SHIELD OF CARE
Protecting Juvenile Justice
Youth from Suicide
™

Shield of Care

PROTECTING
Juvenile Justice
YOUTH from SUICIDE

"System Policy & Protocol"
"Connectedness to Youth"
"Communication Between Protectors"

TDMH

Trainer Set Up Directions

1. Participants will be divided into four (4) groups, with up to seven (7) participants in each group. Ensure that the room arrangement will accomodate this.

2. Fill in any requested information throughout the trainer manual (pages 5, 12, 16, 43, 44, 69).

3. Ensure that you have an emergency kit and rescue tool available to show.

4. The optimum class size is 24; no more than 32 participants recommended per training session.

5. Complete slides specific to your facility.

Table of Contents

ICON GUIDE

- Prompts trainer to start video
- Indicates participants will be using workbook
- Prompts trainer to distribute handout
- Indicates participants will be doing an activity
- Take notes

Audience:

All staff that have contact with youth in the facility.

Prerequisites for The Shield of Care Training:

A REASONABLE AND COMPREHENSIVE SUICIDE PREVENTION POLICY.

Prior to the delivery of this training, all correctional facilities, regardless of size, should have in place a reasonable and comprehensive suicide prevention policy that reflects the facility's unique needs as well as current industry guidance, such as that prescribed by The National Center on Institutions and Alternatives. This training is solely intended as a supplement to your existing policies and procedures. It is in no way intended to serve as or replace those existing policies and procedures.

A SUICIDE INTERVENTION, PRECAUTION AND REFERRAL GUIDE (template provided on page 69).

The Suicide Intervention, Precaution and Referral Guide will help you customize, based on your policies and procedures, critical intervention steps for staff. It also identifies who will receive referrals in the event staff identify a suicidal or depressed youth.

The suicide intervention section should include specific steps that staff should take when they identify youth who:

1. Are in the process of an attempt;
2. Are at imminent risk of suicide;
3. May possibly be at risk of suicide or is exhibiting signs of depression.

The suicide referral section should include 2 contacts to respond to each of the situations above (youth in process of attempt, etc.)

Make copies of your suicide precautions policy and procedures; they should include the following:

1. Levels of observation including a brief explanation of the youth (ex., youth who is actively suicidal) for whom the observation is intended;
2. Observation frequency (ex., Staff shall observe the youth on a continued, uninterrupted basis);
3. Documentation instructions. Model policies require that documentation take place as the observation occurs;
4. Policy regarding upgrading, downgrading or discharge from suicidal watch status;
5. Frequency of mental health staff interaction;
6. Supervision aid policy (use of cameras and other youth). Model policies require that these aids be used to supplement, not replace, staff supervision.

The completed guide will be used in the "protecting" and "networking" section of this training.

Prerequisites for The Shield of Care Training:

SELF-CARE GUIDE

During the introduction to this training, participants will read a self-care guide (page 5 of their workbook). Please be prepared to provide local resources as this is discussed.

RECOMMENDATIONS:

Management/Administrative Support of this training is recommended. The facility manager will be asked to discuss the importance of suicide prevention in the facility and expectations of staff during the introduction.

A Follow-up Meeting is recommended within a month to debrief facility-based issues that arise during the training. The trainer should compile a list of these issues, as well as suggestions from staff, to help the facility achieve stronger suicide prevention policies and procedures.

A Knowledgeable Trainer is strongly recommended. The trainer does not have to be an expert, but should have prior suicide prevention training and be familiar with suicide prevention policies and procedures. Some basic suicide prevention information is available through the following Suicide Prevention Resource Center links:

http://www.sprc.org/suicide_prev_basics/index.asp (http://bit.ly/spbasics)
http://library.sprc.org/browse.php?catid=9 (http://bit.ly/suicideprevention101)
http://library.sprc.org/browse.php?catid=19 (http://bit.ly/juvenilejustice)

and through Violence Education Tools Online:
http://www.vetoviolence.org/education-suicide-resources.html

This training is fairly comprehensive but does not include the following:

1. **Formal Suicide Assessment Training.**
   This training does not include instructions for mental health care staff to formally assess youth at risk for suicide. Training for mental health care staff to assess and manage suicidal youth is a prerequisite for clinical staff before implementing the Shield of Care program.
2. **Standard first aid and cardiopulmonary resuscitation training.** All staff should be trained in the use of all emergency equipment located in each housing unit.
3. **Intake screening training.** Procedures to systematically screen youth for suicide and mental health concerns immediately upon their arrival and throughout their stay are highly recommended.

Prerequisites for The Shield of Care Training:

4. **"Mock drills."** This is recommended, but due to the logistical requirements and the intended audience of this training, these drills should be well planned by the trainer and facility manager and take place among Security Staff soon after the training.
5. **Training in the maintenance of emergency equipment.** Emergency rescue equipment needs to be kept in working order, routinely tested, and be readily available.
6. **Interpersonal training.** The quality of staff-youth relationships is critical in reducing youths' stress levels and maximizing the likelihood that youth will trust staff for assistance when thinking about suicide. While juvenile justice facilities will never be stress-free environments, facility administrators must enact effective strategies for minimizing bullying and other violence in their institutions and for maximizing supportive relationships among youth and staff. If your facility does not promote a positive interpersonal environment, this training will be ineffective.
7. **Communication Plans.** A plan to maintain communication between staff members and mental health care staff regarding youth at risk of suicide is recommended, as well as is the development of a referral plan among internal and external community-based mental health services to ensure access to mental health personnel when required for further evaluation and treatment of youth.
8. **Self-Injury Training.** Self injury as a coping strategy deserves attention and specific training but is beyond the scope of this training.

RESOURCES:

1. **Gatekeeper Training Implementation Support System (GTISS).** This system provides a framework for planning, organizing, and implementing suicide prevention training in any system, organization, or community context. For more information, please visit the GTISS website: **www.gatekeeperaction.org**

2. **Postvention Tool.** The Suicide Prevention Resource Center in collaboration with The American Foundation for Suicide Prevention recently published a toolkit for schools. This tool may be modified for use in detention schools. It can be downloaded here:
http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf (http://bit.ly/afterasuicide_toolkit)

2. **Safe Reporting Guidelines.** Suicides in juvenile justice facilities are often covered by the news media. Safe reporting is essential to prevent contagion. If a youth at your facility should die by suicide, it is strongly recommended that you provide the media contact with the following guidelines:
http://www.sprc.org/library/at_a_glance.pdf (http://bit.ly/sSPpaK)

DEVELOPMENT OF THE SHIELD OF CARE CURRICULUM:

As a result of the Garrett Lee Smith Memorial Act, the Tennessee Department of Mental Health (TDMH) was awarded funding for suicide prevention efforts via the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Initiated in 2005, these grant funds were utilized to develop the Tennessee Lives Count (TLC) Project, implemented in partnership with Mental Health America of Middle Tennessee, Centerstone Research Institute, and the Tennessee Suicide Prevention Network. From 2008 through 2011, the project primarily focused on reducing suicide in the juvenile justice system and specifically providing Applied Suicide Intervention Skills Training (ASIST) workshops to the staff of the state's five youth development centers (YDC) responsible for caring for Tennessee's incarcerated juvenile justice youth. A key outcome was the development of the Shield of Care concept and this curriculum.

The Shield of Care is the culmination of input from research in the field of suicide prevention and juvenile justice and, more importantly, from staff working within the juvenile justice system. As part of the evaluation of ASIST, YDC staff were asked to participate in evaluation activities including pre- and post-training surveys, six-month follow-up surveys, and focus group interviews. The purpose of the evaluation was to learn how suicide prevention knowledge, attitudes, and self-efficacy may change as a result of the training, as well as how staff identified with components of the ASIST suicide prevention model. ASIST was originally developed as a "foundation" curriculum for mixed groups of learners with a focus on specific suicide intervention skills that could be applied to persons of any age experiencing thoughts of suicide. The Shield of Care program owes a debt to ASIST, safeTALK, QPR, and other programs that focus on gatekeeper/helper models. Preliminary survey outcomes suggested that staff seemed to identify with "specialized" components of the ASIST model according to their work roles in the facility. The focus groups allowed us to further explore this concept. Staff were asked for feedback regarding the process of helping suicidal youth in the facility and the degree to which the ASIST model related to policies and protocols for providing such assistance. As the data accumulated, it became apparent that a specialized model for suicide prevention training in juvenile justice systems was needed to: 1) emphasize that staff work together to help suicidal youth according to the policies and work roles; 2) emphasize that policy, connectedness with youth, and communication among staff are essential elements of helping interventions; 3) include steps in the helping model that reflect how staff would describe the process of helping suicidal youth: "Seeing, Protecting, Listening, Assessing, and Networking."

Preface

Outcomes from the evaluation were combined with juvenile justice staff training recommendations from the first national study of juvenile suicides in confinement [Hayes, 2009]. An additional literature review was conducted to ensure that each component of the Shield of Care curriculum was supported by the most recent applicable research. Members of the TLC Task Force in Tennessee, who represent various youth and suicide prevention organizations, were recruited to develop early versions of the curriculum. The supplementary literature review, some additional content, and graphic design images were provided by several organizations including ColumbiaCare Services, Outreach Art, and Kap Art. The final versions of the curriculum were reviewed by leading national experts in the fields of juvenile justice and suicide prevention. Thus, the Shield of Care training is a research-driven training that incorporates input from juvenile justice staff, organization members who specialize in youth services and suicide prevention, and the expertise of content experts nationwide.

The Tennessee Department of Mental Health (TDMH) and partners engaged in the Tennessee Lives Count project would like to recognize and thank programs that paved the way for this curriculum. ASIST, QPR, In Harm's Way, National Juvenile Detention Training Curriculum suicide prevention module, and Response were all considered as informative approaches in the development process. TDMH, owner/author of the Shield of Care curriculum, does not endorse or seek to replace other gatekeeper programs, but to meet the particular needs of staff working in juvenile justice facilities. As with any suicide prevention effort, a layered, multi- disciplinary approach is best.

PARTNERS IN THE SHIELD OF CARE CURRICULUM:

This project could not have been accomplished without funding through the Garrett Lee Smith Memorial ACT grant awarded by the Substance Abuse and Mental Health Services Administration to the Tennessee Department of Mental Health. The partnership of the Tennessee Department of Children's Services was also essential to the development of this training. We would like to thank them for their willingness to support our efforts to provide ASIST to all of the staff in Tennessee's Youth Development Centers and for being highly involved in development of this curriculum targeting the training needs to JJ staff. We would like to also say "Thank You" to the following individuals and organizations who made this training possible:

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Preface

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Presentation Materials/Equipment:

1. Laptop computer
2. LCD projector
3. Screen
4. Audio speakers
5. PowerPoint slides
6. FlipChart with painters tape to post flip chart pages (if desired)
7. Felt tip markers
8. Pens/pencils
9. A trainer's manual for you
10. Name badges, if desired
11. Sign-in sheets, if desired

Handouts (Enough copies of the following for all participants):

1. Pre-training survey
2. Post-training survey
3. Agenda
4. Facility policies and procedures on suicide precautions and room confinement
5. Suicide Intervention, Precaution and Referral Guide
6. Mortality review(s) of suicide in facility (if available)
7. Any additional materials deemed locally appropriate.
8. Workbooks for participants
9. Wallet cards for participants

Other Equipment

1. Facility emergency response kit
2. Facility emergency rescue tool

Advanced Tasks

1. Arrange to have the facility manager come in for 5 – 10 minutes during the Introduction to discuss the following:
   - Administration support of suicide prevention
   - Suicide is often a preventable when youth are identified, referred

and treated. Prevention can succeed when a caring person with the right knowledge is available at the right time. In a detention facility, restricting access to means and anchors from which to hang oneself are also key strategies to prevent suicide deaths.

- History of suicide at the facility
- Reiteration of self-care resources
- Importance of active participation
- Appreciation for attendee attention and participation

2. Using the template provided in the appendix, work with the facility manager to fill in facility-level intervention steps, suicide precautions and referral contacts. Make copies for all participants to be distributed when discussing the Protecting section.
3. Identify facility-level suicide information for PowerPoint slide #12. Information may include number of suicides/attempts at the facility, background factors of victim, as well as information related to their access to means, history of depression/suicide and housing confinement status.
4. Identify specific mental health staff to assist anyone who may need emotional support during the training.
5. Identify administration support staff to distribute any lingering "parking lot" issue responses via e-mail.
6. Carefully compare and contrast the procedures in the Protecting section and your facility's policies and procedures to determine if there are any discrepancies. **Discuss and rectify any discrepancies with the facility manger based on the model suicide prevention training guidelines.**
7. Determine your suicide precaution procedures (ex., close, constant), integrate them into slide #41, and prepare to discuss. Staff will need to know who decides when a youth goes on "suicide watch" and who can upgrade/downgrade the watch status. They will also need to learn documentation and visual checking procedures per your facility's policies and procedures.
8. Be prepared to discuss the location(s) of the emergency response bag and tool.
9. Identify staff person who knows how to use the emergency rescue tool safely to demonstrate the appropriate use of the emergency rescue tool without cutting the skin ("protecting" section).
10. Using the agenda template provided on page 12, fill in the facility-specific details.
11. Review template for local resources in participant workbook. Identify local resources to share during Introduction.
12. Identify local self-care resources for PowerPoint slide #3.
13. Prepare four (4) separate flipchart sheets with the following titles: "parking lot," staff attitudes," "anchors," and "ligatures".

14. **Important PowerPoint Instructions:** ***Do not launch PowerPoint from the CD. If you are using a PC, copy the entire folder from the CD to your desktop. It is critical that you do not move any of the individual files from this folder or videos within PowerPoint will no longer work. If you are using a Mac, download Flip4Mac to view the video files within the PowerPoint. This program can be downloaded at:*** **http://windows.microsoft.com/en-US/windows/products/windows-media-player/wmcomponents**

Follow-Up Tasks

1. Compile parking lot issues. Respond to questions and concerns by consulting with the Facility Manager regarding any issues that pertain to policies and procedures. For other questions/concerns, go to **http://library.sprc.org/ (http://bit.ly/sprclibrary)** for resources from the Suicide Prevention Resource Center.
2. Ask identified administration support contact to distribute responses via email.
3. Discuss policy review feedback and identification of possible anchors and ligatures with Facility Manager.
4. Send pre- and post-surveys within 30 days to Lygia Williams at:
   Tennessee Department of Mental Health
   Andrew Johnson Tower, 10th Floor
   710 James Robertson Parkway
   Nashville, TN 37243

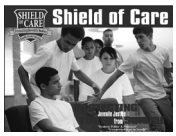
Agenda - Shield of Care Training [SAMPLE]

Subject	Suicide Prevention	Run Dates
Facilitator		Time: Start
Location		Time: End
Attendees: Required		
Attendees: Optional		

Agenda			
Section		Approximate Duration	Actual Time
1	Introduction	30 Minutes	
2	Overview of Youth Suicide	40 Minutes	
3	Shield of Care Model Overview	20 Minutes	
	BREAK	10 Minutes	
4	Shield of Care Model: “Seeing”	1 Hour 15 Minutes	
	BREAK	10 Minutes	
5	Shield of Care Model: “Protecting”	1 Hour	
	Lunch	45 Minutes	
6	Shield of Care Model: “Listening”	40 Minutes	
7	Shield of Care Model: “Assessing”	40 Minutes	
	BREAK	10 Minutes	
8	Shield of Care Model: “Networking”	45 Minutes	
9	After a Suicide	40 Minutes	

This agenda is flexible and is intended to use as a guide. Times and breaks will vary depending on the extent of local information.

1. Welcome Staff to Training



Greeting and introduction.

I want to welcome you and assure you that this facility is taking an active approach to address the issue of youth suicide.

We will be taking a hard look at the problem of youth suicide in juvenile justice facilities, and I think you will agree that we can all play a role in preventing suicide.

Before we get started, let's introduce ourselves by providing our names, titles and sharing something you would like to learn from this training.

Privately take notes on participant expectations. Address as many as you are able during the course of the training. Review others with the Facility Manager after the training to identify any issues that should be addressed at the follow-up meeting.

2. Introduction the Parking Lot

I will try to address your questions, concerns, and expectations, but we may need to revisit them at another time.

I may have to "park" questions or concerns that come up during our discussions in our parking lot (draw attention to flipchart sheet titled "parking lot" post with painters tape as needed) in the interest of staying on schedule. I will follow up on these at the end of the day and/or via email [if available].

3. State the Purpose of Suicide Prevention Training

We're going to begin the training with a few words from an expert in the juvenile justice sector with many years of experience, prior to getting started.

Play Video Refer to video instructions in workshop preparation section if you have difficulty starting the presentation.

I. Introduction

4. Distribute Workshop Pre-training Survey

Workshop Pre-Survey.

I'm distributing a pre-survey for this workshop to capture your current thoughts and opinions about youth suicide, and there will be a post-survey at the end. There are no "right" or "wrong" answers. The purpose of these surveys isn't to grade your knowledge; it is to help us determine whether the objectives of the training have been met. Please take 10 minutes to complete the pre-survey.

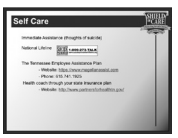
5. Facility Manager Speaks to the Importance of Suicide Prevention at the Facility:

Facility Manager speaks to the importance of suicide prevention at the local facility. He/She may bring up an attempt or completion from the recent past (if applicable) to emphasize that suicide prevention is a critical element of our services and that everyone from the custodian to security staff to administrative and management staff has a role.

6. Terms

If you are unsure about the definition of any of the terms in the training, a glossary is on page 40 of the Appendix in your workbooks.

7. Self Care:



Staff can struggle with thoughts of suicide too, and since we are going to be talking very openly and directly about suicide today, we want you to tune into the need for your own self-care. If you feel uncomfortable for any reason, please approach (name of mental health staff) and let him/her know that you need some assistance. Please respect the fact that some of us may have been impacted deeply over the death of a loved one or a similar experience and be empathetic with colleagues who may have had this kind of experience. Grief is a very complex emotion.

If you need help additional help, we've also provided national and local resources on page 5 of your workbooks.

8. Provide Brief Overview of Training/Content/Logistics:

Distribute agenda.

Today, we're going to begin with an introduction to suicide within juvenile justice facilities where we'll get an overview of the problem and explore what we've learned from the experiences of others. Then we're going dive right into the core of the training and introduce you to a model developed in collaboration with JJ staff called the S-PLAN. We'll finish the day with a discussion on what happens if we should experience a suicide death.

We'll be taking several well-deserved breaks during the training and will break for 45 minutes for lunch. Please return from the breaks and lunch on time because we don't want you to miss key information that may help you assist a youth in crisis.

Please turn off your radios and cell phones. If you need to leave the room outside of the scheduled break times, please let us know you are OK by flashing the OK sign before leaving the room. If you don't, I will assume you are in distress and will ask the mental health contact to check in with you to make sure you are OK.

[Provide other logistical information as needed]

In order to get the most out of this training, you're going to be asked to take some risks and step outside of your comfort zone. Take advantage of these opportunities. They will help prepare you to help youth in this facility.

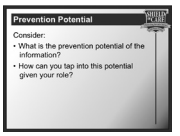
9. Distribute:

Policies and Procedures and The Suicide Intervention, Precaution and Referral Guide.

I'm passing out two documents you'll be using throughout the training: a copy of the facility's policies and procedures and the Suicide Intervention, Precaution and Referral Guide. I will be asking you to refer to them at various times throughout the training.

II. Overview of Youth Suicide

1. Prevention Potential



Some people believe suicide is inevitable, and that there isn't anything we can do to stop it, but people routinely survive deep depression and struggles with thoughts of suicide. Suicide is preventable because it is rare for someone to be completely convinced they want to die. There is usually a part of them that wants to live – even if that part is very small.

People survive because someone identified what was happening and responded with appropriate help.

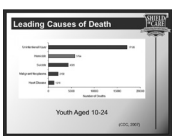
I'm about to provide an overview of youth suicide, but before I do, I want you to consider two questions. The first is: **What is the prevention potential of the information?** In other words, what will you or can you do differently now that you know this information?

For example, let's say that the study I'm about to review with you revealed that half of the youth who attempted suicide were green. The prevention potential would be low because you couldn't do anything to change their color. On the other hand, if the study revealed that half of the youth who attempted suicide had used Calvin Klein cologne just before they acted, the prevention potential would be high because we could simply remove the cologne when they entered the building.

The second question is: **How can you maximize the prevention potential of this information given your role?** How does it apply to you and your job?

Instead of just spouting off a bunch of statistics, I want you to get involved, so I will ask you to periodically reflect on these questions and share your answers with the larger group or with a partner. You ready?

2. National Causes of Death



We're going to take just a few minutes to explore suicide on a national level. As you can see, suicide is the third leading cause of death in the US which reflects the ranking in [your state, where we lose # youth a year] to one of the most preventable deaths on this list. Unintentional injury deaths include motor vehicle accidents, drownings, poisoning, and burns. Some of these "accidents" may actually be suicides, but because there may be a lack of

evidence, the deaths are considered unintentional.

(updates to this slide available here: **http://www.cdc.gov/ViolencePrevention/youthviolence/stats_at-a_glance/national_stats.html)**

The risk of suicide among youth in juvenile justice facilities is estimated to be more than four times greater than in the general population (Memory, 1989).

While there are usually warning signs, people don't always say something or demonstrate these behaviors before they make the decision to kill themselves. In fact, in a study of suicide screening practices, fewer than half of the detainees with recent suicidal thoughts had shared their thoughts with someone else (Gallagher & Dobrin, 2005). Juvenile justice facilities cannot rely on juvenile detainees to inform staff that they are contemplating suicide.

The good news is that there typically are warning signs that will help us identify youth at risk. In other words, there are many steps we can take to prevent youth suicide.

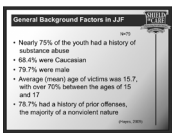
In February of 2009, a national survey of juvenile suicide in confinement was released (Hayes, 2009) and we will be studying the results. While there is a lot of data, we will focus on the information addressing prevention potential and help you prioritize those aspects that are within your control. Some of the information, particularly information that has to do with the physical attributes of a facility and specific policies and procedures, are generally out of your control.

The primary goal of the national study was to determine the number of juvenile suicides in confinement in a number of different types of juvenile facilities including detention centers, reception centers, training schools, ranches and farms.

The secondary goal was to gather more specific data regarding youth suicide during incarceration. This information is based on 79 suicides occurring in various states and has helped develop policies and procedures as well as trainings such as the one you are about to receive. We can learn a lot from these deaths.

II. Overview of Youth Suicide

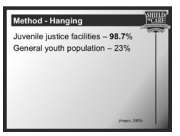
3. Confinement Study: General Background Factors



Here are some background factors among youth across all juvenile justice facilities. While the majority of victims were white males, I assure you that youth of all races and from both genders are potentially at risk. The youngest victim was 12. Consider the prevention potential of this information. **Is there anything we can do to change this?**

Elicit: No. There isn't anything we can do to change someone's background.

4. General vs. JJ Suicide Methods



Nationally, the leading method of suicide death is by firearm, followed by hanging and intentional overdose. However, based on our ability to prevent youth from bringing a gun into the facility, the most common method is hanging.

Outside of these walls, approximately 23% (NIMH, 2007) of youth use hanging as a method; inside it's 98.7% (Hayes, 2009).

We'll be talking quite a bit about preventing hanging in this training and may be using unfamiliar language. I'll be talking about **"anchors"** which are tie off points such as door knobs, vents and hinges.

I will also be using the word **"ligature"** which, for our purposes, means anything that can be used to hang oneself. This may be a bed sheet, rag, plastic bag, shoelace or any other material that can be tied around the neck and that can withstand the weight of a body. We'll also talk a bit about restricting access to other methods, because if a young person is intent on killing him or herself, he or she can get pretty creative.

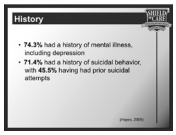
Please turn to page 7 in your workbook and take a minute or two to answer the questions corresponding with this slide.

Debrief: Ask a few participants to provide their answers. Acknowledge and thank them for their responses.

Elicit: Whenever possible restrict access to anchors and ligatures.

Roles: Everyone's awareness of possible ligatures in our environment may prevent suicide.

5. Confinement Study: History



The study revealed that three quarters of the youth who died suffered from a mental health disorder including depression, and that over half had a history of suicidal behavior.

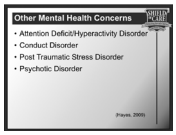
I want you to think carefully about the prevention potential here. Please take a a few minutes to answer the workbook questions corresponding with this slide.

Debrief: Ask a few participants to provide their answers. Acknowledge and thank them for their responses.

Emphasize that, by identifying depression, we can prevent the escalation to suicidal thoughts, attempts and completions.
It's not only important for those who have interactions with youth to identify depression, suicidal thoughts and behavior, but to document and communicate that information to mental health care staff.

Roles: Everyone in this room who works directly with youth is in a position to identify and refer a youth who is displaying signs of depression.

6. Mental Illnesses and Suicide

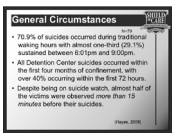


Here are some of the other mental health disorders that can lead to suicidal thoughts and behaviors. Please take a minute to reflect on the symptoms of these disorders on page 7 in your workbook. These disorders increase the risk that a youth will think about suicide and or act on those thoughts.

Any signs of psychosis, such as talking to oneself, claiming to hear voices, or suffering hallucinations, should also be taken as a sign that a youth may be at risk (WHO, 2000; Hayes, 1995). Staff should be especially alert if youth have stopped taking or recently started taking anti-psychotic or anti-depressive medication.

II. Overview of Youth Suicide

7. General Circumstances



One of the most surprising findings of this study is that most of the suicides occurred during waking hours.

Again, take a few minutes to think about this and answer the corresponding questions in your workbooks on page 8.

Ask the participants for volunteers to share their responses.
"So… did you see any prevention potential here?"

Debrief: Ask a few more participants to provide their answers to the remaining statistics. Acknowledge and thank them for their responses.

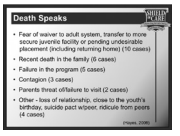
Statistic 1: Security staff should stay vigilant even though there may be additional staff in the building. Because many of the suicides occurred during waking hours, non-security staff may have opportunities to identify a youth at risk.

Statistic 2: The study reinforces the need for an intake assessment to determine a youth's mental health status.

Security staff are responsible for visual checks of a youth on suicide watch, and these should take place at least every 15 minutes.

Statistic 3: The study informs us that security staff needs to follow through with their visual checks.

8. Death Speaks



A lot of valuable information came out of the confinement study, but this set of information helps us understand what was happening prior to the deaths.

Just to clarify, contagion means that one suicide influenced another. Youth are particularly susceptible to this influence. Toward the end of the training, we'll discuss this a bit more.

In the meantime, I want you carefully consider the prevention potential.

Please consider this individually in your workbooks on page 8.

What did you come up with?

Debrief: Ask a few participants to provide their answers. Acknowledge and thank them for their responses.

Elicit: While we might not have much control over certain events, we are certainly in a position ***to help youth change how they feel about these events or refer youth who are struggling with these stressors and losses.***

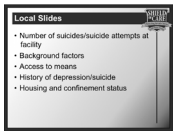
A little later, we'll learn more about how we can help.

9. Local Slides

You will be launching a brief discussion regarding suicides and /or suicide attempts at your facility here with the slides you prepared in preparation for this unit. If possible, obtain mortality reviews or incident reports and discuss precipitating factors along with prevention potential. If you want to share more specific data, consider sharing in the corresponding section or elsewhere in the training. The intent of this chapter is to provide an overview. Be mindful of time if this is a concern for you, and use the parking lot if you find time is becoming an issue.

<Begin local slides>

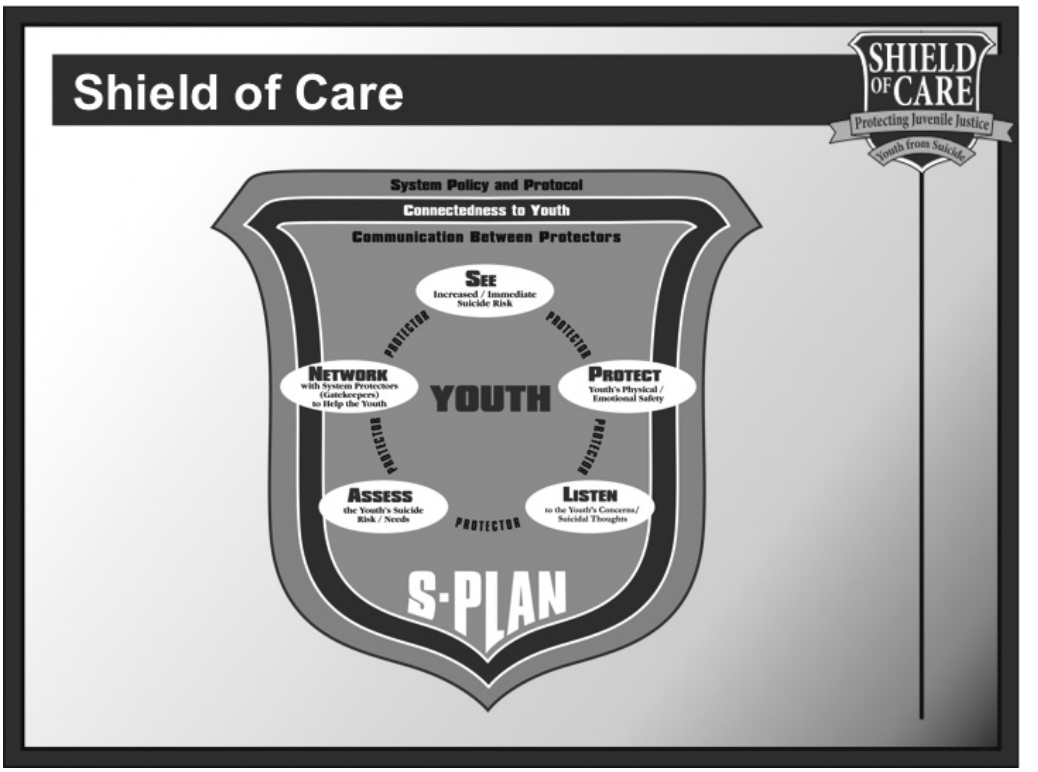
Let's take a look at suicide/suicide attempts in this facility.



When we look at this facility in particular, where do we have the most prevention potential? What can you do in your role to maximize the prevention potential?

III. Shield of Care Model

1. Introduce Shield of Care Model



Now that you have an overview of suicide in juvenile justice facilities, we're going to focus more specifically on a model to help us identify and respond to a youth at risk of suicide.

Please see above, where you'll see the "Shield of Care" diagram.

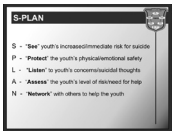
The model, "Shield of Care," was created specifically for juvenile justice environments and was developed directly working with juvenile justice staff in Tennessee. The information gleaned from your colleagues, in combination with evidence about "what works" in suicide prevention, led to the development of the model.

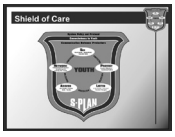
The shield itself is used to represent the fact that juvenile justice staff may view their role as "Protecting" youth from suicide. Inside the shield, you can

see that the youth is in the center and is the focus of the intervention taking place to help. You'll also notice that this help is very specific and requires particular actions that we call the S-PLAN.

Within the Shield are essential actions for protecting youth from suicide. Although these steps may not always happen in the same order or the same way, we will talk about them "in order," so we can remember them easily.

2. Provide an Overview of the Shield of Care Model





Here is a definition of the actions within the Shield of Care model.

The second thing you will notice about this model is that it has three distinct layers of protection. These layers of "thickness" to the shield demonstrate that three essential elements assist the entire process of protecting youth from suicide:

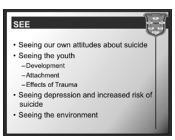
1. The organization's policy and procedures;
2. Staff's connectedness to youth;
3. Staff's connectedness to each other as fellow "protectors" in the suicide prevention community.

Your personal shield reflects your ability to act using S-PLAN as well as the strength of the facility's policies and procedures and your connection to youth and to others in the community to prevent suicide.

The "Shield of Care" was designed with the flexibility to incorporate the facility's policies and procedures.

I'm going to spend a few minutes providing a very brief overview of each S-PLAN action, then we're going to explore each of them in more detail.

3. Define "Seeing"



The core of the **"seeing"** component, is seeing and being aware of the increased risk of suicide among youth in our care. We will spend quite a bit of time on that. However, your reaction to a suicidal crisis is critical, so we will begin by talking about you. Specifically, we're going to talk about attitudes about suicide and how those attitudes may impact a youth.

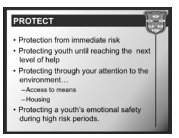
We will also be talking about seeing the youth.

Few youth complete suicide while on suicide watch. The national study revealed that only 16.5% of youth were on suicide precaution status at the time of their deaths (Hayes, 2009).

"Suicide precaution is defined as an observational status placed on suicidal youth requiring increased surveillance and management by staff" (Hayes, 2005).

The challenge is the ability to prevent the suicide of a youth who is not on precaution. This isn't always possible, but more often than not, we can prevent a suicide if we can clearly "see" the youth, warning signs, the environment and access to means. We must be aware of these factors and others which we will explore when we expand our discussion of "seeing."

4. Define "Protecting



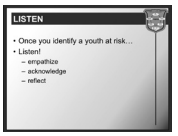
Once suicide risk is identified in youth, we need to **protect** that youth's immediate physical and emotional safety.

The type of protection offered will differ depending on a person's role. For example, non-security staff, will "protect" youth's immediate physical safety by calling security. As an example, let's say that a youth mentions in class that he will stomp on his glasses and use the glass to cut his wrists to kill himself. The teacher will immediately escort the youth to a security officer until he can be assessed by mental health care staff.

Protecting may also mean intervening in an actual attempt.

Staff also need to protect the youth's emotional safety, particularly around high risk periods in confinement such as an upcoming court date and by choosing a private place to talk to the youth whenever possible.

5. Define "Listening"



Once the youth's safety is protected, we need to listen actively and empathetically.

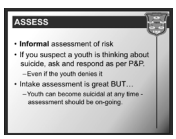
We're going to spend quite a bit of time discussing how to identify and respond to suicidal youth, and once a youth is identified, one of the most powerful things we can do is listen. All of us need someone to listen to our concerns - even youth who may claim just the opposite.

The listening step may be conducted differently depending on the role of the caregiver. Probing or asking deeper questions that get to the "heart" of what is causing the suicidal ideation/behavior is usually the role of the mental health professionals in the facility.

The main objective for non-mental health care staff is to listen to the youth in a non-judgmental way and refrain, as much as possible, from offering advice. Listening should demonstrate support, hopefulness (instilling the belief that there is help for suicide) and a willingness to work with the youth to get help.

This is not to say that staff who are not mental health professionals cannot ask questions. They certainly can, but the questions should primarily be to clarify rather than explore.

6. Define "Assessing"



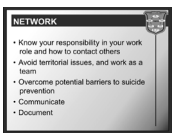
Suicide risk screening and assessment need to be part of the admission process but should not be a one-time occurrence. The shelf-life of the intake assessment is short. Vigilance needs to be on-going, and once thoughts or behaviors about suicide emerge, an additional assessment will be necessary (NCCHC, Hayes 2009).

Mental health care providers are responsible for formal assessments, but there may be situations in which you will be expected to make quick decisions on how to protect a youth from suicide which will require an informal assessment of their risk. Non-mental health staff may also help the assessment process through listening and relaying information.

You may also be in a position to ask directly about suicide if you are "seeing" warning signs, risk factors or worrisome behaviors. If the youth indicates that he/she is considering suicide, you will be expected to bring any information you saw or heard to whomever is designated by policy.

7. Define "Networking"

III. Shield of Care Model



Finally, we will explore the importance of networking. While you will be responsible for protecting the youth in the short-term, you will need to assist the youth in securing longer-term help. This will entail good communication with the next level of care.

Communication with others, flexibility, and cooperation serve many important purposes. These factors help to determine a youth's risk level, understand and implement the suicide prevention plan, and mitigate risk.

For example, a policy may state that Security Staff are primarily responsible for keeping the youth physically safe, whereas the on-site psychologist is primarily responsible for assessing risk and developing a treatment/ response plan. In the context of the organization's policies and protocols, staff members **"network"** with others in the facility, and possibly the outside community, to assist the youth and protect against suicide.

A clear understanding of your role and who to contact given a specific situation is critical to the networking process.

If staff resist dealing with suicide and rely exclusively on intake or mental health care staff to identify and assist youth at risk, we will miss opportunities to help. Remember - you want to develop a strong shield, and communication is one of the protective layers. In the networking section, we'll discuss the importance of cooperation.

8. Comprehension Check

What are the S-PLAN actions we just learned?

Elicit: Seeing, protecting, listening, assessing and networking.

1. "Seeing" Attitudes

Now that you have an overview of each of the components of the S-PLAN, we're going to spend some time exploring each component in detail, and we're going to begin with you.

Please turn to page 10 in your workbook. Take a few minutes to fill out the attitudes survey and answer the four questions that continue to page 11.

Identify Groups

When all participants have completed the workbook exercise, explain that they will be doing a significant amount of group work during this training, and that they are going to be divided into those groups now. Have them number off 1 through 4 and then form groups with other like-numbered people.

Activity: Group Discussion

When people have identified their groups and moved, ask them to discuss the responses to the survey questions in their small groups. (limit to 10 minutes)

Activity: Debriefing Attitudes

Trainer Debriefing Guide – Attitudes

When you debrief the attitudes survey, be sure to point out that ***your goal isn't to judge attitudes, but to explore whether they help or hinder suicide prevention. Tell participants that we'll only address the first four in the interest of time.***

Debrief the exercise by asking each of the groups to share one answer.

Optimally, participants will provide the information you hope to elicit.

PART A: SEEING

If they don't, pose the targeted response as a question. For example, is it possible that we can identify a youth at risk and provide help?

1. If a youth I work with decides to kill themselves, there is not much I can do to stop them.

Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

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

2. Suicidal behaviours are irrational.

Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

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

3. Youth in secure facilities who threaten or attempt suicide only want attention.

Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

Elicit: It would hinder a caregiver's ability because threatening and attempting suicide are 2 of the most significant precipitating factors for suicide.

4. Suicide is wrong.

Does this attitude help or hinder a caregiver's ability to prevent suicide? Why?/Why not?

Elicit: This could go either way. If this attitude is conveyed to youth with strong moral or religious convictions against suicide, talking with someone

who feels the same may possibly be helpful. On the other hand, it is risky because the youth will likely feel judged and shut down.

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

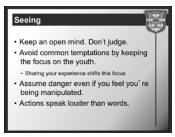
If not, say that it's possible to lose kids if we impose our attitudes on them.

2. Seeing: The Youth in Our Care

For any of the youth we work with, it might be tempting to think, "This kid is going nowhere, he's just going to end up in the adult criminal system." For both male and female youth in confinement, a whole host of life circumstances, experiences, and choices have led them to where they are today. Some of these factors may be compounded by a mental illness and lead to thoughts of suicide.

"Seeing" not only entails identifying warning signs, but "seeing" the person. Youth in confinement often hide their true feelings, so it can be difficult to get to know them, which then makes it more difficult to help them.

Some of the youth we work with build fortresses around themselves to protect against pain. They may have never had someone reach out to them, and when they do, they may shut down. This is okay, as it often requires numerous attempts and numerous people to help break through such defenses. Seeing the person will help you get through to such a closed off youth.



Ask yourself, **"Who do I go to when I need to talk?"** The answer is rarely someone who lectures or judges you or your actions. Teens often have a finely tuned judgment radar and will shut you out if they sense you're judging them. It has been argued that young people believe that they are being watched and judged, and that this may be an accurate perception that emerges as a result of actually being under constant scrutiny (Vartanian, 2000). Real or imagined, these feelings of scrutiny can result in the development of negative feelings and low self-worth often associated with adolescent suicidality (Stillion & McDowell, 1996).

While some of the youth in our care may not have been under constant scrutiny on the outside, they certainly are now. Tread lightly with issues that relate to self-consciousness in general. In regard to personal matters or

suicide, talk to the youth in private whenever possible.

Another temptation is to identify with the youth.

You might be tempted to match or exceed the youth's feelings or experiences to gain credibility. It's a common approach but can turn the focus on you when it should be on the youth. This should be avoided.

What might happen if we try to argue someone out of suicide...

... by saying, "You have so much to live for" or "Your suicide will hurt your family and friends?"

Elicit: We take the focus away from the youth and away from their perspective. Tunnel vision is common with suicidal thoughts, and the youth will be focused on themselves and death. Trying to argue them away from this position may only strengthen their resolve. Instead, our goals should be to understand, listen, and refer.

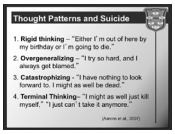
Youth may use suicide threats to manipulate staff at times, but there are cases in which the intent was to avoid or gain something, and the youth ended up going too far . Research has found that youth who appear manipulative may also be suicidal and, at a minimum, suffer from an emotional imbalance that requires a multidisciplinary treatment plan (Dear, Thomson, & Hills, 2000). Always assume there is the possibility for danger when you hear a youth talk or suggest suicide or death. It takes a skilled mental health practitioner to make the distinction between manipulation and true intent. Whether the youth's intent was suicide, secondary gain, or a cry for help, the risk of death always warrants intervention. Always assume it's serious, and refer the youth to mental health care staff.

Youth may deny they are suicidal. After a suicide in Wake County, North Carolina, the sheriff said "He gave no indication that he was suicidal. ***If he had threatened suicide, we would have put him on suicide watch."*** **(**Hayes, 2007). Remember, we can't rely on youth to tell us they are thinking about suicide. As we go through the warning signs and risk factors, pay close attention to the behaviours associated with suicide risk because it's possible for a youth to be suicidal without uttering a word.

In fact, it's imperative to understand that youth may internalize disturbing

emotions. While you're looking for warning signs such as a youth who is acting out, the suicidal youth may actually be the quiet, compliant one who is hanging back from everyone. As we move forward, keep in mind that any youth in this facility may be at risk for suicide.

3. Common Thought Patterns Connected to Suicide



Adolescence is a period of rapid developmental change. It's often much more frustrating to deal with teens when we don't have an understanding of these changes. Research informs us (Aro, Marttunen, & Lolnnqvist, 1993; Bar-Joseph & Tzuriel, 1997) that major developmental processes – how teens think and how they see themselves -- are likely to have an important impact on teen suicide.

Let's take a closer look at how a teen thinks, specifically at thinking patterns that are associated with suicidal youth. A brief definition of each is provided starting on page 12 of your workbook.

Rigid thinking means that the teen has narrowed options down to A or B. Most adults realize that there are many more options, but teens can actually corner themselves with this kind of thinking. It can be dangerous because, if one of the options is suicide and nothing happens to change his or her mind, the teen might follow through.

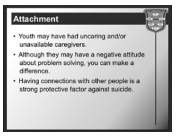
Overgeneralizing means that the teen takes a situation and extends it to an unreasonable conclusion. For example, a family member may have missed a visit due to an emergency, and you hear the youth say, "See, she missed the meeting. She doesn't care and no one else does either."

Catastrophizing is focusing on the worst possible outcome, however unlikely, or thinking that a situation is unbearable or impossible when it is really just uncomfortable. An example of catstrophizing would be "I have nothing to look forward to. I might as well be dead."

A **terminal statement** is any statement, direct or indirect, that hints or is explicit regarding death or suicide. "I just can't take it anymore" or "I might as well just kill myself."

Be alert for these patterns of thinking. We will revisit them again a little later in the training.

4. Attachment



Teens who struggle to develop a stable and secure identity are more likely to be poor problem solvers and are at increased risk of suicide (Stillion & McDowell, 1991).

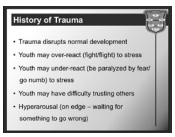
Young adults are exploring the world and their place in it. A key factor related to a secure identity is healthy attachment. Attachment is defined as a lasting bond with another characterized by mutual trust, support, and emotional connection (Armsden & Greenberg, 1987). Not surprisingly, those who have a history of suicide ideation and attempts have often had unavailable or insensitive caregivers (West, Spreng, Rose, & Adam, 1999).

Imagine how difficult it is for a teen to reach out when they haven't had the opportunity or were rejected when they tried. As juvenile justice staff, you might be the one of the first adults in a position to provide healthy support. Remember that one of the protective layers in the Shield of Care is staff's connectedness to youth.

Supportive and secure connections are strong protective factors against suicidal ideation and behaviour. You can increase this protective layer of your shield by working to develop supportive relationships with youth in general, so that when they reach a crisis point, it will be easier to accept your help.

Research suggests that some teens develop a personal fable – a negative story in which they see themselves as misunderstood, alienated and lonely (Elkind, 1981), and as their brains develop, they may experience a stress or stressor that prompts overgeneralizing and rigid thinking to the point of believing suicide is the only solution (Stillion & McDowell, 1996). They may also get to the point where they lose all confidence in their problem-solving abilities and develop a negative attitude toward problem solving in general (Esposito, Johnson, Wolfsdorf, & Spirito, 2003).

5. History of Trauma

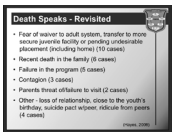


Trauma is the experiencing of an emotionally painful or distressful event that often results in lasting mental and physical effects. In one study, over 90% of juvenile detainees reported having experienced one or more traumatic incidents. Most people, including youth, can deal with adverse experiences without developing trauma symptoms. However, research informs us that exposure to trauma can increase the risk of depression, suicide attempts, or suicide completion.

Trauma can disrupt normal development, but not all children who experience an adverse event will react the same way. Here are some signs that a youth may have been traumatized in the past. If you notice any of these signs in the youth with whom you work, consult with mental health staff and develop strategies to address their behaviours. Punishment can reinforce a traumatized youth's negative view of the world.

6. "Seeing" Risk

It is challenging enough to be confined, but being confined while the brain is undergoing developmental changes can be very difficult. While some youth do better in confinement then others, it's important to keep in mind that confinement is a powerful stressor in itself.



Let's revisit some of the factors present in the confinement study. A mortality review, which is a formal process where staff consider the circumstances surrounding a suicide, was conducted in 51.7% of the cases in the study, and staff identified the following factors:

Notice that several of these factors are specific to being confined.

Take another look. How might a youth have felt before killing him or herself?

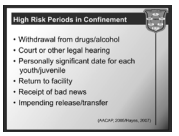
Elicit: Fear of the unknown, loneliness, unsupported, rejected, grief, failure.

Think about your role. What is the main thing we can all do that will help prevent youth feeling like this?

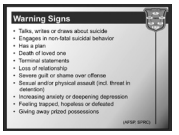
III. Shield of Care Model

PART A: SEEING

Elicit: Connect with them and listen to their worries and fears.

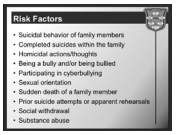


Here are some high risk periods of confinement. Additional factors are on page 14 of your workbook. Review key points specific to room confinement.



And some of the most concerning warning signs or signs that may lead you to think that this person is thinking about suicide right now.

I will talk about depression in a moment. When we get to it, pay close attention because you may very well be able to prevent suicide if you can identify it and refer a youth to mental health care.



Let's move on to risk factors or things that may make you wonder if someone has ever thought about suicide. Risk increases thoughts of suicide. Additional risk factors on pages 16 & 17.

Connecting with youth, particularly those who are suicidal, restricting access to means, and identifying youth who are depressed are some of the most powerful things we can do to prevent suicide in a detention environment.

In fact, research suggests that promoting protective factors such as connecting can be powerful enough to overcome risk factors (McLean, Maxwell, Platt, Harris, & Jepson, 2008).

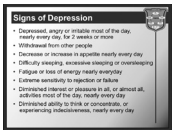
We just learned through the confinement study that close to 75% of youth who died had a history of mental illness – 65.3% of these victims suffered from depression (Hayes, 2009).

Given these statistics, how would you rate the prevention potential of identifying depression?

Elicit: High

To prevent an escalation to suicidal thoughts, report signs of depression to mental health care staff.

A more complete list of signs of depression is on page 15 of your workbook.



Take a look at this list. Many of the youth that come through here will exhibit signs of depression. In fact, in considering this list, many people might assume that most teenagers are depressed. They would be wrong.

Major depression is a serious mental health condition and very different from a few hours or days of sadness, anger or irritability. How do we know if it's depression or typical adolescent behaviour?

When symptoms of depression continue for two weeks or more, the signs continue to get worse, coping skills aren't working or you notice the symptoms affecting the youth's day-to-day functioning (Bernstein, 2001), it's time to consider depression and report these signs to mental health care staff.

7. "Seeing" Video

In a moment, you're going to watch a video. As you do, use the space on page 18 of your workbooks under the heading "video viewing tasks" to note any warning signs or risk factors of suicide as well as signs of depression. When the video is over, please get into pairs and compare your lists.

Play Video

What did you discover?

Elicit: Not eating, withdrawal, past physical abuse, assault, trapped, nodding off, negative thinking and lack of connection.

In the video, Sal says that he's been worried about Jax for a while. Why?

Elicit: He hasn't been eating. He's withdrawing. He has a history of familial abuse.

Did anyone catch the terminal statement?

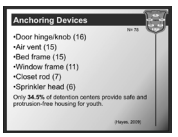
Elicit: *"...like there's nowhere you can go so why even bother trying to make the trip?"*

PART A: SEEING

It might have been easy to overlook Jax. Individually, his signs weren't that concerning, but together they were sufficient to receive attention. A little later, we'll discuss some ways to provide such attention.

8. The Environment

I'm going to ask you to take a moment to see this facility through the eyes of a suicidal youth. What I'm asking you to do is consider possible means and structural hazards such as anchoring devices for hanging that can place a youth at greater risk.



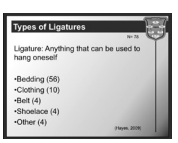
Overlooking anything in the environment which can be used to hang, suffocate, poison, cut, puncture, electrocute or burn can contribute to a suicide.

Here is a list of the anchoring devices used by youth in the confinement study. This list, and the following list of ligatures, includes information culled from secured training schools, reception/diagnostic centers and residential treatment centers.

While the physical facility is beyond your immediate control, your awareness of this factor is important because, whenever possible, you want to avoid allowing suicidal youth access to these devices.

Centers designed with suicide prevention in mind avoid knobs, have devices that can collapse under weight, frameless beds, video cameras in secured housings, and vents that have holes so small that you can only loop a thread through them (Aarons, Crumbley, Khalsa, Mace, 2007).

As mentioned earlier, hanging is the most common method of suicide in juvenile justice facilities. It takes 4 minutes without air to die, and it is not necessary to be suspended to kill oneself. Youth have been found hanging from anchoring devices 18 inches from the floor. Other anchoring devices include video cameras, toilets, sinks, and showerheads (Aarons et al., 2007).



Again, your awareness of these instruments is critical. The confinement study discovered that bedding was, by far, the most common type of ligature. Facilities that want to restrict the ability to use bedding as means will issue suicide resistant blankets that are nearly impossible to tear or fashion into a

noose.

Access to bedding, clothing and other possible means should be detailed in a suicide management plan developed by medical and/or mental health care staff. The Shift Supervisor should immediately notify medical and/or mental health care staff when a decision has been made to remove a youth's clothing (Hayes, 2005).

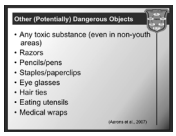
Youth can be very creative in their desire to acquire means. Consider a youth who is using rags to clean the floor. If you are distracted for only a moment, the youth has time to grab the rag and cleaning solution and stuff them down his pants.

Regardless of your role, limit access to anything that may be used to hang oneself despite the suicide risk. When you can't limit the means, provide supervision during use.

What would you do about a suicidal youth's need for a towel for a shower?

Elicit: Allow only after the shower and monitor use.

Shoes also cause concern. Youth have been known to ask other youth for their laces (Aarons et al., 2007). If you ever see a shoe missing a lace, follow up.



Youth who are on suicide watch should not have access, or monitored access, to shaving supplies, writing instruments, and eye glasses. They should not have access to hair ties or eating utensils. Bandages other than medical wraps should be used in the event a youth needs first aid (Aarons et al., 2007).

Flipchart – *Note participant responses to their feedback regarding anchors and ligatures. Share with the Facility Manager after the training.*

For those staff who are aren't new hires - Take a minute to consider the 30 foot radius around your work area if you are stationary for most of the day; and

PART A: SEEING

your foot route if you are mobile...

Is there anything hazardous or anything that could be used as a ligature?
Are there any possible anchors?

Thanks for your feedback. I will share this information with the Facility Manager after the training.

Activity: Youth Stories

Please turn to page 32 of your workbooks where you will find the first of 4 youth stories. Each story will have a corresponding number located on the upper right hand corner. Find the story that matches your assigned number. For example if you are a #1, you will be studying Victoria. If you are a #2, you will be studying David. As we move through the training, I will ask you to refer to these stories and answer questions that relate to components of the model we will be learning today.

We have been talking about seeing, so begin by reading your youth's story. When you are done, please follow the directions in your workbook for the group exercise and identify signs of depression, risk factors and warning signs.

Please take 10 minutes to do that now.

As participants finish, say...

In your group, work on the youth story questions that match your group number. For now, you will only be working on the questions that relate to seeing.

As participants finish, ask...

for a volunteer from each of the groups to provide an overview of their youth story and to note signs of depression, risk and warning signs.

Please see the appendix (page 70) of this manual for the answers.

Some of these youth were clearly in need of help. Victoria and Jake, however, might have been overlooked if someone hadn't observed that interaction and stepped in.

Let's talk about Victoria's case for a moment.

Did anyone identify the staff comment about the pregnancy test as a worrisome behavior?

If so, why?

Elicit: This was personal and should have been discussed in private. Why would room confinement be unadvisable at this point?

Elicit: We know she is taking anti-depressants. The fact that she is depressed, in combination with news of her pregnancy, justifies a referral to mental health staff.

For those of you who studied Haley, did anyone identify the arresting officer's failure to convey her comment to buy a gun to "end her miserable existence" as a worrisome behavior?

Why would this be worrisome?

Elicit: Suicide prevention begins at the point of arrest. Comments or behaviours that indicate a youth is suicidal should always be conveyed by the arresting officer or the probation officer (Hayes, 2005).

If her comment about ending her existence had been reported, Haley would have been put on suicide watch on intake.

Why was having a "strong feeling" that you should probably check on her identified as a worrisome behavior?

Elicit: If you have a strong feeling that a youth may harm themselves, the youth should already be on suicide watch.

Did anyone identify the radio cord as both a warning sign for suicide and a worrisome behavior?

III. Shield of Care Model

PART A: SEEING

Why is this worrisome?

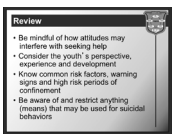
Elicit: Radio cords, and any other objects that could easily be used as ligatures, should not be accessible to youth regardless of whether they are suicidal.

Let's turn to David for a minute. Did anyone identify his cheerfulness as a warning sign for suicide?

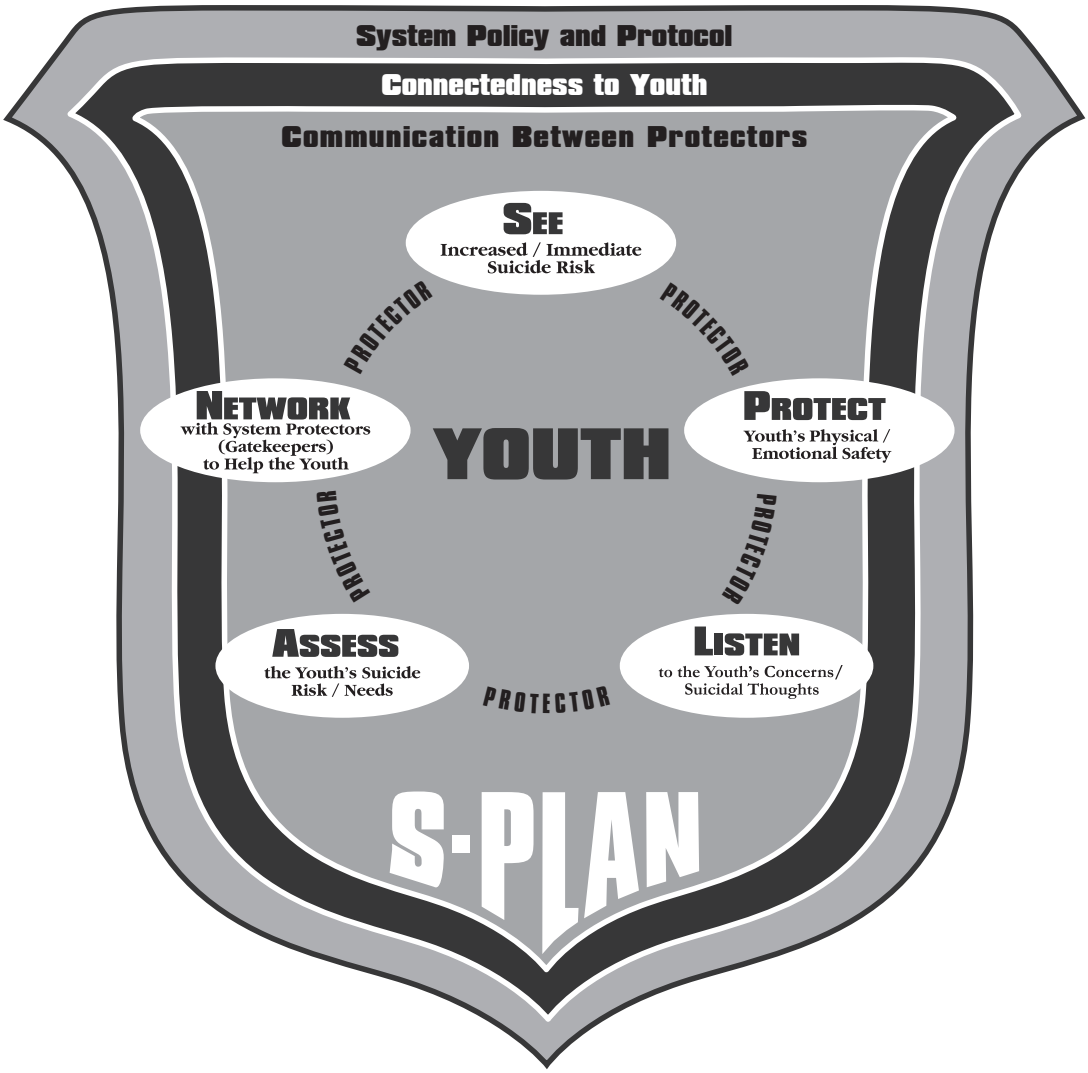
Why would cheerfulness be a warning sign for suicide?

If someone appears cheerful after thinking about suicide, it may indicate that the person has made the decision to go through with it. Why?

Elicit: Indecision often causes anxiety. Making the decision to follow through can provide relief and improve mood.



To summarize, be mindful of your attitudes, consider the youth, know the signs, and restrict means.


System Policy and Protocol
Connectedness to Youth
Communication Between Protectors
SEE
Increased / Immediate Suicide Risk
PROTECTOR
PROTECTOR
NETWORK
with System Protectors (Gatekeepers) to Help the Youth
YOUTH
PROTECT
Youth's Physical / Emotional Safety
PROTECTOR
PROTECTOR
ASSESS
the Youth's Suicide Risk / Needs
PROTECTOR
LISTEN
to the Youth's Concerns/ Suicidal Thoughts
S-PLAN

III. Shield of Care Model

PART B: PROTECTING

1. "Protecting": Introduction

In this section we're going to explore protecting the physical and emotional safety of youth.

In a study of over 2,000 liability lawsuits, 55% alleged there was a failure on the part of correctional personnel to protect (Ross, 2010). These claims assert that correctional personnel failed to implement measures which would reduce the degree of self-harm and take precautionary measures which would reduce the risk of suicide.

Protecting youth begins at the time of arrest. Intake staff should ask any law enforcement and corrections field personnel to report any statement or behaviour that may indicate a youth is at risk of suicide and document these comments (Hayes, 2006). This will include comments or statements made by the youth prior to his/her arrival at the institution and any concerns from family members regarding the youth's suicidal intent.

Facilities should also enact policies that encourage intake staff to relay relevant information regarding past behaviour noted through observation, past involvement with the offender, or community contacts (Hayes, 2006).

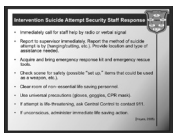
This information, combined with an intake assessment of suicidal thoughts or behaviors, is used by mental health care staff to develop a suicide management plan. The plan will include information such as housing assignments and other recommendations to protect the youth against suicide while detained (Hayes, 2006).

The goal with protecting is to prevent the immediate risk of suicide. Sometimes youth are identified when they are attempting suicide or have direct access to potentially lethal means. In this case, staff must assure the physical and emotional safety of the youth before further broaching or addressing the topic of suicide.

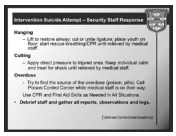
Federal courts have ruled that staff can be held liable for delaying and or failing to provide prompt intervention following a suicide attempt (Hayes, 2008).

2. "Protecting": Physical Safety

A. Responding to a Suicide Attempt



These steps are to be followed upon discovering a youth in the process of a hanging, cutting or overdose attempt. To report, call in as emergency/1033/ insert local code:_____, state that it's a suicide attempt and provide means, location and type of assistance needed. Never assume a youth is dead until confirmed by medical staff (Hayes, 2005).



If the youth is found hanging, assume a neck/spinal injury. Lift carefully to clear airway, cut or untie the ligature and place the victim on the floor – not a mattress or other soft surface. Respond as if the youth is still alive and wait for medical staff to make that determination (Hayes, 2008).

NOTE: Display emergency response kit and emergency rescue tool.

All housing units should contain an emergency response kit that includes a first aid kit, pocket mask, micro shield or face shield, latex gloves and an emergency rescue tool. All staff who come into regular contact with youth should know where the kit and tool are located. At this facility, the emergency response kit and tool are located (fill in the blank)_____
_____
_____.

NOTE: If the emergency rescue tool is kept separately from the kit, be very clear where the tool is kept in every unit.

Life-saving minutes are often wasted when security staff have difficulty loosening or removing a ligature from around the neck. Demonstrate how to use the rescue tool without cutting the skin.

The shift supervisor will ensure that arriving medical staff and EMS personnel have clear access to the scene. Although the scene should be preserved as much as possible, the first priority is saving a life.

An Automated External Defibrillator (AED) is located _____
_____(fill in the blank).

All equipment must be maintained. At this facility, the following staff are responsible for maintaining the corresponding equipment.

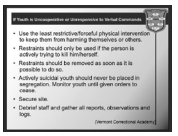
Medical equipment – _____
Emergency response kit – _____
Rescue tool – _____
Other?

An overdose requires swift action to identify the source. Check the immediate area for the source of the overdose. Question the youth if responsive and cooperative. The number for the national Poison Control Hotline is 800-222-1222, you can find it in your workbook on pages 5 and 19.

Ask participants to refer to the Suicide Intervention, Precaution and Referral Guide distributed at the beginning of the training.

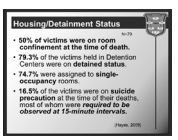
We've summarized our facility's suicide intervention procedures with this guide, and we've also provided you with details regarding suicide precautions, referral names and contact information which we'll get to a moment.

[Discuss facility specific emergency procedures]



For noncompliant youth, force may be necessary but should always be a last resort. If restraints are needed, remove them as soon as it is safe to do so. If the youth is uncooperative, process/debrief the incident with peers on unit to allow them to feel safe and to ask any questions. Respond concretely, and truthfully to any questions.

3. "Protecting": Housing/Detainment Status



When youth are identified at risk for suicide, appropriate housing is a critical concern in protecting youth against suicide, particularly with regard to room confinement.

Room confinement is defined as a behavioral sanction imposed on youth that restricts movement for varying amounts of time. It includes, but is not limited to, isolation, segregation, time-out, or a quiet room (Hayes, 2009).

As you can see, the confinement study shows a strong relationship between juvenile suicide and room confinement (Hayes, 2009). This information is supported by earlier research. In one study (Parent, Leiter, Kennedy, Livens, Wentworth, Wilcox, 1994), researchers found that rates of suicidal behavior appeared to be higher for youth who were isolated from their peers or assigned to single room housing.

The prevention potential is very high with housing assignments, particularly regarding room confinement. While room confinement can be an effective behavioral management tool when appropriately used for short durations with close monitoring and clear documentation (National Commission on Correctional Health Care, 1999; 2004), it can be easily overused and even abused in response to the challenging behavior presented by many youth in juvenile justice settings (Hayes, 2009).

Room confinement is a sanction that can have deadly consequences and should be closely scrutinized and utilized judiciously. In fact, over 50% of all juvenile suicides occur while the youth is under room confinement status. This is a very significant finding. Placement of a youth on confinement status may trigger self-injurious behavior.

Youth who have recently attempted suicide or who are assessed as being at significant risk for suicidal behavior should not be housed in isolated settings and should be housed in close proximity to the staff (Hayes, 2009).

Let's take a minute to review the facility's room confinement policy.

Ask participants to refer to their facility's policies and procedures distributed at the beginning of the training.

Are there any questions regarding these procedures?

Another housing consideration relates to access to means and anchors. Given the risk associated with hanging, youth at the highest level of suicide watch should be housed in a unit that has been cleared of any possible means or anchors.

Mental health staff will determine access to privileges and other details which will be provided in the suicide management plan.

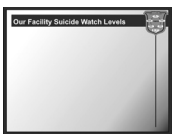
PART B: PROTECTING

4. "Protecting": Suicide Precautions

Let's move on to suicide precautions.

Ask participants to refer back to the Suicide Intervention, Precaution and Referral Guide.

Details regarding the observation levels at this facility are provided in the guide.



[Review the specific details of your suicide precaution policy per the recommendations on the handout. Staff will need to know:

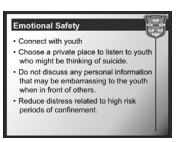
1. How a youth is placed on "suicide watch";
2. Who decides when a youth goes on "suicide watch";
3. Who can upgrade/downgrade the watch status as well as who can discharge a youth from "suicide watch";
4. Documentation requirements;
5. Visual observation/room check procedures per your facility's policies and procedures.

Camera observation should never be used as a substitute (Hayes, 2005) for physical observation checks provided by staff.

Are there any questions regarding these policies?

5. "Protecting": Emotional Safety

When we think of protecting youth, their physical safety probably comes to mind, but we also need to care for their emotional safety.



Detention disrupts key social networks and significantly increases the risk of suicidal behaviours and death (CDC, 2008). On the other hand, significant research supports the view that connectedness between persons reduces the risk of suicidal behaviour (CDC, 2008).

Youth who better handle confinement and refrain from suicidal behaviour are likely to have developed protective factors. The definition of protective factors is on pages 13 and 40 of your workbook.

Please take a look at that definition and subcategories now. If you help youth cultivate these psychological, social and environmental protective factors, you may help prevent the escalation to suicidal thoughts and behaviours.

In the video, we saw that Sal worked to connect with Jax. He would not have been as effective if he didn't already have some kind of connection. If we don't do this foundation work, it will be much more difficult when it really matters.

Earlier in the training, we learned that the thickness of our shields depends on our connections with youth and each other. Fostering connections is a strong protective factor.

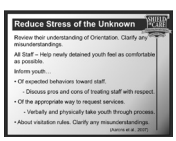
Substantial evidence supports the view that stronger connections can increase a youth's sense of belonging or "mattering" to a group, increase a sense of personal value or worth, and allow access to a larger base of support. In turn, this increases the motivation and ability to cope in the face of adversity (CDC, 2008).

All of us can help protect youth against suicide by connecting to youth and helping them connect to one another in appropriate ways.

In your role, how can you increase connections with youth and help them gain a sense of belonging or mattering?

Whenever possible we want to reduce the stress of the unknown.

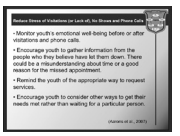
Security staff will most likely provide specific information about what to expect, but all staff can work to help newly detained youth feel more comfortable.



If we see that a youth is anxious or stressed before or after a phone call or visit, debrief the call and allow the youth to express their feelings.

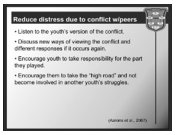
Youth may also become stressed or angry after a "no show" on the part of

PART B: PROTECTING



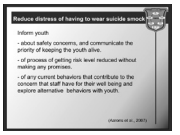
a probation officer, nurse or even a counselor. This may also cause a lot of stress for a youth who put a lot of emotional investment into that meeting. Taking a few minutes to "be there" for the youth after a disappointing visit can make a big difference.

Also be on the look out for warning signs for suicide and depression if a youth appears anxious, sad or distressed prior to and after phone calls and visits.

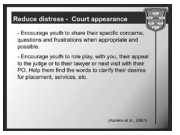


Conflict with peers is very common in this environment and is a known precipitating factor for suicide, especially when that conflict involves bullying or sexual assault. Follow policies and procedures for breaking up fights and then debrief with youth. Identify ways the youth can get help if a peer is combative.

Be alert for warning signs for suicide and depression if a youth appear anxious, sad or distressed prior to and after conflict, particularly after physical or sexual assault.



These strategies are designed for security staff. Wearing a suicide smock is a humiliating experience, and youth will almost always complain. Here are some things to say that might make it easier.



Finally, we want to spend some time with youth who are stressed about an upcoming or disappointing court appearance. The feelings may range from fear of public speaking to shame of the offense. Help reduce this fear by role-playing the court appearance with the youth.

Again, monitor youth carefully for warning signs if they appear anxious or stressed before and after court appearances.

Respect for youth privacy is critical. Be sure to discuss any personal matter in private.

6. Activity: Youth Stories

It's time to revisit the youth stories. Please turn back to the youth stories on page 32 of your workbooks, read and then spend 10 minutes discussing in your group how you can apply what you've learned to protect your assigned youth.

Ask the groups to use their Suicide Intervention, Precaution and Referral Guide as they discuss specific procedures to address physical safety and the information in their workbooks to address emotional safety.

Debrief: Let's start with Victoria. What is the priority in terms of protecting?

Elicit: Her emotional safety. She is obviously feeling isolated and stressed because of her pregnancy.

How about Jake? What is the priority here?

Elicit: Both emotional and physical safety. He needs to talk about the death of his father with mental health staff. He also needs to be placed on suicide precautions and get an assessment as soon as possible.

Haley?

Elicit: Physical safety. Engage emergency response procedures as discussed for hanging.

David?

Elicit: Physical and emotional safety. His signs require suicide precautions as well as the opportunity to debrief the disturbing phone call.

7. Activity: Policy Review

It's time for a policy review. Please take out your copy of the policies and procedures and stay in your groups to discuss the policy review questions on page 20 of your workbooks.

In what ways are these policies helpful to you as a staff member when thinking about protecting a youth at risk for suicide?

In what ways is your role limited by policy in regard to protecting youth at risk for suicide?

Protecting a youth's physical safety is paramount, but we can prevent the escalation to suicide if we also focus on the emotional safety of youth in our care.

III. Shield of Care Model

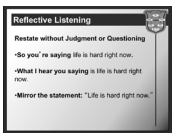
PART C: LISTENING

1. "Listening": Introduction

This next section is about listening to youth. As mentioned earlier, the S-PLAN components may not necessarily be implemented in order. A youth may, for example, say or do something that triggers a red flag for you regarding their risk of suicide, but you aren't quite sure. In this case, we would be more focused on listening than protecting. On the other hand, the signs might be more obvious. In this case, your priority should be protecting the youth's immediate safety.

When you suspect a youth may be depressed or suicidal, you should ask directly about suicide while in a safe environment. Mental health care staff is responsible for getting to the root of suicidal thoughts, so limit your questioning to clarify your understanding of what the youth is saying and determine whether they are suicidal.

We'll talk about the questions in a moment. However, questions about suicide are often more effective once the youth feel listened to and understood.



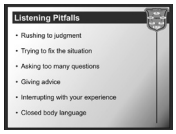
I want you to think about a person you reach out to when you need someone to listen.

More than likely this person doesn't offer advice or try to fix the situation because they realize this isn't nearly as important as helping you feel understood. They probably don't interrupt, minimize your feelings, tell you you're crazy or that everything is going to be okay.

Imagine that a youth says, "Life is just too hard right now." How might you respond?

If participants respond with any of the pitfalls on the following slide, ask them to hold that thought and continue to elicit the following responses: accept/acknowledge feelings, empathize, and/or paraphrase.

One way in which we can demonstrate we're listening is to paraphrase what we've heard. The goal is to reflect back what we're hearing while retaining as much as the youth's original meaning.

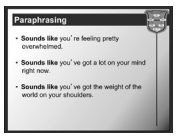


Paraphrasing may feel awkward or even silly to some of you, but don't underestimate its power. It's a way of showing youth that you are really listening and hearing what they have to say.

A teen may be so shocked that an adult doesn't try to offer advice, interrupt, judge or minimize their feelings that he might begin to really open up. Developing this skill can be challenging for some people because the pitfalls are tempting. The desire to ask questions can be overwhelming.

Remember that the goal is to reflect back what we're hearing while retaining as much as the youth's original meaning. Consider the previous "Life is just too hard right now" example.

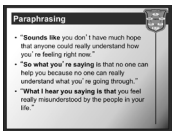
It can help to have a standard lead in to your statement. Here we're using "sounds like..."



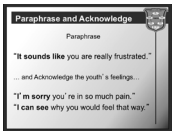
Sounds like you're feeling pretty overwhelmed.
Sounds like you've got a lot on your mind right now.
Sounds like you've got the weight of the world on your shoulders.

Let's try another one using "sounds like" and some other lead in statements on page 20 of your workbooks. "No one understands. No one will ever understand." Take a few minutes to complete the sentences retaining as much meaning as possible.

Here are some possibilities



Another listening strategy is acknowledgement. With acknowledgement, you are simply telling the youth, in your own words, that you are taking in what he's saying.



We're not asking you to agree with what you see or hear, and we don't want you encourage the youth to go on a rampage. You are simply empathizing and telling the youth, in your own words, that you are taking in what he's saying.

It's very possible to use this skill without getting drawn into any drama. A good rule of thumb is to "lean in, not fall in."

PART C: LISTENING

For example, let's imagine that the youth had a family visit scheduled with his brother who didn't show up. The youth had been looking forward to it for a long time and is visibly angry.

You might say something like, "I'm sorry Charles didn't show up. I can see you're really angry."

You will avoid getting drawn into drama by resisting the temptation of judging Charles by saying he's a flake or worse. Depending on the situation, sometimes it might be helpful to nudge the youth to think about other considerations. For example, "I don't think people really understand what's it's like to look forward to a visit."

Once the youth begins to open up, you might also be tempted to offer advice or share stories from your own history. **Why should we resist that temptation?**

Elicit: The solution isn't as important as being listened to.

The focus shifts from the youth to you.

How do we use non-verbal cues to indicate that we're truly listening?

Elicit: Eye contact, posture is open vs. crossed legs/arms, person is attentive.

Pair Work: Reflective Listening

We all probably know someone who is highly skilled with reflection or acknowledgement. For almost all of us, these techniques take practice. Let's take the opportunity today to hone these skills a bit using an experience most of us can all relate to: driving. Open your workbooks to page 21 and think about something another driver did recently that really made you mad. Write it down.

In a moment, you'll share that experience with a partner. Your partner will practice reflecting that experience as closely as possible while using the lead in statements in your workbook; the other will take the role of listener. Then you'll switch.

Resist the temptation of offering a solution, questioning, sharing a similar experience on the road or judging the other driver.

Let's start with paraphrasing. You will begin the exercise with the statement, "You look really upset."

[Give pairs 5 minutes to practice reflection]

Debrief

[Ask for a few examples. Gently redirect if the example includes judgment or questions.]

Did it help, even now, for someone to reflect your feelings of that experience?

Was it difficult to resist offering a solution, sharing a similar experience or bashing the other driver?

Activity: Youth Stories

Let's take a few minutes to revisit the youth stories. Please turn back to the youth stories on page 32 of your workbooks. We're going to spend 10 minutes practicing our listening skills. If you are in a group studying Haley, assume that you had the opportunity to listen before the risk increased to the point of the attempt.

Now let's practice in the roles of youth and staff. In pairs, you will decide on a negative emotion that would likely be demonstrated by your youth and a reason for that emotion in the story.

The person in the role of staff will simply reflect that emotion and the reason. "S" stands for "staff" in this exercise; and "Y" stands for "youth".

PART C: LISTENING

Example:

S - I see that you're really angry. What's going on?
Y – My mom didn't show up again.
S – It sounds like you're really disappointed. I can understand why you would be angry about that.

Debrief: Ask for a few volunteers to demonstrate their skills.

Reinforce or gently redirect as needed.

Activity: Policy Review

It's time for a policy review. Please take out your copy of the policies and procedures.
In what ways are these policies helpful to you as a staff member when thinking about listening to a youth at risk for suicide?

In what ways is your role limited by policy in regard to listening to a youth at risk for suicide?

1. "Assessing": Introduction

When we hear the word "assessment," our minds may automatically think about an intake assessment or a formal mental health assessment, both of which provide a snapshot of risk. Assessment is not a time-limited event. It is ongoing. Youth can become suicidal at any time.

2. Asking About Suicide

While mental health care staff are responsible for formal assessment, any one of us can conduct an informal assessment which may entail asking youth if they are thinking about suicide.

For example, let's say you are listening to a youth, and he or she says something that makes you wonder whether suicide is an issue, but you're not quite sure.

We saw Sal model this in the video clip when he asked Jax, "Are we talking about suicide here?"

When you suspect a youth is suicidal, ask directly. This will not put the idea in their head. If anything, it conveys the message that you are concerned and ready to help.

Notice how direct Sal's question was. What might happen if he had asked "You're not thinking about suicide, are you?"

Elicit: Jax would probably deny it because the question is asked in a discouraging way.

Or if he had asked "Are you thinking of doing something stupid?"

Elicit: The youth may think you're saying he's stupid and not reply. He may also immediately answer with a "no" because he thinks that is what you want to hear.

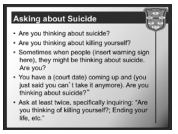
Direct questions without judgment will help the youth provide a direct answer. It also gives the youth permission to answer honestly about suicide because the youth will sense that you aren't afraid of the answer.

PART D: ASSESSING

Can you think of additional examples of direct questions? Write these down on page 24 of your workbooks. Ask for volunteers to share their answers.

Elicit: Are you thinking about suicide? Are you thinking of killing yourself?

Here are some additional examples



You might help the youth with feeling alone with their thoughts by saying something like "When someone gets trapped in negativity and says things like 'I just can't take it anymore,' it is an indication of suicidal thoughts. Are you thinking about suicide?"

When you suspect a youth might be suicidal, use the reflection and acknowledgement skills you learned in the last section to lead up to the question.

An example is on page 24 of your workbook. Take a look at that now.

The following dialogue is in the participant workbook:

S - I see that you're really angry. What's going on?
Y – My mom didn't show up again.
S – You're saying that your mom didn't show up again. I can understand why you would be angry about that.
Y – She doesn't care. No one does. I won't be a problem for her much longer.

What might lead you to think that suicide is an issue?

Elicit: The youth is angry, overgeneralizing and says he "won't be a problem much longer."

Would it be too soon to ask about suicide?

Elicit: No. Once you suspect suicide, ask.
A youth might also just say he wants to blow his brains out without any questioning on the caregiver's end. If this is the case, protecting the youth and networking, which we'll discuss later, will be your priority.

Once the youth responds with a "yes" to a question about suicide, tell them that their safety is a priority - protect and refer immediately.

3. "Assessing": Video

We are going to watch another video clip. This time you're going to work in groups to identify the elements of S-PLAN and answer additional questions after the video.

In your groups, decide who will be focusing on **seeing**, who will be focusing on **protecting**, who will be focusing on **listening**, and who will be focusing on **assessing**. Take notes in your workbook.

Once these roles are assigned, take notes on page 25 of your workbooks while you are watching the clip.

Play Video

When the video is over, ask the groups to discuss their notes (5 min.). Continue to write down anything others may have discovered.

Compare answers within your group. (5 min.)

How did you do?

No matter how skillful we are about asking, youth still may deny they are thinking of suicide and harbor suicidal thoughts.

PART D: ASSESSING

4. "Assessing": Denial

What would you do if you were in Darlene's position and Tricia denied thinking of suicide?

Elicit: Try asking one more time, providing evidence of what you've seen and heard that makes you think otherwise.

For example, "Tricia – I'm not going to walk away right now. I can see you are really struggling. You just said that you wanted to see your son 'one more time.' Be straight with me. Are you thinking of suicide?"

If she still gives a "no" response, the statement regarding her son is enough to warrant immediate protection until mental health care arrives. Convey your concerns to the mental health provider or other designated person and document.

To protect Tricia's emotional safety, it would be important to tell her that you want to believe her, but given what you've heard and seen, your first priority is keeping her safe. For this reason, you're going to take some steps to protect her.

Notice that Darlene didn't ask about a plan. Asking about plans is in the realm of the mental health care provider, but if a youth should disclose a plan and any related details while talking with you, you must document what was discussed or discovered.

Darlene also didn't get into Tricia's background or ask any questions other than what was needed to determine whether Tricia was suicidal. Again, these types of questions are the responsibility of mental health care staff.

5. Activity: Youth Stories

We're going to extend our listening practice to informally assess for suicide risk. Find the partner you had for the listening practice. Using the same negative emotion and reason for that emotion, you're going to add a warning sign for suicide and ask directly about suicide.

Please turn back to the youth stories on page 32 of your workbooks and spend 10 minutes practicing your assessing skills. If you are in a group studying Haley, assume that you had the opportunity to listen before the risk increased to acting upon her thoughts.

Debrief: Ask for a few volunteers to demonstrate their skills.

Gently redirect if someone asks about suicide indirectly (are you thinking of harming yourself?) or in a way that discourages a positive response (you're not thinking of suicide?).

6. Activity: Policy Review

Let's take a few minutes to review our policy regarding what we've learned about assessing a youth's risk. Please stay in your groups to discuss the policy review questions on page 26 of your workbooks.

What does the policy say about assessing a youth at risk for suicide?

In what ways are these policies helpful to you as staff when thinking about assessing a youth you perceive at risk for suicide?

In what ways is your role limited by policy in regard to assessing a youth you perceive at risk for suicide?

III. Shield of Care Model

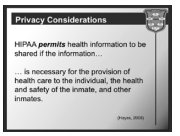
PART E: NETWORKING

1. Introduction to "Networking"

One of the primary goals of this training is to ensure that you are clear regarding your role in helping a suicidal youth as well as the role of others.

Once you suspect a youth is suicidal, you will be sharing this information with designated staff. Different staff members are contacted to perform different jobs to help. It is important to learn who to contact and how to get in touch with that person when you need their help.

2. Privacy

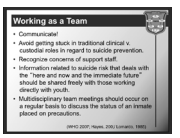


One of the biggest barriers in assisting a youth at risk of suicide is the false belief that sharing information conflicts with privacy laws. Contrary to this belief, the federal HIPAA law permits the exchange of information in a number of situations including those shown here (Hayes, 2008)

This is not to say that non-medical professional staff should have access to a youth's medical file. They shouldn't. But they should have working knowledge of a youth's suicide management plan which includes the youth's current functioning, levels of observation, frequency of contact, access to clothing and possessions, privileges, and side effects of medications (Hayes, personal communication, August 26, 2011).

While confidentiality is a concern, no professional should ever use confidentiality as an excuse to keep pertinent information regarding suicide risk from another staff member.

3. The Importance of Team Work and Communication



Team work and communication between mental health care staff and security staff are essential to any suicide prevention program (Hayes, 2005). Those facilities that maintain a multidisciplinary approach and share information to keep youth safe avoid preventable suicides (Hayes, 2008).

Sharing information with other security staff is also important. Shift changes are critical especially if a youth receives bad news or requires immediate

supervision while waiting for mental health staff. Always document and share any behaviours with incoming staff (Hayes, 2005).

Working effectively as a team also entails immediately providing feedback to each other regarding staff performance or youth behaviour.

4. "Networking": Video

You're going to watch another video clip. Before you do, review the video viewing tasks on Page 27 of your workbooks and consider these questions while you watch.

Play video

Catching Eddie in the act was mostly luck, but Nick would have been too late if he hadn't staggered his bed check.

Debrief: How did staff work together to help Eddie?

Elicit: Initially, both are focused on his physical safety – Nick calls in the attempt and location, while Sal obtains the necessary equipment.

Once it's clear that Eddie is okay, Nick works hard to help protect his emotional safety.

At what point did Sal stand back and let Nick continue?

Elicit: When it was clear Nick had established an emotional connection and was having success deescalating the situation.

How did Nick help protect Eddie's emotional safety?

Elicit: By acknowledging Eddie's feelings and conveying that he cares, Nick not only protected Eddie's emotional safety, but helped calm the situation.

How did Nick make the referral easier for mental health staff?

Elicit: Nick helped increase the possibility that Eddie would be more successful with his interaction with mental health care staff by assuring Eddie that Mrs. Harris will help him this time. Nick recognized that a team approach to suicide prevention was imperative.

He recognized that, while security staff are primarily responsible for **safety** requirements and mental health clinicians are primarily responsible for **clinical** requirements, both must **work together** to ensure Eddie's safety.

5. Wallet Cards

Networking is a critical step within S-PLAN. The "Suicide Intervention, Precaution and Referral" handout I provided earlier in the training gives you key networking contacts for a variety of situations. Please take a minute to transfer these contact numbers onto your wallet cards, which also contain much of the core information that we've learned today.

6. Activity: Youth Stories

Let's take a look at how we can network to help our kids. Please turn back to the youth stories. In your groups, using the Suicide Intervention, Precaution and Referral Guide, determine who you would contact given the situation and how you would contact that person.

Debrief referral choices for each of the youth stories.

7. Barriers to Suicide Prevention

Barriers to identifying and referring youth at risk of suicide can clearly interfere with suicide prevention efforts. Examples of barriers may include:

- Disagreement among staff as to how to help a youth who is at risk for suicide.
- A lack of responsibility (the feeling of "someone else will do it").
- Concerns about liability ("If I start a paper trail on this youth, I will be liable).
- These barriers keep us from taking a proactive approach to suicide

prevention, so it's important to devote some time to think about other possible barriers and how we can work together to overcome them.

- In your workgroups, identify at least 3 barriers to helping youth at risk and discuss how you would work together to overcome those barriers.

Debrief as a group.

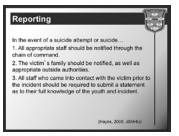
IV. After A Suicide

1. Suicide is preventable

While suicide is highly preventable, there is still a possibility that a suicide could happen here. The risk of this happening decreases with our attention and application of what we've learned today.

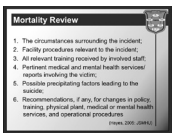
Nonetheless, we need to be prepared. This section is about what happens after a serious attempt or suicide.

2. Reporting



In the event of a suicide attempt or suicide, the following reporting procedures are recommended. Be prepared to submit a statement that details your knowledge of the youth and details of the incident.

3. Mortality Review

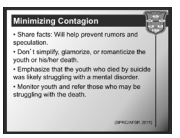


In addition to the reporting requirement, a multidisciplinary Mortality Review Team that includes representatives of both line and management level staff from the corrections, medical and mental health staff will conduct an in-house review of the death otherwise known as a mortality review.

Here are a few of the essential components of a thorough mortality review. A thorough review will help our facility prevent additional suicides.

If you have a mortality review from a suicide at your facility, distribute it now. Point out any actions the facility has taken to prevent additional suicides. Note any changes that still need to be made, if any.

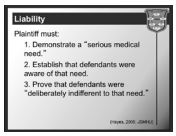
4. Minimizing Contagion



We learned from the confinement study that contagion is a real threat after a suicide. Research suggests an increased risk of suicide within a four-week period following the initial suicide, with a reduced risk over time. (Cox & Skagg, 1993). Here are some things we can do.

Youth are especially vulnerable to so-called copycat suicide attempts (Hales, Davison, Misch, & Taylor, 2003), so if we do experience a suicide, be on the lookout for youth who are deeply affected, monitor for signs of depression and warning signs and inform mental health care staff if you observe anything concerning. Debriefing a suicide with mental health care staff will help youth process the death in a healthy way.

5. Liability



It's possible that a lawsuit will follow an attempt or completion. Courts, including federal courts, have found that some responsibility falls to the juvenile justice facility to protect youth from suicide. The test to determine that duty is called **"deliberate indifference."**

An individual demonstrates **"deliberate indifference"** if he or she recklessly disregards a substantial risk of harm to the youth. It is a higher standard than negligence and requires that the individual knows of and disregards a substantial risk of suicide and/or self-injurious behavior (Hayes, 2008; Hayes, personal communication).

At the beginning of the day, we asked you to reflect on a few attitudes that relate to liability. The first was:

I may choose not to intervene with a suicidal JJ youth so I do not become liable.

The second was:

In JJ facilities, a staff person who intervenes when a youth is considering suicide becomes legally responsible for that youth's life or death.

Choosing not to intervene, or assuming you'll become legally responsible if you intervene when a youth is considering suicide, will not protect you or this facility from lawsuits. You will not escape liability "if evidence shows that you refused to verify underlying facts or you decline to confirm inferences of risk that you suspect to exist" (Ross, 2010).

IV. After A Suicide

6. Self Care

With all of the activity that follows a suicide, it is important to be aware of your own reactions. People process death and the experience of responding to an attempt or completion in different ways. Some may prefer to get help on their own, while others may benefit from Critical Incident Stress Debriefing.

Some of the stress symptoms that individuals may experience after traumatic incidents are listed on page 31 of your workbooks. They are normal reactions to unusual circumstances. Review several with the participants.

The signs and symptoms may last a few days, weeks or months, based on the severity of the event. With understanding and support from peers, management and loved ones, the reactions usually pass more quickly.

If the stress symptoms intensify, do not decrease over time or interfere with your day-to-day functioning, professional assistance from a counselor or group debriefing may be necessary.

Please see page 5 and 6 of your workbooks for information on how to obtain help. [Trainer should also repeat information from self-care slide (look back to page 14, if needed).].

Include any information you have regarding Critical Incident Stress Debriefing (CISD) available through your facility and how to access this service. Ask if the facility has a qualified CISD response team.

7. Shield of Care Review:

Today you learned how juvenile justice staff can create a Shield of Care in communities to protect youth from suicide. As we all know, it's one thing to "sit through" a training and absorb the information. It's quite a different thing to think through how we can REALLY apply the information we learn in our facility.

Please turn to pages 28 & 29 of your workbooks and take 15 minutes to respond to the questions regarding facts, responding to risk and the action plan.

As participants are finishing, ask them to share responses with their group.

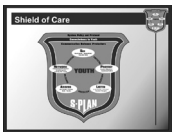
Debrief as a whole group.

8. Parking Lot

Let's revisit the parking lot to review the questions and concerns that came up today.

If you can't answer a question or address a concern, be sure to research it using the SPRC library **http://library.sprc.org/ (http://bit.ly/sprclibrary)** *and get back to the group via email. As time allows, elicit any other questions. Note any items that were raised as hopes for learning or things to get out of training that did not get addressed earlier (just in case they did not get on the parking lot list).*

9. Shield of Care Conclusion



All of us have a responsibility to keep youth safe from suicide. The most critical component of the Shield of Care is to see warning signs and depression in these kids before they get to the point of considering suicide. If you notice these signs, consult with mental health care staff as soon as possible.

I'm going to bring this day to a close with some words from our good friend Sal. Directly after the video, we will be taking a post-training survey to capture what you've learned today, so please stay seated.

Play video

10. Administer Post-Training Survey

There is one final task before you go today, and that is to complete a post test. Please complete and turn it in to me when you are finished.

Thank you.

Appendix

SUICIDE INTERVENTION, PRECAUTION AND REFERRAL GUIDE

Suicide Intervention Procedures

Insert the following details of your suicide intervention procedures for the following situations:

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

Suicide Precautions Policy and Procedures

Have copies of the policies and be prepared to discuss the following:

1. How a youth is placed on "suicide watch."
2. Levels of observation including a brief explanation of the youth (ex., youth who is actively suicidal) for whom the observation is intended.
3. Observation frequency (ex., staff shall observe the youth on a continued, uninterrupted basis).
4. Documentation instructions.
5. Policy regarding upgrading, downgrading and discharging from suicidal watch status.
6. Frequency of mental health staff interaction.
7. Supervisory aid policy (use of cameras and other youth). Model policies require that these aids be used to supplement, not replace, staff supervision.

SUICIDE REFERRAL GUIDE

Contact the following in the event a youth has attempted suicide:

First Referral: _____
Detailed Contact Info: _____
_____
_____
Second Option (if first is unavailable): _____
Detailed Contact Info: _____
_____
_____

Contact the following in the event a youth is at *imminent risk of suicide* (youth exhibiting warning signs of suicide and/or exhibiting behaviors that may indicate imminent risk):

First Referral: _____
Detailed Contact Info: _____
_____
_____
Second Option (if first is unavailable): _____
Detailed Contact Info: _____
_____
_____

Contact the following in the event a youth may *possibly be at risk of suicide* or is *exhibiting signs of depression:*

First Referral: _____
Detailed Contact Info: _____
_____
_____
Second Option (if first is unavailable): _____
Detailed Contact Info: _____
_____
_____

Appendix - Key

"SEEING" Key

Key: (signs of depression**)**, risk factors or warnings signs of suicide, **[**high risk periods of confinement**]** or **{**other worrisome behavior**}**
What do you **see** that may indicate suicidal thoughts?

Victoria, 16

Victoria picked up her supper tray in the cafeteria line and looked for a place to sit in the dining room. She saw a seat at a table near Jennifer, Latisha and Monica, who always seemed to be having fun, but it seemed like {they suddenly stopped talking and looked down at their trays as she approached}, so she walked past and sat at the very next table.

She couldn't tell what {they were whispering about, but they stopped again when she got up to get more water}. She was drinking a lot of water the last day or so because her anti-depressant was making her mouth so dry. (She hasn't had much appetite), and you've noticed that (she hasn't been her chipper self recently) or (been interacting with staff and other youth).

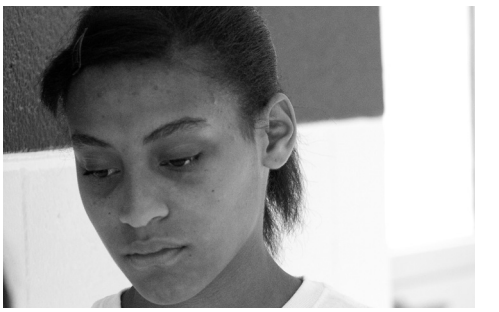
Victoria was just thinking of turning her tray in and heading back to her quarters when an officer walked up and announced, "Come on, Vicky. {The health clinic can take care of your request for a pregnancy test now."} {Victoria could hear the girls snickering as she stood up and looked at the officer, hissing "Thanks, bitch," through clenched teeth}. {"Oh yes you will get some ISO time for that mouth, Miss Taylor," the officer replied.} As they marched out of the cafeteria, she could hear Monica's distinctive voice: "You in trouble now, tricky Vicky. That rabbit done died!".

Jake, 14

Your Role: Support Staff

You hear Jake and Matt talking about [Jake's upcoming transfer to another facility] and "CTB" catches your attention. You begin listening closely now and hear Matt asking Jake whether he "has a ticket." You're listening closely because you recognize these terms from a suicide prevention training. During the training, you learned that people will sometimes use the phrase "catch the bus" to mean suicide, and that "having a ticket" means that a person has the means and a plan to complete suicide.

You don't want to let them know you're listening, but you move closer because you want to hear what Jake says in response to Matt's question.



You can't hear what Jake said in reply to Matt's question, but Matt moves away, leaving Jake sitting at a table with his head down. Jake approached you last week and told you that his father had died. He also said that {he has a hard time talking to anyone about it}.

Haley, 17

At 17, Haley was raised in a family with money.

After an abusive episode on vacation with her father 6 months prior to entering the facility, Haley had attempted to kill herself by jumping in front of a car on a busy highway near her home. Although she had several broken bones, she lived through the attempt. She was recently arrested outside a pawn shop after stealing jewelry from a high end store. She told the arresting officer that she needed the money to buy a gun because she "was just done with her miserable existence."

Once she entered your facility, other youth avoided her. She spoke and acted very differently than others. {The remark about getting a gun to kill herself was not conveyed by the arresting officer}, and {she denied any suicidal thoughts or behaviors on intake, so she was not placed on suicide watch}.

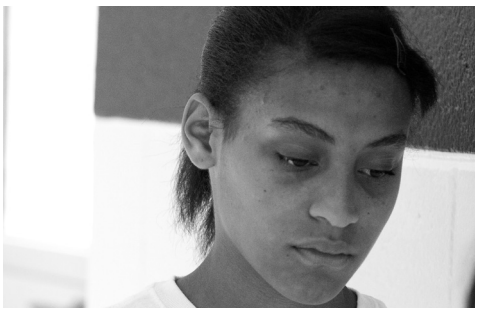
However, she became (extremely upset) whenever staff discussed either [her upcoming visit with her mom and younger brother] or [her court date]. As the family visit approached, (Haley began to refuse meals). When asked about it, she said that she wanted to see her family, but that [she was extremely embarrassed to be there, and that she felt torn between seeing them and being seen in "juvenile jail."] A few days prior to the visit, (she would nod off in the day room) and {had to be reminded that sleeping was not allowed}. The third time she put her head down and slept, {staff placed her on [room confinement] for the rest of the day.}

Despite the fact that Haley wasn't on suicide watch, {you get a strong feeling that you should probably check on her}. When you do, you discover that {she had obtained a radio cord} which she used in a suicide attempt. She is barely responsive.

David, 15

Your Role: Security staff

David, 15, did not have a history of conflict with other youth at the facility, but lately, he has been spending {quite a bit of time in [room confinement]} (for physical and verbal



conflicts with youth and staff). After he was discharged [from room confinement] (for yelling at staff again) earlier this week, David became (particularly upset) after a phone call from his father, [concealing his visit for the second time that month.]

David had been outspoken prior to the call, {but hasn't said much since}. Once an active participant in class, {he has started to do the bare minimum}. A teacher saw him drawing a noose in the margins of his notepaper today and alerts you immediately. While you are waiting for mental health staff, you talk with him and discover that, although his girlfriend broke up with him, he seems disturbingly cheerful.

"ASSESSING" Key

"Seeing" Tricia

Signs of depression, risk factors/warning signs for suicide or high risk periods of confinement

Substance abuse
Upcoming court date
Receipt of bad news (wanted to see her son, but mom wasn't helping)
Terminal statements

- Said she would rather be dead during the phone call.
- "That's alright, it'll pass - or I will! One or the other! Seriously, you can only take so much,...something's gotta give.
- "I just wanted to see him...one more time."

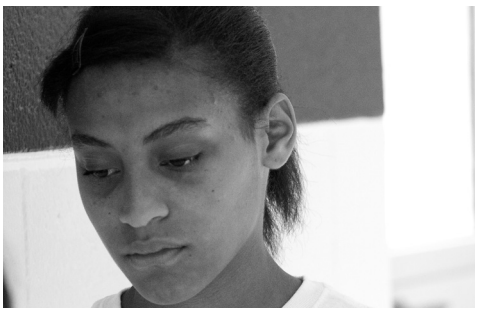
"Protecting" Tricia

Emotional Safety

- Finding a private place to talk.
- Debriefing a stressful phone call.

Physical Safety

- Referring her to mental health care staff.



"Listening" to Tricia

Asked Tricia to look at her.

Darlene asked a few questions, but the questions were to clarify her understanding.

Paraphrased and acknowledged:

"You sounded pretty upset..."
"But you're not."

"Assessing" Tricia

Darlene asked directly - "Are you thinking about suicide?"

What prompted Darlene to begin talking with Tricia?

- She was visibly upset after a phone call.
- Overheard her telling Darla that "she'd rather be dead."

What warning signs led to Darlene asking directly about suicide?

- Tricia said that she "would rather be dead" and that she wanted to see her son "one last time."

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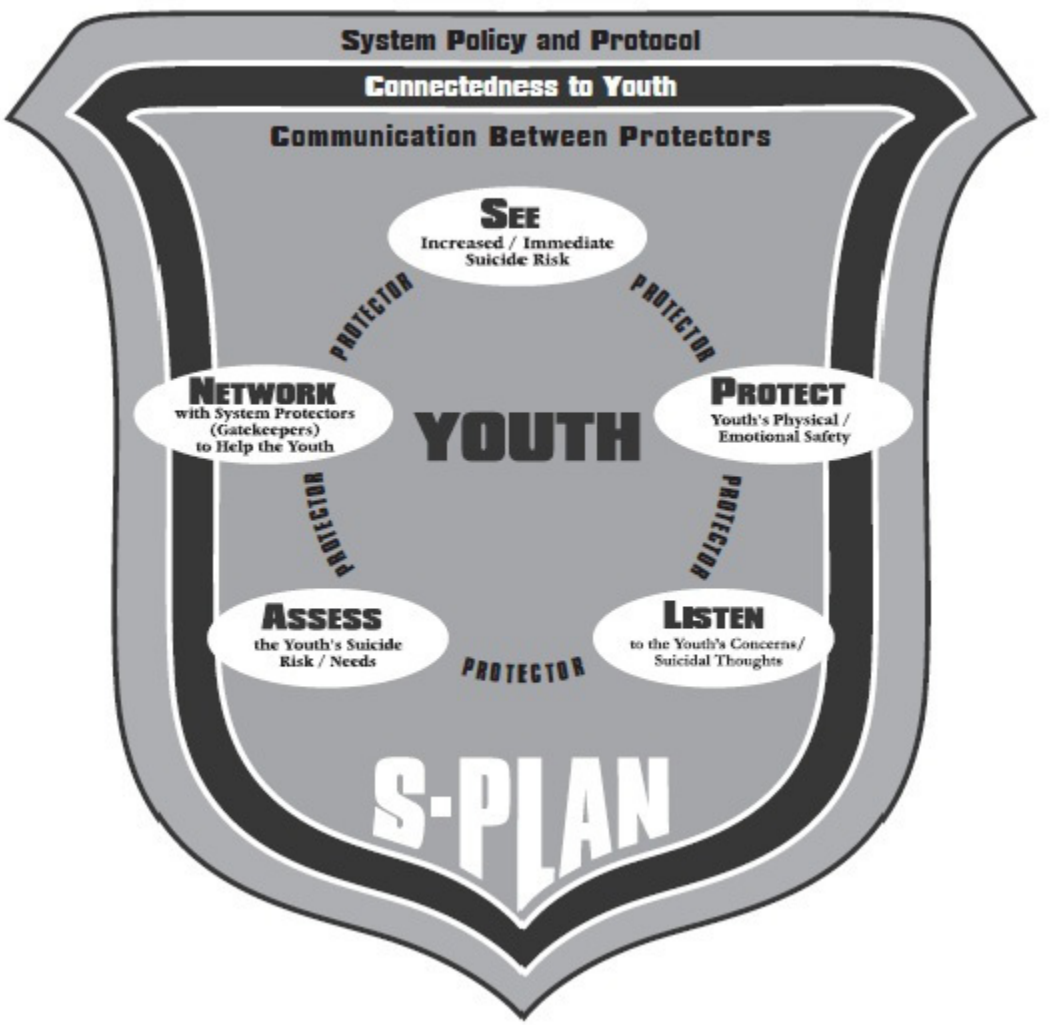
NOTES

SHIELD OF CARE
Protecting Juvenile Justice Youth from Suicide



For more information visit:

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