

GEORGIA DEPARTMENT OF JUVENILE JUSTICE	Transmittal # 17-17	Policy # 12.21
Applicability: {x} All DJJ Staff { } Administration { } Community Services { } Secure Facilities (RYDCs and YDCs)	Related Standard & References: O.C.G.A. §§49-4A-7, 49-4A-8 ACA Standards: 4-JCF-3C-01, 4-JCF-4B-06, 4-JDF-4C-38, 4-JCF-4C-12, 4-JCF-4C-54, 4-JCF-4D-07, 3-JDF-4C-26, 27, 3-JDF-4C-35 NCCHC Juvenile Standards, 2011: Y-A-10, Y-G-0-5 DJJ 1.4, 3.26, 3.80, 4.2, 4.4, 5.5, 8.4, 8.5, 9.2, 12.4, 12.5, 12.10, 12.11, 12.12, 12.20, 12.22, 12.23, 15.11, 18.2	
Chapter 12: BEHAVIORAL HEALTH SERVICES	Effective Date: 12/28/17 Scheduled Review Date: 12/28/18	
Subject: SUICIDE PREVENTION	Replaces: 9/20/16 Division of Support Services	
Attachments: A – Safety Protocol B – Behavior Record C – Special Management Plan D – Suicide Protective Garments Inventory E – Approved Suicide Protective Garments F – Notification of Precautions Letter	APPROVED:  _____ Avery D. Niles, Commissioner	

I. POLICY:

The Department of Juvenile Justice shall operate a suicide prevention program that focuses on early detection of at-risk youth and proactive multidisciplinary supportive measures to address the mental health treatment and supervision needs of at-risk youth.

II. DEFINITIONS:

Behavior Record: A chronological log used to record behavioral observations and activities of youth on a Safety Protocol or Special Management Plan.

Behavioral Health Staff: At a minimum, Social Service Provider, Juvenile Detention Counselors, Sex Offender Treatment Specialist, Sex Offender Treatment Supervisor, Institutional Program Directors, Social Services Coordinator, Psychologist, Psychiatrist, nurse trained in mental health duties, Professional Social Service Worker, Social Service Worker, substance use treatment staff, and masters and doctoral level mental health students, and other staff with the education, training and experience adequate to perform the duties required in accordance with professional standards, as authorized by the Designated Mental Health Authority.

Constant Supervision: Level of supervision requiring direct observation and documentation of the youth’s behavior at irregular intervals at least every 5 minutes while in confinement.

Determination of Risk: Estimate of risk for self-harm or suicide made by an LMHP or a QMPH in consultation with an LMHP after consideration of information about the youth’s behavior, history, present situation, state of mind, and emotional functioning.

Levels of Observation: The frequency of youth supervision.

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Level 1, Routine Observation: Level of supervision requiring no special services or precautions due to the absence of any apparent risk of harm. Direct observation and documentation of the youth's behavior occurs at irregular intervals at least every 30 minutes while in the room.

Level 2, Special Observation: Level of supervision requiring direct observation and documentation of the youth's behavior at irregular intervals at least every 15 minutes while in the room.

Level 3, Close Observation: Level of supervision requiring a continuous, clear and unobstructed view of the youth at all times. Close observation will be documented every 15 minutes while in the room or removed from regular programming.

Licensed Mental Health Professional (LMHP): A licensed Psychiatrist, licensed Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), or Clinical Nurse Specialist (CNS) in psychiatry/mental health. Licensure must be at the independent practice level in order for a clinician to be considered an LMHP.

Mental Health Assessment: A standardized process that includes review of mental health records, interview, and symptoms/behavioral observations to delineate the nature, severity, course, and associated risks of any mental health problems that may affect a youth's emotional, social or cognitive functioning in a secure facility. The mental health assessment will identify and address the needs of youth in their setting.

Mental Health Caseload: Those youth who have been identified following assessment as requiring behavioral health services. These youth are assigned a primary clinician to coordinate the behavioral health treatment team presentations of this youth and to ensure that services recommended by the team are provided.

Mental Health Screening: A process designed to identify youth with mental illness, substance abuse, or suicide risks that need further attention or evaluation.

One-to-One Observation: A part of close observation (Level 3) where one youth is assigned to one designated staff member at all times. The designated staff member must closely and directly supervise all of that youth's activities in an effort to protect him/her from harm. He or she must document that observation every 15 minutes while the youth is in the room or is removed from regular programming.

Qualified Mental Health Professional (QMHP): Mental health staff with education, training and experience adequate to perform the duties required in accordance with professional standards. When the QMHP is required to complete assessments or provide individual counseling to youth with mental illness, the QMHP must have at least a master's degree in a mental health related field, training, and experience in the provision of mental health assessment and counseling procedures. A master's level student under the supervision of a QMHP may perform the functions of a QMHP.

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Safe Area: A designated area of the facility that provides for maximum visibility and safety of the youth.

Safety Protocol: A safety-oriented, written protocol for each youth who is on special (Level 2) or close (Level 3) observation. A safety protocol may be developed and initiated only by a qualified mental health professional (QMHP) or by direct care staff under the direction of a QMHP.

Self-harm Behavior: An overt act or expression of intentional self-injury.

Special Management Plan: A treatment-oriented, written plan by a qualified mental health professional that includes a description of the youth's typical response to crisis, known events that may precipitate a crisis, behaviors that suggest the youth may be beginning to escalate or lose control, personal issues that may increase the youth's vulnerability to stressful situations, specific actions for preventing and managing crisis, and/or situations in which the youth may be at risk for victimization.

Special Management Team: The team of individuals responsible for the creation and revision of a Special Management Plan that includes but is not limited to: Psychologist, Psychiatrist, Social Service Coordinator, Social Service Provider or Treatment Program Specialists, Substance Abuse Counselor, Registered Nurse, Juvenile Detention Counselor, education representative (e.g. teacher, principal and counselor), security representative and administration representative. The Team may also include clinical consultants, community case managers, community mental health providers, DFACS caseworkers, youth parent/guardian, and other community support persons.

Suicide: The intentional taking of one's own life.

Suicide Attempt: A self-destructive act with the potential for death or serious injury.

III. PROCEDURES:

- A. In community non-residential programs local procedures will provide for the immediate referral of suicidal youth to a community mental health provider.
- B. Upon admission to an RYDC or YDC every youth must be screened for the presence of suicide risk factors in accordance with DJJ 12.10, Mental Health Screening. The screening results will determine the Level of Observation. A mental health assessment must also be completed in accordance with DJJ 12.11, Mental Health Assessment. If the screening results in Level 2 or 3 precautions, the youth will remain on that Level of observation until the assessment is completed.
- C. A youth who exhibits suicide risk factors must be referred to an appropriate level qualified mental health professional (QMHP) in accordance with DJJ 15.11, Request for Services, and will receive a mental health assessment by an appropriate level QMHP or master's-level intern in accordance with DJJ 12.11, Mental Health Assessment.

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- D. Any staff member may place a youth on close observation (Level 3) based upon presentation of suicide risk factors.
- E. If a youth is at risk of suicide or self-harm the QMHP or direct care staff under the direction of a QMHP must develop a Safety Protocol (Attachment A).
1. Youth will remain on close observation (Level 3) until a QMHP assesses the youth and a LMHP determines the appropriate Level of Observation.
 2. The QMHP will document precautions on the Safety Protocol Form (Attachment A).
 3. The Safety Protocol must include:
 - a) Reasons for Protocol;
 - b) Level of Observation;
 - c) Any precautionary measures (such as: one-to-one observation, suicide gown, suicide blanket, room assignment, limitations on program involvement, limitations on access to physical items that may be used for self-harm, etc.). Precautionary measures may also include a special diet, such as finger foods, in accordance with DJJ 9.2, Menu Planning and Meal Service. Precautionary measures will be individualized and based on the youth's clinical presentation; and
 - d) Other special instructions.
 4. A Behavior Record (Attachment B) will be immediately implemented with the Safety Protocol.
 5. Determination of risk:
 - a) If there is a QMHP on site then staff will make the determination of risk through face-to-face evaluation.
 - b) If a QMHP is not on site the direct care staff will contact the on-call QMHP to determine appropriate precautionary measures. If the on-call QMHP is not an LMHP he/she must consult with an LMHP before assigning any Level of Observation other than close observation (Level 3). The QMHP will document the contact in accordance with DJJ 12.4, Staffing and On-Call Mental Health Services.
 - c) It is not necessary to complete a Safety Protocol prior to the determination of risk if the determination of risk is initiated within 30 minutes of the

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QMHP being notified. In this situation, a clear and unobstructed view of the youth must be maintained until determination of risk has been made.

6. The Shift Supervisor will notify and keep informed the facility Director or designee (i.e., administrative duty officer) of any youth who has attempted or threatened to commit suicide or presents other indicators of increased risk of self-harm.
7. Only an LMHP may authorize a decrease in a youth's Level of Observation.
8. For youth who remain on close or special observation following determination of risk the youth must be maintained on the Level of Observation assigned by the LMHP for a minimum of 24 hours prior to any decrease. Youth on close observation (Level 3) may only be decreased to special observation (Level 2) and must remain at that Level for at least 24 hours before the youth may be placed on routine observation (Level 1).
9. Youth who remain on a Level 3 Safety Protocol following a determination of risk will be placed on the mental health caseload and be provided treatment services. The QMHP will determine if the youth needs emergency psychiatric hospitalization in accordance with DJJ 12.23, Emergency Psychiatric Hospitalization.
10. In addition to a Safety Protocol, a QMHP may develop a Special Management Plan (SMP) for self-harm (Attachment C) for a youth who requires close observation (Level 3) following a mental health assessment. The QMHP must develop a SMP when the youth remains on close observation for 72 continuous hours following assessment and that SMP must be implemented no later than 72 hours following assessment.
11. Behavioral health staff will see daily all youth who have a Safety Protocol to provide counseling, monitor current mental status and evaluate the need for additional services or precautions. The evaluating behavioral health staff member will determine whether a QMHP or licensed mental health professional needs to be contacted for consultation. The evaluating behavioral health staff member will document the daily review on the Behavior Record.
12. If a Safety Protocol is changed or discontinued, the clinical rationale for the change will be documented on the Behavior Record (Attachment B) and will be documented as an OBHS progress note, a mental health assessment, or a psychodiagnostic evaluation in the Juvenile Tracking System (JTS).
13. Only an LMHP may discontinue a Safety Protocol. Discontinuation of a Safety Protocol will be documented in JTS in an OBHS progress note, a mental health assessment or a psychodiagnostic evaluation.

F. One-to-one observation:

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1. For youth placed on close observation (Level 3), the QMHP may consider one-to-one observation as an intervention to protect the youth. The QMHP will consider one-to-one observation only in circumstances when the youth cannot be safely managed with close observation. When the clinician is considering the use of one-to-one observation, he/she will coordinate the management of the youth with the facility Director or designee.
 2. If a clinician authorizes one-to-one observation the staff member assigned to the youth will not be responsible for supervising other youth when assigned this duty and their other duties will be minimized to eliminate distractions that would inhibit proper supervision of the youth.
- G. Youth who remain on a Level 2 or 3 Safety Protocol following an determination of risk by a QMHP will be evaluated by a Psychologist or Psychiatrist as soon as possible, but no later than 10 days from the time the Safety Protocol is initiated. If the Safety Protocol is discontinued prior to 10 days, the Psychologist or Psychiatrist must still evaluate the youth within 10 days of the initiation of the Safety Protocol. The Psychologist or Psychiatrist will document the evaluation in accordance with DJJ 12.12, Psychodiagnostic Evaluation.
- H. A behavioral health staff member must review the Behavior Record daily as part of a monitoring process to assess the need for continued precautions. The behavioral health staff member must document the daily review on the Behavior Record. However, the behavioral health staff member will only document confidential information obtained during this review that is not related to the self-harm behavior/thoughts in a progress note in JTS (see DJJ 5.5, Health Record), not on the Behavior Record.
1. At the beginning of each shift, a shift supervisor (or designee) will review the Behavior Record and will ensure that all staff responsible for implementing Safety Protocols complied with them. If any changes are made to a protocol or plan developed earlier supervisors will review the changes with the staff at the beginning of each shift. Shift supervisors will sign the Behavior Record attached to each youth's Safety Protocol as soon as possible following shift briefing to document that the reviews have been completed.
 2. At the end of each shift, the shift supervisor (or designee) will document in the Behavior Record a summary of the youth's behavior for that shift. Night shift supervisors will document any behavior inconsistent with what would be expected during the night hours. Staff may not backdate Behavior Record entries. Entries that are not completed within 2 hours of the end of the shift must be left blank.
 3. Youth on close or special observation will be evaluated daily by behavioral health staff. Documentation of the evaluation will be made on the Behavior Record. Behavior Record entries will not be backdated. Entries that are not completed within 2 hours of the end of the shift must be left blank.

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4. Each secure facility will have a plan to provide for coverage to ensure youth on close or special observation are evaluated daily. The coverage plan will specify the level of staff to provide these evaluations and may include staff other than behavioral health staff that is specifically trained to provide these visits. The coverage plan must be approved by the Regional Behavioral Health Services Administrator, Designated Mental Health Authority (DMHA), Designated Program Authority (DPA), and facility Director.
 5. At the request of the DMHA, the Chief of Psychology Services may grant a written waiver to the requirement of daily Behavior Record documentation in special circumstances (such as: youth on long-term protective plans, very young youth, etc.). These waivers will not be granted or apply to youth in any type of isolation.
 6. The Psychologist and Psychiatrist must review the active close observation alerts, special observation alerts, and special management alerts at each facility visit. The Psychologist and Psychiatrist will also review all the close observation alerts, special observation alerts and special management alerts initiated since their last visit to the facility and determine if further clinical intervention is warranted.
 7. When a youth's Safety Protocol and Special Management Plan are discontinued, these documents must be filed in accordance with DJJ 5.5, Health Records. The DMHA or designee must review all required documentation (Protocols, Special Management Plans, shift supervisor reviews, and behavioral health daily reviews) at least once a week and determine if all required documentation is present and is properly maintained. The DMHA must report any discrepancies to the Regional Behavioral Health Services Administrator and facility Director, who will take appropriate disciplinary action in accordance with DJJ 3.80, Employee Progressive Discipline.
- I. Suicide protective garments (such as: suicide gowns and blankets) may be used on a case-by-case basis in a manner that respects the youth's basic needs, sense of dignity and right to least-restrictive interventions.
1. Suicide protective garments will not be used as a routine precautionary measure for every youth placed on close or special observation.
 2. Suicide protective garments will never be used as a means of coercion or punishment.
 3. Suicide protective garments will be used only when clinically indicated for prevention of self-harm following consultation and preferably after evaluation by a QMHP.
 4. In all facilities, when a behavioral health staff member makes a determination that a youth needs to be placed into a smock and a blanket, all other items must be

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removed from the youth's room. The Behavioral Health Staff member who made the determination will also notify the shift supervisor of the need.

5. The security staff will ensure that the smock and blanket and any other items belonging to the youth are removed. The authorizing QMHP must clearly document the decision to use a suicide protective garment on the youth's Safety Protocol.
6. A youth clothed in a suicide protective garment will not be moved outside of his/her room except in extreme circumstances. If the youth must be transported to another facility or another building within the facility, reasonable effort will be made to have the youth change into appropriate clothing.
7. If the youth uses an article of clothing to attempt to harm him/herself, staff will remove that item of clothing using the least restrictive alternative.
8. If it becomes apparent that the youth will continue to use other items of clothing for self-harm, physical control measures may be used as a last resort in order to remove the youth's remaining items of clothing. Staff will provide a suicide protective garment for the youth to wear if he/she chooses.
9. Close observation shall be provided by a same-sex staff member if the youth has removed his/her clothing and chooses not to wear a suicide protective garment. In extreme circumstances when this is not possible, the facility Director may make an exception to this rule, but only during the time it takes to obtain a same-sex staff member to provide the supervision. Physical control measures will never be used to force a youth to wear a suicide protective garment.
10. The DMHA will conduct an annual inventory of suicide protective garments to ensure that all such garments are operable and usable. The DMHA will document this inventory on the Suicide Protective Garment Annual Inventory Form (Attachment D). The DMHA will send a copy of the completed form to the facility Director and to the Regional Behavioral Health Services Administrator. The DMHA will also file a copy in the facility program plan.
11. The facility Director, in coordination with the facility DMHA, will ensure that there are a sufficient number of approved suicide protective garments (see Attachment E) and blankets available to meet the needs of the facility in accordance with the annual Suicide Protective Garment Annual Inventory.
12. After each use, the shift supervisor or designee will assess a garment to determine if it remains in working condition and will document this evaluation in the logbook. If a garment is damaged or soiled beyond the ability to be effectively cleaned, it will be discarded and the Director and DMHA notified.

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- J. Youth who are exhibiting suicidal and/or self-harm behaviors will be housed in an appropriate least restrictive environment.
1. Youth placed on close (Level 3) or special (Level 2) observation should be housed in closest proximity to staff duty stations for ease of observations. Rooms used by youth on close or special observation will be searched each time the youth enters the room to ensure that it is safe and secure.
 2. A youth with an active special observation (Level 2) Safety Protocol who is placed in isolation will receive constant supervision (i.e., level of supervision requiring direct observation and documentation of the youth's behavior at irregular intervals at least every 5 minutes while in isolation.)
 3. At-risk youth will be searched prior to each entry into their assigned rooms. The youth will not be strip searched unless there is sufficient reason to believe that the youth possesses contraband or items that could be used to self-harm.
 4. Each RYDC and YDC will have at least one designated safe area. A youth may be placed in a designated safe area if the youth is considered to be in imminent danger of harming him/her self. A QMHP must authorize placing a youth in a safe area. If placement is authorized, the QMHP must initiate a Safety Protocol. Only a QMHP may authorize removal of a youth from the safe area. When removal is authorized the youth will return to regular programmed activities or if during sleeping hours, to his/her assigned sleeping area or room.
 5. The facility Director will ensure that every sleeping room is consistently monitored for proper maintenance in accordance with DJJ 8.4, Inspections. Items such as light fixtures, air vent covers, window screens, etc. will be kept in good working order and maintained in such a manner as to minimize the risk for suicide.
- K. Each facility/program will have first aid kits, mouth shields and rescue tools readily accessible to all staff at all times.
- L. Any staff who discovers a youth who is attempting or has attempted suicide will respond immediately.
1. The staff member will survey the scene, and promptly intervene to eliminate any immediate danger. In every case staff will assume the youth is still alive.
 2. The staff member will call out for assistance from other staff on the unit. A staff member must remain with the youth until the emergency has resolved.
 3. If the youth is found hanging, the staff member who discovers the youth will attempt to support the youth by the legs while the youth is facing the staff member to reduce tension on the neck. Upon arrival of additional staff, the first staff

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member on the scene will continue to support the youth's body while another staff member uses the rescue tool to cut the youth down. The noose will be immediately removed from around the youth's neck.

4. Emergency first aid and CPR will be immediately applied. Health care staff will be immediately notified. If necessary CPR will continue until the youth has a pulse/respirations or a trained rescuer takes over.
 5. Staff will call the local emergency medical service (911) as necessary or as advised by health care staff.
 6. All youth who attempt suicide will be immediately referred to facility health care staff and mental health staff for assessment and treatment as soon as possible. In the absence of a QMHP the on-call staff member will be notified.
- M. The DMHA will ensure that the behavioral health treatment team discusses any youth maintained on a Safety Protocol. If the team determines that it is necessary the youth will be added to the mental health caseload after the determination of risk has been made, or for youth who are on the mental health caseload the primary clinician will revise the plan if needed in accordance with team recommendations to address the risk of suicide attempt or self-harm behavior.
- N. When a youth who is on close or special observation is to be removed from the facility for any reason (e.g., release to parent/guardian, transportation to court, etc.), the facility staff will provide the receiving officer/person with a copy of the Notification of Precautions Letter (Attachment F). Staff will document provision of the letter in the log book.
- O. All self-harm behaviors will be reported through the special incident reporting process, in accordance with DJJ 8.5, Special Incident Reporting. Self-harm statements that are discussed during a clinical encounter with a masters-level QMHP, master's level intern, Psychologist, or Psychiatrist do not require a Special Incident Report. Self-harm behaviors that are displayed during a clinical encounter with a QMHP do require a Special Incident Report. The clinician will initiate all of the other requirements of this policy (assessment, safety protocol, etc.). (Unlicensed mental health staff must consult with an LMHP regarding the statement/behavior and document the consultation.)
- P. Every youth on the mental health caseload who is scheduled for release from a YDC should be reviewed by the behavioral health treatment team within two weeks of release to update diagnosis, discuss follow-up appointments, discharge medications, etc. The team discussion will include concerns about possible increased risk for self-harm or exacerbation of symptoms. For youth who are on level 2, level 3, or a special management plan for suicide/self-harm within seven days of release:

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1. An LMHP will evaluate the youth as close to release as possible but no later than within 72 hours of release. If no LMHP is available, a QMHP can evaluate the youth in consultation with an LMHP.
 2. This contact should be documented as a Discharge Note in the OBHS Progress Notes module, and should address:
 - a) Level of precautions;
 - b) Any emergent symptoms;
 - c) Any recent risk behaviors (self-harm, suicidal behavior, etc.);
 - d) Any anticipated risks in the release process and/or discharge setting; and
 - e) Recommendations and actions taken, including possible psychiatric hospitalization referral.
- Q. Statistical data regarding self-harm behaviors will be reviewed during the facility's behavioral health quality assurance monthly meetings (see DJJ 12.5, Behavioral Health Quality Assurance) in order to identify and address any potential operational problems, trends or procedural issues that may compromise the prevention of self-harm behavior.
- R. In the event of a suicide, a Special Incident Report will be completed and the required notifications made, as outlined in DJJ 8.5, Special Incident Reporting.
1. Post-crisis intervention for youth will be conducted as authorized by the Director of Behavioral Health Services or designee. Critical incident stress management for staff will be conducted through the employee assistance program. (See DJJ 3.26, Employee Assistance Program.)
 2. The Commissioner will appoint a Fatality Review Committee in accordance with 8.6, Fatality Review in Secure Facilities. In the event of a suicide in a secure facility, the Fatality Review Committee will be chaired by the Director of Behavioral Health Services, with the Commissioner serving as an ex-officio member. The committee will not interfere with or take the place of any ongoing investigation. The committee will review aspects of the incident including, but not limited to:
 - a) Events or conditions that may have contributed to the suicide;
 - b) Interviews or reviews of documentary evidence and information from staff or youth who may have knowledge about the incident;
 - c) Policies and procedures relevant to the issue; and

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d) Evaluation of the emergency response procedures.

- S. The Department will develop and maintain a training curriculum for suicide prevention.
1. All staff who have routine contact with youth will receive suicide prevention training, including emergency response, first aid and CPR, accordance with DJJ 4.2, Security Staff Training Requirements, and DJJ 4.4, Non-Security Staff Training Requirements. A representative of the Office of Behavioral Health Services will review the training lesson plans annually and offer recommendations.
 2. All QMHPs, both licensed and unlicensed, will undergo ongoing training and clinical supervision that focuses on the skills necessary to determine a youth's suicide risk. The training will be conducted by a mental health organization, consultants, or licensed mental health professional(s).
- T. The facility Director, DMHA and Regional Behavioral Health Services Administrator will establish local operating procedures for:
1. The staff responsible for entry of Level 2 and Level 3 alerts by the end of the shift in which the Level is ordered;
 1. The staff responsible for discontinuing Level 2 and Level 3 alerts by the end of the shift in which the Level is discontinued;
 2. Communication of Safety Protocols and Special Management Plans to direct care staff responsible for supervising youth;
 3. Maintenance of the Safety Protocol, Special Management Plan and Behavior Record in a location that is readily accessible to all direct care staff;
 4. Review of the Safety Protocol and Special Management Plans including any changes at each shift briefing;
 5. The staff responsible for notifying the parent/legal guardian and court service worker/Community Case Manager of a Special Management Plan for suicide risk as soon as possible but always within 72 hours of the Special Management Plan implementation;
 6. The maintenance, storage, location and inventory of clean, operable suicide protective garments;
 7. The month in which the annual Suicide Protective Garment Inventory will be completed;

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8. The process for informing the facility Director or designee about any youth that has attempted or threatened to commit suicide, or presents other indicators of increased risk of self-harm;
9. The process for issuing the Notification of Precautions Letter;
10. The location of the facility's designated safe area; and
11. The process by which the psychologists and psychiatrists will be made aware of youth placed on precautions (Level 2 or 3) or a Special Management Plan since the provider's last visit to the facility.

IV. LOCAL OPERATING PROCEDURES REQUIRED: YES

- The Designated Mental Health Authority and Designated Health Authority must review and sign the facility LOP.
- Specify the appointed designee.