Webinar: Reducing the Risk of Suicide with Vulnerable Populations

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Welcome from the National Center for Youth in Custody (NCYC)

Carol Cramer Brooks: Welcome to the National Center for Youth in Custody Webinar series, Improving Conditions of Confinement for Youth in Custody. Our Webinar today is entitled, Reducing the Risk of Suicide with Vulnerable Populations. My name is Carol Cramer Brooks and I am the Director of the National Center for Youth in Custody, or NCYC. NCYC is a National Training and Technical Assistance Center created by the Office of Juvenile Justice and Delinquency Prevention, and coordinated by the National Partnership for Juvenile Services. The National Institute of Corrections also serves as a partner with the Center. We are very pleased to have you with us for what will be an excellent and informative presentation. This Webinar is the second in our series of Webinars focused specifically on improving conditions of confinement for vulnerable youth. There is one more Webinar scheduled to conclude the series in March.

Carol Cramer Brooks: Before we begin, I would like to address two housekeeping matters. First, this Webinar is meant to be interactive. I would encourage everyone to submit questions through the Chat function on your screen. Following the panelists’ presentations, we will have a question and answer period during which time we will address as many of your questions as possible. You may submit questions at any time during the Webinar.

Carol Cramer Brooks: Second, at the conclusion of the Webinar, we would appreciate it if you would complete a survey on the presentation. The survey will pop up automatically when you exit the program. Having your feedback is vitally important to us as we plan for future Webinars and training.

Carol Cramer Brooks: Before we begin the Webinar, staff with the National Training and Technical Assistance Center will go over some technical aspects of today’s presentation. Callie Long?

Adobe Platform Information

Callie Long Murray: Thanks so much, Carol. Good afternoon, everyone. My name is Callie Long Murray and I am with OJJDP’s National Training and Technical Assistance Center. As your host, I would like to take a few minutes to discuss a few features of Adobe Connect which will help you maximize your
opportunity to participate in today’s Webinar. To view the bios and photos of the presentation panel, please access the Word documents which are available now in the Handouts pod of the Webinar dashboard. Numerous handouts will be referenced today that are also located there for your resource library. To send a chat message to me, your host, a panelist, or another attendee, click the menu icon in the upper-right corner of the Chat pod, choose Start Chat With, then select Host, Presenters, or specific attendees. Type your message into the Chat box, and then hit enter or click the message bubble icon to send.

**Help Us Count!**

Callie Long Murray: For those of you who are participating in today’s Webinar as a group, please take a minute and help us count. Go to the Chat window and type in the name of the person registered and the total number of additional people in the room with you today. This will help us with our final count. Again, if you are viewing with a larger group, please type in the name of the person registered and the number of additional people joining you today.

Callie Long Murray: There will be an opportunity for Q & A at the end of the presentation today. Questions will be answered as time permits during the Q & A session. And, as Carol mentioned, at the conclusion of today’s Webinar, you will be provided with a link to take a 5-minute online survey about today’s presentation. We appreciate your feedback regarding this Webinar. This information is used to assist us in future planning and training. You will be able to access the evaluation link on the last slide of the PowerPoint. For those of you participating as a group, when you return to your office please enter the link on the last slide into your Web browser to share your feedback.

**Webinars on OJJDP’s Online University**

Callie Long Murray: This event will be archived in OJJDP’s Online University at www.nttac.org in approximately 2 weeks. You can also check out past Webinars by NCYC that have been archived on the Online University. They have presented some great information that we are happy to share with you. So please access these important resources at your convenience. Again, thank you for joining us today. I will now turn it back over to Carol.

**Webinar Learning Objectives**

Carol Cramer Brooks: [begins midsentence]… psychiatric and substance abuse disorders and a history of physical abuse, neglect, and trauma are far more common among youth in the justice system than in the general population, placing these youth at great risk for suicide. Today, we will be talking about the critical role the [unclear] staff play in preventing and responding to suicidal behavior, keeping in mind that at the time they are contemplating suicide, all youth are vulnerable.

Carol Cramer Brooks: Specifically, we will focus on the following learning objectives. Heighten awareness about the impact on youth and families of the successes and failures of implementing a comprehensive suicide prevention program. Identify and analyze the key elements of a comprehensive suicide prevention program. And discuss the successes and failures facilities have experienced their efforts to implement best practice approaches to preventing and responding to suicidal behavior of vulnerable populations in custody.
Presenter: James Anderson, Program Administrator, Anti-Recidivism Coalition (ARC), California Alliance for Youth and Community Justice (CAYCJ)

Carol Cramer Brooks: We are going to open the Webinar by giving everyone the opportunity to hear from James Anderson. James Anderson has gone through an amazing transformation in his life. After a very tumultuous adolescence and young adulthood, including a suicide attempt, he had made a commitment to dedicate his life to helping those who have also been faced in misfortunate situations. Since his release from incarceration 20 months ago, James has boarded a plane 25 times traveling the country to speak at conferences and schools to inspire hope and help raise awareness and give individuals a better perspective on the reasons why juveniles become involved in delinquent behaviors. He has finished three semesters at community college with a 3.8 GPA, and plans on transferring to UCLA in the near future to major in political science. James is now the Program Administrator for a nonprofit he helped start known as the Anti-Recidivism Coalition, or ARC. On behalf of ARC, James has become a mentor to many individuals who have been released from prison. His complete bio is available in your handouts section. James, we are so fortunate to have you with us. Let me turn it over to you.

James Anderson: It is a great honor to be here with everyone, and in all truth, I am only an expert in my own field through my experiences. Growing up, I had a very rough childhood and grew up in a dysfunctional family, as many youth I deal with do. And I remember coming home from school at this time, I was still a straight A student, and all I ever wanted was for a pat on the back and to be accepted by my parents, and I soon realized I was not going to find this within my own household. Constantly there was a battle between my mother and my father, and there was a lot of dysfunction going on. I remember thinking to myself, every time I would see that my mother or father or older brother would get into a difficult situation, I was the one they took out their anger upon. At that young age, I did not have the psychological capacity to truly understand what was going on, so my instincts told me that there was something wrong with myself. So already at this young age I began to question who I was and what was wrong with me, with no one to pull me to the side, no counselors, no coach, not being able to afford to get into sports. I was kind of thrown into this dark hold, and I remember as the fights continued in my house to get worse and worse, I prayed to God and asked him to bring someone into my life. And I realized that request was being muffled and not heard.

James Anderson: Soon my parents divorced and I found myself living in a household with my older brother and father. And at this time, my brother became deeply addicted to crystal meth and involved in gangs, and everything began to collapse at this moment in time. I remember crying a lot because it was a difficult time in my life, and my parents were divorced, and I did not really know where I was headed. I remember every time they would pass by me, they would look at me and tell me I was weak and that I was a coward, and that I needed to become stronger and be able to be a man.

James Anderson: Soon, at the age of 14, being in this environment where I was constantly searching for approval from my father and my brother, and could not find it, I became deeply addicted to crystal meth and involved in gangs. I got to a dark place in my life where I did not care what was happening or what happened. And I remember 2 months prior to my first attempt at suicide, my brother attempted suicide and he tried to overdose on pills. I remember taking him to the hospital and his heart stopping twice, and, by the grace of God, he survived. And I remembered to myself, 2 months later when I was in this really, really dark place, I could not reach out to anyone or anything. It was like a black abyss and I could not find the light. It was moments like this that, honestly, as a child, all I truly wanted was to be loved. All I ever wanted was to know that somebody wanted me. I remember going to the pill cabinet and grabbing a full container of prescription pills and telling myself in my head I was not going to make the
same mistake as my brother did, and I was going to finish the job. I remember filling up handful after
handful, and the only thing I could think of while my eyes were full of tears and I was swallowing these
pills was the fact that even if I died, I was not even sure who would show up to my funeral. I remember
as the time passed and I started to go in and out of consciousness, and I started to feel great pains in my
stomach, I realized I was too young and I did not want to die. I still wanted to live. I was just calling out
for attention, as many young children in my position often do.

James Anderson: When my father came home, I realized my dad was going to take me to the hospital,
and I ran to him and I told him, “Dad, please, please take me to the hospital.” And when he realized
what was happening and saw the empty pill bottle on the counter, he got into this rage and began to
beat me. As I fell to the ground, I remembered these words that penetrated deep within me. He said, “If
you want to die so bad, now you are going to have to deal with it,” and he locked himself in his room.

James Anderson: The next couple of days were horrible. I was in bad condition, throwing up blood. I
survived those days and it is crazy because most people said I was a miracle of God, “Did not that
resonate within you?” And knowing that resonated within me was not the fact that I was able to move
past that horrible moment, it was the fact that in my deepest, darkest moments when I truly needed
someone there for me, my father turned his back on me. Honestly, at that moment is when I told
myself, if nobody else cared about me, why should I care about myself? And I really started putting
myself in dangerous positions, going out into rival territory when I was out there with my fellow gang
members, and I did not care if I died because it was actually a present to me. I did not want to live in this
world anymore. There was nothing there for me. And I started to go in and out of jail, and I was actually
one of those sad kids that actually believed I was going to spend the rest of my life in there and I had to
accept it, all the way up to my prior incarceration when I was facing 35 to life.

James Anderson: Although I might go a little off-topic, I just wanted to bring to people’s attention that
suicide can take many different forms. Just because you are alive does not mean you are living. And I am
grateful for this panel because it actually made me question myself, because originally I said, “No, I have
never had suicidal tendencies or thoughts while I was incarcerated.” And as I started to dive deeper and
deeper into it, I realized I did. I was one of the most violent kids in this facility, always pushing to get
sentences, 35 to life sentences. I wanted it. I wanted to get sent away. In a sense, I was trying to commit
mental and emotional suicide. Just as so many kids are, it is such a huge spectrum of the way our
children in our society now are trying to end their lives, and it is something that we have to be aware of.

James Anderson: While I was in there, I also realized the others who were trying to commit the physical
sense of suicide. There was such a lack of programs and it was so difficult for them to really reach out.
You are constantly in a negative environment with a lack of resources. Just to give you an example, first
of all, there was not a support group where I was at. There was not an opportunity to come and speak
amongst each other and open up. And for the programs that were available, like the religious counsel
that a lot of individuals needed, there was an ultimatum that was placed upon these kids, which was
either everyone is going to go down from day room, which is watching TV and dominos, or we are going
to have religious services. So, of course, the kids who wanted religious services would be outweighed by
the kids who wanted to stay up and watch movies, and would get pressured to put their hands down. I
think this is critical for those that needed someone to reach out to, someone to talk to, but yet put in
this position. Instead of separating the two times or removing them from the day room and taking them
to another location where they could have those one-on-ones and not be pressured by the group. I think
it was critical and huge.
James Anderson: Although there is the opportunity to speak to a psychiatrist while in there, I feel like people failed to realize that is a huge step for someone. It is like telling a smoker that smokes cigarettes every single day, and just throw away his pack. Very few people can do that. It is difficult. It takes steps. Or in the psychological aspect, it takes steps for someone in there who is already uncomfortable with himself, who is always being analyzed and assessed, and always has someone writing down something about their behavior, to go and take that step to speak to a psychiatrist. And even so, it is sometimes difficult when you go in there and you pour out your heart and oftentimes the ending result is a medication prescribed to you. And I have seen a lot of individuals become worse on this medication because we are not identifying the problem, the fact that they just want to be heard.

James Anderson: And for those who go on suicide watch, it became something really, really nasty and something that the probation staff looked down upon. And although I realize there are some kids who took advantage of the system, for those who did not, I believe it was very unjust to the fact that if I have an issue and I am calling out, I am going to be punished, I am going to be segregated, and I am going to be pushed off to the side. I remember it used to be a joke that people would go on suicide watch. It would be like, “Are you really going to go on it? That is such a cowardly way to go.”

James Anderson: I just feel like, once again, for these kids who needed attention, these kids who always have been pushed down, have constantly been told they are not good enough, this was time and time again only proving that right. That we have followed them throughout many systems before they got to the juvenile justice system, and while they are in here calling out for help and crying out for another opportunity, we are once again turning a need into a punishment, something that should never have happened.

James Anderson: Luckily, in my life, when I was at this brink of pushing myself to just forget about who I was and just give up my life, the one thing that changed me, and the reason why I made this correlation between the emotional and mental suicide to the physical is because they both are calling out for the same things. While I was trying to get the sentence, honestly I just wanted to be loved, I wanted someone to reach out and tell me I was worth something. And this kid that everyone pointed at and said, “Forget about him, he is never going to change,” was able to change because someone believed in me, because someone loved me and helped me to make a change, and it truly touched my heart. I was able to make a transformation and come home and be this inspiration, this light for others who need help.

James Anderson: And if I leave this Webinar with anything being said, it is just to understand that sometimes it takes such a minimal effort to help prevent suicide. Because what we oftentimes oversee is the fact that most of these kids only need a caring adult, and everyone here can be that caring adult. Thank you.

Carol Cramer Brooks: Thank you, James. Your insights, I have been watching a lot of the chat comments, and your insights into this topic are amazing. We hope to talk to you more in the question and answer section. Thank you very much.

Presenter: Lisa Boesky, Ph.D., Clinical Psychologist, National Speaker/Trainer, Consultant and Author

Carol Cramer Brooks: Our next presenter is Dr. Lisa Boesky. Dr. Boesky is a clinical psychologist and author of the second edition of Juvenile Offenders with Mental Health Disorders: Who Are They and What Do We Do With Them? She provides consultation to juvenile justice agencies across the country
on issues related to mental health services and suicide prevention among youth in custody, and provides mental health and suicide prevention training to juvenile justice professionals at every level, and serves as an expert witness on legal cases related to mental health and/or suicide among youth in custody. Dr. Lisa has worked as a clinician in a juvenile detention center, helped implement mental health services in state juvenile correctional facilities, and has assessed mental health and suicide prevention services within juvenile justice facilities. Dr. Lisa Boesky, it is a privilege to have you as a panelist.

Dr. Lisa Boesky: Thank you. James, I so appreciate you sharing your personal experience. It really gives the emotional and compelling context as to why I am going to talk about the more clinical piece, because the goal of this Webinar is to prevent painful situations and potential tragedies that you so articulately and eloquently described. So thank you for that.

Dr. Lisa Boesky: In addition, as Carol mentioned, I have been an expert witness on lawsuits related to suicide, including incarcerated youth. And although the information that I am going to talk about is designed to help you keep suicidal youth in your facilities safe, it can also be helpful in relation to liability. I have found that when you provide good clinical care and you have a strong suicide prevention program in your facility, not only are your youth safer, but your risk of liability is significantly less.

**What We Know**

Dr. Lisa Boesky: What we know. So what we know is the best way to prevent suicide is to keep youth from becoming suicidal in the first place. So oftentimes I think we mistakenly start the discussion at the moment that a youth talks about suicidal ideation. But really, our goal should be preventing them from becoming suicidal in the first place, even thinking about suicide. So, hopefully, all of you at your facilities are already focusing on protective factors, so treating mental health disorders, teaching positive coping skills, and creating attachments to adults, which we just heard from James how important that is. And, again, we should already be doing that.

Dr. Lisa Boesky: So, there is a national survey that was done, and it is the only national survey of incarcerated youth who have actually died by suicide, and it was done by Lindsay Hayes and released in 2004, and that survey found that most of the youth who died by suicide in custody were Caucasian, between 15 and 17 years old, and confined on nonviolent offenses. Most had a substance abuse history, but all were sober at the time of their death. Many of them had histories of emotional abuse, physical abuse, or sexual abuse. And, not surprisingly to anybody on this call, three-quarters had histories of mental health disorders, with most thought to be suffering from depression when they actually took their lives. Almost half of the youth had made a prior suicide attempt, and over half were taking psychotropic medication.

Dr. Lisa Boesky: So it is interesting. Contrary to what we hear, only a small percentage of those youth kill themselves within the first 24 hours of confinement. A key finding, and I focus on this a lot when I do consultation, is half of the youth were on room confinement status at the time of their death. Sometimes they are there for failing to follow program rules, maybe they displayed inappropriate behavior, or they may have threatened or assaulted staff or peers. Almost all of them died by hanging, and sadly, only 16 percent were on any type of suicide watch at the time of their death.

Dr. Lisa Boesky: So, despite what I just said, there is no typical youth who die in custody by suicide. We all know that both boys and girls, youth of all colors have died by suicide in custody. Some have had major mental health disorders, some did not. Some told someone they were suicidal, and some did not
tell anybody. So the hard part of this call is that, at this point, there is really no reliable way to predict exactly which juveniles are going to take their own lives. Because when it comes to risk factors, if you look at the research, everybody on this call or this Webinar is really working with youth who are at the highest risk for suicide in your county or your state. And your job is to look at those high-risk youth and determine who is the highest, highest, highest risk youth among an already high-risk population, and that is incredibly challenging to do. The good news is it is being done in facilities across the country, but it is an incredibly difficult thing to do.

**Key Components of a Suicide Prevention Program for Youth in Custody**

Dr. Lisa Boesky: So let us talk about some key components of a suicide prevention program. And I want to say, these recommendations are going to be similar whether you work in a large facility, a small facility, if you are at short-term detention, or if you are at a long-term correctional facility. And much of this information is based on the 2011 NCCHC Standards, so the National Commission on Correctional Health Care. Also, Lindsay Hayes’s 2004 National Survey on Juvenile Suicide in Confinement, which I mentioned earlier, as well as best practice in the field. The American Correctional Association and Juvenile Detention Alternatives Initiative (JDAI) also have standards related to suicide prevention. And I have given references for all of these resources so you can follow up with them. They are up in the handouts section so you do not have to feel like you furiously have to take notes, but most of everything is coming from there.

**Policies and Procedures**

Dr. Lisa Boesky: So let us talk about policies and procedures. So, number one, everybody here at their facility should have detailed suicide prevention policies and procedures, but the key is they should be written in clear and concise language. So both your administrators and your line staff should clearly know what to do and when to do it. It should not be hundreds of pages long. It should be very short and straight to the point so everybody is clear what to do and what is their role.

**Suicide Prevention Training**

Dr. Lisa Boesky: Second is suicide prevention training. Staff need practical, up-to-date, and interactive training on suicide prevention. So this should be mandatory for every staff before they hit the floor and before they start interacting with youth. The standard is about 8 to 16 hours minimum. My view is the longer, the better. My suicide prevention training is 2 full days, but I also include working with youth who self-injure, so those who cut and hit themselves to feel better, as well as the mood disorders so facilities folks can identify and intervene with youth who are depressed or have bipolar disorder before they become suicidal. Training should not be on the policy. It should be suicide prevention training and everything that goes into suicide prevention. And, every year there should be a mandatory suicide prevention refresher training, probably usually about 2 to 4 hours, that should be for staff that work directly with youth.

**Suicide Screening and Referral**

Dr. Lisa Boesky: Next, and also importantly, is suicide screening and referral. I am sure almost everybody on this Webinar is already, at your facilities, screening for suicide risk upon admission. Not only is this critical for good clinical care, but it is also the first place attorneys are going to look if you are involved in suicide liability. This has got to be done before a youth is placed on a living unit. And a lot of times people think a mental health professional has to do this. That is not necessarily true. Just an
appropriately-trained staff that uses the standardized form, and that suicide screening form should have interview questions, but also a space for staff to put down their behavioral observations, because they do not always match up with what the youth are telling us. Youth who appear to be potentially suicidal should be placed on suicide precautions, and immediately referred to a qualified mental health professional – I am going to be calling that a QMHP for the rest of this Webinar – for a more in-depth assessment. So what we are talking about here is an intake screening. It is usually done during intake by the person who is gathering all the other information, and it is not a big deal, no one is sitting down saying, “We are going to talk about suicide now.” It is just a very quick and dirty way to determine if the youth is at high risk for suicide.

Dr. Lisa Boesky: Also, youth should be rescreened at important transition points throughout the system. So if there is a change in placement, before they are released to the community, and whenever youth say or do something that indicates their risk for suicide may have changed. Anytime juveniles exhibit any kind of suicidal statements or actions, or just staff are concerned about them, they should have a screening or immediately be referred to a QMHP for suicide assessment.

Suicide Assessment

Dr. Lisa Boesky: When we talk about assessments, QMHPs should conduct a face-to-face suicide assessment of youth as soon as possible of being contacted with a referral, but no longer than 24 hours. And I know that is going to make some of you nervous, especially if you are a small facility, but it is important within 24 hours, and staff should continuously observe and monitor youth who are potentially suicidal while everyone is waiting for that clinician to do their evaluation.

Dr. Lisa Boesky: So, as I mentioned, when we are talking about suicide screening and assessment, there are a couple of things that need to be included in there. One is you are looking at what observable things are you noticing about the youth. Do they look irritated or agitated? Do they seem depressed? Do they seem lethargic? You also want to look at their history, and usually we get that by asking them questions. Have you ever been suicidal? Interviewing a youth is important, but it is not the holy grail of suicide prevention. We all know that some kids say they are suicidal when they are not, and other kids deny they are suicidal when they are. So it is important that you are looking at how they are behaving. What do we know about their history? Getting previous information or finding out information from transporting officers or other folks who have seen them, and then interviewing them, obviously. And very importantly is your particular facility. What is it about your facility that makes them more of a suicide risk or less? Are there dangers within your facility that make it more or less likely that a youth at high risk would be able to kill themselves?

Dr. Lisa Boesky: Now, when we talk about more in-depth suicide assessment, this is what would be done by a QMHP. As I mentioned, a QMHP should be available 24 hours a day, 7 days a week. That does not mean onsite, but if you are a large facility, onsite if possible. We are talking about being available. This does not mean they need to be in the facility, but that someone could call them and they could come in within 24 hours. If not, you want to be able to call someone at any time of the day and let them know what is going on and let them give some consultation. Suicide assessments determine the juvenile’s risk of suicide, if there is any, what level of monitoring is needed, and if a transfer to a psychiatric hospital is required.

Dr. Lisa Boesky: As I mentioned, youth on suicide precautions, if they are on suicide watch, need to be reassessed in person, not through a door, by a QMHP at least once per day, so every 24 hours, to
determine if that juvenile’s suicide status has changed, and if it has, what action needs to be taken. So do they need to be lowered to a less intensive monitoring? Do they need to be raised to a higher level of monitoring? Do they need to be transferred to a psychiatric hospital? Or possibly, they are doing better and they need to be removed from suicide precautions altogether.

Dr. Lisa Boesky: I really think it is essential that the QMHP gathers information about these youth from a variety of staff. Again, talking to the youth is only one piece of the puzzle. They must talk to line staff, other staff that have had interactions with that youth, they have very important information as to how that youth is doing.

Dr. Lisa Boesky: Because the period after a youth has been removed from suicide precautions, this is actually a very high-risk time for some juveniles, that it is important that even if the youth has just been removed from suicide watch that the QMHPs remain in close contact with them and still periodically assess them for risk.

**Key Treatment Issues**

Dr. Lisa Boesky: Now, when we talk about treatment, it is important to remember that suicide precautions or suicide watch is not treatment. Those are not treatment, per se. A lot of facilities, when I visit them, say, “We treat youth by putting them in their rooms or placing them on one-to-one status.” That is not treatment. Facility administrators, managers, line staff, and clinicians all need to recognize that, yes, closely observing juveniles and restricting access to items they could use to kill themselves does help keep these youth safe, but it usually does little to decrease their distress, their mental health symptoms, or their feelings of hopelessness. In fact, if suicidal youth are isolated from their peers and from programming, their suffering can actually get worse.

Dr. Lisa Boesky: So what we talk about with treatment is that the QMHPs need to develop individualized treatment plans for these youth that specifically address youth suicidal thoughts and behaviors, as well as other key issues and needs the youth is having. This should be evidence-based or best practice psychotherapy whenever it can be done. So right now, there are some psychotherapies that are used to reduce suicidal thoughts and behavior and address underlying issues. It is not just getting together with them and saying, “How are things going,” and then talk about all of their gripes that are happening on the unit. People really need to be doing evidence-based treatment.

Dr. Lisa Boesky: Psychotropic medication, James brought that up, should only be prescribed when necessary. And I think it is definitely not the key to treating suicide. It may be a piece of the puzzle, but it is certainly not the key piece of the puzzle when we are talking about suicide in custody.

Dr. Lisa Boesky: QMHPs should be providing treatment to suicidal juveniles during high-risk periods, as well, as I mentioned before, follow up with them afterwards to reduce the risk of relapse after the suicidal crisis is over. And line staff are critical to suicide prevention efforts. Front line staff should be encouraged to connect with youth, to form positive relationships with youth, just during day-to-day interactions, and provide support to those who are suicidal. I believe that these relationships are key and invaluable to suicide prevention, and we have heard that echoed in James’s story as well.
Safe Housing of Suicidal Youth

Dr. Lisa Boesky: Now, when we talk about safe housing of suicidal youth, even though we are concerned for their safety, suicidal juveniles should still be housed in the least restrictive manner, given their severity of suicidal behavior. There is no one-size-fits-all response to housing suicidal youth. If the youth can safely participate in facility programming, they should do so. You may have to put them on more intensive levels of supervision, so maybe 10-minute checks or 5-minute checks, even a one-to-one. But a youth is much safer going to school, if they can do that, than being alone in their room or alone on the unit. So suicidal youth should have access to the same academic, recreation, and leisure activities as their peers. You may have to modify them for safety purposes. Only the QMHPs should implement and remove these modifications. These should be documented and communicated to all staff.

Dr. Lisa Boesky: One of my biggest concerns is it really needs to be clear to everyone who comes into contact with the suicidal youth exactly what they are and are not allowed to do in the facility, and the reasons why. I was recently at a facility, and actually it has happened several times, where even the one-to-one staff who is responsible for monitoring a suicidal youth, sometimes they are not even clear why a youth is not able to, or what activities the youth is not able to participate in, and that should never, never happen.

Dr. Lisa Boesky: Juveniles should not be isolated, so placed in isolation or seclusion, as you can see here in this picture. Sometimes it is called protective custody and it is done for safety reasons. If it is done for safety reasons, this should only be done in collaboration with the QMHP and suicidal youth must be continuously monitored. The number one place that kids can die by suicide in custody is alone in their rooms. So there are likely several folks who are listening who might believe that keeping a suicidal youth in an empty room really is the best way to keep them safe. But I can tell you, social interaction is critical to preventing suicide, and when you remove youth from their standard programming and their peers, this can actually add to their feelings of alienation and depression. Because, if you think about it, when you are alone in a cold and empty room and you are suicidal, you have very little to distract you from your problem, and these kids have a lot of time to think about very creative ways to kill themselves.

Dr. Lisa Boesky: If they are unable to remain on their own living unit, if you have a mental health unit or you have a health clinic, oftentimes they can be managed there. But regardless of where they are housed, staff should be stationed in close proximity and regularly interact with and closely supervise any youth at high risk for suicide.

Dr. Lisa Boesky: When we talk about clothing, I know there is a lot of controversy around this, but the standard really is that suicidal youth should remain in their regular clothing, unless the clothing that you issue them has shoelaces or belts, they should not – really no youth in a facility today should ever have shoelaces and belts, given the high risk of all the kids that are in these facilities. Unless they start to use their clothing to harm themselves. So if they are using their tee-shirt or a bra or sock, then in those instance, yes, you should remove that article, but you should not just automatically strip kids or put them in special clothing. Some of you on this Webinar may use suicide smocks or what you call safety smocks. These are actually not recommended, except in the very rare circumstances where it is indisputably necessary for youth safety and done in collaboration with QMHPs. The majority of youth on suicide watch do not need to be wearing suicide smocks.
Dr. Lisa Boesky: I was at a facility last year where the youth at that facility that were on suicide watch were in bright yellow jumpsuits to make it easier for staff to watch and monitor them. This should never happen. Juveniles should not be given special clothing that signifies that they are at risk for suicide. And that kind of goes to what James was saying, you do not want to stigmatize them any further.

**Suicide-Resistant Rooms**

Dr. Lisa Boesky: And when we talk about rooms, most of you are aware that rooms and cells that house juveniles that are suicidal must be suicide resistant. So no sprinkler heads hanging from the ceiling or other protruding objects. The windows have to be large enough for staff to see in every corner. There should not be any bunk beds or towel racks or clothing hooks. No vents that you can weave something through. They should not have large door hinges or door handles, or other secure objects that youth can hang themselves with, because they can often tie a shirt, a sock, or underwear onto those and hang themselves. If your facility does not have a room that is free of all of these things, you really need to create one immediately.

Dr. Lisa Boesky: The picture that is up right now is not a suicide-resistant room. As you can see, with that bunk bed there is a variety of ways a youth could tie those sheets or his clothing to it and kill himself.

**Intensive Monitoring**

Dr. Lisa Boesky: Now, when we talk about intensive monitoring, staff should monitor youth at high risk for suicide on variable or irregular schedules, and we usually say every 5 minutes or every 10 minutes, between those two checks depending on their level of risk. We used to say every 15 minutes, but youth are becoming more sophisticated and creative in their attempts, and 15 minutes can be a long time. So if it is an actively suicidal juvenile, so they are threatening or engaging in suicide-related behavior, they should be observed by staff continuously, so one-to-one staff. But as I mentioned, it should be irregular and variable, so it should never be 2:00, 2:10, 2:20, 2:30. It should be broken up, 2:05, 2:08, 2:18, so the youth never really know when you are coming. And anyone, whether you are juvenile justice staff, mental health staff, a medical professional, anyone in the facility should be able to put a potentially suicidal youth on suicide precautions, but only a QMHP should be able to take them off suicide precautions. And there should be training as to when to put them on suicide precautions. Sometimes youth talk about being suicidal 3 years ago, staff get nervous, and immediately put them on suicide precautions. That is not a good use of resources. If you want to use a CCTV, those closed-circuit televisions, those are fine, but they are on top of staff monitoring, not instead of staff monitoring.

**Staff Communication**

Dr. Lisa Boesky: When we talk about staff communication, this is critical to monitoring and preventing suicide in facilities. Mental health, medical, and juvenile justice staff must communicate daily about which youth in the facility are suicidal and the most effective strategies to observe and manage those particular youth, because it differs depending on why that youth is suicidal or why they were placed on suicide watch. Juvenile justice staff should communicate with each other, from one shift to another, and they should talk about which youth are on suicide precautions, what intensive monitoring is required, and any specific information that is needed to keep these youth safe.

Dr. Lisa Boesky: Communication should also occur between facility staff and community agencies, whether it is an arresting or transporting officer, the local court, a psych hospital if there is information
there, and family members can be incredibly helpful at providing important information. As I mentioned earlier, facility staff and clinical staff should be communicating with youth throughout the day. So if a youth is suicidal, we want to be talking with them every day, every 24 hours, and QMHP should always communicate with juvenile justice and medical staff before removing youth from suicide precautions. You do not want your mental health professionals just talking, again I mentioned this before, just talking with youth and taking their word for it. They need to be talking to other staff in the facility because everybody sees something a little bit different.

**Responding to an Active Suicide Attempt**

Dr. Lisa Boesky: Now, when we talk about responding to an active suicide attempt, staff should know how to respond to suicide attempts that are in progress, especially hangings since those are the most common. They should be trained in providing first aid, CPR, and any other lifesaving measure. Realistic, and I really do mean realistic, suicide intervention drills should always be conducted. We cannot afford for staff to make mistakes during a true emergency, so staff really need to practice cutting a youth down and really look at how difficult that is. What do you do when you walk upon a room and you see someone hanging and you are the only staff on the unit? You need to run through these drills. Suicide cut down tools should be located on every unit. Many of you probably have these tools already. They should be easily accessible to staff and inventoried at every shift. If the staff discovers a youth who is hanging, they should respond immediately, assess the severity of the emergency, and then alert staff to call for medical personnel if needed, and start lifesaving measures. Staff should never assume that youth are dead, and they should begin and do all they can to keep a youth alive until the medical professionals take over.

**Reporting and Notification**

Dr. Lisa Boesky: Now, reporting and notification of suicidal behavior, as I mentioned before, policies and procedures should be in place to easily document who is a high suicide risk. There should be standardized forms to document when you are monitoring them every 5 minutes, 10 minutes, or one-to-one, and they should be easy to understand and easy to complete. Sometimes they are hard for me to even understand. Staff should know when and how to notify administrators about what happens.

**Review and Debriefing**

Dr. Lisa Boesky: And then, finally, review and debriefing. If a tragedy such as a serious suicide attempt or completed suicide does occur, several reviews should take place, an administrative review, a mental health review, a medical review, to better understand what had happened and what necessary improvement measures are required, if any. This should be a learning opportunity and the goal is to gain information, not finding fault. A psychological autopsy should be conducted within 30 days of a completed suicide, usually by a psychologist or psychiatrist, to better understand the specific factors that may have contributed to that particular youth taking his or her own life.

Dr. Lisa Boesky: Then a debriefing is critical. It should be made available to all staff and juveniles who may have been impacted by a serious suicide attempt or a completed suicide. Because it is important to keep in mind that youth are often upset and confused when another resident makes a serious suicide attempt or dies by suicide, and this is a particularly high-risk time period for other youth in custody to take their own life. Therefore, staff should be vigilant to signs of distress, especially among vulnerable
juveniles, and youth should be encouraged to talk with the QMHP about any thoughts or feelings they have in relation to the suicide attempt.

**Impact of Suicide**

Dr. Lisa Boesky: Now, just as importantly, staff should be encouraged to seek additional support through the EAP, Employee Assistance Program, or other sources. And although it is painfully obvious, I think it is rarely talked about – and I will wrap up with this – how working with youth who have made a serious suicide attempt or who have died by suicide, how incredibly traumatic it can be for staff. Some front line staff have intervened with youth who have been hanging or seriously sliced their wrists or their neck. Some of them have performed lifesaving procedures, and sometimes the youth still die. And sadly, many of these staff are required to return to work immediately after one of these tragic incidents, and then they have to supervise the rest of the youth on the unit. This should never happen.

Dr. Lisa Boesky: Intense guilt is common among staff who are unable to save a juvenile who died by suicide. They may wonder if they overlooked key warning signs or what would have happened if they checked on the youth a few moments earlier. Not surprisingly, some staff feel guilty when juveniles kill themselves on a day when they were not at work, believing the death may have been prevented if they had been working on the unit that day since they knew the youth so well.

Dr. Lisa Boesky: So because working with these youth can have such a significant emotional and psychological effect on direct care staff, and these are intensified if you have worked with multiple youth over their career, investigations and litigation add to this already disturbing, stressful, and traumatic situation. So unless there is significant wrongdoing, I encourage administrators, managers, and supervisors to provide support and have patience with staff who have been involved with seriously suicidal youth.

Dr. Lisa Boesky: The last thing I will say, I know we talked earlier that these youth are incredibly high risk. They possess three, four, five, or more risk factors for suicide and, as I mentioned, they are the highest risk for suicide often in your entire county or state, which is why we screen every single one of them and pay such close attention to them throughout their stay in our facilities. But, despite their risk factors, the majority of juveniles in custody do not try to kill themselves. So we work with an incredibly resilient group of young men and young women. And even when juveniles in custody are thinking about suicide or threaten it, it is really difficult for staff to deal with these youth. But we also have a lot of very well trained and caring professionals, such as yourselves, that take action every day to help keep these youth alive, and I deeply am grateful for that. Because it is because of you and all that you do every day that we do not have more suicides in our facilities. Thanks.

Carol Cramer Brooks: thank you so much, Dr. Boesky. Your comments are right on target and we look forward to hearing more from you in the question and answer session.

**Presenter: Michele Sharp, QA Coordinator, Louisville Metro Youth Detention Services**

Carol Cramer Brooks: Our final presenter is Ms. Michele Sharp. Michele Sharp is the Quality Assurance Coordinator at Louisville Metro Youth Detention Services (LMYDS) in Louisville, Kentucky. Her responsibilities include Compliance Manager, Prison Rape Elimination Act (PREA) Coordinator, Health Care Liaison, and representing the agency to the community. Ms. Sharp has been with LMYDS for 14 years. She is a graduate of Morehead State University. The Youth Detention Center, which is a division of
Louisville Metro Youth Detention Services, has been accredited by the American Correctional Association (ACA) since 1983, and the National Commission on Correctional Health Care (NCCHC) since 1988. Michele, thank you for joining us today. We look forward to your presentation.

**National Commission on Correctional Health Care: Prevention of Juvenile Suicide in Correctional Settings**

Michele Sharp: Thank you. Hello, everyone. I have been asked to speak about the National Commission on Correctional Health Care's Position Statement on prevention of juvenile suicide in correctional settings and how my agency meets compliance with the seven components of a successful suicide prevention program. You can find the complete Position Statement and the seven components by going to the NCCHC Web site. I have it up on the slide. If you click on the Standards and Guidelines tab, and then on Position Statements tab, you will find the statement. The gist is that every juvenile facility needs to develop and implement a comprehensive suicide prevention program.

Michele Sharp: I work for Louisville Metro Youth Detention Services. Our department consists of a 96-bed secure detention center, a 12-bed group home, group process, home incarceration, and home supervision programs. Since the Youth Detention Center has been accredited by NCCHC and ACA, I will discuss that when I am talking about our suicide prevention program.

**Staff Training in Suicide Prevention**

Michele Sharp: The first component of a successful suicide prevention program is staff training. Our new hires go through about 180 hours of training prior to starting work with the residents. We have specific suicide training that includes signs, preventions, precautions, and intervention, but there are other topics that we include to complete the program. It is emergency procedures, first aid and CPR, behavior management, diversity, communication, staff-resident relationships, adolescent growth and development, unit management, policies, and procedures. We used to do all classroom training, and when the new hires got that glazed-over look and started to drool, we would send them on up to the units.

Michele Sharp: I am happy to say that we have gotten a little more intelligent, and we have added job shadowing to our training program. So now the new hires alternate between classroom training and on-the-job training over several weeks. They shadow admissions staff, secure staff, on different shifts so everybody gets to see what happens on the individual shifts. They go to the group home, they go to court and see what happens in court. It just gives them a better understanding of why we do everything that we do, and why the different departments do what they do.

Michele Sharp: Additionally, every year staff go through that 80 hours of training, and that includes the suicide program, they review all of that. They also go back over emergency procedures, first aid and CPR, adolescent mental health, interpersonal communications, and we review all the policies and procedures.

Michele Sharp: We have a full-time trainer on staff. We also have full-time medical staff and a mental health professional, and they all help with the training, which is wonderful. But, in addition to that, we look for guest trainers. It helps to break up the monotony of hearing the same person talking over and over again. So look around, see who is available in your area, the worst they can say is no, they do not want to help you. But we use the police, we use adult corrections, the Health Department, hospital staff, school staff, particularly some of the universities that we have in the area, and local
advocacy groups. So if you are truly out in the middle of nowhere, look to the Internet. There is a wealth of information out there, just like this Webinar. You have NCYC, OJJDP, NCCHC, ACA, you will have to do some filtering, but for the most part you can get some really good information.

**Ongoing Identification of Risk**

Michele Sharp: The second component is ongoing identification of risk. We start this process before actual admission to the facility. Admissions staff ask a series of medical condition questions relating to drug and alcohol intoxication, disorientation, wounds, trauma, any time when a juvenile comes in the door. If the juvenile answers yes to any of the questions, medical staff is asked to make an assessment as to whether we should admit the juvenile. If medical are not on duty at the time, then we will just tell the police officer they are going to have to take them to the hospital and get a clearance. You can imagine that the police love us.

Michele Sharp: During the admissions process, a mental and medical profile is compiled. Staff make notes based on their observation of the juveniles' physical appearances and their mental state. Are they alert? Are they responsive? Are they irrational? Staff ask questions about a history of suicide and self-harm, counseling and psychiatric care, hospitalization for emotional or mental problems, family history of suicide or depression. Have they been a victim of assault or abuse? And current feelings about being detained. If they answer yes to any of those questions and state that the behavior happened within the past 6 months, or they are really, really upset about being detained, we do what we call a Staff Alert. That is a form that gets completed and it is communicated to everyone in the building. It is just basically to communicate security and/or mental health status. Every time that a juvenile comes in, even if they were just in a couple of days ago, we go through the mental and medical profile and the medical conditions again.

Michele Sharp: Once they are in our program, we refer to them as residents, so you will hear me use the word residents now. Within 24 hours of admission, our mental health professional makes contact with the resident. If she feels any resident needs more attention, she implements an appropriate plan of action. Within 7 days of admission, our physician sees the kids. If he learns of any mental health issues, medical staff will work with the facility staff to get the appropriate care needed. Within 14 days of admission, it is usually actually within 7 days, the mental health professional conducts a mental health assessment. Any housing changes, referrals, or necessary followup care that she feels is necessary is then communicated to the pertinent staff.

Michele Sharp: On a day-to-day basis, any staff member – that is whether they are in secure or they are in admissions, anywhere, me walking down the hallway, if I have a concern about a juvenile I can write a Staff Alert. Medical staff visit with the residents every day. We have social workers on staff who are on the units daily visiting with the kids. Residents on Staff Alert are visited daily by the mental health professional, and the Staff Alerts are updated as needed. And residents can also request to see the nurse, the physician, the psychiatrist, or the mental health professional as needed.

Michele Sharp: So if you do not have full-time mental health staff, designate staff members on each shift and train them to be the go-to person to initiate the suicide precautions until you can get a mental health person in there to see the resident. See if there is a nearby hospital that is willing to admit juveniles for psychiatric issues. Check with your schools or other agencies in your areas, or anyone who has professionals who are qualified to train your staff or to assist with residents in need. Do not be afraid to ask for their help.
Communication

Michele Sharp: The third component is communication. I will give you an example of just a general lack of communication that we had. We use a medical instruction sheet to alert staff to any special needs of a resident, like food allergies, gym restriction, inhaler use. We kept having residents on gym restriction down in the gym participating. A resident would go to the doctor with an injured ankle. The doctor would tell the kid no gym for 7 days. He would make a note in the chart. The kid would go back up to the unit just in time to go to the gym and play. Of course, he is not going to tell his worker that he has a medical restriction or a gym restriction. So in the meantime, medical staff have set the file off to the side so they can go through it and complete all the orders as soon as they have time, and next thing you know, that resident is back in medical and now he has a really injured ankle. So we had to sit down with people from secure, medical, the physician, we had to talk with everybody and sit down and say, “Okay, where are we going wrong with this,” and just brainstorm and get our problems resolved. It was just basic lack of communication.

Michele Sharp: So think about your daily procedures. Are all of your staff really getting the information that they need to do their jobs effectively and keep the residents safe? Is pertinent information gathered in admissions shared with staff and medical, mental health, and on the living units? What information acquired on the living units needs to be given to medical and mental health? And what information can medical staff pass on to other staff? Are the staff given the time needed to communicate the information, especially at shift change? Look at the forms that you are using. Could they be used more effectively? You do not necessarily have to create a new form. Look at what you are already using. Can you combine some forms?

Michele Sharp: The staff leaving the shift brief the oncoming shift. The staff document observations on each resident during the shift. Is that information readily available to the oncoming shift? And does the oncoming shift read the observations? You do not have to recreate the wheel. You just need to improve on it.

Housing

Michele Sharp: The fourth component is housing. Is room confinement your go-to option for problem residents? I know for a lot of facilities it is. We are in the same boat and we are trying to get out of that boat. We have to think of other ways where it is possible to keep a resident out of room confinement. What we have done is started to track our room confinement times. From that, we have been able to determine what shift and, specifically, what staff person has issued the most time. And from that information, we are trying to determine is this a programming issue or is this a staffing issue? Whatever the reason, anytime the residents are on room confinement they must be closely observed. In admissions, we try to keep the kids in an open area, on a bench where they can be observed by everyone. If a resident has to be put in one of the holding cells, staff must check them at least every 15 minutes and master control also has a camera that they can do a constant video observation. But anyone with a Staff Alert, they have to stay on the bench.

Michele Sharp: In the detention center, we have a behavior management system that uses positive reinforcement allowing the residents to earn points. The points are used to buy hygiene items, snacks, and privileges, and are also used when they fail to earn, and we try to do failure-to-earn sanctions prior to putting them in room confinement. We want them out. We want them participating. We do not want them in the rooms where they are bored, where they can think of all kinds of terrible things to do. Anytime residents are in the rooms, they must be checked at least every 15 minutes. And we have the
problem also of the staff writing 3:00, 3:15, 3:30, 3:45, and it is a constant training process. You cannot do that. I know it is a time saver, but you have to get up and check those kids at all different times, and write the time that you checked them. We have a camera system, we can see when you are actually checking them, but you need to have it documented.

Michele Sharp: Any kids with a Staff Alert are seen by the mental health professional daily. They are checked anywhere from constant observation to every 15 minutes, and that mental health professional is there to check them. Occasionally, we have kids who are evaluated for psychiatric issues and the evaluator will recommend that the residents stay in isolation until they are rechecked. Those kids are kept under constant supervision and definitely seen by the mental health professional every day.

Michele Sharp: So look at your environment. Is it safe? Are there hooks, exposed hinges, knobs, anything accessible inside the room? Does any of your staff carry the cut down knives that Lisa was talking about? And, most importantly, are they sharp? And I am talking about the person carrying it and the tool. You do not want a dull person carrying a dull tool. That does not work. Go into a room. Can you find a way to hurt yourself? If you can, you know the residents can.

Levels of Monitoring

Michele Sharp: The fifth component is levels of monitoring. NCCHC recommends three levels of monitoring: constant, intermediate, and close. Constant observation is one-on-one monitoring when the suicide risk is high. We consider this acute and we have somebody right there watching those kids. Usually that is until they can be evaluated or transferred to a hospital.

Michele Sharp: Intermediate observation is moderate risk and the juvenile is checked every 5 minutes. We consider this a high risk Staff Alert. The resident, if possible, is going to travel with their unit, but they are going to be under a 5-minute watch when they are in the rooms, and the mental health professional is going to check with this child daily.

Michele Sharp: Close observation is for low risk and the juvenile is checked every 15 minutes. We consider this low risk, the resident is on the regular living unit and checked every 10 to 15 minutes when in the room, but the mental health person is still going to check with them daily.

Michele Sharp: One thing I wanted to talk about was the restraint chair. We have one. I know a lot of agencies use it. Please do not make it your go-to item for children who are trying to hurt themselves. If you have ever been put in that restraint chair as a training practice, you will know how stressful that is. So if you already have a child who is anxious, and then you put them in that chair, it is a bad combination.

Michele Sharp: Think about your monitoring and your staffing levels, I know that can be a problem. Do you have enough staff on each shift to use one staff member for constant monitoring? If not, what is your plan? How are you going to keep that resident safe? And, most importantly, during transportation. If you have to transport a child somewhere, to an outside facility, do you have two people who can go and make sure that not only the child is safe, but that your staff is safe?
Intervention
Michele Sharp: The sixth component is intervention. This is where all your training comes into play. Suicide policy and procedure, first aid, communication. Does everyone know how to handle a suicide attempt in progress? How do you get available staff there? Does someone have a cut down knife? Does everyone know first aid and universal precautions, and how do you get medical assistance? And after the attempt, is counseling available for staff and residents? Very important.

Mortality and Morbidity Review
Michele Sharp: The final component is a mortality and morbidity review. We have never, I am very happy to say, had a completed suicide and I really hope we never do. Definitely that would require an extensive review. But attempts also need reviews. Sometimes we find that everyone did all they could to prevent the attempt and it still happened. But, unfortunately, some reviews have found where we missed something that enabled a resident to [audio interference]. It is usually something small, it seems totally inconsequential at the time, but it ends up having a huge impact. The dim light was out, the cut down tool was dull, the staff took 17 minutes between checks. So these reviews have allowed us to see what we need to revise in training policies and procedures.

Michele Sharp: In conclusion, do not overthink the whole suicide prevention process. Keep it simple enough that staff are able to complete the process without becoming overwhelmed, but review it often so you can ensure that you are covering all the bases. Thank you for allowing me to be a part of this presentation.

Questions
Carol Cramer Brooks: Thank you, Michele, and I would like to thank all of our presenters for the wealth of information that they have shared with us today. At this point, we are going to field as many of the questions asked by all of you in response to what you have heard from today’s panelists. But before we begin that, I just want to thank all of the participants for your support for James in the chat box. It has just been amazing. And I think that George Williams summed it up as well as anybody when he made the comment that there are many forms of suicide, that we can be alive or dead on the inside. It is such a profound insight, and I thought that was just an amazing comment from James, and thank you, George, for commenting on that.

Carol Cramer Brooks: We are going to start with a question to James that came in from several of the participants, and they were all talking about the relationship that you built with this one person that helped you instill hope. And they wanted to know, James, what exactly did this person do in terms of building this relationship with you and what were some of those specific things that the adults in your life did that were able to help you break through? If you can give us some insight into this.

James Anderson: Most definitely, and thank you for the question. Many times when I speak with individuals that deal with this population, as everybody that works in these facilities understands, sometimes these kids are not the most receptive to an adult trying to reach out and speak to them. What I comment on is if you also grew up in an environment where every adult either abused you or used you, you would also be very reluctant to allow someone else to help you. And the real, real tool here is staying in that kid’s life and really being there through thick and thin. The difference between other adults, because, of course, throughout my entire life there has been the occasional, “You should do something better with your life,” or, “You should move forward.” That is always going to happen, but
it was not substantial because I knew they were only in my life for a temporary amount of time, and I knew in my mind I looked at it as a way for them to make themselves feel better and it had nothing to do with me. And the short period that they were involved in my life helped to reinforce that thought. The thing that was different about this person is that they stuck through my entire process and was there for me, even when I did not want them to be there for me. And it is going to be difficult, there were times when I tried to push this person away, there were times when I even insulted the person and told them that they were only there for me because they pitied me. And the truth is in being someone that is going to stand by one of these youth’s side is you have to be able to withstand that. Now, I am not saying never allow responsibility to put a great weight on you, because sometimes I see a lot of adults that go to be a mentor and they feel horrible because they ask themselves, “What did I do wrong?” Now, although there are always ways to improve yourselves, please understand that at the end of the day, it is going to be their choice to make the decision to change or to better themselves. So do not allow that weight to come back on you. I even saw a poster right here where they were talking about the staff that were not able to stop certain suicides and how they carry that guilt, and I feel that is a very real thing because I do understand there are a lot of staff that do care about these kids. The only thing to really show that you are honestly there for a good purpose is staying in their lives. And as they stayed in my life...

Carol Cramer Brooks: Thank you, James. The next question is for Dr. Boesky. Lisa, we are writing policy and procedure for suicide prevention. We trained for direct and indirect questions to be asked by the probation officers. Should we mandate direct questioning by probation officers about suicide, or leave probation officers with indirect and direct questions to be asked?

Dr. Lisa Boesky: I am a fan of both. I think you want to definitely make sure you have some key questions that they make sure to cover. I always encourage them, and that is why training is important, you never want folks to go down the checklist as if it is an interrogation. Have you ever made a suicide attempt? When was the last time you made a suicide attempt? What did you use when you made that suicide attempt? You want to make it very conversational so that they are covering those questions but in a conversation so they sound like indirect questions but you are really getting at what is on that checklist. So it is less about what is on that paper and more about training them to use that paper in a conversation so they are accessing that information and the youth does not feel that someone is asking them things, but is actually listening and wants to know the answers.

Carol Cramer Brooks: Great, thank you. And to Michele. Michele, are your suicide assessments for all detailed juveniles or just those with increased risk?

Michele Sharp: We do a visit, just kind of a sit down, get to know you, our mental health person does on every juvenile within 24 hours of admission. Then we do a 14-day, what we call a 14-day mental health assessment on every juvenile. From that, our mental health professional can determine if she needs to see this child every day. Does the child need to see the psychiatrist? Just exactly how far she needs to go. But it is actually done at least once on every juvenile.

Carol Cramer Brooks: And for either Dr. Boesky or Michele, as a followup to that, what are some examples of commonly-used assessment models used in either short-term or longer-term residential facilities? And I am not sure, either one of you could take this question I am sure.

Dr. Lisa Boesky: I can take that. There is a variety of different ones out there. If you are looking for ones that have kind of validity with them, you can look at the SIQ, which is the Suicidal Ideation
Questionnaire. There is also something called the SBQR, which is the Suicidal Behaviors Questionnaire Revised. But you do not necessarily need something like that. I know some folks on the call, I saw in some of the comments they are using the MH-JDAT, which is the Mental Health - Juvenile Detention Assessment Tool that has suicidal questions built into it. The key is having a tool that is specific to suicide and not totally built into another type of questionnaire. So I know a lot of people use the Massachusetts Youth Screening Instrument (MAYSI) and that is what they use for suicide. I recommend if you use the MAYSI, that you use an additional suicide questionnaire or screening tool in addition to that. What I would recommend is that you contact some of the facilities near you to see what they are using. Really, these kinds of tools are very face valid. Have you ever made a suicide attempt? When was the last time? Your key question is partly their history, but what is more important is are they suicidal now and how suicidal are they?

Michele Sharp: If I could add to that for a minute. We are actually looking at going to the MAYSI, but we are not going to get rid of what we call our 14-day mental health assessment. After looking at the MAYSI, I think our 14-day, if nothing else, it gives time for our mental health professional to sit and talk one-on-one with each one of our residents, and she gets so much information from those conversations. So in addition to just having a piece of paper in front of her, she gains a wealth of information just in chatting with the kids.

Michele Sharp: If I can take a minute, I ran out of time earlier but now it appears that I have a couple of minutes. I was going to discuss a young man that we had here and what happened with him and what we learned from that. He came to us, he was living with his mother in Cincinnati. She got scared of him, she became afraid, and I know the one thing is that she would wake up and he would be staring at her in the middle of the night. So she shipped him down here to his father. The father tried, but every time he would tell the young man to do something, I think there was some resistance, and the young man admitted he did not want to be told what to do. So dad tells him to get up and go to school, and he decides he does not want to go to school so he stabs his father to death. Then he decides to burn the body. He continued to live in the apartment with the father for several days until some friends came over and saw what happened. The police got there. So we get this 15-year-old on murder charges and arson charges. We knew we had a special situation at that point. So we did not immediately – we asked all the regular questions, he did not immediately go on any kind of watch, although we were watching him, and he would kind of come in and out of our program. Sometimes he was great, we had no problems. Other times, he would just become completely withdrawn. Eventually, because he was with us for quite a while, eventually he got comfortable enough to say to staff, “I am going to combust. I am going to hurt someone,” and they could pull him out of the program. Sometimes he asked to be put in isolation, which we do not like to do, but with him it worked. He was on constant observation. As soon as he got himself together, we got him back in the program.

Michele Sharp: Several months went by, no problems. He is on a unit, they are going to the gym. Right before they left the unit, he actually stepped in the middle of the line, no one thought anything of it. Got a recreation specialist in the front, we have a unit worker in the back, eight kids in between. They start to go down the steps, he dives over the railing, lands face first 16 feet down on the steps, concrete steps.

Michele Sharp: There was a moment of, “I cannot believe this is happening,” but then everyone kicked into the action. The recreation specialist ran down, because the young man was trying to get up, he was conscious but he was dazed, he was injured. He was trying to get him to sit down. The unit worker got the kids back to the unit. They called for additional help. They called for medical. Someone had the
wherewithal to get our mental health professional onto that unit to talk with those kids and that staff member, because a lot of people were freaking out. Some staff came into the stairwell, they had a good relationship with this young man, and they were able to get him to sit down and calm down. Long story short, he broke his nose, he broke bones in his face, he lost teeth, there was blood everywhere, but everybody did what they were supposed to do.

Michele Sharp: Our problem came when we did a review and we sat down and we looked at what we did not do because we had never experienced it and we never thought about it. Keep those kids packed in tight. If you have an additional person to walk down the steps, do it. Just the little things that we missed, but that review came in so handy. Also, we realized – I believe Lisa talked about this earlier – how many people were so upset. We made sure we had counseling available for them. So it does help.

Dr. Lisa Boesky: I will take a couple of minutes to talk about manipulating youth, because I am sure many of you [audio interference] youth who are not truly suicidal but they are pretending that they are suicidal, either because they want attention, they may want the goodies that come along with it. And the hard part is, the reality is there really is no way to tell if juveniles are manipulating or truly want to die. And I have been involved with a number of youth who have died, who really died by their own hands and really did not mean to kill themselves, but were manipulating. And so, although it is frustrating and difficult to manage, juveniles who engage in suicidal behavior just to get attention or get a transfer or get coveted resources, remember that they can accidentally kill themselves, which is why we do take them all seriously, why we refer them all to the QMHP – some people were asking what that means – qualified mental health professional for an evaluation, and why we closely monitor them. The reality is many of these manipulative youth actually have underlying mental health, substance abuse, and trauma-related disorders, as well as other risk factors that raise their suicide risk.

Dr. Lisa Boesky: One of the keys to do, if you have a youth who you believe is using the suicide system to get things, rather than set up a power struggle and just not give it to them, they will always up the ante and they will win. So what you want to do is have an interdisciplinary staffing in which individualized and customized suicide prevention strategies are developed, so you can help keep the youth safe and also minimize the goodies, the secondary gains that they can get. What you do not want to do is try to make them miserable by being on suicide precautions or not put them on because you do not think that they are serious.

Dr. Lisa Boesky: In the end, because safety is number one, even if it means that a juvenile is pulling the wool over our eyes and manipulating the system, it is still better to err on the side of being conservative rather than the alternative, because the risk of death really is too great. But I do think a lot can be done when we do interdisciplinary staffing [audio interference] the key is more reinforcing [audio interference].

Dr. Lisa Boesky: I was at a facility that had over a hundred kids, it was a detention facility, 28 of them were on one-to-one status. And I thought that is crazy. Either, number one, they are doing horrible things to their kids, or, number two, it is very [audio interference] dark hole of a facility with very little programming, one TV that was pretty snowy, and these youth were very smart and figured out if they said they were suicidal, they got an automatic one-to-one staff on them and they got a lot of attention. The youth liked it. The staff were happy about it, they got a lot of overtime. But the problem was that when you have people abusing the suicide system, people stop taking it seriously and the youth who are truly suicidal can actually slip through the cracks. So you want to make sure only those who are truly
suicidal are on suicide watch, and if you believe someone is not suicidal, you figure out a way how to make sure that it is more reinforcing for them to be off suicide watch.

Carol Cramer Brooks: Lisa, thank you so much for your comments, and Michele, for your comments, and James also. And also for covering when we have technical difficulties. I want to thank all the panelists at this time for participating in today’s Webinar. We want you to watch for registration information for the next OJJDP NCYC Webinar, which is scheduled for March 26, 2014, at 2:00. The topic will be, *Providing for the Healthcare Needs of Vulnerable Populations.*

Carol Cramer Brooks: I also at this time want to make sure that you are aware of more information coming out from The Nation Action Alliance for Suicide Prevention’s Task Force for Youth in Contact with the Juvenile Justice System Webinar series, which will begin in March, March 17, and they will begin to talk about more research that is coming out regarding suicide in the juvenile justice system.

Carol Cramer Brooks: We want to thank NTTAC and their staff, and remind you that when you exit out of the Webinar to make sure that you complete the evaluation. Thanks to all of you for participating in this Webinar. Have a great day.

[End.]