated youth found that 51 percent those that died by suicide were on room confinement status at the time of death and 62 percent had a history of room confinement.[97]

A task force appointed by the U.S. Attorney General concluded:

> Nowhere is the damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement.... Juveniles experience symptoms of **paranoia, anxiety, and depression** even after very short periods of isolation. Confined

[93] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[94] TDMH. (2012).
[95] Hayes, L.M. (2013).
[96] Hayes, L.M. (2013).
[97] OJJDP. (2009).

> youth who spend extended periods isolated are among the most likely to attempt or actually commit suicide.[98]

The American Medical Association has called for restricting the use of isolation in juvenile correction facilities for only extraordinary circumstances.[99]

The American Academy of Child and Adolescent Psychiatry (AACAP) opposes the use of solitary confinement in juvenile facilities because youth are especially vulnerable to the adverse effects of solitary confinement. The AACAP recommends, **youth who are confined for more than 24 hours must be evaluated by a mental health professional**.[100]

The National Commission on Correctional Health Care (NCCHC) **opposes the use of solitary confinement of youth for any duration**. Regarding solitary confinement in general, it states:

> Even those without a prior history of mental illness may experience a deterioration in mental health, experiencing anxiety, depression, anger, diminished impulse control, paranoia, visual and auditory hallucinations, cognitive disturbances, obsessive thoughts, paranoia, hypersensitivity to stimuli, post-traumatic stress disorder, self-harm, suicide, and/or psychosis. Some of these effects may persist after release from solitary confinement.[101]

Regarding youth, NCCHC states "**Psychologically, children are different from adults, making their time spent in isolation even more difficult** and the developmental, psychological, and physical damage more comprehensive and lasting."[102]

Because of the immediate and long-lasting impact of isolation on youth, there has been a movement away from placing youth in any sort of restricted environment. In January 2016, President Obama **banned solitary confinement for youth in federal custody** based on the recommendations from the Department of Justice. In May 2015, the Illinois Department of Juvenile Justice (IDJJ) settled a lawsuit with the ACLU over the use of isolation in its juvenile correctional facilities. The **new rules adopted by IDJJ** include the following:[103]

- Punitive isolation is not allowed.
- Youths separated from the general population for any non-punitive reason must be provided their ordinary education and mental health services.
- Youths separated for 24 hours or longer must be allowed out of their rooms, and provided an opportunity to interact with staff, for at least eight (8) hours each day.

[98] U.S. Department of Justice. (2012).
[99] AMA. (2014).
[100] American Academy of Child and Adolescent Psychiatry. (2012).
[101] NCCHC. (2016).
[102] NCCHC. (2016).
[103] Illinois Administrative Code, Title 20, Section 2504, Subpart B.

8.2.1 Reducing the Use of Isolation[104]

The Council of Juvenile Correctional Administrators (CJCA) has developed a toolkit on reducing the use of isolation. A response to behavioral problems in many facilities has been reliance on isolation for acting out youth who are mentally challenged, chronically violent, or gang involved. Instead of being a last resort to protect youth from self-harm, hurting others or causing significant property damage that is terminated as soon as a youth regains control, **isolation too often becomes the behavior management system by default**. Isolation is defined in this report as any time a youth is physically and/or socially isolated for punishment or for administrative purposes (not including protective or medical isolation.) The report includes CJCA position on isolation, steps and guidelines to reduce isolation and measuring and monitoring the use of isolation.

Alternative approaches to managing behavior and staff beliefs and attitudes that isolation is a necessary management tool—despite research showing it counterproductive and harmful—need to be addressed to prevent suicide.

8.3 Recommendations for Housing in Different Settings

8.3.1 Courts

The NAASP recommends that 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[105] (see general recommendations in Section 8.1).

8.3.2 Probation

According to NAASP recommendations, 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.[106]

[104] CJCA and CCAS. (2015).
[105] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[106] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

9. LEVELS OF OBSERVATION, FOLLOW-UP, AND TREATMENT PLANNING

9.1 Levels of Observation

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 post-release. 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**.[107]

Jurisdictions vary in the types of observation they use to monitor suicidal youth.

According to the NAASP, **two levels of supervision** are recommended for suicidal youth:[108]

1) **Close Observation**: Reserved for youth who are not actively suicidal but who express suicidal ideation. Close observations occur at staggered intervals not to exceed **10 minutes**.
2) **Constant Observation**: Reserved for youth who are actively suicidal, either forming a specific plan or engaging in suicidal behavior. Staff should observe youth on a continuous, uninterrupted basis.

The NCCHC outlines **three levels of monitoring:**[109]

1) **Constant Observation:** 1:1 monitoring is used when suicide risk is high.
2) **Intermediate Observation**: This monitoring is used for youth assessed as being at moderate risk for suicide. It occurs at staggered intervals not to exceed five minutes.
3) **Close Observation:** Used for youth assessed to be at low risk for suicide. It occurs at staggered intervals not to exceed 15 minutes.

Staff should document all checks for close and constant observation on an observation form. CCTV, roommates, etc. can be used as a supplement to, but **never as a substitute** for any level of observation.[110]

9.2 Upgrading, Downgrading, and Discontinuing Suicide Precautions

The NCIA curriculum advises that any designated staff may place a youth on suicide precautions or upgrade those precautions, but **only a qualified mental health professional (QMHP)** may downgrade and/or discontinue suicide precautions. Mental health staff should assess and interact with (not just observe) suicidal youth on a daily basis. The NCIA curriculum includes questions that should be part of the reassessment inquiry.[111]

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[107] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[108] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[109] NCCHC. (2012).
[110] Hayes, L.M. (2013).
[111] Hayes, L.M. (2013).

The Shield of Care training provides a template for a written "**suicide intervention, precaution, and referral guide**." During the training, the participants discuss suicide precautions and procedures specific to their facility, including:[112]

- How a youth is placed on suicide watch
- Levels of observation including a brief explanation of the youth (e.g. youth who is actively suicidal) for whom the observation is intended
- Observation frequency (for example, staff shall observe the youth on a continued, uninterrupted basis)
- Documentation instructions: model policies require that documentation take place as the observation occurs
- Policy regarding upgrading, downgrading, or discharge from suicidal watch status
- Frequency of mental health staff interaction
- Supervision aid policy (e.g. use of cameras and other youth); model policies require that these aids be used to supplement, not replace, staff supervision

9.3 Guidelines for Treatment Planning After Youth Are Released from Suicide Observation

According to the NAASP, the juvenile justice system has two responsibilities for suicide prevention: assuring safety while in custody and facilitating treatment and rehabilitation to promote positive youth development. This constitutes a long-range and therapeutic approach that goes beyond identification to risk mitigation through the development of a suicide risk reduction plan.[113]

The NCIA curriculum advises that **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. There is no nationally accepted schedule for follow up. Unless the individual treatment plan directs otherwise, the reassessment schedule should be as follows:[114]

- Within 24 hours, then
- within 72 hours, then
- within one week, and then
- once a month until release from custody.

The 2006 report *Endangered Youth* gives recommendations for systemic changes to improve service delivery and coordination of care for suicidal youth in the juvenile justice system. The report recommends **empowering youth and families** by **actively engaging** them in service

[112] TDMH. (2012).
[113] NAASP. (2013). *Screening and assessment for suicide prevention: Tools and procedures for risk identification among juvenile justice youth*.
[114] Hayes, L.M. (2013).

provision and **educating** them about available options related to assessment, treatment, discharge and post-care phases of intervention.[115]

Youth (and family) motivation for follow-up care often are low. One program that has shown promise for improving motivation is **Youth Partners in Care (YPIC)**, developed to facilitate youth seeking treatment for depression in primary care settings. The program had a positive effect on rates of severe depression among participating youth.[116] Interventions to enhance motivation and participation in treatment should be a priority for juvenile justice system improvement.

9.4 Recommendations for Different Settings

9.4.1 Courts

The NAASP recommends a similar approach for courts and detention facilities when it comes to levels of observation, follow-up, and treatment planning. 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.[117]

9.4.2 Probation

The NAASP suggests that probation should adopt 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.[118]

The 2006 report *Endangered Youth* recommends that multiple support systems for the youth and family should be securely in place before a case is closed by juvenile probation. Discharge plans should include **ongoing support services** and a **continuity of care** that would **allow the family to continue to access services when in need.**[119]

[115] Dore, M.M. et al. (2006).
[116] Wells, K.B. et al. (2012).
[117] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[118] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[119] Dore, M.M. et al. (2006).

10. RESPONDING TO A SUICIDE ATTEMPT

10.1 Emergency Response to Suicide Attempt

The NAASP reminds us that a **suicide attempt can occur at any point of contact within the juvenile justice processing continuum.** Therefore, providers from all points of contact must be prepared to intervene with an emergency response. The degree and promptness of intervention, plus the efficiency of communication among relevant staff, can influence 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.[120]

The Shield of Care training advises detention facilities to adopt a written **suicide intervention, precaution, and referral guide** that includes specific steps that staff should take when they identify:

1. A youth who may possibly be at risk of suicide or is exhibiting signs of depression
2. A youth at imminent risk of suicide
3. A youth in the process of an attempt

The suicide referral guide should provide each staff member with **two referrals** (name and detailed contact information) **for each of the situations above**.[121]

10.2 Recommendations for Responding to a Suicide Attempt in Different Settings

10.2.1 Detention

The NAASP outlines three guiding principles for emergency response in detention centers: [122]

1) All staff members who come into routine contact with youth 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).

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[120] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[121] TDMH. (2012).
[122] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

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.

The NCIA curriculum stresses that **scene preservation always receives secondary priority** after life-saving measures. Facility/program staff can be held liable for not promptly and effectively initiating life-saving measures to youth in the act of a suicide attempt.[123]

10.2.2 Courts

The NAASP advises that 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 for detention facilities[124] (Section 10.1 and Section 10.2.1).

10.2.3 Probation

The NAASP recommends that 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.[125]

[123] Hayes, L.M. (2013).
[124] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[125] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

11. REPORTING AND NOTIFICATION

11.1 Documentation and Notification

11.1.1 Importance of Documentation

To facilitate more effective suicide prevention efforts in the future, documentation of suicide attempts and suicides must be completed. The steps of this process are agency-specific, but the NAASP indicates that there are generally two steps: **a) reporting to officials through the chain of command, including incident reports** and **b) notification of the family of the victim.** Any staff in contact with the victim prior to the incident should submit a statement that includes knowledge of the youth and incident, to the extent of their involvement with the victim.[126] Staff will want to document:[127]

1) specific events surrounding the suicide attempt or completed suicides;
2) the provision of appropriate services;
3) that accepted practices or guidelines were followed;
4) that appropriate consultation was sought, and supervisory staff were notified; and
5) the individual was referred for clinical services as required.

11.1.2 Timely Reporting

The NCIA curriculum emphasizes that **staff should never play catch-up** or attempt to recreate an observation log. In anticipation of investigation and litigation, some staff attempt to retrace their steps after the incident and falsely document that observations were made as required. There can be serious legal repercussions for this.[128]

11.2 Suicide Clusters and Contagion

Suicide contagion sometimes occurs after a suicide attempt or completed suicide and can lead to suicide clusters. **Suicide contagion** is the process by which exposure to the suicide or suicidal behavior of one or more persons triggers a cluster of subsequent suicides and/or suicidal behavior. A **suicide cluster** is multiple deaths by suicide that occur within a defined geographic area and fall within an accelerated period of time.[129]

11.2.1 Guidelines for Minimizing Suicide Contagion

Although suicide contagion is a rare event, individuals working in the juvenile justice processing continuum must be prepared for it. The NCIA curriculum provides guidelines for minimizing contagion after a suicide attempt or completed suicide:[130]

- Suicide should never be discussed in positive terms.

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[126] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[127] Shea, S.C. (2002).
[128] Hayes, L.M. (2013).
[129] Hayes, L.M. (2013).
[130] Hayes, L.M. (2013).

- Neither the act nor process of suicide should be idolized, sensationalized, or romanticized.
- When a suicide occurs, administrators should dispense enough information about the event to control rumors without discussing the details.
- Individuals working with youth should provide emotional neutrality.
- Individuals working with youth should identify others who may be suicidal risks.
- Individual counseling is recommended to contain the emotion, whereas group counseling can arouse emotions, which can contribute to risk of contagion.
- Administrators should keep publicity to a minimum.
- Suicide should never be presented as a possible solution to any problem.

11.2.2 Safe Reporting Guidelines

Suicides are sometimes covered by the news media. Safe reporting is essential to prevent contagion.[131] Reportingonsuicide.org provides research-based recommendations for online media, message boards, bloggers, and citizen journalists.

11.3 Recommendations for Reporting and Notification in Different Settings

11.3.1 Courts

The NAASP recommends that 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.[132]

11.3.2 Probation

According to the NAASP, 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.[133]

[131] TDMH. (2012).
[132] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[133] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

12. MORTALITY AND MORBIDITY REVIEW

12.1 Postvention

Postvention is a strategy or approach implemented after a crisis or traumatic event has occurred.[134] Suicide among youth involved with the juvenile justice system is devastating personally and professionally to providers and personally and socially to other youth. The NAASP states that **debriefing and review** should follow every completed suicide to **address the extreme stress associated with the incident** and to **identify necessary revisions to policies and protocols**.[135] Debriefing after attempted suicides would also provide valuable lessons for review, revision, and implementation of policies. There would also be stress associated with such incidents, although not as great as completed suicides, still worth addressing.

Youth are often traumatized by critical events in a facility, and this trauma may lead to contagion. When staff and youth are affected by a traumatic event, they should be offered immediate assistance. The NCIA curriculum recommends **Critical Incident Stress Debriefing (CISD)** as one method of crisis intervention.[136] CISD is a facilitator-led group process conducted soon after a traumatic event with individuals considered to be under stress from trauma exposure.[137] CISD should be limited to small, homogenous groups (not primary victims) and delivered by a properly trained crisis response team.[138]

12.2 Self-Care

Adults who work with juvenile justice-involved youth should take care to monitor their own stress levels, especially after a traumatic event like a youth suicide. If the symptoms intensify, counseling may be necessary. The Shield of Care training provides a list of signs of stress that may indicate a need for help:[139]

- **Tension:** Physical and emotional tension, being excessively hyper, unable to relax or sit still for very long, muscle tremors or twitches
- **Nausea:** Especially during or immediately after the incident
- **Body temperature regulation**: Profuse sweating or chills at unusual times
- **Sleep disturbances**: Either the inability to fall asleep, disruptive dreams or nightmares or waking up earlier than usual
- **Fatigue**: Always tired. No pep or energy
- **Intrusive thoughts or memories**: Uncontrollable thoughts about the incident or some recurring memory

[134] Massachusetts Coalition for Suicide Prevention.
[135] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*
[136] Hayes, L.M. (2013).
[137] OSHA. *Critical Incident Stress Guide.*
[138] Mitchell, J.T. *Critical Incident Stress Management*.
[139] TDMH. (2012).

- **Negative feelings/Crying**: Unpleasant feelings that may come without warning, such as profound sadness, helplessness, fear, anxiety, anger, rage, discouragement, frustration or depression.
- **A feeling of vulnerability or lack of control**: Feeling exposed to threats, not in control of one's life, experiencing paranoia.
- **Interpersonal problems**: Increased irritability, insensitivity, blaming others, distancing from others.
- **Substance Abuse**: Self-medication can be a symptom of stress.
- **Compulsive behavior**: Increased problems such as compulsive eating or other uncontrolled, repetitive behaviors.
- **Self-Blame**: Usually this fixes on some particular aspect of the incident. A sense of having lost self-value or diminished self-esteem ("I could have done this or should have done that.")

12.3 Psychological Autopsy

Psychological autopsy is an oral examination of a deceased person's family, friends, colleagues, and acquaintances to determine the deceased person's state of mind at the time of death and **whether suicide can be ruled as the official cause.**[140] The NCIA curriculum includes an outline for completing a psychological autopsy:[141]

- Incident
- Autopsy/toxicology findings
- Background information
- Mental health history
- Medical history
- Institutional functioning
- Personality dynamics
- Precipitating events
- Pre-suicidal functioning
- Motive for suicide
- Summary/conclusions
- Recommendations

Further information about training for psychological autopsy is available from the American Association of Suicidology.

12.4 Mortality and Morbidity Review Process

The NCIA curriculum recommends that every attempted or completed suicide should be examined through a mortality and morbidity review, which acts as a quality assurance process. The primary purpose of this review is to answer **1) what happened in the case under review**

[140] USLegal.com.
[141] Hayes, L.M. (2013).

and **2) what can be learned to reduce the likelihood of future incidents**. The curriculum provides the following guidance on the process:[142]

- The review should be conducted by outside agency to ensure impartiality.
- If in-house, the review team should be multidisciplinary to ensure integrity of the review.
- The review 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 (i.e. circumstances which may have caused the suicide or serious suicide attempt);
    - Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.
- The process should be protected from disclosure to outside parties, so the review can be conducted objectively and participants can participate candidly.
- Documents generated during review should not be kept in youth's legal or medical file; they should be kept separately in a quality assurance file.

A SPRC and CJCA webinar series from 2012 includes a **checklist** of questions for youth suicides and serious suicide attempts. The checklist reviews each policy/procedure area to see if there are any gaps to address in: [143]

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

12.5 Recommendations for Mortality and Morbidity Review in Different Settings

12.5.1 Courts

The NAASP recommends that 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.[144]

[142] Hayes, L.M. (2013).
[143] SPRC and CJCA. (2012).
[144] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

12.5.2 Probation

The NAASP suggests that probation departments should conduct an immediate review of possible risk factors when youth engage in suicidal behaviors. 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.[145]

[145] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

13. TRAINING

Sections 1-12 of this document include key content, recommendations, and resources to incorporate into new or existing suicide prevention training and policy in the Illinois juvenile justice system. Section 13 outlines minimum training requirements for detention, courts and probation as recommended by the NAASP, and suggested topics for training sessions as recommended by the NCIA curriculum and the Shield of Care training.

Appropriate care of youth requires awareness and sensitivity to culture, ethnicity, gender, race, sexual orientation, age, social class, and the pervasive effects of trauma.[146] In general, best practice suggests that any suicide prevention training should reinforce the importance of **culturally appropriate and trauma-informed approaches**.

13.1 Minimum Training for Detention, Courts, and Probation[147]

13.1.1 Minimum Training for Detention

According to national standards outlined by the NAASP, all security, direct care, medical, mental health, and education personnel, as well as other staff who have 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. An outline of suggested training topics is in Section 13.2.1 and Section 13.2.2.

13.1.2 Minimum Training for Courts

According to national standards outlined by the NAASP, judges, prosecutors, public defenders, and allied juvenile court professionals should be trained in suicide prevention. Court hearings bring together juvenile justice stakeholders, youth, and families; a shared understanding of suicide dynamics is critical for case management and youth well-being. **One-hour suicide awareness training** should be incorporated into standard training for new court personnel. Training should also be incorporated into annual conferences via continuing education requirements for public defenders. At minimum training for court staff should cover:

- Facts about youth suicide (in general population and justice-involved youth)
- Risk and protective factors for suicide
- How to respond to warning signs of suicide, particularly at key decision points (e.g. detention, disposition)

13.1.3 Minimum Training for Probation

According to national standards outlined by the NAASP, all probation staff should be required to complete **two-hour suicide prevention workshop**, followed by an annual **one-hour refresher**

[146] Dore, M.M. et al. (2006).

[147] Minimum training standards adapted from NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

course. Content should include discussion of topics from training and refresher courses for detention and secure/non-secure care facilities (Section 13.2.1 and Section 13.2.2).

13.2 Suggested Training Topics

13.2.1 Training Topics for Initial 8-Hour Course

The NCIA curriculum suggests the following topics be covered in initial eight-hour training for detention and secure/non-secure care facilities:[148]

- Youth Suicide Research
- Guiding Principles to Suicide Prevention
- Why Facility Environments Are Conducive to Suicidal Behavior
- Staff Attitudes About Suicide
- Potential Predisposing Factors to Suicide
- Warning Signs and Symptoms
- Identification of Suicide Risk Despite the Denial of Risk
- High-Risk Periods
- Components of the Facility's Suicide Prevention Policy
- Proper Role of Staff in Responding to a Suicide Attempt
- Critical Incident Stress Debriefing
- Liability Issues[149]
- Mock Drills (see Section 13.2.5)

13.2.2 Training Topics for 2-Hour Refresher Course

The NCIA curriculum suggests the following topics be covered in two-hour refresher training for detention and secure/non-secure care facilities:[150]

- Staff attitudes about suicide
- Warning signs and symptoms/high-risk periods
- Identification of suicide risk despite the denial of risk
- Review of any recent suicides and/or serious suicide attempts
- Review of any changes to the suicide prevention policy
- Mock drills (see Section 13.2.5)

13.2.3 Other Training for Detention Facilities

The Shield of Care training offers a list of additional training topics for detention and secure/non-secure care facility staff that are not included in the eight-hour training:[151]

- Formal suicide assessment training (see Section 13.2.4)
- Standard first aid and cardiopulmonary resuscitation training

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[148] Hayes, L.M. (2013).
[149] In depth training on liability issues, including case studies, is available in the NCIA curriculum. The Shield of Care training also provides a short overview of liability issues.
[150] Hayes, L.M. (2013).
[151] TDMH. (2012).

- Intake screening training (see Section 13.2.4)
- Training in the maintenance of emergency equipment
- Interpersonal training
- Communication plans
- Self-injury training

13.2.4 Risk Screening and Assessment Training

The NAASP advises that **staff must be trained to properly implement suicide screening and assessment tools.** They must understand the purpose for implementing the tools, the meaning of their results, and the team response to particular scores/results. If non-clinical staff are administering screening tools, they must not only have classroom training (didactic exposure) but also practice administering the tool under supervision of a skilled trainer. Periodic monitoring for quality of administration is important.[152]

All individuals who have regular contact with youth in the juvenile justice system would benefit from formal training in an evidence-based approach to suicide risk assessment, such as **gatekeeper training**. More information about gatekeeper trainings (e.g. Question, Persuade, and Refer) and other suicide prevention training is available in Appendix A.5.

13.2.5 Mock Drills for Detention Staff

It is not sufficient for staff to be familiar with suicide prevention skills - they must practice using these skills on a regular basis. The NAASP states that **mock drills should be a part of both the initial and refresher trainings for all detention staff**. Practicing these skills increases the likelihood that staff members will understand how to best respond in the event of a suicide attempt. 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.[153]

[152] NAASP. (2013). *Screening and assessment for suicide prevention: Tools and procedures for risk identification among juvenile justice youth*.
[153] NAASP. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System.*

SOURCES

American Academy of Child and Adolescent Psychiatry. (2012). *Policy Statements: Solitary Confinement of Juvenile Offenders*. Accessed July 2016. Retrieved from http://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx

American Foundation for Suicide Prevention (AFSP). *Risk Factors and Warning Signs*. Accessed June 2016. Retrieved from http://afsp.org/about-suicide/risk-factors-and-warning-signs/

American Medical Association (AMA). (2014). *Policy statement: Solitary confinement of juveniles in legal custody*. Accessed July 2016. Retrieved from http://www.ama-assn.org/ama/pub/news/news/2014/2014-11-20-ama-policies-improve-health-of-nation.page

Armsden, G.C. & Greenberg, M.T. (1987). The Inventory of Parent and Peer Attachment: Individual Differences and Their Relationship to Psychological Well-Being in Adolescence. *Journal of Youth and Adolescence,* 16(5), 427-454.

Batty, G., Whitley, E., Deary, I., Gale, C., Tynelius, P., & Rasmussen, F. (2010). Psychosis alters association between IQ and future risk of attempted suicide: Cohort study of Swedish men. *British Medical Journal*, 340, c2506.

Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. *National Suicide Statistics, 2014*. Accessed June 2016. Retrieved from http://www.cdc.gov/violenceprevention/suicide/statistics/

Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. *Nonfatal Injury Data, 2014.* Accessed June 2016. Retrieved from http://www.cdc.gov/injury/wisqars/nonfatal.html

Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. *Suicide Risk and Protective Factors*. Accessed June 2016. Retrieved from http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

Centers for Disease Control and Prevention (CDC). *Youth Risk Behavior Surveillance System (YRBSS), 2015*. Accessed June 2016. Retrieved from http://www.cdc.gov/healthyyouth/data/yrbs/index.htm

Council of Juvenile Correctional Administrators (CJCA) and Center for Coordinated Assistance to States (CCAS). (2015). *CJCA Toolkit: Reducing the use of isolation.* Braintree, MA: Author.

Curtin, S.C., Warner, M., & Hedegaard, H. (2016). *Increase in Suicide in the United States, 1999–2014*. NCHS Data Brief No. 241. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Accessed June 2016. Retrieved from http://www.cdc.gov/nchs/products/databriefs/db241.htm

Cusack, K.J., Steadman, H.J., & Herring, A.H. (2010). Perceived coercion among jail diversion participants in a multisite study. *Psychiatric Services*, 61(9); 911-6.

Development Services Group, Inc. (2015). *Risk Factors for Delinquency.* Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention.

Dore, M.M., Aseltine, R., Franks, R.P., & Schultz, M. (2006). *Endangered Youth: A Report on Suicide Among Adolescents involved with the Child Welfare and Juvenile Justice Systems*. The Connecticut Center for Effective Practice (CCEP) of the Child Health and Development Institute (CHDI).

Draper, B., Pfaff, J.J., Pirkis, J., Snowdon, J., Lautenschlager, N.T., Wilson, I., & Almeida, O.P. (2008). Long-term effects of childhood abuse on the quality of life and health of older people: Results from the depression and early prevention of suicide in general practice project. *Journal of the American Geriatrics Society*, 56(2), 262-271.

Freeman, A. & Reinecke, M. (1994). *Cognitive Therapy of Suicidal Behavior*. New York: Springer.

Grisso, T., Fusco, S., Paiva-Salisbury, M., Perrauot, R, Williams, V., & Barnum, R. (2012). *The Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2): Comprehensive research review.* Worcester, MA: University of Massachusetts Medical School.

Grisso, T. & Underwood, L. (2004). *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System.* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Programs.

Gould, M.S., King, R., Greenwald, S., Fisher, P., Schwab-Stone, M., Kramer, R., Flisher, A.J., Goodman, S., Canino, G., & Shaffer, D. (2009). Psychopathology Associated With Suicidal Ideation and Attempts Among Children and Adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(9), 915-923.

Hayes. L.M. (2009). *Juvenile Suicide in Confinement: A National Survey.* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Programs.

Hayes, L.M. (2013). *Training Curriculum and Program Guide on Suicide Detection and Prevention in Juvenile Detention and Correctional Facilities.* Baltimore, MD: National Center on Institutions and Alternatives (NCIA).

Illinois Department of Public Health (IDPH), Division of Patient Safety. *Discharge Data*. Accessed July 2016. Retrieved from http://www.dph.illinois.gov/topics-services/prevention-wellness/patient-safety-quality/discharge-data

Illinois General Assembly. *Illinois Administrative Code*, Title 20, Section 2504, Subpart B. Accessed July 2016. Retrieved from ftp://www.ilga.gov/JCAR/AdminCode/020/020parts.html

Mace, D., Khalsa, V., Crumbley, J., & Aarons, J. (2003). *In Harm's Way: A Primer in Detention Suicide Prevention*. The Lane County Model, July 2003.

Massachusetts Coalition for Suicide Prevention. *Terminology & General Information*. Accessed June 2016. Retrieved from http://www.masspreventssuicide.org/resources/terminology/

Merrick, J., Merrick, E., Lunsky, Y., & Kandel, I. (2005). Suicidal behavior in persons with intellectual disability. *Scientific World Journal, 5*, 729-35.

Mitchell, J.T. *Critical Incident Stress Management*. Accessed July 2016. Retrieved from http://www.info-trauma.org/flash/media-e/mtichellCriticalIncidentStressManagement.pdf

National Action Alliance for Suicide Prevention (NAASP). *Action Alliance Framework for Successful Messaging: Positive Narrative.* Accessed July 2016. Retrieved from http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/narrative

National Action Alliance for Suicide Prevention (NAASP), Suicide Prevention Resource Center (SPRC), and Substance Abuse and Mental Health Services Administration (SAMHSA). *About Zero Suicide.* Accessed July 2016. Retrieved from *http://zerosuicide.sprc.org/about*

National Action Alliance for Suicide Prevention (NAASP): 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, D.C.: Author.

National Action Alliance for Suicide Prevention (NAASP): Youth in Contact with the Juvenile Justice System Task Force. (2013). *Need to Know: A Fact Sheet Series on Juvenile Suicide.* Washington, D.C.: Author.

National Action Alliance for Suicide Prevention (NAASP): Youth in Contact with the Juvenile Justice System Task Force. (2013). *Preventing Suicide: Working with Youth Who Are Justice Involved*. Washington, D.C.: Author.

National Action Alliance for Suicide Prevention (NAASP): Youth in Contact with the Juvenile Justice System Task Force. (2013). *Screening and assessment for suicide prevention: Tools and procedures for risk identification among juvenile justice youth*. Washington, DC: Author.

National Action Alliance for Suicide Prevention (NAASP): Youth in Contact with the Juvenile Justice System Task Force. (2013). *Suicidal Ideation and Behavior among Youth in the Juvenile Justice System: A Review of the Literature.* Washington, D.C.: Author.

National Commission on Correctional Health Care (NCCHC). (2012). *Position Statement: Prevention of Juvenile Suicide in Correctional Settings*. Accessed February 2016. Retrieved from http://www.ncchc.org/prevention-of-juvenile-suicide-in-correctional-settings

National Commission on Correctional Health Care (NCCHC). (2016). *Position Statement: Solitary Confinement (Isolation).* Accessed July 2016. Retrieved from http://www.ncchc.org/solitary-confinement

National Suicide Prevention Lifeline. *How Can a Safety Plan Help?* Accessed July 2016. Retrieved from http://www.suicidepreventionlifeline.org/learn/safety.aspx

Occupational Safety & Health Administration (OSHA). *Critical Incident Stress Guide*. Accessed July 2016. Retrieved from https://www.osha.gov/SLTC/emergencypreparedness/guides/critical.html

Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2014). *Suicidal Thoughts and Behaviors Among Detained Youth.* Juvenile Justice Bulletin, July 2014. Washington, DC: U.S. Department of Justice.

Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2012). *Understanding the Importance of Implementing an Effective Justice System Response for Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Youth in Custody.* Webinar slides and transcript. Accessed June 2016. Retrieved from https://www.nttac.org/index.cfm?event=trainingCenter.traininginfo&eventID=12

Osman, A., Downs, W., Kopper, B., Barrios, F., Baker, M., & Osman, J. (1998). The reasons for living inventory for adolescents (RFL-A): Development and psychometric properties. *Journal of Clinical Psychology*, 54, 1063-1078.

Peña, J. B., & Caine, E. D. (2006). Screening as an Approach for Adolescent Suicide Prevention. *Suicide and Life-Threatening Behavior, 36*(6), 614-637.

Pilnik, L. (2008). Youth Suicide and Self-Harm: What advocates Need to Know. *The American Bar Association Child Law Practice Bulletin*, 27(4), 49-54.

Pope, K. S., Butcher, J. N., & Seelen, J. (2006). *MMPI, MMPI–2, and MMPI–A in court, a practical guide for expert witnesses and attorneys*. Washington, DC: American Psychological Association.

Posner, K., Brown, G.K., Stanley, B., Brent, D.A., Yershova, K.V., Oquendo, M.A., Currier, G.W., Melvin, G.A., Greenhill, L., Shen, S. & Mann, J. J. (2011). The Columbia-Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults. *American Journal of Psychiatry*, 168(12), 1266-1277.

Reinecke, M. (2006). Problem-solving: A conceptual approach to suicidality and psychotherapy. In: T. Ellis (Ed.) *Cognition and suicide: Theory, research, and therapy*. Washington, DC: American Psychological Association. 237-260.

Shaffer, D., Gould, M.C., Fisher, P., Trautman, P. Moreau, D., Kleinman, M., & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, 53(4), 339-48.

Shea, S.C. (2002). *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors.* Hoboken, NJ: John Wiley & Sons. Inc.

Stillion, J.M. & McDowell, E.E. (1991). Examining suicide from a life-span perspective. *Death Studies,* 15, 327-354.

Stillion, J. M., & McDowell, E. E. (1996). *Suicide across the life span: Premature exits.* Washington, D.C.: Taylor & Francis.

Stokes, M.L., McCoy, K.P., Abram, K.M., Byck, G.R. & Teplin, L.A. (2015). Suicidal Ideation and Behavior in Youth in the Juvenile Justice System. *Journal of Correctional Health Care,* 21(3), 222-242.

Substance Abuse and Mental Health Services Administration (SAMHSA): Trauma and Justice Strategic Initiative. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication No. (SMA) 14-4884. Rockville, MD: Author.

Suicide Prevention Resource Center (SPRC) and Council of Juvenile Correctional Administrators (CJCA). (2012). *Suicide Prevention in Juvenile Detention and Correctional Facilities – two-part webinar series by SPRC and CJCA.* Accessed June 2016. Retrieved from http://www.sprc.org/training-institute/juvenile-correctional-curriculum

Suicide Prevention Resource Center (SPRC) & Rodgers, P. (2011). *Understanding risk and protective factors for suicide: A primer for preventing suicide*. Newton, MA: Education Development Center, Inc.

Tennessee Department of Mental Health (TDMH). (2012). *Shield of Care: A System-Focused Approach to Protecting Juvenile Justice Youth from Suicide*. Nashville, TN: Author.

University of Rochester Health Encyclopedia. *Understanding the Teen Brain.* Accessed June 2016. Retrieved from https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=1&ContentID=3051

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention (NAASP). (2012). *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS.

U.S. Department of Justice. (2012). *Report of the Attorney General's National Task Force on Children Exposed to Violence.* Washington, D.C.: U.S. Department of Justice.

USLegal.com. *Psychological Autopsy Law & Legal Definition*. Accessed June 2016. Retrieved from http://definitions.uslegal.com/p/psychological-autopsy/

Wells, K.B., Tang, L., Carlson, G.A., & Asarnow, J.R. (2012). Treatment of youth depression in primary care under usual practice conditions: observational findings from Youth Partners in Care. *Journal of Child and Adolescent Pharmacology*, 22(1), 80-90.

West, M.L., Spreng, S.W., Rose, S.M. & Adam, K.S. (1999). Relationship Between Attachment-Felt Security and History of Suicidal Behaviors in Clinial Adolescents. *Canadian Journal of Psychiatry*, 44, 578-582.

Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute.

Zagar, R.J., Zagar, A.K., Busch, K.G., Garbarino, J., Ferrari, T., Hughes, J.R., Patzer, G., Kovach, J.W., Grove, W.M., Tippins, S., Imgrund, S., Dempsey, J.Q., & Basile, B. (2016). Finding High Risk Persons with Internet Tests to Manage Risk —A Literature Review with Policy Implications to Avoid Violent Tragedies, Save Lives and Money. *Journal of European Studies*, 8(1), 212-256.

APPENDIX

A.1 Additional Terminology[154]

Adapted from Massachusetts Coalition for Suicide Prevention, *Terminology & General Information*.

- **Best Practice**: Activities or programs that are in keeping with the best available evidence regarding what is effective.
- **Evidence-based**: Programs that have undergone scientific evaluation and have proven to be effective.
- **Gatekeepers:** Individuals trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate; gatekeepers can be non-professionals who work with at-risk populations including administrators, coaches, home health aides, and others.
- **Intervention**: A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as strengthening social support in a community).
- **Means**: The instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).
- **Means restriction:** Activities designed to reduce access or availability to means and methods of deliberate self-harm.
- **Mental disorder:** A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.
- **Postvention**: A strategy or approach that is implemented after a crisis or traumatic event has occurred.
- **Prevention:** A strategy or approach that reduces the likelihood of risk of onset, delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.
- **Stigma**: An object, idea, or label associated with disgrace or reproach.
- **Substance abuse**: A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

[154] Massachusetts Coalition for Suicide Prevention.

A.2 Survey of Suicide in Confinement (2009)[155]

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) awarded a contract to the National Center on Institutions and Alternatives (NCIA) to conduct the first national survey on youth suicide in confinement. The study analyzed the characteristics of 79 youth suicides that occurred between 1995 and 1999. Below are the key findings from this study.

Demographics of the Victims

- More than two-thirds (68 percent) of victims were Caucasian.
- A substantial majority (80 percent) of victims were male.
- Average age of victims was 15.7, with more than 70 percent of victims ages 15–17.
- A sizable number (38 percent) of victims were living with one parent at time of confinement.

Criminal Background

- More than two-thirds (70 percent) of victims were **confined for nonviolent offenses.**
- Approximately two-thirds (67 percent) of victims were held on commitment status at time of death, with 33 percent on detained status; the vast majority (80 percent) of victims held in detention centers were on **detained status.**
- A substantial majority (79 percent) of victims had a **history of prior offenses;** most of these (73 percent) were of a **nonviolent nature**.

Length of Confinement before Suicide

- With the exception of detention centers, deaths were evenly distributed during a more than 12-month period, with the same number of suicides occurring within the **first three days of confinement** as occurring after more than 10 months of confinement; only four percent of all suicides occurred within the first 24 hours of confinement.
- All detention center suicides **occurred within the first four months of confinement**, with more than **40** percent **occurring within the first 72 hours**.

Mental Health History

- **Nearly three-quarters** (73 percent) of victims **had a history of substance abuse**, 19 percent had a history of medical problems, 44 percent had a history of emotional abuse, 34 percent had a history of physical abuse, and 28 percent had a history of sexual abuse.
- A majority (66 percent) of victims had a **history of mental illness** (with 65 percent of these victims suffering from depression at the time of death); 54 percent of victims were **taking psychotropic medications.**
- More than **two-thirds** (70 percent) of victims had a **history of suicidal behavior**, with suicide attempt(s) the most frequent type of suicidal behavior (46 percent), followed by suicidal ideation/threat (31 percent) and suicidal gesture/self-mutilation (24 percent).

[155] Hayes. L.M. (2009).

Suicide Incident Characteristics

- Approximately **half** (51 percent) of suicides **occurred during a six-hour period between 6 p.m. and midnight**, and almost **a third** (30 percent) **occurred between 6 p.m. and 9 p.m**.; 71 percent of suicides occurred during traditional waking hours (6 a.m. to 9 p.m.), and 29 percent occurred during nonwaking hours (9 p.m. to 6 a.m.).
- Almost all (99 percent) the suicides were by **hanging;** 72 percent of these victims used their **bedding** (e.g., sheet, blanket) as the instrument. A variety of anchoring devices were used in the hangings, including **door hinge/knob** (21 percent), **air vent** (19 percent), **bedframe** (19 percent), and **window frame** (14 percent).
- **None of the victims was under the influence of alcohol or drugs** at the time of the suicide.
- Almost **three-quarters** (75 percent) of victims were a**ssigned to single-occupancy rooms**.
- Approximately **41** percent **of victims were found in less than 15 minutes after the last observation of the youth**: however, slightly more than 15 percent of victims were found more than one hour after last being seen alive.
- About half (51 percent) the victims were on **room confinement status** at the time of death (and 62 percent of victims had a history of room confinement). The circumstances that led to room confinement at the time of death included **failure to follow program rules/inappropriate behavior** (47 percent), threat/actual physical abuse of staff or peers (42 percent), and other (11 percent). Only 17 percent of residential treatment center victims were on room confinement status at time of death.
- A large majority (85 percent) of victims who died by suicide while on room confinement status died **during waking hours (6 a.m. to 9 p.m.)**, a higher percentage than those victims who died by suicide during waking hours but were not on room confinement status (71 percent).
- A s**mall percentage** (17 percent) of victims were on **suicide precaution status at time of death,** most of whom were required to be observed at 15-minute intervals. Despite their identified risk, almost half of these victims were found to be last observed in excess of the required 15-minute interval.
- More than **two-thirds** (70 percent) of victims were **assessed by a qualified mental health professional before their death** (although only 35 percent of detention center victims received such assessments); **slightly less than half** (44 percent) of all victims either **had never been assessed by a qualified mental health professional or had not been assessed within 30 days of their death**.

Juvenile Facility Characteristics

- **Only 38** percent **of the suicides took place in facilities that provided annual suicide prevention training to its direct care staff.**
- Although a large majority (79 percent) of victims died in facilities that maintained a **written suicide prevention policy a**t time of suicide, only 20 percent of victims were in facilities that had all seven suicide prevention components (written policy, intake screening, training, CPR certification, observation, safe housing, and mortality review) at time of suicide. The degree to which suicides took place in facilities that had all seven suicide prevention components varied considerably by facility type: detention centers (10 percent), training schools/secure

facilities (24 percent), reception/diagnostic centers (40 percent), and residential treatment centers (25 percent).

A.3 Shield of Care Suicide Attitudes Survey[156]

The Shield of Care curriculum includes a survey about suicide attitudes, reproduced below.

Instructions for the participants:

Directions: Below, you will see several statements about suicide. After reading each statement, decide whether you **1)** Strongly Disagree, **2)** Disagree, **3)** Neither Agree Nor Disagree, **4)** Agree, or **5)** Strongly Agree. There are no right or wrong answers, only what you think or believe. Use the answer grid provided to record your responses.

1. There is not much I can do to stop a youth from killing him/herself.	1	2	3	4	5
2. Suicidal behaviors are irrational.	1	2	3	4	5
3. Youth in secure facilities who threaten or attempt suicide only want attention.	1	2	3	4	5
4. Suicide is wrong.	1	2	3	4	5
5. I may choose not to intervene with a suicidal JJ youth so I do not become liable.	1	2	3	4	5
6. If a youth I work with in the facility considers or attempts suicide, I have failed at helping that youth.	1	2	3	4	5
7. The facility environment increases JJ youth's risk for suicide.	1	2	3	4	5
8. Suicide prevention training can help me save lives of JJ youth.	1	2	3	4	5
9. JJ youth think about suicide more often than non-incarcerated youth.	1	2	3	4	5
10. Youth in secure facilities have fewer reasons to live than non-offending youth.	1	2	3	4	5
11. A staff person who intervenes when a youth is considering suicide becomes legally responsible for that youth's life or death.	1	2	3	4	5
12. I feel comfortable discussing suicide issues with youth in JJ facilities.	1	2	3	4	5

Once you've completed the survey answer the following questions:
Does attitude #1 help or hinder a caregiver's ability to prevent suicide? Why? Why not?
Does attitude #2 help or hinder a caregiver's ability to prevent suicide? Why? Why not?
Does attitude #3 help or hinder a caregiver's ability to prevent suicide? Why? Why not?
Does attitude #4 help or hinder a caregiver's ability to prevent suicide? Why? Why not?

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[156] TDMH. (2012).

Instructions for the trainer:
When you debrief the attitudes survey, be sure to point out that your goal is not to judge attitudes, but to explore whether they help or hinder suicide prevention. Tell participants that we will only address the first four in the interest of time.

Debrief the exercise by asking each of the groups to share one answer. Optimally, participants will provide the information you hope to elicit. If they do not, pose the targeted response as a question. For example, is it possible that we can identify a youth at risk and provide help?

1. If a youth I work with decides to kill themselves, there is not much I can do to stop them.
Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

Elicit: It hinders a caregiver's ability to prevent suicide because it is very possible for juvenile justice staff to identify and assist a youth at risk.

2. Suicidal behaviors are irrational.
Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

Elicit: It would hinder a caregiver's ability if this attitude is conveyed to a youth because that youth may feel judged and shut down.

3. Youth in secure facilities who threaten or attempt suicide only want attention.
Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

Elicit: It would hinder a caregiver's ability because threatening and attempting suicide are two of the most significant precipitating factors for suicide.

4. Suicide is wrong.
Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

Elicit: This could go either way. If this attitude is conveyed to youth with strong moral or religious convictions against suicide, talking with someone who feels the same may possibly be helpful. On the other hand, it is risky because the youth will likely feel judged and shut down.

Optimally, participants have generated a response that states that **our attitudes can negatively affect our conversations with youth**.

If not, say that it's possible to lose kids if we impose our attitudes on them.

A.4 How to Help Youth during High Risk Periods of Confinement[157]

Adapted from Mace, D. et al. (2003). *In Harm's Way: A Primer in Detention Suicide Prevention*. *The Lane County Model.*

Scenario 1: Reduce distress due to new admission to detention.

- Orientation is very informative, but youth may not have digested all, or even any, of the information at the time it was presented (for any number of reasons).
- Inform youth of expected behaviors towards staff members. Discuss pros and cons of treating staff with respect. Remind them that staff can be a great resource to them and care very much about their well-being. Discuss the value of choosing several staff that they can develop a special rapport with—even if they are not willing to accept that all staff are potentially helpful.
- Inform youth of the appropriate way to request services. Verbally instruct them and also take them physically through the process of filling out a request form to see their attorney, their probation officer, medical assistance, etc.
- Inform youth about visitation rules. Clarify, as possible, any misunderstandings (e.g. about expected contact visits, how the visitor list is compiled, etc.).
- Normalize and validate the emotions they feel at this time. They are not the first to be distressed by "not knowing" while in detention.

Scenario 2: Reduce distress due to visitations (or lack of).

- Under the best of situations, visitations are stressful for youth in detention.
- Debriefing the visitation can be enormously soothing for these youth. Allowing youth to express their feelings (e.g. apprehensions, hurt, anger, homesickness) after these contrived visits can be critical.
- Assist youth to see the wider context of their visitors' behaviors during visitation. Youth may not realize the stress (e.g. anxiety, sadness, frustration) that their visitors may experience when visiting detention. They may not be able to see, without guidance, their visitor's perspective.
- Assist youth to understand their immediate reactions to visitation. This includes normalizing and validating their experience and, again, assisting them to see the situation in a wider context.
- Validate and normalize their emotions around visitations. They are not likely to be the first, or the only, youth to feel this way. Encourage them to discuss this with peers who are coping fairly well if this seems appropriate.

Scenario 3: Reduce distress due to conflicts with peer relations in detention.

- Listen to youth's version of the conflict. Collaboratively discuss new ways of viewing the conflict and different responses if it is to occur again. Encourage youth to take responsibility for the part they played in the conflict.

[157] Mace, D. et al. (2003).

- Encourage them to take the high road and not become involved in other youth's struggles.
- Talk about making the right choice even if it is not the easy choice.
- Validate and normalize the experience of difficult peer relations in this setting. Perhaps it will be useful to discuss how the commonly held emotions of frustration, fear, anger, and lack of social control in this setting contribute to creating a very challenging social environment.

Scenario 4: Reduce distress due to having to wear the smock.

- Inform youth about safety concerns and convey desire to, above all, keep them alive.
- Inform youth of process to get risk level reduced, and expectations for time-line for review to best of your knowledge (no promises, but realistic expectations).
- Inform youth of any current behaviors that contribute to the concern that staff have for their wellbeing. Explore appropriate alternative behaviors that might be satisfying (in some way) to the youth.
- Normalize and validate this complaint. It is universal.

Scenario 5: Reduce distress due to upcoming court or disappointing court appearance.

- Encourage youth to share their specific concerns and questions and frustrations. Share information, answer questions, and validate their frustrations when appropriate and as possible.
- Encourage youth to role-play, with you, their appeal to the judge or to their lawyer or their next visit with their probation officer; help them put words to and clarify their desires for placement, services, etc.
- Validate and normalize the level of distress felt and find constructive and concrete ways to minimize them (see above)

Scenario 6: Reduce distress due to "no shows" or "no follow-through" on part of probation officer, nurse, staff member, other professionals in psychological services, etc.

- Encourage youth to gather information from the people who are believed to have let them down. Frequently, the youth assume that this person did not take a certain action because the person does not like them. There may be quite understandable reasons for the actions, or failure to act. There could also be a misunderstanding about the commitment in the first place.
- Role-play the information gathering described above emphasizing ways to gather information without being offensive, judgmental, or otherwise alienating or putting the service provider on the defense.
- To the best of your knowledge, clarify professional role of service providers in question if there seems to be a misunderstanding about services they have or have not provided.
- If appropriate, encourage youth to consider alternative, or additional, actions they can personally take to get their needs or desires met rather than merely waiting for others to take a particular action.

- Validate and normalize these commonly perceived slights. Be cautious, however, about siding with the youth and condemning accused staff or service provider. It may be useful to find constructive and concrete ways to minimize these perceptions (see above).

A.5 Evidence-Based Suicide Prevention Training Programs

Suicide Prevention Resource Center (SPRC)

The Best Practices Registry (BPR) was a section of the SPRC website that was maintained from 2007 to 2016. It served as a source of information on evidence-based programs; expert and consensus statements; and programs, practices, and policies addressing suicide prevention whose content had been reviewed according to specific standards.

Section I of the Best Practices Registry (BPR) of the Suicide Prevention Resource Center (SPRC) lists evidence-based programs. Evidence-based is defined as interventions that have undergone rigorous evaluation and demonstrated positive outcomes. Section I programs are considered effective, although their effectiveness may not hold true for all audiences or settings. These programs all came from one source: SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

Though the BPR no longer exists as a standalone resource, it is part of the Resources and Programs section of the new SPRC website. All of the programs, guidelines, and other resources previously listed in the BPR are included. Use the "Resource and Program Type" filter to select the type of program or resource you are looking for.

- To find programs: To see all programs, select "Program/Practice" from the "Resource and Program Type" filter. Or, narrow the search by selecting a Program/Practice subtype (e.g. Education/Training program, Screening program, Information/Outreach program, Treatment/Services program, Environment/Systems program). Programs with evidence of effectiveness will display in the results with a ✓.
- To view only programs with evidence of effectiveness**:** Check the box that says, "Display only programs with evidence of effectiveness." These are programs that have been evaluated and found to result in at least one positive outcome related to suicide prevention.

Below are few of the programs from the SPRC that have evidence of effectiveness.

- SOS Signs of Suicide Middle School and High School Prevention Programs
- Family Intervention for Suicide Prevention (FISP)
- Attachment-Based Family Therapy (ABFT)
- Kognito At-Risk for High School Educators
- LEADS: For Youth (Linking Education and Awareness of Depression and Suicide)
- Model Adolescent Suicide Prevention Program (MASPP)
- Sources of Strength
- Emergency Department Means Restriction Education
- Reconnecting Youth: A Peer Group Approach to Building Life Skills
- Lifelines Curriculum
- Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)
- Emergency Room Intervention for Adolescent Females

- CAST (Coping and Support Training)

For more information, visit:
http://www.sprc.org/faqs-best-practices-registry

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)
Many other registries and lists are available, each with its own focus and criteria. The resource below offers many additional sources of information on programs, including programs targeting specific groups and upstream prevention programs.

Links to Other Evidence-Based Repositories and Resources on Evidence-Based Programs

A.6 National Center on Institutions and Alternatives (NCIA) Curriculum

The ***Training Curriculum and Program Guide on Suicide Detection and Prevention in Juvenile Detention and Correctional Facilities and Residential Programs*** was developed by Lindsay M. Hayes, an NCIA project director, and a nationally recognized expert in the field of suicide prevention within jails, prisons, and juvenile facilities.

The curriculum is designed to equip direct care, security, medical, mental health, and education personnel with a comprehensive understanding of suicidal behavior as it relates to the facility environment of a detention center, training school, and/or residential treatment center. It includes a discussion on juvenile suicide research, guiding principles to suicide prevention, why facility environments are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, warning signs and symptoms, identification of suicide risk despite the denial of risk, high-risk periods, components of the facility's suicide prevention policy, instruction regarding the proper role of staff in responding to a suicide attempt, critical incident stress debriefing, and liability issues.

The 190-page curriculum is contained in a three-ring binder and accompanied by a CD containing 163 PowerPoint slides. The cost is $199, including shipping and handling, and can be purchased via check or PayPal.

For more information or to purchase the curriculum, please visit the NCIA website.