Suicide Prevention Among Youth In Custody: What You Need to Know

Facilitator Guide
The NCYC/NPJS Youth Care Curriculum Series is made up of a collection of modules designed to develop or enhance the skills and knowledge of those working with youth in secure settings. Modules in the series are designed to support individual professionals and the cultures in which they operate to embrace best practices in the field of juvenile justice.

Suicide Prevention Among Youth in Custody: What you need to know is one training module in this series. Because youth care work and suicide prevention strategies is a dynamic process concepts from other topic areas, which are detailed elsewhere in the series, may be introduced in this module. Youth care workers may benefit from participation in all the training modules in the series.

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Course Description:
What would you do if a youth tried to kill themselves on your shift? Suicide is the leading cause of death in juvenile justice facilities. Participants in this session will learn about key issues related to who is at risk for suicide, screening confined youth for suicide risk, national standards and best practices in suicide prevention among youth in confinement, strategies for minimizing liability, and much more. Video clips of Dr. Lisa Boesky, one of the country's foremost experts in suicide prevention among youth in custody, will also be included.

Curriculum Goal
The goal for this training is for staff to gain a better understanding of youth that are suicidal as well as to discuss best practices regarding staff and facility responses to suicidal youth.

Learning Objectives
After completing this training, participants will be able to:
1) Describe why youth in custody are at risk for suicide and better identify those who may be at the “highest” risk
2) Identify ways to more effectively implement their facility’s current suicide prevention program (i.e., prevention, intervention, post intervention) based on national standards and best practices
3) Describe suicide screening and assessment, why both are important, and the essential role direct care staff play in both
4) List suicide hazards specific to their facility and potential ways to mitigate them
5) Describe the role of the Quality Mental Health Professional (QMHP) with regard to suicide prevention and how direct care staff can effectively assist him/her/them.
6) List specific ways the behavior of the direct care staff and their relationships with youth can positively or negatively impact suicidal youth
Target Audience
This learning experience is designed for Youth Care Workers – staff who work directly with youth in any facility, juvenile or adult, that holds youth in secure confinement.

Number of Participants
This learning experience is designed for a minimum of 12 participants and a maximum of 30 participants.

Level of Training
Intermediate

Recommended Training Pre-requisite Courses
Understanding Adolescent Brain Development Through Current Research (2014), National Partnership for Juvenile Services, www.npjs.org or a similar training course covering current research on adolescent development and brain research

Instructional Methods/Techniques:
Lecture, small group discussions, large group discussions, role plays, small group activities, demonstrations, examples

Classroom Set-up
Large room with table groups (4-6 per table)

Required Materials
1. Printed Facilitators Guide
2. Participant Guide for each participant
3. PowerPoint slides
4. Laptop or computer
5. Projector or LCD Flip Chart and stand
6. Flip chart Pad (Post-it type is recommended)
7. Markers (flip chart and dry erase)
8. Masking Tape
9. Handouts:
   Opening Role Play Instructions
   Interview With a Suicidal Youth Script
10. NPJSpeaks Video: Suicide Prevention Among Youth in Custody: What You NEED to Know is divided into the following segments for use during this training:
   Segment #1: “Introduction & Risk Factors” (0:00-5:00)
   Segment #2: “Facilities Have Strategies in Place” (5:01-7:56)
   Segment #3: “All Youth At All Times” (7:57-10:29)
   Segment #4: “What Do We Do” (10:30-18:32)
   Segment #5: “No Desire to Die” (18:33-19:35)
   Segment #6: “Suicide Precautions/Michael” (19:36-22:47)
   Segment #7: “There Are Few More Intense Fears” (22:48-24:01)
**Information For The Trainer**

Learning leads to change, change in how we think and how we act. It involves altering our mental processes, expanding and adapting our repertoire of behaviors, and reviewing our habits.

It is critical that participants in the training feel supported in the new learning and in the expected changes in attitude and behavior, starting from the administrative team. To help create the culture for the support of this training, invite the Director of the facility to welcome the participants to training. This could be done live or through a video embedded into the power point if the director is unavailable to attend.

Using an interactive and experiential approach increases the likelihood that participant's will consistently implement youth development approaches and skills in their work place, community and personal lives. Participants bring with them the ideas, intuitions, and behaviors they have spent a lifetime building. Trainers have only a brief time in which to encourage effective learning and real and useful change.

How is this best achieved?

- **Identify Participants' Current Views** – Help participants to recognize and clarify their current ideas and behaviors and assess the usefulness of these ideas in working effectively with youth. This heightens their interest in learning effective alternative ideas and strategies.

- **Help Participants Construct Their Own Understandings** – Training isn't about just giving people a new set of ideas. The ideas have to fit into a framework of what they already know. You activate the framework by discussing their current views and then helping them to make new links to the material you are presenting. New meanings are not transferences by the trainer; they are transformations by the learner.

- **Be Aware of Participants' Level of Readiness to Learn** – Participants in a course will be ready to learn if they are there voluntarily, and if they identify problems and their limitations in solving them. If participants are not yet "ready", it is not advisable to proceed too far. Instead, work on encouraging their commitment, identifying their needs, and helping them to recognize the weaknesses in their current ideas and behaviors.

- **Use a Variety of Interactive Approaches** – Learning occurs by engaging the participant actively in the process. Use lots of questions. Questions hook the mind. Encourage debate and discussion within the confines of your time limits. This will be most fruitful if your questions do not require the "right" answer. Try to treat all answers as a contribution to the group's understanding. When people are assured that they won't be made "wrong" they are far more likely to contribute actively. The attitude shifts and understandings you are working towards can usually be elicited from the group, by astute questioning. They are more likely to become part of the person's behavioral repertoire if they can say "I thought of that myself". People love stories. Tell personal anecdotes that illustrate a point. Keep them short and relevant to the group's purpose. With the same provisos encourage participants to personalize the materials with their own stories. Wherever possible, work on current challenges experienced by participants. This heightens the significance of the example. Active investigations and practical experiences are especially valuable because they engage participants in moving repeatedly between mental concepts and actual behaviors.

- **Be Precise** – People also need to be reminded of what they have learned and what they are about to learn. Use introductions, summaries, and chart key points to focus and reinforce learning. This manual will help you be precise about the teaching points you are getting across. Muddled thinking does not promote change. Sharp clarity does.

- **Use Language Appropriately** – Ideas are made and shared using language. Where the vocabulary and syntax is precise and engaging (without being pedantic and over-blown),
ideas can more clearly be expressed, recognized and adapted to the uses of the participants.

Before The Learning Event

Facilitator should:

• Review the resource: Lisa Boesky, Ph.D.: Juvenile Offenders With Mental Health Disorders Who They Are, And What Do We Do With Them
• Read the entire Facilitation Guide, prepare necessary materials and rehearse presentations and activities.
• Coordinate with the agency or program administrator to attend the beginning of each learning event, share the importance of this topic to the program and how staff will be expected to use the concepts and skills they are learning in their work. [OPTION: Work with the administrator to create a 3- to 5-minute video to be shown to staff at the beginning of each session.]
• Arrange for a room large enough to hold the expected number of participants at tables of 5-6 people each, with room to move around between the tables and chairs. You will also need a table for materials.
• Model in your facilitation style the kind of empowering strategies youth workers could be using with youth. That is, encourage participants to ask questions, challenge the information and share opinions, even when they are not supportive of the content of this program. Encourage higher-level thinking and evaluation of their own attitudes and beliefs. Recognize risk-taking in trying out new ideas and behaviors. Support their learning efforts.
• Conduct a QMHP Pre-Training Interview:
  Prior to the training, interview the facility’s QMHP or the facility administrator (only if the QMHP is not available to you). Use the following questions in the interview. Record their responses, one response per card (write responses on a 12"X12" stock card).

  1) What is the name of the Qualified Mental Health Professional (QMHP) at your facility? Do you have access to more than one QMHP? If so, write down as many names as you can.

  2) What type of mental health professional(s) is your QMHP(s)? (e.g., Psychologist, Psychiatrist, Social Worker).

  3) What are the FORMAL ways staff communicate with your QMHP(s) about suicidal youth? What are the INFORMAL ways staff communicate with your QMHP(s) about suicidal youth?

  4) What are QMHPs expected to do once contacted about a youth at potential risk for suicide?

  5) Which of the QMHP(s) you listed is/are responsible for conducting in-depth suicide “assessments”? 
6) If this process runs smoothly in relation to suicidal youth, what do you think is the primary reason? If this process does not run smoothly in relation to suicidal youth, what do you think could make the process more effective?

Setting Up The Learning Event

Facilitator should:
- **Write on Flip Chart Paper: (bolded print is what should be on chart paper)**
  - “Please review the Agenda, Housekeeping and Ground Rules for the training in your workbooks prior to the start of training.”
  - “What If” and hang in the classroom. This is different than the Task List, these questions will be answered during an activity in class.
  - “Task List” or “Parking Lot” and hang in the classroom. Throughout the training, use this page to list promised or unresolved items that the trainer has committed to following-up with a participant or with the entire class.
- Make sure the room is arranged in table groups of 5-6 people and that no seats have their backs to the front of the room so everyone will easily be able to see you and the visuals.
- **Gallery Crawl Activity Preparation** Prior to the activity, prepare the flip-chart pages. On the top of two (2) pages write the question: **What observable behaviors should elicit concern for possible suicide risk?** Label these pages #1 and #3. On the top of two other pages write the question: **What in a youth’s history should elicit concern for possible suicide risk?** Label these pages #2 and #4.
- **Opening Role-play Preparation**
  - Materials Needed: CPR dummy, bed sheet, chair, cut-down tool, script card (2 copies)
  - Prior to the beginning of the session, hang CPR dummy in the training room suspended from a chair using a bed sheet and “hide” the cut-down tool in plain sight, but somewhere a ways away from the dummy and the chair. Select two volunteer actors for a short role-play. Share the role-play script with the volunteers.
- **Interview With A Suicidal Youth Activity Preparation**
  Choose two Actors in advance of the beginning of the training for the role-play. (See Role Play instructions in the handout section)
  - Role-play Instructions: Two will play the role of the staff and two the role of the youth. The rest of the group will play the role of active observers. Provide ALL actors with a copy of the “script”. Place the staff and the youth in two chairs facing each other. Remind the actors playing the role of the staff to read directly from the script and those playing the role of the youth to respond accordingly to their verbal and non-verbal cues.
PRIVATE Instructions for Interviewers: Give these instructions ONLY to the two actors playing the role of the “Interviewer.” Each interviewer will use the exact same list of questions but will receive different instructions for how to conduct the interview. Explain (without anyone else hearing) to the first interviewer that he/she is to do everything incorrectly, the interviewer should be distracted, uncaring, use no eye contact, pressed for time, and rude. In the second interview, the interviewer should do everything correctly: Be very attentive, be caring and supportive, use good eye contact, appropriate voice tone etc. Both interviewers should read directly from the script.

PRIVATE Instructions for residents: Give these instructions ONLY to the two actors playing the role of the resident. Explain to the “resident” that they will play the role of a resident who has a plan to commit suicide. They will respond to the staff questions exactly how they feel a youth would respond to the questions and to the manner in which they were being interviewed. Actors are encouraged to ad-lib their responses accordingly.

• Review Video Clips

The NPJSpeaks video: Suicide Prevention Among Youth in Custody: What You NEED to Know is divided into the following segments for use during this training:
Segment #1: “Introduction & Risk Factors” (0:00-5:00)
Segment #2: “Facilities Have Strategies in Place” (5:01-7:56)
Segment #3: “All Youth At All Times” (7:57-10:29)
Segment #4: “What Do We Do” (10:30-18:32)
Segment #5: “No Desire to Die” (18:33 – 19:35)
Segment #6: “Suicide Precautions/Michael” (19:36 – 22:47)
Segment #7: “There Are Few More Intense Fears” (22:48-24:01)
*NOTE: These segments are not used in numerical order in the training design. Be prepared to cue the segments using the counter numbers provided.

After The Learning Event

Facilitator should:
• Review the feedback forms for any patterns in participant comments or critical concerns.
• Consider alterations and adjustments to the workshop design in response to the feedback.
References

The following sources were referred to during the writing of this training:


Resources

For additional information:

“Mental Health” Chapter--Desktop Guide to Quality Practice for Working with Youth in Confinement [www.desktopguide.info](http://www.desktopguide.info)

Boesky, Lisa, Ph.D, (2011). *Juvenile Offenders With Mental Health Disorders: Who Are They & What Do We Do With Them* (2nd Edition) [www.aca.org](http://www.aca.org) or [Amazon.com](http://amazon.com)

Substance Abuse And Mental Health Services Administration [www.samhsa.gov/suicide-prevention](http://www.samhsa.gov/suicide-prevention)

Suicide Prevention Resource Center [www.sprc.org](http://www.sprc.org)

National Suicide Prevention Lifeline 1-800-273-TALK

Western Michigan University. Suicide Prevention Program. [http://wmich.edu//suicideprevention/basics/protective](http://wmich.edu//suicideprevention/basics/protective)
FACILITATION GUIDE

Pre-Training Set-Up

- Write on Flip Chart Paper: (bolded print is what should be on chart paper)
  - “Please review the Agenda, Housekeeping and Ground Rules for the training in your workbooks prior to the start of training.”
  - “What If” and hang in the classroom. This is different than the Task List, these questions will be answered during an activity in class.
  - “Task List” or “Parking Lot” and hang in the classroom. Throughout the training, use this page to list promised or unresolved items that the trainer has committed to following-up with a participant or with the entire class.

- “QMHP Activity Cards”
  Prior to the training interview the facility’s QMHP or the facility administrator (only if the QMHP is not available to you). Record their responses on 12”X12” cards, one answer per card. Use the following questions in the interview:

  1) What is the name of the Qualified Mental Health Professional (QMHP) at your facility? Do you have access to more than one QMHP? If so, write down as many names as you can.
  
  2) What type of mental health professional(s) is your QMHP(s)? (e.g., Psychologist, Psychiatrist, Social Worker).
  
  3) What are the FORMAL ways you communicate with your QMHP(s) about suicidal youth? What are the INFORMAL ways you communicate with your QMHP(s) about suicidal youth?
  
  4) What are QMHPs expected to do once contacted about a youth at potential risk for suicide?
  
  5) Which of the QMHP(s) you just listed is/are responsible for conducting in-depth suicide “assessments”?
  
  6) If this process runs smoothly in relation to suicidal youth, what do you think is the primary reason? If this process does not run smoothly in relation to suicidal youth, what do you think could make the process more effective?

- Gallery Crawl Activity Preparation (See page 25 & 26)
  Prior to the activity, prepare the flip-chart pages. On the top of two (2) pages write the question: What observable behaviors should elicit concern for possible suicide risk? Label these pages #1 and #3. On the top of two other pages write the question: What in a youth’s history should elicit concern for possible suicide risk? Label these pages #2 and #4.
- **Role-play Preparation**
  Materials Needed: CPR dummy, bed sheet, chair, cut-down tool, script card (2 copies)
  Prior to the beginning of the session, hang CPR dummy in the training room suspended from a chair using a bed sheet and “hide” the cut-down tool in plain sight, but somewhere a ways away from the dummy and the chair.

  Select two volunteer actors for a short role-play.

- **Give the following instructions to the Actors and prepare them in advance of the beginning of the training for the role-play.**

  **Instructions for Role-Play:** When you enter the room you find a youth with a sheet tightly wrapped around his neck suspended from his chair. You are to follow agency protocol on what to do if you ever find a youth hanging. You know you need a cut-down tool. However, neither of you is sure where the tool is located. Both of you frantically walk around the training room looking everywhere for the cut-down tool. *(In the meanwhile the youth is still in his room, suspended and unable to breathe).* After a couple minutes one of you finally locates the tool and rushes back to the youth. Once back in the room with the cut-down tool, neither of the staff holds the youth up to relieve the pressure on his neck. Instead you try to cut the ligature but find it’s so tightly wrapped around the youth’s neck- that cutting the ligature means cutting the youth’s neck. You both decide that cutting the youth’s neck is the lesser of the problems and cut the ligature. After finally getting the ligature off the youth’s neck you start administering CPR. After a few minutes of administering CPR you believe the youth is dead and you stop CPR. At this point, the trainer **STOPS** the role-play.

- **Set up table in back of training room. On the table put pieces of bedding sheet approximately 3 feet in length. You should have one piece of sheet for each participant in the training class. Also place a suicide cut-down tool on the table. Throughout the training, provide participants with the opportunity to experience cutting through the pieces of sheet – how much pressure does it require? Is it difficult to use the cut-down tool?**

- **Purchase prizes for the game “How well do you know your QMHP?” on page 38 of the lesson plan.**

**Training Design**

The training design is written to include two 10-minute breaks (one in the morning session and one in the afternoon session) and one 45-minute lunch. The trainer should use his/her discretion based on the flow of the training, input from the group, previously arranged schedule, etc. when those should occur. They are not written into the design to occur at a specific time. The trainer can find slides at the end of the power point deck to use to indicate break and lunch time.
OPENING ROLE PLAY- RESPONDING TO AN ACTIVE SUICIDE – 17 minutes

Welcome

SAY: Welcome to the workshop “Suicide Prevention Among Youth in Custody: What You NEED to Know.”

DO: Introduce the training team (by name and position only)

SAY: On behalf of the National Partnership for Juvenile Services and the National Center for Youth in Custody we are pleased to provide . . .

DO: At this point the volunteers who are going to do the role-play should walk into the room and “discover” the dummy “suspended” from the chair and the role-play should begin as scripted.

Role-Play Script: When you enter the room you find a youth with a sheet tightly wrapped around his neck suspended from his chair. You are to follow agency protocol on what to do if you ever find a youth hanging. You know you need a cut-down tool. However, neither of you is sure where the tool is located. Both of you frantically walk around the training room looking everywhere for the cut-down tool. (In the meanwhile the youth is still in his room, suspended from the chair, and not breathing). After a couple minutes one of you finally locates the tool and rushes back to the youth. Once back in the room with the cut-down tool, neither of you holds the youth up to relieve the pressure on his neck. Instead you try to cut the ligature but find it’s so tightly wrapped around the youth’s neck- that cutting the ligature means cutting the youth’s neck. You both decide that cutting the youth’s neck is the lesser of the problems and cut the ligature. After finally getting the ligature off the youth’s neck you start administering CPR. After a few minutes of administering CPR you believe the youth is dead and you stop CPR. At this point, the trainer STOPS the role-play.

DO: Stop the role-play at the point that the volunteers believe the youth is dead and stop CPR.

SAY: What if this were YOU? Would YOU know what to do in this high-stress situation?
Note to trainer: This is rhetorical—you are not waiting for answers.

**DO:** Thank the actors for their participation in the role-play.

**SAY:** You have just gotten a glimpse into what we are going to be covering today. Let’s review what we saw so that everyone is operating from the same perspective in this discussion.

**DO:** Display Slide: Responding to an Active Suicide – Did they do it right?

**SAY:** There is a table in the back of the room that has strips of sheets and a cut-down tool to provide you an opportunity to practice using the tool. If you have never had a chance to practice, I hope that you take advantage of this sometime during the training today, at a break or lunch time. Practice with a partner who can twist the sheet strip and hold it taut as you experience how much strength and pressure must be exerted to cut through the sheet.

**SAY:** Thank the group for their responses. We must now move on.

**Expectations**

**SAY:** The material we will be discussing today is based on national standards and best practices in our field. However, your facility has very specific policy and procedures that you are supposed to follow. Some facilities have policies that are up-to-date and consistent with national standards and best practices, and some are moving toward that goal. Please follow your current policies. We are not
telling you to deter from them. However, if you have any questions or concerns about your agencies/facility’s current suicide policy, we encourage you to talk with your supervisor. As indicated in the previous activity, our goal for this training is that as staff you gain a better understanding of youth that are suicidal as well as to discuss best practices regarding staff and facility responses to suicidal youth.

Note to trainer: If the group is already working on unit:

SAY: We would like to hear from you now and throughout the day, you work with these youth every day and many of you have had emotional, challenging or scary experiences with suicidal youth in your facility. It can be helpful to others to hear what their colleagues have been through.

Note to trainer: If the group is newly hired staff,

SAY: We would like to hear from you now and throughout the day, some of you have worked with suicidal youth or adults in other jobs, it can be helpful for others to hear what you have experienced since working with these youth can be emotional, challenging or scary.

SAY: For now, let’s focus on why you are here today and what you hope to get out of this training session to take back with you to do your job more effectively. Turn to page 7 in your workbooks and write down your expectations for today’s training? I will give you a minute to do that.

DO: Ask a few participants to share their hopes for the day. As participants respond, record their responses and post them on the wall.

Note to trainer: if you find that there are expectations that will not be covered in this session, identify those up front.

SAY: You have listed some very relevant expectations. We will cover many of these and will hopefully exceed what you might expect in some areas. There are/may be some listed however, that we may not cover in this training. I will put them on our Task List and get back to you after the session with answers or suggestions where you may find additional information. Thank you for sharing your expectations. One reminder, you will find today’s agenda, ground rules and other important logistic information in your workbook on pages 7-9. Please locate these items and reference as needed. Toward the end of the training we have set aside time to address your questions and concerns in a “What If” activity. Throughout the course of the training, if questions come up, write them on a piece of post-it paper and make sure that it gets stuck to the “What If” wall. Let’s get started with the learning.

Note to trainer: Create a Task List and make the commitment to follow-up on the items ONLY if that is something you are actually going to be able to do.
INTRODUCTION - 12 minutes

SAY:  As we go through the session today I will be using clips from a video that was taped as part of the NPJSpeaks series, this one presented by Dr. Lisa Boesky (NOTE: pronounced “Bo-S-Key), a psychologist and national expert on Suicide Prevention in juvenile justice facilities. Let’s listen as she introduces our topic of suicide prevention among youth in custody and identifies suicide risk factors for teens, including those in confinement.

DO:   Play Segment #1– “Introduction & Risk Factors” (0:00 – 5:00)

Script: Davonte was a 16 year old, who had been in and out of juvenile detention since he was 13. He’d always been sensitive to disrespect, used a lot of profanity and had a temper-- but he could usually keep his cool while serving his time. He liked to goof around—both on the unit and at school. Something was different when he returned to the facility in October. He was quieter than normal and he kept to himself. Everything and everyone seemed to get on his nerves. When peers would try to engage him, he would respond with cruel and cutting remarks. He was resistant to any staff direction and he directly challenged staff when they made basic requests. Davonte refused to get up in the morning and go to school--the few times staff forced him to go to school, he would threaten a teacher and get sent back to the unit where he would sleep in his room for most of the day. Staff overheard Davonte on the telephone telling his mom that his young son would be better off without him. That same night--when there was only one staff on shift--Davonte made a noose out of his sheet, climbed onto the top of his sink and tried to tie the sheet around the light box on the ceiling.

Suicide is the leading cause of death among youth in juvenile detention and correctional facilities.

As if that isn’t tragic enough—most of these suicides are preventable.

Today I want to talk about why youth in custody are at high risk for suicide, what we’ve done to try to stop these tragic deaths, and some of the ways I believe we can do it better.

Over the past decade, there has been a major reduction in the number of youth residing in juvenile justice facilities. Many of the youth who remain in juvenile justice facilities are some of the most violent and mentally ill adolescents in our country. They also are the most at risk for taking their own lives.

A study of youth in detention found 1 of 10 had thought about killing themselves in the past 6 months, and a little over 1 in 10 had made an actual suicide attempt at some point in their lives, with many trying to kill themselves more than once. Fewer than half of the youth with recent suicidal thoughts had told anyone about them. Rates are likely even higher among youth who are deeper in the system, those who reside in longer-term juvenile justice facilities.

Some of strongest risk factors for suicide among teenagers include:

- Suffering from a mental health disorder, especially Depression or Bipolar Disorder
- Abusing alcohol or other drugs
- Aggression or fighting
- Conflict or lack of connection with family—or other important relationships
- Physical or sexual abuse
- Childhood neglect
- Sporadic school attendance or completely dropping out
- Legal or discipline problems
Go to any juvenile detention or correctional facility and you will find youth with 3, 4 or 5 or more of the suicide risk factors I just mentioned.

Being detained or incarcerated would be stressful for most young people, but is even more so for those who are mentally ill. Studies have found 63-92% of youth in custody have a diagnosable mental health or substance use disorder.

And the typical coping skills used by many of these youth (cigarettes, alcohol, other drugs, fighting, sex, running away) are understandably forbidden while confined.

So our juvenile justice facilities are filled with young people possessing a multitude of suicide risk factors, currently in stressful circumstances or environments, with restricted access to their typical coping skills.

And then something happens. Sometimes it’s huge, sometimes it’s not. But, for some youth in confinement, life becomes too much to bear. One study found youth WHO WERE BULLIED IN CUSTODY were 9x more likely to try to kill themselves.

Most suicidal teens don’t want to die—they want to ESCAPE 1) unbearable emotional or psychological pain 2) an unbearable situation or circumstance or 3) an unbearable future or lack thereof.

Some confined youth become so angry, frustrated, or hopeless they just can’t take it anymore. Suicide attempts in facilities may be planned for days or weeks or they can be impulsive acts that happen in an instant.

**DO:** Display Slide: Risk Factors

![Risk Factors](image)

**SAY:** In her book, Juvenile Offenders with Mental Health Disorders: Who Are They & What Do We Do With Them, Dr. Lisa also talks about how previous suicidal thoughts, previous suicide attempts, stressful events, and hopelessness also raise a youth’s risk for suicide. Turn to page 10 and record your responses to the questions as we discuss Risk Factors.

**DO:** Allow participants 3 minutes to reflect on the questions on page 10 in their workbooks.

**SAY:** Why do you think some of these factors would raise a youth’s RISK for suicide?
Look for: Symptoms of mental health disorder might be heightened in confinement, feel depressed, feel alone, have low-self-esteem, causes stress, things not going right, no family support, can’t cope well, if tried it before knows how to do it, if have no hope there’s no reason to live.

SAY:  So can someone summarize the picture so far?  In terms of risk factors and coping strategies, what is happening with youth in custody?

Look for: We have youth with multiple suicidal risk factors, we have pretty much eliminated their preferred coping strategy and replaced it with something that in actuality causes them more stress.

SAY:  YES!  And then events happen – some in their control and some outside of their scope of control but many can potentially have a big impact as if lighting a match to a gasoline soaked pile of wood. These events can be big, as in the case of Jonathon McClard, the son of Tracy McClard, parent advocate and Juvenile Justice Reformer from Missouri, who committed suicide before being transferred to an adult facility. Or the events may seem little to us adults, but huge in the mind of a youth such as a break-up of a romantic relationship, harassment by peers on the unit or receiving bad news in a letter or on a phone call.

So how can we prevent suicide in confinement facilities? To get us started thinking through responses to this question, let’s listen to Dr. Lisa again.

DO:  Play Segment #3 “All Youth At All Times”: (7:57-10:29)

Note to trainer: The segments on the NPJSpeaks video are used in the training in a different order than they were presented in the video. Please use the counter numbers and script provided to find the correct location for the training

Script:  The best way to prevent suicide in juvenile justice facilities is to prevent youth from becoming suicidal in the first place!

These suicide resistant rooms and safety smocks are for youth on “Suicide Precautions”-- but 1) if most youth in custody have a multitude of suicide risk factors, 2) are under significant stress, and 3) are limited in strong healthy coping skills-- ALL youth in custody should be viewed as “at-risk” for suicide.

The hardworking men and women who supervise and manage these often volatile, often vulnerable, and often violent youth--plus the mental health professionals who assess these youth—are being asked to identify youth at the highest, highest, highest suicide risk among an already “high risk” population-- so they can protect them by putting them on suicide precautions. As you can imagine, this is a very challenging task.

It is also important to KEEP IN MIND, the majority of youth who have die by suicide in juvenile justice facilities were not on any type of suicide precaution at the time of their death. We need to be vigilant about suicide among ALL incarcerated and detained youth at ALL times.

The fact is – youth in custody are housed ALONE in rooms with doorknobs, handles, large hinges, protrusions on the ceiling, vents, towel racks, bunk beds, towels, floor drains, clothing hooks and other secure items to which they can tie a sheet, t-shirt, bra or torn blanket and asphyxiate themselves. Even toilet paper or plastic trash can liners can be twisted or braided into strong enough material to strangle oneself.
If a youth want to die, they can jump off the second tier of a 2 story unit, jump in front of a moving vehicle on campus. Strangle or hang themselves with hair extensions, or suffocate themselves by putting plastic liners of trash cans over their heads.

Despite being safe and secure facilities, there are multitudes of ways confined youth can kill themselves.

**PREVENTION: DOING THE THINGS WE DO WELL BETTER – 25 Minutes**

**DO:** Display Slide: Stop Suicide: Suicide Prevention: Doing the Things We Do Well – Better

**SAY:** Predicting suicide is an inexact science. Currently there is no way to predict exactly who will and will not take their own lives and this is even truer among youth in custody. We know that there are youth that have plans to kill themselves, but don’t, and there are youth that don’t make a plan, and do attempt to take their lives. This is why decisions regarding who is at highest risk to kill themselves must be based on a variety of different factors. On page 11 in your workbooks are examples of screening tools.

**Doing What Works – Better**

**DO:** Display Slide: Effective Strategies
SAY: There are several strategies that we will address throughout this training that direct care staff have a role in to help prevent suicide in confinement facilities. We will discuss how these strategies can be implemented most effectively.

Suicide Screening

DO: Display Slide: Suicide Screening

SAY: All youth in custody should be screened for suicide risk upon entering a juvenile detention or correctional facility. Perhaps this occurs with brief interview questions asked by the intake officer, or your nurse during the medical screening. It is recommended that facilities also use a reliable and valid standardized tool to screen for suicide.

DO: Display Slide: Screening Assessment Instruments

SAY: Examples of suicide screening assessment instruments include the Suicidal Ideation Questionnaire (SIQ), the Suicidal Behaviors Questionnaire-Revised (SBQ-R) or the Massachusetts Youth Screening Instrument or (MAYSI-2). The strengths of the SIQ and SBQ-R are that they specifically focus on suicide. Unfortunately there is not much research related to using these tools with youth in custody. The MAYSI-2 DOES have a lot of research showing it is helpful for detained or incarcerated youth, but as most of you know, it is a “mental health” screening tool
with a “suicide scale”. Facility administrators should work closely with their Qualified Mental Health Professional (QMHP) to decide how to best screen for suicide in their facility. The goal of a screening instrument is to alert staff to the level of potential risk of suicide. The outcome of the screening tool determines staff and the facility’s next response. If you recall from the beginning of the training, our goal is to inform you of national standards and best practice regarding suicide prevention. As you consider the information we have provided you regarding suicide prevention screening, now think about your agency’s/facility’s policies and practices in response to the following questions on page 12 in your workbooks.

Interactive Group Activity

DO: Display slide: What you should know about suicide screening tools

Note to trainer: Reveal the questions one at a time allowing the participants enough time to respond before moving on to the next question.

**SUICIDE SCREENING QUESTIONS**

1. What “mental health” screening tool is used upon intake in your facility? Does it ask about “suicide”?
2. Does your facility use a specific “suicide risk” screening tool? If so, do you know what it is called?
3. Who in your facility conducts this type of screening? What type of training do they have to prepare them to screen youth for suicide?
4. What types of questions are youth asked about to assess their risk of suicide? What types of behaviors would be concerning to staff who are screening youth for suicide?
5. If a youth scores “high” on one of these screening tools in relation to “suicide”—what is your facility’s response? What happens to that youth?
6. Are you given the results of either of these screenings? If not, would you want to see the results for the youth in your care? Why? If you are given the results, how are they helpful? If they are not helpful, what would make the process more helpful?

Questions on the Slide (these will appear one at a time on the slide):

1) What “mental health” screening tool is used upon intake in your facility? Does it ask about “suicide”?
2) Does your facility use a specific “suicide risk” screening tool? If so, do you know what it is called?
3) Who in your facility conducts this type of screening? What type of training do they have to prepare them to screen youth for suicide?
4) What types of questions are youth asked about to assess their risk of suicide? What types of behaviors would be concerning to staff who are screening youth for suicide?
5) If a youth scores “high” on one of these screening tools in relation to “suicide” risk—what is your facility’s response? What happens to that youth?
6) Are you given the results of either of these screenings? If not, would you want to see the results for the youth in your care? Why? If you are given the results, how are they helpful? If they are not helpful, what would make the process more helpful?
DO: Summarize the discussion by asking participants to rate how they feel about their 1) knowledge of and 2) participation in the screening process for a youth’s risk of suicide in the facility.

SAY: Using a scale of 1-5 with 1 being “I have no knowledge of the screening process”, and 5 being “I am fully knowledgeable of the screening process for suicide risk at my facility”, please stand when I call your number and stay standing until I have called off all of the numbers. If you would rate yourself a 5 – fully knowledgeable, please stand . . . stay standing, and let’s add to this group those that would rate themselves a 4 . . . a 3, a 2 . . . and a 1. Now I have a different question for you (all participants should be standing). Do you feel that you, as direct care staff, should have an increased role in the suicide prevention screening process? If yes stay standing, if no, you can sit down.

DO: Thank the group for their participation. Ask a few of the participants to share their reasons for responding the way that they did to the participation question – either why they felt they wanted a bigger role or they didn’t.

SAY: We are fully aware that the distribution of suicide screening information is based on your agency policies. However, having this information may enable you to better meet the needs of potentially suicidal youth in your care. Thank the group and move on.

Re-Screening

SAY: Screening youth at intake is essential. However, is it possible that a youth might NOT be suicidal when they first arrive at your facility—but become suicidal LATER?

Note to trainer: This is rhetorical, the obvious answer to this question is yes.

DO: Display Slide: When Should a Youth be Re-screened for Suicide Risk?
What types of things could occur later in their stay that might trigger suicidal thoughts or behaviors in a youth? Turn to page 13 in your workbooks and record your answers to the following questions:

- When should a youth be re-screened for suicide risk?
- What do “transition points” mean in the facility?
- Why would these transition points be particularly important for youth at risk of suicide?

Look for: when a youth is displaying symptoms of depression, after a youth returns from a court appearance and finds out they aren’t going home, lots of time in isolation, harassed by peers, gets additional charges, is getting transferred to the adult system, gets bad news, etc.

Youth should be re-screened for suicide risk ANYTIME they elicit concern due to their statements, behaviors, or incoming information from others. They should also be re-screened at important “transition” points—meaning a change in placement—this could be going from detention to a correctional facility, transfer to a group home or residential treatment facility, for some youth it may be prior to release if they have struggled with suicidal thoughts or behavior in the recent past.

So how do we determine those youth that are the HIGHEST suicide risk? How do we identify those youth that should be put on Suicide Precautions (i.e. Suicide Watch)? Direct care staff, supervisors, and QMHPs should work together to focus on the following 4 factors: Observable Behaviors, Youth History, Interview with Youth, Institutional Hazards.
Observable Behaviors & Youth History

SAY: “Observable behaviors” are what a youth is displaying this week, today, or right now.

DO: Display Slide: Youth’s History

SAY: A “youth’s history” refers to events or behaviors that have occurred prior to their stay in your facility—they may have happened days, weeks, months or years before you meet them.

DO: Conduct a “Gallery Crawl” Activity to share this information.

Pre-Activity Preparation

A. Flip-Charts
Prior to the activity, prepare the flip-chart pages. On the top of two (2) pages write the question: **What observable behaviors should elicit concern for possible suicide risk?** Label these pages #1 and #3.

On the top of two other pages write the question: **What in a youth’s history should elicit concern for possible suicide risk?** Label these pages #2 and #4.

**B. Hang the Flip-Charts**

Hang the flip-chart pages in numerical order around the room, spaced so that the learner teams have to walk from one question to another.

**C. Markers**

Have a different color marker available for each team, i.e. if you have 4 teams, you will need to have 4 different color markers.

**DO:** Conduct the Gallery Crawl Activity

Divide the class into 4 teams. Assign each team to start at the flip chart page corresponding to their team number and record their answers to the question on the paper, either: 1. **What observable behaviors should elicit concern for possible suicide risk?** (2 teams), or 2. **What in a youth’s history should elicit concern for possible suicide risk?** (2 teams).

Allow three (3 minutes) at the first station. At the end of the first time segment, groups should rotate (clockwise) to the next flip chart paper. Ask each group to read the responses already written on the flip chart paper, respond to those responses and/or add unique responses to the list. Allow four (4) minutes at this station. At the end of the second time segment, rehang the flip chart papers, #1 with #3 and #2 with #4. Instruct the groups to conduct a Gallery Crawl (as in an art gallery, walk around and see the responses from all of the groups). As the participants return to their seats, the trainer should prepare to ask the final processing questions.

*Note to trainer: Save these lists to reference in later activities.*

**DO:** Refer to the lists created for Observable Behaviors

**SAY:** *When thinking about the lists created for Observable Behaviors, what did you see that surprised you on the list that made you think, “Wow – I will have to remember that?”* Did you see any behaviors on the list that you would question or disagree with? Why?

**SAY:** To compare, and to complete the lists in your participant workbooks on page 14, look at the lists on the screen that were compiled from the research and literature.

**THE IMPORTANCE OF OBSERVABLE BEHAVIORS – 20 minutes**

**DO:** Display Slide: Observable Behaviors (2)
SAY: **Knowing the youth you work with are already at risk for suicide, you would want to pay even closer attention if they ALSO start showing these “observable behaviors.”** Displaying 1 or 2 of them does not mean a youth is going to kill themselves, but the more “observable behaviors” we see, the more concerned we are about a youth’s risk of dying by suicide. And, as you can see, some “observable behaviors” are more concerning than others.

SAY: **When you look at the list of “observable behaviors”—what mental health disorder has many of those symptoms?**

Look for: Depression, Bipolar, Persistent Depressive Disorder

DO: Display Slide: “Mood Disorders”

SAY: **Turn to page 15 in your workbooks and record your thoughts as we discuss Mood Disorders. We talked earlier about the “Mood Disorders” being one of the biggest risk factors for suicide. Teenagers can suffer from Major Depression, Bipolar Disorder, Persistent Depressive Disorder or any of the other Mood Disorders. Many people do not know that Depression in teenagers, particularly those in custody, does not typically appear as sad and tearful. “Major Depression” and “Persistent Depressive Disorder” (a chronic form of Depression that used to be called Dysthymia) in OUR population is more commonly expressed through irritability, agitation, or aggression—in addition to the other symptoms of Depression (for example, sleep problems, losing interest in things they used to like, difficulty concentrating).**
SAY: Youth with Bipolar Disorder (which used to be known as “Manic Depression”)—alternate between symptoms of MANIA and symptoms of DEPRESSION—again, both can be expressed through irritability, agitation, or aggression, especially among the youth we work with.

SAY: This is a CRITICAL point for “Suicide Prevention” in your facility because Mood Disorders are a key risk factor for youth who die by suicide—YET many detained and incarcerated youth with Mood Disorders are overlooked or misdiagnosed with Conduct Disorder. Not only do they not receive the treatment they need, youth with Mood Disorders, especially when undiagnosed and untreated, tend to receive multiple and repeated sanctions and restrictions, intensifying their depressive-related symptoms.

THE IMPORTANCE OF YOUTH’S HISTORY – 25 minutes

Note to trainer: Thank the participants for coming back from break on time. Check for Understanding regarding the previously covered material before proceeding.

DO: Refer to lists related to “Youth’s History” from Gallery Crawl activity.

SAY: When thinking about the lists you wrote in the Gallery Crawl activity for “Youth History,” what did you see that surprised you on the list or that made you think, “Wow – I will have to remember that?” Did you see any history factors that you would disagree with? Why?

DO: Display Slide: Youth History

SAY: When you look at this slide and your lists, some of the items may look familiar because we talked about some of them this morning when we talked about “Risk Factors”. Access to a youth’s history is often dependent on your setting or facility policy, and how much youth are willing to disclose to you. Given the population you work with, when you review a youth’s history, it will likely contain one or more of the items listed on this slide. BUT that does not necessarily indicate an imminent threat of suicide. However, the more risk factors in a youth’s history, the higher their “risk” of
suicidal behavior. Which of the issues listed under Youth’s History should elicit the MOST concern for suicide precaution/prevention—and Why? On page 16 in your workbooks is the list of items in a Youth History’s to consider when determining “Risk”.

Look for: previous suicide attempt, exposure to someone’s suicide

SAY: Are there any further questions or comment on the importance of knowing a youth’s history prior to entering your agency?

DO: Answer any questions or comments and move on.

Briefly Interviewing Youth For Suicide Risk

SAY: Youth themselves are the only ones who truly know if they are thinking about suicide or are planning on taking their own lives. Therefore, being comfortable talking to youth about suicide-related information is essential. A word of caution with interviewing youth however, you never want this to be the sole source of information-gathering as youth may not be truthful or totally forthcoming with all of the information.

SAY: What are some reasons a youth may pretend they are suicidal when they really are not?

Look for: attention, special treatment, a 1:1 staff to chat with, special housing, transfer to a hospital, drugs/medication, get out of doing something they don’t want to do

SAY: What are some reasons a youth may deny suicidal thoughts or behavior, despite truly having them?

Look for: embarrassed, don’t want to seem weak or crazy, don’t want to be put on suicide “watch,” don’t want someone to stop them

SAY: In the book “Juvenile Offenders with Mental Health Disorders: Who Are They & What Do We Do With Them” Dr. Lisa says that staff should approach juveniles they are concerned about, convey the specific behaviors that have them worried, and directly ask youth if they have been thinking about killing themselves. Staff should ask how youth would go about killing themselves if they report suicidal thoughts. She emphasizes the importance of differentiating juveniles with passing thoughts of dying from those seriously considering ending their lives. If youth describe having a suicide plan, staff should ask questions to assess 1) the specificity, 2) availability, and 3) lethality of the plan.

DO: Display Slide: SAL
SAY: The acronym (SAL) on the slide can be used to guide your interview questions. For more information on SAL turn to page 17 your workbooks.

S stands for be SPECIFICITY. How “specific” is the youth’s plan to kill themselves? You should gather as much detailed information as possible. The more “specific” a youth’s plan, the higher their risk of suicide.

A stands for AVAILABILITY. Is the youth’s plan “available” to them? Do they have a sheet to hang themselves or psychotropic medication to overdose?

SAY: What other methods might youth have access to in your facility that they could use to kill themselves?

Look For: jump off 2nd tier, strangle self with t-shirt, etc.

SAY: The more access juveniles have to carry out their plan the higher their risk of dying by suicide.

SAY: L stands for LETHALITY. How likely will the youth’s suicide plan result in death? For example, a plan to hang him/herself in his/her room during the night shift, is more lethal than a plan to slice their wrist with a safety pin. The higher the lethality of the plan, the more youth are at risk of dying by suicide.

DO: Display Slide: Additional Questions

Additional Questions
1. If the youth has ever made a previous suicide attempt. If so, when and how, and were they hospitalized?
2. If they ever thought about suicide and did NOT make an attempt. If so, what did they do to cope in that situation?
3. What ONE THING would help them no longer feel suicidal?
SAY: In the book “Juvenile Offenders with Mental Health Disorders,” Dr. Lisa says if there is enough time after going through SAL, it can be very helpful to ask 1) if the youth has ever made a previous suicide attempt. If so, when and how, and were they hospitalized? 2) If they ever thought about suicide and did NOT make an attempt. If so, what did they do to cope in that situation? And 3) what ONE THING would help them no longer feel suicidal?

SAY: I wish we could say this formula is foolproof. That youth with specific, lethal and available plans are most likely to kill themselves and those who don’t have these types of plans won’t. But suicide is complex, especially among youth in custody. Some detained or incarcerated youth have killed themselves impulsively without any type of plan. And there may have been others with specific, lethal plans with availability who have never made an actual attempt. But, this is a good guide. Refer all youth of concern to the QMHP so they can assess a youth’s suicide risk further. Equally important to having a plan for talking with youth about suicide is honing your “interview skills.” Your approach or demeanor during the interview can make the difference in whether or not a youth admits or denies suicidal thoughts or behaviors, and whether or not they disclose specifics to you. Before we go on to our next activity, let’s quickly review staffs’ ideal demeanor during a one-on-one interview.

Interview Activity: Pre-Interview Preparation

Note to trainer: This is an interview between a staff and a youth. The objective of the role-play is to demonstrate both an effective and an ineffective interview technique. The purpose of the interview is to gather as much information as possible—as quickly as possible—to determine if the youth has specificity, availability and lethality to their suicide plan using SAL as guidelines to ask the questions.

DO: Choose four volunteers from the group letting them know they will be doing a role play in front of the entire group. Distribute a copy of the Handout titled “Staff Interview with a Suicidal Youth” to each role-play participant.

Note to trainer: When possible, look for volunteers who are enthusiastic, outgoing, and engaged participants willing to take on the roles necessary to provide a dramatic and impactful role-play.

Role-play Instructions:
Two will play the role of the staff and two the role of the youth. The rest of the group will play the role of active observers. Provide ALL actors with a copy of the “script”. Place the staff and the youth in two chairs facing each other. Remind interviewers to read directly from the script.

PRIVATE Instructions for Interviewers: Give these instructions ONLY to the two actors playing the role of the “Interviewer.” Each interviewer will use the exact same list of questions but will receive different instructions for how to conduct the interview. Explain (without anyone else hearing) to the first interviewer that he/she is to do everything incorrectly, the interviewer should be distracted, uncaring, use no eye contact, pressed for time, and rude. The interviewer can stop the interview at the point...
they feel that the youth is non-responsive to their questions. In the second interview, the interviewer should do everything correctly: Be very attentive, be caring and supportive, use good eye contact, appropriate voice tone etc. This interviewer should complete the entire interview.

Instructions for residents: Give these instructions ONLY to the two actors playing the role of the resident. Explain to the “resident” that they will play the role of a resident who has a plan to commit suicide. They will respond to the staff questions exactly how they feel a youth would respond to both the questions and to the manner in which they were being interviewed. In round one we are expecting that the youth will shut down and become non-responsive.

Handout: Interview Script

Staff Interview With A Suicidal Youth

STAFF- Jose, can I talk to you for a minute?
YOUTH—I guess. (affect is appropriately responsive to the affect of the interviewer)

STAFF—Been watching you around the unit the last few days and you don’t seem to be acting like your regular self.

YOUTH—I’m cool man.

STAFF—I’ve noticed you’ve been spending a lot of time in your room, during meals you haven’t been sitting with Charlie or Desmond and you guys are usually the three musketeers.

YOUTH—I said I’m cool man.

STAFF—Okay, you may be, but I wanted to check in. Did anything happen on the unit or at home that may have changed things?

YOUTH—Nah. Just my little brother. He was beat up bad over the weekend. He’s in the hospital, he’s really messed up.

STAFF—I’m sorry to hear that….

YOUTH—….Think they were after me. The guys who did it. But since I’m locked up they went after my brother. So it’s pretty much my fault. That’s what my mom says. She says I mess up everything. First my life, and now my little brother’s life. She probably wished it was me. She wouldn’t even care if I died.

STAFF—You don’t really believe that about your mom do you?

YOUTH - Damn straight. I know it.

STAFF—Have you thought about dying?

YOUTH—Doesn’t everyone?

STAFF—I mean like killing yourself while you’re in here.

YOUTH—After this happened. I guess. A little bit.
STAFF - If you were to kill yourself in here, what would you do?
YOUTH – I don’t know, probably use my sheets to hang myself.
STAFF – What would you hang it from?
YOUTH— I don’t know. Someone said you can tie it around your desk or the end of bed. I don’t know.
STAFF--Have you decided when you would do this?
YOUTH – Nah. Although I would do it in my room and would wait until late at night after the staff does their checks, because they don’t really check us very often
STAFF - It sounds like you have this all figured out. Can I ask you a few more questions?
YOUTH - I guess.
STAFF – Have you ever tried to kill yourself before?
YOUTH - I tried to kill myself a little before Christmas. .
STAFF- What did you do then?
YOUTH – Got a gun and was gonna blow my brains out.
STAFF—What happened? Did you have to go to the hospital?
YOUTH—Nah man, I chickened out.
STAFF – How often do you think about killing yourself Jose?
YOUTH—I don’t know.
STAFF--Have you ever thought about it and NOT tried to kill yourself
YOUTH – Yeah, I think about killing myself a lot but I don’t do it.
STAFF—What has kept you from doing it?
YOUTH—My little brother, he looks up to me. Our dad is locked up, and who knows where my other brother is. I’m all he has. I couldn’t do that to him.
STAFF – I want to thank you for being so honest with me and answering my questions. I also want you to know that when you think about this type of stuff, you can come to me or any staff member any time—day or night. That’s an important part of why we're here.
YOUTH: So now what?
STAFF: Given what we talked about, Have to admit, I’m concerned for your safety. And I want to help you get back to the funny guy who helps so much around the unit. I have to share this information with Mr. Johnson, my supervisor and Ms. Ramen the psychologist. I’m not sure what will happen after that, but they’ll probably have some more questions for you and then they’ll want to do what’s best to help you stay safe and get you back involved on the unit. Why don’t we go and talk with Mr. Johnson together.
YOUTH: Okay.
End of Interview
Conducting The Activity

SAY: *Equally important to having a plan for talking with youth about suicide is honing your “interview skills.”* Your approach or demeanor during the interview can make the difference in whether or not a youth admits or denies suicidal thoughts or behaviors, and whether or not they disclose specifics to you. Before we go on to our next activity, let’s quickly review staffs’ ideal demeanor during a one-on-one interview.

SAY: **How should you conduct yourself during a sensitive and serious interview with a youth?**

Look for: relaxed, quiet tone, direct, maintain eye contact, open listening

DO: Allow a few responses from the group before displaying the slide: Staff Interviewing Behavior

SAY: *It’s important to remember that you may be dealing with a very volatile or sensitive youth and how you react to them: what they say, what you say, your eye contact, and voice volume and pacing could dictate the success of your interview. They will take their cues from you. Even though we are suggesting that you use the SAL format, you must become comfortable enough using the format that you can use it “conversationally.” The worse thing you can do is to make a youth feel like you are running down a “checklist.”* Please turn to page 17 in your workbooks for further information on suggestions of how staff should conduct themselves in the interview. We will now go on to the actual interview activity.

SAY: *I have asked four volunteers to conduct a demonstration of effective and ineffective interviewing techniques.* Please pay specific attention to the impact the staff affect has on the youth. We will process this activity after the two demonstrations are completed.

DO: Instruct volunteers to demonstrate ineffective and effective interview techniques.

Post-Activity Processing

DO: After the interviews are completed, ask the following questions of the observers and actors.
• Ask “Interviewers”: How did it feel for you conducting the interview?
• Ask “Observers/Audience”: How might this be alike or different from what a staff might feel in a “real” interview?
• Ask “Observers”: How do you think the suicidal youth felt during the interviews?
• Ask “Youth Actors” How did it feel for you as a suicidal youth being interviewed?
• How might this be alike or different from what a youth might feel like in a “real” interview?

Note to trainer: Be sure to elicit responses regarding the feelings of staff and youth in both the effective and the ineffective role-play. Emphasize that the staff demeanor plays a critical role in the youth’s willingness and ability to feel comfortable and engaged in the interview.

DO: Ask “Observers/Audience:”
• Did staff ask the right questions?
• Do you think SAL helped keep the interview on track? Why or why not?
• Please state the specific differences between the two interviews.
• Which interviewer or interview style is likely to get honest, accurate information from the youth?

SAY: In closing this activity, the important takeaways are: 1) having a plan for how you will interview youth about suicide from the outset helps you quickly get to the pertinent information, and 2) paying attention to your own demeanor helps set a comfortable environment for conducting a good interview and obtaining critical information you need.

DO: Display Slide: Who Is Most At Risk?

SAY: We have covered Observable Behaviors, Youth History, and the Interview with Youth. The fourth component we consider when determining which youth are potentially at HIGH risk of suicide is environmental or facility factors or hazards that could contribute to a youth’s risk of killing themselves.

Identifying Facility Hazards
SAY: *In the book “Juvenile Offenders with Mental Health Disorders” there is a list of some of the most common suicide facility hazards. As you can see, these can range from how many staff are available to watch the youth to the physical layout of the units.*

DO: Display Slide: Suicide Facility Hazards

![Suicide Facility Hazards](image)

DO: Divide the group into teams of six to eight participants, give each group flip chart paper and markers.

SAY: *For this activity each group needs to choose a reporter and recorder. We are going to have a competition—think about YOUR SPECIFIC FACILITY—looking at the list on the slide, come up with as many specific facility hazards in each of those categories as possible in 3 minutes, for example not having QMHP to distribute psychotropic medications would be a hazard under the category of psychotropic medications. Think about where youth are housed, how they are supervised, what they wear, etc. When I say go, start listing off as many hazards as you can. Your reporter should write them on your flip chart paper. You can also record your answers on page 18 in your workbooks.*

*Note to trainer: To add some excitement to the activity, continually give time updates. When time has lapsed have the reporters post their lists. The winning team is the team that has listed the most hazards.*

SAY: *Thank you for your efforts to compile a comprehensive list of facility hazards. Similar to the other factors we’ve discussed—the more suicide hazards your facility has, the higher the likelihood a youth could kill him or herself while in your care.*

DO: Time permitting, allow participants to explain how and where they might find these items in the facility.

*Note to trainer: Save the lists to use in a later activity.*
SAY: After you have reviewed all aspects of screening: Risk Factors, Observable Behaviors, Youth History, and Facility Hazards and completed the Interview with Youth, then you will make the decision to refer to the Qualified Mental Health Professional or QMHP.

QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP) - 50 minutes

Who Is a QMHP?

SAY: You work with young people day in and day out—you get to know them in a way that no other professional in the facility does. That is why your observations—what you see and hear—are a critical part of suicide “screening”. However, you are probably not a mental health professional or trained in suicide assessment, so it would be unfair to expect you to make advanced judgments about which youth is most likely to kill him or herself and who is not.

SAY: Fortunately, most juvenile justice facilities now have access to one or more “Qualified Mental Health Professionals” (QMHP’s). If a youth is determined to be a potential risk for suicide at intake or if at any time during a youth’s stay staff are concerned that youth may be a potential risk for suicide—an immediate referral should be made to the facility’s QMHP so they can conduct an in-depth suicide “assessment.”

DO: Display Slide: QMHP

SAY: According to the National Commission on Correctional Health Care (NCCHC), QMHP’s are psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

(Activity: How Much Do You Know About the QMHP That Works In Your Facility?)
Pre-activity Preparation: Interview the qualified mental health provider and/or the facility administrator (if the QMHP is not available to you) using the 6 questions listed below. Record their responses on answer cards, one response per card.

Note to trainer: It is acceptable to add a trivia question or two about the facility or administrator of the facility just to add some fun to the training activity.

Materials needed: 6 - (12”X12”) cards per table and one marker per table.

SAY: Prior to the training we asked a series of questions to your facility administrator/QMHP regarding your facility’s QMHP. Their responses are written on these cards. We are going to play a quick game to see which table can match the most responses to the responses on our cards. These questions are also on page 19 in your workbook.

DO: Instruct each table to choose a recorder and a reporter. Ask the following questions and instruct the recorder to write the table group’s response on the card.

1) What is the name of the Qualified Mental Health Professional (QMHP) at your facility? Do you have access to more than one QMHP? If so, write down as many names as you can.

Note to trainer: Most facilities have access to a psychiatrist and one other type of MH professional at a minimum.

2) What type of mental health professional(s) is your QMHP(s)? (e.g., Psychologist, Psychiatrist, Social Worker).

3) What are the FORMAL ways you communicate with your QMHP(s) about suicidal youth? What are the INFORMAL ways you communicate with your QMHP(s) about suicidal youth?

4) What are QMHPs expected to do once contacted about a youth at potential risk for suicide?

5) Which of the QMHP(s) you just listed is/are responsible for conducting in-depth suicide “assessments”?

Note to trainer: Even though most facilities have access to psychiatrists, that is often NOT who does the in-depth suicide assessment.

6) If this process runs smoothly in relation to suicidal youth, what do you think is the primary reason? If this process does not run smoothly in relation to suicidal youth, what do you think could make the process more effective?

DO: After you have asked all 6 questions, ask the reporters from each group to come to the front all at the same time, with their cards. When you re-ask the question and reveal the QMHP/administrator’s response, each reporter reveals their table’s response, one at a time (like a game show). The winning team is the group that matches the most responses to the administrator/QMHP card.
Making A Referral To Your QMHP

SAY: Now we know WHO your QMHPs are—and what they DO in relation to suicide. Turn to page 20 and follow along as we discuss making a referral to your QMHP. Just to reinforce the point—if your QMHP is on duty in the building and a youth is identified as “potentially suicidal” either from their 1) intake screening, 2) a suicide screening later during their stay or 3) based on something staff saw or heard—Staff should remain with youth until the QMHP can do a “suicide assessment”. If there is NO QMHP on duty in the building, youth identified as “potentially suicidal” in any of these ways should be placed on “suicide precautions” and your QMHP should be contacted immediately.

SAY: When preparing the referral to your QMHP (either on a referral form or directly speaking to the QMHP), there are several sources of information that should be communicated when completing the referral. These include behavior observations, a review of the youth’s history, key information from your or someone else’s interview with the youth (which should have been done in person), and hazards in your facility. None of these sources are complete and accurate predictors of suicidal behavior in youth and certainly not when considered in isolation. Which also means—a LACK of concern in one of these areas does not automatically mean a youth is not going to attempt suicide. Suicide is a very complex behavior, particularly among youth in custody.

Suicide Assessment

DO: Display Slide: Suicide Assessment

SAY: So……What should the QMHP do with the referral information?

Note to trainer: This is a rhetorical question; no response is required.
**SAY:** Suicide “assessments” go more in-depth into the areas covered in suicide “screening”; an assessment is more comprehensive. QMHPs consider what they already know about a youth, and should also gather information from others in the facility that have been interacting with him/her.

**DO:** Display Slide: What should the QMHP do with the referral information?

- Degree of suicide risk
- Level of monitoring required by staff
- Develop youth’s safety plan
- Communicate plan with staff

Suicide assessment should be completed as soon as possible, but must occur within 24 hours.

**SAY:** ALL of this information, and possibly other sources as well, are integrated, taking into account what we know about teen suicide and suicide in custody—and decisions are made about:

1) Youth’s level of suicide risk
2) Level of staff monitoring the youth requires

The QMHP is also responsible for:

1) Developing the youth’s safety plan AND
2) Communicating that safety plan to relevant staff

A QMHP should complete a suicide assessment as soon as possible, but no longer than 24 hours after being contacted. Staff should continuously monitor (1:1 supervision) potentially suicidal youth while they are waiting for a QMHP’s assessment.

**How To Do What We Are Currently Doing—Better**

**DO:** Display Slide: Stop Suicide: Suicide Prevention
SAY: Given the high-risk nature of the youth in our facilities, we must be doing something right, because most youth in custody do NOT kill themselves. Partly it is because many of the youth we work with are resilient. Partly it is because facilities have policies and procedures that specify how to monitor and house suicidal youth. But, youth still die in custody. One suicide death is tragic, and there have been many.

DO: Ask for a show of hands

SAY: Think about the facility you work in, how many think we could be doing better with our Suicide Prevention efforts? How many think your facility has all the right components in place for good Suicide Prevention?

Note to trainer: if training new staff that hasn’t begun working yet, skip these 2 questions.

Let’s listen to Dr. Lisa again:

DO: Play Segment #2 “Facilities Have Strategies in Place” (5:04 – 7:56)

Note to trainer: The segments on the NPJSpeaks video are used in the training in a different order than they were presented in the video. Please use the counter numbers and script provided to find the correct location for the training.

Script: Fortunately, most juvenile justice facilities have strategies in place to protect these high risk youth from killing themselves. They provide suicide training for their staff upon hire. They screen every youth for suicide risk upon entry to the facility. When youth appear potentially suicidal upon intake, they refer them to an in-house or contracted mental health professional for a more in-depth suicide assessment. These components are essential to keeping youth alive. Line staff are required to more intensively supervise and monitor youth who report suicidal thoughts or exhibit suicidal behavior and these youth are typically housed in “suicide-resistant” rooms. Keeping youth away from things that can kill them is critically important, which is why very few suicides occur in “suicide resistant” rooms.

BUT, if youth already feel depressed, hopeless, humiliated or alone—what potential effect will spending hours in this room have on them?
What if suicidal youth must remain in this room for 23 hours a day for several days in a row—and is only let out of their room to go to the bathroom and for 1 hours to exercise?

What if these youth have to remove their clothes and are made to wear a suicide safety smock?

What if they have an adult authority figure watch them CONSTANTLY as they sit alone in their misery, anger or frustration, wearing nothing but their underwear or a smock?

These are all-too-common scenarios. Will these strategies help reduce suicidal youths’ feelings of Depression? Humiliation? Frustration? Anger? Isolation? Or could it potentially make it worse?

Suicide precautions are different than “treatment”—Restricting juveniles’ access to potentially lethal methods and closely supervising them helps keep them safe.....but often does little to decrease their distress, mental health symptoms, or hopelessness. In fact, when isolated from peers, staff, and programming, the suffering of suicidal youths can actually worsen. When alone in a cold and empty room, suicidal youth have little to distract them from their problems, and A LOT of time to think about creative ways to kill themselves.

Precautions Are Different Than Treatment

SAY: Dr. Lisa made a statement in the video that I would like for us to ponder She said “Suicide precautions are different than “treatment”—Restricting juveniles’ access to potentially lethal methods and closely supervising them helps keep them safe, but often does little to decrease their distress, mental health symptoms, or hopelessness.” It sounds like there are practices that we engage in that fall under the category of “suicide precautions” that focus on trying to keep youth from making a suicide attempt in our facilities (which is important), but do not address WHY youth are feeling suicidal and do not attempt to actually HELP them feel better. Let’s see if we can list some of these practices.

DO: Record participant responses on flip chart paper.

Look for: isolate suicidal youth, pull suicidal youth from programs, stare at youth, force youth to talk to someone they don’t want to talk with.

Note to trainer: Please keep in mind that this could be a very lively discussion so please be mindful of time. Also, this should be a constructive conversation instead of a destructive one.
SAY: **If these are practices that we should modify, it begs the question, what should we do instead?** For the answer, let’s look to another piece in the NJPSpeaks video, this one titled, “The Best Way to Prevent Suicide in Juvenile Justice Facilities is to Prevent Youth from Becoming Suicidal in the First Place.”

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**THE BEST WAY TO PREVENT SUICIDE – 30 minutes**

**DO:** Play Segment #4 “What Do We Do” (10:30-18:32)

**Script:** Jayda, 14 at the time, had a fiancé, whom she had met only 4 months prior. She had been diagnosed with bipolar disorder, and prescribed mood stabilizing medication, which only she took sporadically. Jayda said alcohol and meth balanced her moods best. While she was detained she heard from some of the other girls that her fiancé had gotten another girl pregnant. She carved the words ugly, alone and bitch into her leg with a paper clip. Two days later when she went to shower, she took an unusually long period of time. When staff went to check on her they found her hanging—she had ripped the bottom of her t-shirt, tied it into a noose, and hung it from the shower head. So what **DO** we do?

Assign a 1:1 staff to all youth so there is a set of eyes on them at all times? Of course not. Keeping every youth locked up in suicide resistant rooms is not only unrealistic, but would likely be psychologically harmful and make things worse. What we need to do is ensure we have “protective factors” in place to decrease the chances that ANY youth in the facility becomes suicidal. These are often overlooked elements, yet they are **fundamental** to effective suicide prevention.

If stress can push an already high risk youth over the edge—we can help reduce the stress. Some individuals (within juvenile justice & the general population) believe that if juvenile justice facilities are unpleasant enough, harsh enough and punitive enough, teens will be less likely to commit crimes so they don’t have to return.

The research not only demonstrates this isn’t true—it actually shows just the opposite. We get much better outcomes for adolescents when they spend time in juvenile facilities that emphasize positive relationships, education and skill-building over punishment—and the less likely they are to return.

So.... We can help youth develop positive RELATIONSHIPS w/ staff & peers while they are in custody--as well as help them maintain (and strengthen) the relationships they have with parents, other caregivers, family members, & key individuals in the community.

We can and should train, encourage and reward staff who regularly engage w/ youth and develop trusting and supportive relationships w/ them.

--Listening, caring, & connecting w/ youth can happen during card games, shooting hoops, lifting weights, or just passing time on the unit.

--Line staff will never know how many potentially suicidal youth chose NOT to take their lives because of the support or concern they knowingly or unknowingly provided.

**What else can we do????**

We can and should keep youth busy with relevant and meaningful PROGRAMMING—educational (PHOTO), vocational and creative. Earning school credits, passing the GED or earning a high school diploma can increase youths’ self-worth and hopeful thoughts about their future. (PHOTO) Facilities have
seen dramatic changes in youth and staff’s mood and behavior after implementing creative programs such as gardening, welding, computer repair, auto repair, pet therapy or graphic design.

If 63 to 92% of youth in custody meet formal criteria for a mental health or substance use disorder—these are two of the biggest risk factors for suicide—we should have an adequate number of “Qualified Mental Health Professionals” in facilities to provide quality mental health assessments, and individual and group mental health TREATMENT.

There are a variety of evidence-based treatments that can help youth in custody learn important skills in relation related to anger management, emotion regulation, social skills, and effective coping. Many of these programs can be provided during short term detainments, and they are essential for youth confined for more than 30 days.

We can and should make units more home-like in look and feel instead of correctional or institutional. Pleasant colors, designs or youth artwork on the walls, plus comfortable chairs, rugs or carpet to absorb sound, and decorations made by youth for each holiday are just some possible examples. Depending on their charges, court date, sentence, or placement options, some youth live in detention and correctional facilities for months or even years.

We need to increase collaboration between juvenile justice, mental health, medical, and educational professionals—a meeting should occur each day (even if only briefly) with a representative from each discipline to discuss which youth are on “Suicide Precautions” which youth are struggling, getting in trouble, fighting, not going to school, isolating themselves—or DEMONSTRATING other behaviors of concern AND then we’d discuss the best strategies to SUPPORT them.

This is essential FOR every facility—it’s not easy—we’re all busy—but it is fundamental to true suicide prevention.

Line staff are the eyes/ears of the facility. That’s who is there when:

--youth get a bad phone call
--an expected visit doesn’t happen
--bad news is delivered
--youth return from court
--and there are changes to youths’ medication

Formal systems should be in place for line staff to communicate what they see/hear, as well as provide feedback regarding dynamics on the unit.

Plus--Line staff make key referrals to QUALIFIED MH Professionals—

Clinicians’ suicide assessments of youth are much more accurate they have information from the unit staff who work with these young people day in and day out. We can and should provide challenging and fun recreation and leisure activities. Vigorous exercise can decrease depression, reduce anxiety & help youth sleep better. Yoga does too!

Basketball, video games, and corn hole can be a lot of fun, but it’s important to integrate additional “team” AND “individual” recreation activities.

Many of us have seen youth who barely cracked a book in the community become avid readers (or actually learn to read) during their confinement—especially when the facilities library has a diversity of appropriate reading material.
For youth who truly DO become suicidal while in custody, these strategies are just as important—if not more so—for them.

**SAY:** So, how do we prevent the youth in our facilities from becoming suicidal in the first place? And if they come to us wanting to die or have thoughts of dying during their stay—what can we do to balance the need to provide the appropriate levels of protection and to limit or cause no harm? Plus provide strategies that will actually help them stop wanting to kill themselves. Dr. Lisa provides us with some very good suggestions.

**DO:** Display Slide: Preventing Suicide

![Preventing Suicide](image)

**SAY:** The first way to prevent youth from becoming suicidal and helping youth that already are, is by mitigating Facility Hazards and Individual Risk Factors with Protective Factors.

**DO:** Display Slide: “Mitigating Facility Hazards and Individual Risk Factors with Protective Factors”

![Preventing Suicide](image)

**SAY:** If you recall the information from earlier in the training regarding Risk Factors and the activity where we divided you up into teams and you listed as many Facility Hazards as you could think of. Let's return to those lists and also look at the list displayed on the screen.
DO: Display Slide: Risk Factors and repost the lists (Facility Hazards) from the previous activity.

SAY: Now we will take a couple minutes to discuss how your facility can actually help protect youth from suicide through the use of Protective Factors. Protective Factors are internal or external characteristics or attributes that reduces the likelihood of attempting or completing suicide.¹ For the sake of this next activity we are going to look at individual and facility protective factors. As with “youth” protective factors, the idea is that “Facility” Protective Factors mitigate the negative effect of Facility Hazard Factors. For example, if you identified a suicide hazard factor in your facility as being a blind spot in youths’ rooms when you look in their windows what might be a Protective Factor that would mitigate this factor?

Look for: more frequent checks, require youth come to window during checks if you cannot see them.

DO: Divide the class in half, instructing half of the class to respond to the questions as they relate to individual protective factors and the other half responding to the questions related to facility protective factors. Allow 10 minutes for completion of the questions and then ask for volunteers to share a few of their responses.

SAY: Turn to page 21 in your workbooks after you jot down the definition to the term Individual/Facility Protective Factors, if you are in Group 1, list what you would consider to be individual protective factors that could mitigate some of the risk factors. If you are in Group 2, list what you would consider to be mitigating factors for the facility hazards. Each group should refer to the list on the screen and the list created in the activity. I will give you ten minutes to record your answers.

DO: Display Slide: Facility Protective Factors

¹Western Michigan University. Suicide Prevention Program. http://wmich.edu/suicideprevention/basics/protective
DO: After ten minutes bring the group back together and allow a few participants from each group to share their responses. Refer to the list on the slide Facility Protective Factors as the participants share their ideas.

DO: Display Slide: Preventing Suicide – Programming

SAY: A second critical way that we can prevent youth from becoming suicidal in our facilities is through programming.

DO: Display Slide: Positive Programming
**SAY:** Programming includes activities conducted in your facility that have an educational – in the broadest definition of the term - basis and a desired outcome for youth participation that increases the likelihood that they will be successful both while in custody and when they return to the community. Youth engaged in relevant programming while in confinement often experience less stress. Here are a few ideas of positive daily programs that may keep youth busy and less focused on issues upsetting them, which in turn, may positively impact a youth’s mood and behavior.

**DO:** Distribute a sheet of flip chart paper to each table group and display the slide “Daily Unit Programming.”

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**SAY:** In your table groups brainstorm a list of the kinds of activities/programs that youth have access to at your facility. Write the list on the flip chart paper. You will have 3 minutes, choose a different reporter and recorder from the previous activity. You can also record your answers on page 22 in your workbooks.

**DO:** At the end of the allotted time, ask each group to post their list and prepare to share with the larger group.

**SAY:** As you look at this list of programming currently occurring in your facility, which would you say have an outcome of reducing stress, changing mood, refocusing behavior or building pro-social skills? Programs that have these objectives also have the added benefit of helping to lessen the risk of suicide.

**DO:** Highlight or circle those programs on the list that participants identify as having the desirable outcome of reducing stress, changing mood, refocusing behavior or building pro-social skills.

**SAY:** What’s missing from your lists?

**DO:** Have the participant’s brainstorm a list of possible programming that they don’t currently have that meet the criteria of being “educational” and could help reduce the risk of suicide for youth in custody.

**SAY:** Do you have any further questions or comments about unit programming?

**DO:** Answer any questions or comments and move on.
SAY: In addition to programming, effectively preventing suicide requires that we effectively utilize the services of our QMHP’s.

DO: Display Slide: Preventing Suicide: Qualified Mental Health Professional (QMHP)

PREVENTING SUICIDE: QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP) – 25 minutes

SAY: We talked about your QMHP this morning. In addition to conducting suicide risk assessments, developing safety plans, and being the ONLY staff that can remove youth from Suicide Precautions, QMHPs are the ones who should be providing “talk therapy” specifically focused on reducing youth’s suicidal thoughts or behaviors. Hopefully youth at your facility can see the QMHP even when they are not in crisis, so the QMHP can help prevent a crisis from happening.

DO: Display Slide: Preventing Suicide – Healthy Relationships with Healthy Adults in Healthy Environments

SAY: A fourth strategy in preventing suicide is relationship building. Our mission always is: Building Healthy Relationships With Healthy Adults in Healthy Environments. What would this look like in the facility? Turn to page 23 in your workbooks to record your thoughts.
Look for: youth and staff with open communication, staff that are good role models, staff that are well trained, good conditions of confinement, strong ethics.

**SAY:** At times, staff may question the sincerity of these relationships and doubt the motive, thoughts and behaviors of the youth. In the next clip Dr. Lisa speaks about youth who engage in suicidal threats or suicidal behavior but have no desire to die.

**DO:** Play Segment #5 “No Desire to Die” (18:33-19:35)

**Script:** Although most suicide attempts in custody are sincere, there are some youth who engage in suicidal threats or suicidal behavior but have no desire to die. They may want additional attention from staff or to be transferred to a different unit, facility or a psychiatric hospital. Some youth have put things around their necks while locked in their room so staff will enter and youth can assault them.

Facilities who utilize the strategies I’ve just discussed (building positive relationships, relevant and meaningful programming, quality mental health assessments and treatment, home-like environments, challenging and fun recreation and leisure activities, and collaboration between juvenile justice, mental health, medical and education staff) see far less of this type of behavior.

**DO:** Display Slide: Teenage Boy

**SAY:** I would like to spend a few minutes to explore this issue a bit further. Raise your hand if you would like to share with the group how you have dealt with what you believe to be youth engaging in manipulative/attention seeking behavior. You can record your answer on page 24 in your workbook.

Look for: Staff’s relationship with youth is most important, creating trust, not making promises you can’t keep, and never lie to youth.

*Note to trainer: if participants give any responses that are unethical or disrespectful to youth, diplomatically point out why that response to “manipulative” behavior should be avoided.*

**SAY:** Wondering if you are being manipulated is stressful and frustrating, however, because there is no way to tell if a youth is manipulating or truly suicidal, you need to take it seriously—plus many youth who engage in manipulative behavior related to suicide often have a significant number of suicide “risk factors.”

**REMEMBER:** whether you believe the youth is being manipulative or not—follow
your agency protocol for suicide threats and actions, such as tying a sweatshirt around their neck or pretending to jump off the second tier.

**DO:** Thank the group for their responses and move on.

**SAY:** Let’s listen again to Dr. Lisa.

**DO:** Play Segment #6 “Suicide Precautions/Michael” (19:36-22:47)

**Script:** Although Youth on “Suicide Precautions” SHOULD be housed in suicide resistant rooms, they should be OUT of their rooms as much as is safely possible engaging in these essential activities.

They still require intensive monitoring and supervision, and some activities may need to be modified for safety reasons, but they should be encouraged to participate in the majority of the opportunities available (educational, vocational, recreation, leisure) as their non-suicidal peers.

Suicidal youth should remain in the same clothing as their peers (except if wearing shoelaces or belts) unless they use their clothing to try to kill themselves. In those instances, only the article of clothing used should be removed. Safety smocks should not be used, except in rare circumstances where it is indisputably necessary for youth safety and done in collaboration with a QMHP.

And speaking of QMHPs—we now have evidence-based treatments specifically targeting suicidal thoughts and behavior. Our goal for youth on “Suicide Precautions” is not to get them “off” suicide watch—our goal is for them to no longer feel suicidal and or engage in suicidal behavior. Michael, 17, had never had trouble with the law. When his girlfriend of 2 years broke up with him—he was heartbroken. When he found out she was dating one of his close friends, he was devastated. She wouldn’t return his calls or let him come inside when he’d stop by her house. Michael saw Katie at a party—but she completely ignored him. So he got drunk. Really drunk. He pulled her into one of the bedrooms and begged her to take him back. He pleaded. He cried. And then he tried to kiss her. When she pushed him away, he pushed her down on the bed and got on top of her. He said he just wanted her to remember how good they were together. He raped her. After his arrest, He sat in detention, each day becoming more and more despondent. Based on his charges, he would possibly be transferred to the adult system. And that terrified him. Katie hated him, her parents hated him, the kids at school hated him. And his parents were paralyzed with grief on every level. Michael hated himself for what he had done to Katie and those that cared about her. He believed his life was over and he had no one to blame but himself.

Michael spent 3 days planning his death. He hung himself while alone in his room during shift change. He made a noose with his bed sheet, tied it around the toilet, put it around his neck, got on his knees, turned away and thrust his body forward—cutting off his airway and the blood vessels in his neck. A youth returning from a medical appointment happened to walk by Michael’s door, saw what was happening and screamed for help.

**SAY:** In your table group, I would like you to discuss what staff should have done differently to possibly prevent Michael from trying to kill himself. Think about the things that we have talked about up until this point. You will have 5 minutes to complete the task. Please record your responses on flip chart paper, choose a different reporter and recorder from previous activities.

**DO:** After 5 minutes bring the group back together and process the activity. Have the reporter post their responses on the wall and share with the group.
Look for: Be aware of first timers, especially with serious or stigmatizing charges, Paid attention to “observable behaviors”—should have noticed he was becoming more despondent, talked with him to find out why he was becoming more despondent, refer Michael to QMHP, know which youth are facing potential transfer to the adult facility and assess how handling it, check on youth during shift change. Paid attention to “Youth history”—no previous contact with law and now detained and looking at transfer to adult system so significant stress/possible trauma, lost most of his support system

SAY:  *Keep in mind, we don’t know if Michael had developed Depression or abused alcohol after his girlfriend broke up with him—or if he had any other risk factors in his history. But, if we just look at his recent history—his devastating break-up, arrest, rejection by many of those he was close to—these put him at risk for suicide before he even walks through your door. Then, add being locked up in detention and facing a possible transfer to the adult system—additional risk factors. Yet, without this knowledge and staff paying close attention, Michael could be viewed as a “typical” youth and placed in a “typical” room, with no extra monitoring or support.*

SAY:  *During the morning session we took the stance that truly all youth in your facility could be at risk for suicide. We recognize however, that there are certainly some youth who are at extremely high risk for suicide and we would like to shift the focus of the training to those youth who, like Michael, are more at risk than others.*

**Instructional Input**

SAY:  *In the video clip, before she spoke about Michael, Dr. Lisa identified several areas for us to explore further with youth that are at the highest risk of killing themselves: Intensive monitoring, safe housing, and clothing considerations—common components of “Suicide Precautions.” There are other components as well, but the key point is “Suicide Precautions” are the SPECIAL things we do to try to prevent youth we believe are at HIGH risk of suicide from taking their own lives.*

SAY:  *Who in your facility can put youth ON “suicide precautions?”*  
Look for: any concerned staff

SAY:  *Who in your facility can take OFF “suicide precautions?”*  
Look for: ONLY the QMHP

SAY:  *Dr. Lisa also spoke about the importance of “treatment,” because as I said earlier “Suicide Precautions” and “Treatment” are very different. But both are essential.*

**INTENSIVE MONITORING – 10 minutes**
**SAY:** Let’s start with **Intensive Monitoring**—a key component of “Suicide Precautions”

*Note to trainer: Familiarize yourself with your agency’s protocol regarding Intensive Monitoring. It may be prudent to have this portion of the policy available to ensure participant’s responses correspond to the policy. If your training class consists of participants from multiple agencies/jurisdictions, the trainer may want to provide copy from a facility’s Suicide Precautions/Prevention Policy for the sake of the training exercises.*

**SAY:** Would we all agree that youth deemed to be “suicidal” need to be supervised and monitored more closely than their peers?

Look for: Yes

**SAY:** Why?

Look for: to see if they grab something sharp or make a noose, to stop them if they try to kill themselves

**DO:** Display Slide: Intensive Monitoring

**SAY:** This is why “intensive monitoring” is so important for suicidal youth. To ensure their safety, we need to watch and supervise them much more closely than their non-suicidal peers. You may have heard the terms “close watch” or “constant watch” or “continuous watch”—all refer to intensively monitoring youth in the facility.

**SAY:** What is your agency’s policy for “Intensive monitoring” of youth who are at high risk for suicide? You can record your answers on page 25 in your workbooks.

Look for: descriptions of what staff should do when a youth is on 1:1 supervision, such as he/she will be within arm length at all times, staff must supervise youth while in the restroom and while taking a shower; identification of who is allowed to put a youth on monitoring and who is allowed to take a youth off intensive monitoring; how staff should monitor suicidal youth if not imminently suicidal (e.g., at 5 or 10 minute intervals), activities that the youth is allowed to participate in while on intensive monitoring status

*Note to trainer: Most youth on Intensive monitoring are NOT on 1:1. Much more common for intensive monitoring is 5 or 10-minute interval checks.*
SAY: As you just stated, ANY concerned staff can put a youth ON “suicide precautions,” but ONLY a QMHP can take them OFF

Note to trainer: if this is not the policy of the facility, tell the group that is Best Practice, then discuss with administrator after the training.

SAY: When a youth is determined in need of intensive monitoring, direct care staff is responsible for conducting the checks. Checks should be made "in-person, on a regular basis but at irregular intervals. What does that mean?"

Look for: if have to watch or check them every 10 minutes, we watch or check them at 3 minutes, then at 9 minutes, then at 2 minutes, then at 10 minutes—but never more than 10 minutes. If the youth is on a 10-minute watch never let more than 10 minutes go by and scatter times between.

DO: Wait for understanding or questions before continuing.

Note to trainer: Clarify if necessary—VERY KEY POINT.

SAY: Closed circuit monitors or room cameras cannot be a substitute for these in-person checks. Depending on the level of risk, direct care staff will be responsible to supervise the youth either one-on-one, every 10 minutes, or every 5 minutes.

SAY: What is the requirement for staff conducting 1:1 intensive monitoring with a suicidal youth?

Look for: sight and sound, arm’s length, close proximity NOTE: if there is disagreement or confusion, look to policy for resolution

SAY: Intensive Monitoring status requires that line staff document EVERY monitoring time and the activity the youth is engaged in. For example, 12:15pm eating lunch 3:30pm reading a book. Anything unusual or relevant regarding a suicidal youth’s mood or behavior should also be documented. For example, 3:50pm tore up letter received in mail today

SAY: Do you have a standardized form to write down these observations?

Look for: yes!

Note to trainer: if not, bring up with administrator after the training

SAY: Staff should communicate from shift to shift which youth are on suicide precautions, the level of supervision and “intensive monitoring”—5 minutes, 10 minutes, or 1:1—required to keep the youth safe.

SAY: What is the best way to communicate this information?

Look for: shift change meetings, log books, supervisor tell line staff when they come onto shift
Safe Housing Of Suicidal Youth

SAY:  *If there are no other questions or comments we must move on to our next section on Safe Housing.*

DO:  Display Slide: Safe Housing,

SAY:  *We heard from Dr. Lisa earlier on the importance of SAFE HOUSING for all youth in custody. “She said that youth on Suicide Precautions should be housed in “suicide resistant rooms.” Why would youth that are at highest risk for actively engaging in suicidal behavior need to be housed in “suicide resistant” rooms? Look for: so there is nothing they can use to kill themselves, so they don’t have access to anything that can kill them*

SAY:  *What makes a room “suicide-resistant?” What should it have or not have? Look for: large viewing windows, no secure objects youth can tie something to and asphyxiate themselves, nothing youth can use to suffocate themselves, no electrical outlet.)*

SAY:  *Suicidal youth should not be isolated. If this must be done for safety reasons, the decision should be made in collaboration with a QMHP and the youth continuously monitored (1:1 supervision). Social interaction is essential to suicide prevention; removing suicidal youth from peers and programming can add to feelings of alienation and depression. Suicidal youth should be housed near staff stations, with staff regularly interacting with them.*

DO:  Display slide:  Safe Housing, Least Restrictive
Safe Housing

Least restrictive:
* Housing
* Supervision
* Clothing
* Programming

NECESSARY TO KEEP YOUTH SAFE AND HEALTHY

SOCIAL INTERACTION IS ESSENTIAL

SAY: Given we must consider the following: least restrictive housing option, least intrusive supervision option, participation in programming when possible, and least restrictive clothing options necessary to keep the youth safe and healthy—where might we have to make practice and/or policy changes?

DO: Allow participants to share their ideas and invite them to answer the yes/no questions on page 26 in your workbooks.

PROPER RESPONSE TO AN ACTIVE SUICIDE ATTEMPT – 45 minutes

DO: Display Slide: Proper Response to an Active Suicide Attempt

SAY: I would like to take a few minutes to discuss your agency protocol for responding to an active suicide attempt. In your table group, discuss the step-by-step procedures for responding to an active suicide. Record the steps on flip chart paper. You will have 5 minutes, choose a different reporter and recorder. You can also record your answers on page 27 in your workbook.

Note to trainer: Make sure you have reviewed your agency’s most recent protocol for responding to an active suicide. As the group’s report out be prepared to correct/add any steps that may be stated incorrectly or not included in the group’s responses.

DO: After 5 minutes bring the groups back together and have the reporters post their responses. As the groups report out pay particular attention to differences between the
reports. If there are extreme differences, ask the participants what they think the source of the differences is. If the lists are relatively close and accurate based on protocol, congratulate the participants for knowing their protocol.

**SAY:** Now, that we have reviewed your agency’s protocol for responding to an active suicide. We will view a role-play of a proper response to a suicide attempt.

**Role-Play Activity – Revisited**

**Pre-Activity Preparation**

Prior to the role-play (during lunch or a scheduled break) provide the actors from the morning role-play with the script for the Role-Play Revisited. Ask them to read through the role-play script and be prepared to act it out realistically when the time comes in the training session. Answer any questions they may have.

**Activity**

**DO:** Begin the role-play

**SAY:** As you recall, you saw a role-play this morning of an active suicide attempt where two staff demonstrated how to respond to a youth who asphyxiated himself in his room. You probably thought that they made a few mistakes, you were correct. By the way, the mistakes made were on purpose. Now, I would like to bring those volunteers back to demonstrate the proper response to an active suicide attempt. The rest of you in the group will again be observers. As observers please watch carefully and be prepared to respond when the role-play has completed.

**SAY:** This incident occurs on the 11 pm-7 am shift.

**DO:** Have the actors come into the room and follow the proper procedures for responding to an active suicide attempt. After staff have administered CPR and first aid properly for a couple minutes **STOP** the Role Play. Thank the actors.

**Role-Play Script:** This incident occurs on the 11 pm -7 am shift

As staff is performing his regular evening 10 minute room checks, he finds a youth in his room with a sheet tightly wrapped around his neck suspended from his chair. Following agency protocol, he looks into the room to make sure it is safe and immediately rushes in to hold the youth up to relieve the pressure on the youth’s neck. Because he is alone, he radios for assistance, asking them to bring the emergency bag/cut-down tool. The second staff arrives on the scene with the cut-down tool. While still holding the youth up, they cut and remove the sheet from the youth’s neck. They gently lay the youth on his back and begin first aid and CPR. They are not sure if the youth is still breathing, however, they are fully aware that only a qualified medical professional can declare death they continue CPR until relieved. At this point, the trainer STOPS the role-play.

**DO:** Facilitate the processing with energy. Divide the room in half. Assign one-half of the room the role-play from the morning and one-half the role-play that they just observed.
SAY: Now, that you have seen both the improper and the proper procedures for responding to an active suicide, what were some of differences between the two role-plays? Morning Group, give me one thing that was done improperly. Afternoon group, give me the counter of what you saw in your role-play. Morning Group, give me another. Afternoon group, what did you see in response to that?

Look for: staff made sure the room was safe before entering they knew where the cut-down tool was located, they held the youth up relieving pressure from his neck, they conducted first aid and CPR and didn’t stop until medical staff relieved them.

Note to trainer: Keep going back and forth at a very quick pace until they have exhausted all of their ideas. Ask questions to probe for more answers if you feel they are giving up too quickly.

SAY: There is a table in the back of the room that has strips of sheets and a cut-down tool to provide you an opportunity to practice using the tool. If you have never had a chance to practice, I hope that you take advantage of this sometime during the training today.

PROPER PROCEDURES FOR PREPARING FOR AND RESPONDING TO AN ACTIVE SUICIDE ATTEMPT – 25 minutes

DO: Display Slide: Preparing for an Active Suicide Attempt

DO: Review and expand on the points on the slide, revealing each point one at a time:

SAY: According to the NCYC/NJPS “Desktop Guide to Quality Practice for Working with Youth in Confinement” and Lindsay Hayes, National Expert on Suicide in Custody, the following are key issues related to being prepared for a suicide attempt and responding to an active suicide attempt.

In terms of being prepared:
1. **Be Trained** - You must be trained in how to respond to suicide attempts in progress, especially hangings and other forms of asphyxiation, as well as in providing first-aid, CPR, and other life-saving measures. This is partially done in trainings like this, but it is essential that your facility have random and realistic mock drills so you can practice intervening with suicidal youth when a mistake would not be lethal.

2. **Location of Emergency Bag** - Know where the Emergency Response Bag is located. There should be at least one on every unit. It should be easily accessible and it must be inventoried and checked for completeness and sharpness of cut-down tool on each shift. If you do not wear an “emergency bag” as part of your uniform, you will have to grab it in a suicide emergency or tell someone to immediately bring it to you.

**DO:** Display Slide: Responding to Active Suicide Attempt

**SAY:** When **RESPONDING** to an active suicide, follow six important steps: 1. Survey the Scene to determine the genuineness of the emergency, 2. Call for back-up/alert others/request the emergency bag, 3. Enter the room safely, 4. Assess the severity of the suicide attempt, 5. If life threatening, contact control to start protocols, and 6. Begin life-saving measures, continuing the life-saving measures until medical professionals arrive to take over.

*It is essential that you never assume the youth is dead. Even if he appears to be, do all you can to keep the youth alive until medical professionals take over.*

**SAY:** What are some of the reasons a staff would want to slowly and vigilantly enter the room and/or survey the scene before entering a suicidal youth’s room or cell?

Look for: staff maybe walking into an ambush; there may be exposed electrical wiring; may want to make sure the youth is not faking an attempt to distract or gain attention from staff.

*Note to trainer: Keep going back and forth at a very quick pace until they have exhausted all of their ideas. Ask questions to probe for more answers if you feel they are giving up too quickly.*
SAY:  In closing to this section, remember all suicide attempts should be treated as serious regardless of whether you feel the youth is being manipulative or not, and you should follow your agency’s protocols.

DO:  Display Slide:  Serious Attempt

SAY:  In the event of a “serious” suicide attempt, you will also want to make sure that someone calls 911 and Central Control to alert them to the emergency. An administrator or supervisor should ensure emergency medical professionals can easily find the facility entrance, as well as gain rapid access to the injured youth on the unit. If the youth must be removed from the facility, an administrator or supervisor should ensure the exit is quick and uncomplicated.

SAY:  If a youth is hanging from above, support the youth’s weight in order to reduce the pressure and tension on the neck. Dangerous neck and spinal cord injuries can occur when youth make suicide attempts by tying things around their necks. Remove the sheet, blanket, sweatshirt or whatever the youth used—cutting it if necessary. Lie the youth VERY CAREFULLY on the floor and initiate CPR if the youth has no pulse or does not appear to be breathing. Again, continue the CPR until qualified medical personnel relieve you.

SAY:  The suicide intervention strategies we’ve talked about today work best when there are 2 or more staff present on a unit. We realize that is not always the case. What if you are the ONLY staff on a unit? What if you work in a small facility and there are only two staff in the entire facility—for example, during the overnight shift. How would that change things when intervening with a youth making a suicide attempt?

Look for: need to carry the “emergency bag” with you at all times, may not be able to wait for back up staff before going into room, may have to be creative in getting noose off of youth, may need to modify suicide prevention policy as written.

SAY:  (if not already stated) If you are by yourself and a youth is hanging, do whatever you can to support the youth’s weight to reduce the pressure and tension on the neck until help comes.
SAY: Are there any questions related to working alone in the event of an attempted suicide?

DO: Display Slide: Assessments

Assessments

- Medical
- QMHP

SAY: There is a wide range of severity among the types of suicide attempts made by youth in custody. A youth should receive a “medical assessment” after an attempt, no matter how minor, if there is any question that the youth may have been impacted physically or medically by their suicidal behavior. Youth should always be assessed by a QMHP after a suicide attempt—regardless of the severity of the incident.

SAY: Because this is so important, let’s review to make sure that you understand what you should do if you come across an active suicide attempt.

DO: Display Slide: Responding to an Active Suicide Attempt –

PREPARING FOR & RESPONDING TO AN ACTIVE SUICIDE ATTEMPT
1) Be Trained
2) “Emergency Bag”
3) Survey the scene
4) Alert others/Call for back-up/ Request emergency bag
5) Enter the room, SAFELY
6) Assess severity of attempt
7) Contact control to start protocols
8) Begin life-saving measures & Continue life-saving measures

SUICIDE LIABILITY ISSUES - 10 minutes

DO: Display Slide: Suicide Liability Issues
I would like to take a few minutes to talk about “liability issues,” as some of you may be wondering “Can I get in trouble if I do something wrong and a youth dies?” The short answer is yes. When a facility has a serious suicide attempt or a completed suicide, there may be a lawsuit. If you were involved with the youth, you could potentially be named in the lawsuit. The courts typically focus on two issues in relation to suicide among youth in custody: Negligence and Deliberate Indifference. Turn to page 29 in your workbooks and record your comments Negligence and Deliberate Indifference.

These are complex legal terms, but for the sake of this training, what is important for you to know is:

“Negligence” is when a suicidal youth is injured or has died due to “carelessness”—either by: Someone doing something they should not have OR someone NOT doing something they should have. Your agency, a group of people, or a particular staff member can be sued for negligence. They will typically compare your behavior to what a “reasonable” person in your job role would have, or should have, known or done.
SAY: “Deliberate Indifference” is even more serious and refers to your agency, a group of people, or a particular staff member KNOWING that a youth was suicidal and “choosing” to do nothing or delaying taking action. And because of that choice, the suicidal youth was injured or died.

SAY: Hopefully, it is clear that the best way for a facility to protect itself is to have all of the key components of a Suicide Prevention Program in place—we’ve talked about many of them today. And I have supplied your administration with a link to the “mental health chapter” from the NCYC/NPJS Desktop Guide To Quality Practice for Working with Youth in Confinement”—which describes these key components.

SAY: The best way to protect YOURSELF is to keep potentially suicidal youth safe by utilizing the types of strategies and addressing the issues we’ve been talking about today. That means follow your policy, identify youth who may be a potential suicide risk, communicate what you know to supervisors and QMHPs, provide support to youth who need it, encourage youth to engage in programming, respond in safe and effective ways to youth who engage in suicidal behavior, and similar strategies. These strategies are important for youth ON suicide precautions and those who are NOT. Remember, Dr. Lisa stated in the video that “the majority of youth who have died by suicide in juvenile justice facilities were NOT on any type of suicide precautions at the time of their death.”

DOCUMENTATION – 15 minutes

DO: Display Slide: Documentation
SAY: Documentation related to suicidal youth is essential to keeping youth safe in your facility, providing good clinical care, and protecting yourself from liability.

SAY: Where are the most common places you will be “documenting” about potentially suicidal youth?

Look for: In log books, referrals to QMHP, incident reports, intensive monitoring forms

SAY: Documentation should include factual information—what you saw and heard—as well as behavioral observations related to youth’s mood or behavior. You should avoid comments or opinions regarding youth’s underlying motivation. Allow me to check to see if you understand what I mean. Which are better examples of documentation? *Turn to page 30 in your workbook and answer the questions.*

DO: Display Slide with Options 1 and 2

Option #1: Youth says she wants to die and “can’t take it anymore”

Or

Option #2: Youth is trying to get attention by making suicidal threats

Look for: Answer is Option #1

DO: Display Slide with Options 3 and 4

Option #3: Youth is isolated from peers and appearing depressed.

OR

Option #4: Youth is showing signs of self-harm or suicidal ideation.

Look for: Answer is Option #4
Option #3: Youth appears more agitated since lunch. Youth talked with his mother on the phone and I heard yelling.

OR

Option #4: Youth is angry at his mother.

Look for: Answer is Option #3

SAY:  
*Intervening in an active suicide attempt seems fairly clear-cut as we discuss it right now, but we all know that in the midst of a highly emotional and stressful situation, things do not always go as planned. At this time, I would like to discuss any questions or concerns you may have about intervening in an active suicide attempt that we have not covered or that we have not covered clearly. We talked about “What if there is only one staff on the unit”…..are there any other “What Ifs” that you are thinking about?*

DO: Display Slide: What If

**AFTER A SUICIDE ATTEMPT - 25 minutes**

SAY:  
*Dr. Lisa researched and wrote the “Mental Health” chapter in the NCYC/NPJS Desktop Guide that we have been referring to today. In the section on “Suicide Prevention,” she states that facilities should conduct several types of reviews*
after any serious suicide attempt or completed suicide to understand exactly what happened—and how to prevent it from happening again. The goal is to gain information and to learn, not to find someone to blame. In addition, a “psychological autopsy” should be conducted within 30 days of a completed suicide by a psychologist to better understand the specific factors that may have contributed to THAT particular youth taking his or her own life. You can record your comments on page 31 in your workbooks.

**SAY:** How many of you have ever been involved with someone who was suicidal?

*Note to trainer: question is intentionally vague since some staff are new to the facility, some participants may have experienced someone suicidal in their personal lives or another job, and some staff have experienced it in current facility

**DO:** Display Slide: After Suicide

![AFTER A SUICIDE](image)

• Feelings
• Thoughts
• Behaviors

**SAY:** In your table groups, take 5 minutes to discuss what likely 1) Feelings 2) Thoughts 3) Behaviors would be expected in an adult after someone they know dies by suicide or makes a serious suicide attempt—especially if they tried to save the suicidal person in some way.

**DO:** After 5 minutes ask for volunteers to summarize the discussion that took place at the different tables.

Look for: guilt, sadness, depression, hopeless, angry, I could have done more, I had no idea, it was my fault, they are so selfish, nightmares, crying, not eating, withdrawn, drinking alcohol, missing work, sleeping a lot

**SAY:** As we just heard, staff or others who are involved in suicide-related incidents can experience a wide range of reactions—and this is normal. Because of this, Dr. Lisa recommends that facilities hold a “post-suicide debriefing” for staff as soon as possible after a serious suicide attempt or completed suicide for any staff that may have been impacted by the incident. No one should be forced to attend or participate.

**SAY:** What types of things do you think would be helpful for staff to hear or experience at the “debriefing?”
Look for: support, understanding, explanation of what really happened to clear up any rumors, being told how they are feeling/thinking/behaving is normal, that everyone did their best

SAY: What types of things do you think would NOT be helpful for staff to hear or experience at the “debriefing?”

Look For: blame, anger, focus on policy, finger pointing, others viewing them as weak or crazy, alienation

SAY: Involvement with a suicidal individual, especially a young person, is stressful and it can be traumatic if he/she makes a serious suicide attempt or dies. It is important to seek additional support through the Employee Assistance Program (EAP) or other sources, if needed.

SAY: In addition to staff, who else in the facility may be upset and potentially traumatized if a youth dies or almost dies?

Look for: the other youth/residents

SAY: It is very important to encourage the other residents to talk with a QMHP about any thoughts and feelings they have in relation to a peer’s suicide or suicide attempt. Dr. Lisa emphasizes that this is a particularly high-risk period for other juveniles in the facility to take their OWN lives; therefore, staff should be vigilant to signs of distress, especially among vulnerable youth.

SUMMARY & WRAP UP – 10 minutes

SAY: Here is our final clip from Dr. Lisa, she reiterates the importance of having clear suicide prevention strategies in place that will help you keep youth who may be suicidal safe in your facility.


Script: There are few more intense fears than a young person dying on your watch, in your unit, or in your facility. Focusing our suicide prevention efforts on youth who report suicidal thoughts or who engage in suicidal behavior is essential—putting them on Suicide Precautions is a requirement and a duty.

Suicide Precautions have clear concrete steps we can take to help keep youth safe—and that helps reduce our anxiety. But, we will not reduce the number of youth who kill themselves in custody until we take a broader look at suicide prevention strategies for ALL youth—so we can help prevent them from becoming suicidal in the first place.

And for those youth deemed a high risk for suicide, we must implement our SP strategies in a more compassionate and supportive manner.

Please join me in making this (prop 1), this (prop 2), this (prop 3) and this (prop 4) become a thing of the past.

DO: Pause to allow the impact of the video to sink in.
SAY:  

No one could have said it better or more powerfully. When we started this project we said that we wanted a different suicide prevention training, a training that emphasized the importance of the work that direct care staff do in contributing to the safety and security of youth in your care and possibly preventing suicidal deaths. We hope that we were successful, we thank you for your contributions to this powerful day of training. Please complete the training evaluation before you leave.

DO:  

Display the Slide: Resources as you distribute training evaluation.

RESOURCES

- "Mental Health" Chapter--Desktop Guide to Quality Practice for Working with Youth in Confinement, [www.desktopguide.info](http://www.desktopguide.info)
- Juvenile Offenders With Mental Health Disorders: Who Are They & What Do We Do With Them (2nd Edition), [www.aja.org](http://www.aja.org) or [www.amazon.com](http://www.amazon.com)
- Substance Abuse And Mental Health Services Administration [www.samsa.gov/suicide-prevention](http://www.samsa.gov/suicide-prevention)
- Suicide Prevention Resource Center, [www.sprc.org](http://www.sprc.org)
- National Suicide Prevention Lifeline, 1-800-273-TALK
- Western Michigan University, Suicide Prevention Program, [http://wmich.edu/suicideprevention/basics/protective](http://wmich.edu/suicideprevention/basics/protective)