

Suicide Prevention and Management of Youth in Custody

Position Statement

The National Commission on Correctional Health Care recommends that all juvenile correctional facilities develop and implement a comprehensive suicide prevention program that takes into consideration the unique characteristics of self-harm and suicide behaviors in youths. This includes all facilities that house youths — pre- and post-adjudication, small and large, public and private — as well as non-juvenile facilities that might house youths such as jails, prisons, and U.S. Immigration and Customs Enforcement (ICE) settings. The suicide prevention program should include the following key components:

1. Staff training in self-harm and suicide prevention:
 - a. Includes all facility staff working directly with youths – including custody, program, and health staff
 - b. Consists of an initial training as well as regular follow-up trainings at least every two years (annual training is a best practice and is highly recommended)
 - c. Covers risk factors and red flags for self-harm and suicide behaviors
 - d. Reviews the specific screening tools, custody and health care practices, resources, and policies of the facility
2. Identification of risk:
 - a. Uses a standardized suicide risk screening tool that clearly indicates a suggested level of monitoring
 - b. Provides screening at the time of initial admission/intake by health staff or health-trained custody staff when health staff are not on site
 - c. When current risk of suicide is identified, requires timely communication with mental health care staff, and identification of the timeframe in which to conduct a clinical evaluation/assessment by a qualified mental health professional (QMHP) to further determine the level of risk and level of supervision needed
 - d. Is continuously assessed throughout a youth’s period of incarceration
 - e. Takes into consideration any acute changes such as changes in legal status (e.g., disappointing news from attorney/the courts), changes in situational stressors or losses (e.g., death of a family member or peer, family conflict, family not visiting youth, recent breakup with significant other), individual behaviors (e.g., fights, outbursts, recent disciplinary issues), or medication initiation or change that might impact risk
 - f. Includes review, documentation, and communication of risk factors (especially history of past self-harm, suicide attempts, peer bullying, traumatic brain injury, or physical or emotional trauma)
3. Monitoring level system:
 - a. Consists of two levels based on suicide risk:
 - i. Constant observation with 1:1, 24-hour staff supervision – associated with acute risk
 - ii. Close observation with frequent checks by staff at unpredictable intervals with no more than 15-minute intervals – associated with nonacute risk
 - b. Requires that observation checks are documented
 - c. May include supplemental monitoring through video cameras, which may augment, but must not replace the above in-person checks by staff

POSITION STATEMENT

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NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

- d. Includes a process for additional monitoring and treatment planning with custody and health care staff, for patients at the highest risk
 - e. Is determined and reevaluated by a qualified health care or mental health professional at least daily, including review by a qualified mental health professional or psychiatric provider when indicated to consider further evaluation, transfer to another housing unit, higher level of treatment services such as emergency department for possible inpatient psychiatric hospitalization, or psychotropic medication treatment for primary mental disorders
 - f. Is clearly communicated to custody and health care staff in terms of both individual status and facility protocols
 - g. May never be used as punishment or retaliation, nor include unnecessary isolation or removal of certain personal items (e.g., clothing, reading materials, hygiene items) unless determined necessary for safety reasons by a qualified health care or mental health professional
4. Communication about self-harm, suicide risk, and behaviors:
- a. Is clearly outlined in written policies and procedures
 - b. Defines when, how, and which facility administrators, outside authorities, and family members are to be notified of suicides, self-harm, or suicidal behaviors
 - c. Takes place between youth, health staff, and custody staff on an ongoing basis
 - d. Is documented clearly in staff logs and clinical notes
 - e. Must be passed on between shifts
5. Housing status:
- a. Must be considered when reviewing suicide risk, including increased risk for youth on confinement status (e.g., disciplinary housing) or awaiting disciplinary issues/review who are alone in their rooms and who will require additional monitoring or clinical evaluation
 - b. Considers potential safety risks inside the room, including available means for ligature risk and asphyxiation and hanging (such as strings, linens, or clothing items) in particular, but also access to sharps (such as eating utensils) or other objects, and hygiene products or other chemicals that could be swallowed or ingested
6. Treatment:
- a. Requires training of custody, program, and health staff in evidence-based treatment approaches for working with youth who engage in suicidal and self-injurious behaviors.
 - b. Incorporates short-term and long-term treatment planning, in the form of multidisciplinary treatment planning, by clinical staff with custody staff involvement/input.
 - c. Requires clinical evaluation and recommendations prior to the removal of any standard items (e.g., clothing and hygiene) and routine privileges (e.g., school or recreational activities). Removal of any items must be clinically based and not a type of punishment/disciplinary action.
 - d. Documents roles and strategies for multidisciplinary team members in addressing the suicidal or self-injurious thoughts and behaviors while the patient is being monitored and stabilized.
7. Intervention strategies:
- a. Makes tools, such as 911 access and emergency cut-down/cutting tools, immediately available to staff for use if they find a youth engaging in self-harm or suicide attempts via hanging/suspension
 - b. Ensure that all staff maintain CPR training and have access to an AED (automated external defibrillator)

POSITION STATEMENT

ncchc.org/position-statements



NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

- c. Ensure that there are existing agreements in place with local emergency services and hospitals to facilitate transport of youth in a timely manner
8. Implementation of quality assurance processes to ensure the above standards are met and processes continuously refined as needed to meet youths' health, developmental, social, and safety needs, including the examination of data related to suicide prevention processes, with a specific focus on identifying and addressing disparities related to race, ethnicity, and other intersectional factors
 9. Postincident review process:
 - a. Takes place as soon as possible after any suicide attempt, near miss (e.g., potentially lethal self-harm event), or severe self-harm for which emergency off-site/911/hospitalization was needed
 - b. Death by suicide initiates a detailed administrative review process. This includes a formal, multidisciplinary sentinel event review that includes a morbidity and mortality review and psychological autopsy and utilizes a root-cause analysis approach to understand the factors that contributed to the event and identify potential system-wide improvements and continuous quality improvement interventions to be reviewed for future implementation
 - c. Incorporates appropriate debriefing for all staff involved in the incident
 - d. Considers any potential impact of the incident on other youth and staff in the facility

Definitions*

Custody staff: Line security and custody administration

Facility staff: All custody, program, and health staff who provide services to the youths

Health staff: Includes all full-time, part-time, and per diem qualified health care professionals as well as administrative and support staff

Provider: A nurse practitioner, physician assistant/associate, or physician

Qualified health care professionals: Physicians, physician assistants, nurses, nurse practitioners, dental professionals, mental health professionals, and others who by their education, credentials, and experience are permitted by law to evaluate and care for patients

Qualified mental health professionals: Psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients

Suicidal

- **Acute suicidal ideation:** Active engagement in self-injurious behavior and/or threatening suicide with a specific plan
- **Nonacute suicidal ideation:** Expressing current suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or having a recent history of self-injurious behavior

*All definitions are from *Standards for Health Services in Juvenile Detention and Confinement Facilities* (NCCHC, 2022)

POSITION STATEMENT

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Discussion

Suicide among young people in the general population is a national tragedy and a major public health problem.¹ For youth between the ages of 10 and 24, suicide is the second leading cause of death, resulting in more than 7,000 lives lost each year.² Suicide rates for youth between the ages of 10 and 24 increased by 52.2% between 2000 and 2021.³ Youth involved in the juvenile legal system have high rates of exposure to trauma and adverse childhood experiences; they are at higher risk than the general youth population for suicidal ideation and attempts.⁴

This position statement highlights the key components of a successful suicide prevention program in the juvenile correctional setting. A more comprehensive description can be found in NCCHC's *Standards for Health Services in Juvenile Detention and Confinement Facilities* (2022), Standard Y-B-05 Suicide Prevention and Intervention.⁵

Adopted by the National Commission on Correctional Health Care Board of Directors October 14, 2007
October 2012 — reaffirmed with revision
October 2019 — reaffirmed with revision
January 2025 — reaffirmed with revision by the National Commission on Correctional Health Care Governance Board

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

References

- ¹ Carmona, R. H. (2005, June 15). *Suicide prevention among Native American youth*. Statement of Richard H. Carmona, MD, MPH, FACS, Surgeon General, U.S. Public Health Service, U.S. Department of Health and Human Services. Testimony before the Indian Affairs Committee, U.S. Senate.
- ² Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS), fatal injury reports, 2023, for national, regional, and state (restricted).
- ³ Centers for Disease Control and Prevention. (2023). *Disparities in suicide*. <https://www.cdc.gov/suicide/facts/disparities-in-suicide.html>
- ⁴ Stokes, M. L., McCoy, K. P., Abram, K. M., Byck, G. R., & Teplin, L. A. (2015). Suicidal ideation and behavior in youth in the juvenile justice system: A review of the literature. *Journal of Correctional Health Care*, 21(3), 222-242. <http://doi.org/10.1177/1078345815587001>
- ⁵ National Commission on Correctional Health Care. (2022). *Standards for Health Services in Juvenile Detention and Confinement Facilities*.