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## Suicide Prevention Policy

### 735.1 RESPONSIBILITIES:

It is the intent of this policy to prevent suicide in our Juvenile Institutions and affirm that human life is to be protected. We believe the preservation of human life supersedes all other institutional concerns. It is our responsibility to protect the youths detained in our Detention and Assessment Centers and placement facilities. Furthermore, it is the intent of this policy to focus our efforts on meeting the needs of the youth rather than solely controlling the youth's behavior.

The Department will maintain a comprehensive written suicide prevention program and procedure. The Suicide Prevention Procedure includes the following components, as set forth by the National Center on Institutions and Alternatives:

- Staff Training
- Intake Screening/Assessment
- Communication
- Housing
- Levels of Observation
- Intervention
- Reporting
- Mortality/Critical Incident Review
- Inspections

### **I. Staff Training**

The key to any successful suicide prevention program is properly trained line staff, which is the backbone of the juvenile facility. Because line staff are generally the only staff in the juvenile facility 24 hours per day, they form the front line of defense in suicide prevention. As recommended by the correctional standards of the American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCHC), and the National Center on Institutions and Alternatives, suicide prevention training should be given to all staff who come into contact with juveniles.

All San Bernardino County Probation Department line, medical, and mental health staff shall receive eight (8) hours of initial suicide prevention, assessment, recognition, and response training, followed by two (2) hours of annual suicide prevention training. The training shall include the following, at a minimum: 1) Why facility environments may be conducive to suicidal behavior, 2) Potential predisposing factors to suicide, 3) High-risk suicide periods, 4) Warning signs and symptoms, 5) How to access and use a 911 cut-down tool, and 6) Components of the department's suicide prevention procedure.

### **II. Intake Screening**

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Intake screening is crucial to any juvenile facility's suicide prevention efforts. It is imperative that each youth be screened for potentially suicidal behavior upon entry into the facility. A youth can commit suicide at any time during confinement, beginning immediately following intake and continuing through a stressful aspect of confinement.

A process for screening and assessment shall be maintained to systematically screen youths upon arrival at the facility and throughout their stay in order to identify those who are at-risk for suicide, including those youths who are emotionally disturbed, mentally disabled or otherwise at-risk. The screening process should take place prior to the youth being assigned to a housing unit. The screening must include inquiry regarding past suicidal ideation, threat, plan; prior mental health treatment and hospitalization; recent significant loss (job, relationship, death of family member or close friend, etc); history of suicidal behavior by family member or close friend; suicide risk during prior confinement; and arresting/transporting officer's views of any potential suicide risk. The screening must also include a process for referral to Consult Services and/or medical personnel. The Watch Commander is responsible for ensuring that the screening process is followed.

Screening includes, but is not limited to, the following:

- A. **Arresting/Transporting Officers** - Information (including observed behavior, documentation from sending agency/facility, reports from family members/guardians, etc.) that indicates a youth is a medical, mental health or suicide risk now.
- B. **Intake/Release PCO** - A review of prior information on file, including a review of the youth's suicide observation notes in the minor's back-file (from prior periods of confinement). The Intake/Release PCO is responsible for notifying the Booking/Holding PCO of any alerts/flags showing any prior suicide risk.
- C. **Booking/ Holding PCO** - Completion of a face-to-face interview with each youth upon admission into the facility.
- D. **PCO/Mental Health Staff** - The completion of a psychometric assessment, designed to identify mental health issues, on all youths being admitted into the facility. (See Attachment A)
- E. **Intake Probation Officer** - Completion of a clearance form and initial interview on each youth, upon admission into the facility.
- F. **Medical Services Nurse** - Completion of a Pre-Physical within twelve (12) hours of admission into the facility.
- G. **Mental Health Staff** - Assessment on all youths, within 14 days of admission into the facility, Qualified Mental Health staff will further assess youths at-risk for suicide in an effective and timely manner and determine the need for mental health treatment. (See Attachment A)

### **III. Communication**

There are essentially three levels of communication in preventing juvenile suicides: 1) Between the arresting/transporting officer and facility staff, 2) Between and among facility staff (including mental health and medical personnel), and 3) Between facility staff and the

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suicidal youth. Because youths can become suicidal at any point in their confinement, line staff must maintain awareness, share information and make appropriate referrals to mental health staff and medical staff. In addition, as part of an effective communication plan, it is important that medical and mental health staff have unimpeded access to each other's patient files and charts, for both review and note/chart entries. Furthermore, whenever a youth is transferred from one facility to another it is important that the youth's probation mental health file be sent with the minor.

#### **IV. Housing**

Whenever possible, suicidal youths should be housed within the general population of the facility and/or in close proximity to staff, and be allowed to participate in regular programming. Housing assignments should not be based upon decisions that heighten depersonalizing aspects of confinement, but on the ability to maximize staff interaction with youths. Suicidal youths should be housed in suicide-resistant, protrusion-free rooms. Removal of clothing, as well as the use of restraints, should be avoided whenever possible, and only utilized as a last resort for periods in which the youth is physically engaging in self-destructive behavior.

#### **V. Levels of Observation**

youths determined to be at-risk for suicidal behaviors shall be placed on an appropriate level of Suicide Observation Status, in accordance with the departmental Suicide Prevention Procedure. Furthermore, observation checks will be documented and daily mental health reassessments will be conducted, in accordance with the Suicide Prevention Procedure.

#### **VI. Intervention**

Any suicidal gestures, statements, or behaviors shall be considered serious and will be addressed in a manner consistent with the Suicide Prevention Procedure. Providing prompt and effective emergency first aid and medical services can save a youth's life. The policy regarding intervention is three-fold: 1) All staff who come into contact with youths should be trained in first aid and CPR, 2) Any staff member who discovers a youth attempting suicide should survey the scene, administer first aid/CPR immediately and alert other staff to call for back-up, and 3) Upon arriving at the scene never presume a youth is dead, but rather initiate appropriate aid and continue life-saving measures until relieved by medical personnel.

#### **VII. Reporting**

In the event of a suicide attempt or suicide, all appropriate facility officials should be notified through the chain of command, in accordance with the departmental Suicide Prevention Procedure. Following any incident that results in serious injury and hospitalization, the youth's family should be notified (in accordance with DCB Procedure 1341.2), as well as any appropriate outside authorities (in accordance with DCB Procedures 1341 and 1341.1). All staff that came into contact with the youth prior to the incident should be required to submit a statement as to their full knowledge of the youth and the incident.

#### **VIII. Mortality/Critical Incident Review**

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For every serious suicide attempt (i.e.: requiring hospitalization) and completed suicide, the Professional Standards Unit will conduct a Mortality/Critical Incident Review. The Mortality/Critical Incident Review should include: 1) Review of the circumstances surrounding the incident, 2) Review of procedures relevant to the incident, 3) Review of all relevant training received by involved staff, 4) Review of pertinent medical and mental health services/reports involving the youth; and 5) Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. Further, all staff involved in the incident should be offered critical incident stress debriefing.

To be successful, the Mortality/Critical Incident Review team must be interdisciplinary and include representatives of both line staff and management level staff from corrections, medical and mental health. The area Division Director will be responsible for requesting the Mortality/Critical Incident Review.

#### **IX. Inspections**

A minimum of two (2) independent inspections, "outside the chain of command", shall be conducted each year. These inspections shall be initiated and performed by the Professional Standards Unit. The Professional Standards Unit may choose to utilize staff from outside agencies (i.e.: SBSB) to assist in conducting these inspections. A detailed inspection report, addressing various aspects of the Suicide Prevention Policy and Procedure, shall be prepared for each completed independent inspection and shall be submitted to the Chief Probation Officer for review.

In addition to the above independent inspections, random inspections "within the chain of command" shall be conducted, on a regular basis within each facility, by the PCSI, PCSII and Division Director to ensure the steps outlined in the procedure are being followed. These random inspections shall be performed as follows: 1) By the PCSI no less than once per shift; 2) By the PCSII no less than once per day and; 3) By the Division Director no less than once per week. A "Suicide Prevention Inspection Logbook" shall be maintained in the Watch Commander's office wherein each PCSI, PCSII and Division Director shall document a record of each random inspection conducted, along with the results.

#### **735.2 ATTACHMENTS:**

[See attachment: Suicide Prevention Policy Attachment A \(Lexipol 5-12-20\).pdf](#)

[See attachment: Suicide Prevention Policy Attachment B \(Lexipol 5-12-20\).pdf](#)

## Attachments

# **Suicide Prevention Policy Attachment A (Lexipol 5-12-20).pdf**

**SAN BERNARDINO COUNTY PROBATION DEPARTMENT**  
**POLICY MANUAL**  
**SUICIDE PREVENTION MATRIX – ATTACHMENT A**

Currently a Project Director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts, **Lindsay M. Hayes** is nationally recognized as an expert in the field of suicide prevention in jail, prison and juvenile facilities. In addition, he has authored model training curricula on suicide prevention in both jails and juvenile facilities. Mr. Hayes has published extensively within the field of jail and prison suicide and has authored more than 50 articles, columns and book chapters. Finally, he was recently presented with the National Commission on Correctional Health Care’s Award of Excellence for outstanding contribution in the field of suicide prevention. The following matrix summarizes the recommendations made by Mr. Hayes for a comprehensive suicide prevention plan in a juvenile detention facility. (Note: The Inspection category is department-based and is not part of Lindsay Hayes’ material.)

<i>Critical Components for Prevention</i>	<i>Suicide Prevention Policy Section</i>	<i>Suicide Prevention Procedure Section</i>
<b>Staff Training</b> – All medical, mental health & line staff should receive 8 hrs initially & 2 hrs each year thereafter of suicide prevention training, including warning signs & symptoms, high-risk suicide periods, potential predisposing factors & why facility environments are conducive to suicidal behavior.	I	VI(1)
<b>Intake Screening</b> -Immediately upon confinement & prior to unit classification, to assess past suicidal ideation and/or attempts; current ideation, threat plan; prior mental health treatment/hospitalization; recent significant loss; history of suicidal behavior by family member/close friend; & arresting/transporting officer(s) views of potential suicide risk.	II	IX(A)-(D)
<b>Communication</b> -Effective communication of suicide risk among the transporting officer, facility staff, medical & mental health personnel, line staff & minor is critical. Staff must maintain awareness, share information & make appropriate referrals.	III	II(A)(1),(2),(4), & (7) VI(F),(G) & (H), III(A)(3)-(11) & IV(A)(1), V(A)(3) & (5) VI(B) & (F)-(H)
<b>Housing</b> -Whenever possible, keep minor in general population & in close proximity to staff. Avoid isolation, paper gowns & restraints whenever possible; use only as last resort if minor is engaging in self-destructive behavior.	IV	II(B)(4) & (5), VI(K)
<b>Levels of Observation</b> -Constant observation is used for the actively suicidal minor, who is threatening or engaging in a suicide attempt. Close observation (5 & 10 min.) is used for the minor who is not actively suicidal but expresses suicidal ideation and/or has recent prior history of self-destructive behavior.	V	II(A)(3) & (B)(5), III(A)(3),(5), & (12), V(A)(2)(a) VI(B) & (C), VII(A)-(C)
<b>Intervention</b> -Staff intervention prior to & during the occurrence of a suicide/suicide attempt: 1) All security staff should know CPR & First Aid, 2) Survey the scene, immediately give aid, and call for back-up, 3) Never presume the minor is dead; continue life-saving measures until relieved by medical personnel.	VI	II(A)(1)-(7), II(B)(1)-(10), III(A)(1)-(12), IV(A)(1), VI(A)&(B)
<b>Reporting</b> -Following a suicide/suicide attempt, appropriate facility staff should be notified through the chain of command, the victim’s family should be notified immediately, as well as appropriate outside authorities.	VII	II(A)(4) & (7), III(A)(5),V(A)(2)(d), VI(G),(H)&(L)
<b>Mortality/Critical Incident Review</b> -For every serious suicide attempt (ie: requiring hospitalization) & completed suicide. In addition, all staff involved should be offered critical incident stress debriefing.	VIII	VI(L)
<b>Inspection</b> -To ensure compliance. Two Types: 1) Within the Chain of Command, 2) Outside the Chain of Command.	IX	See Policy Section IX

<i>Guiding Principles &amp; Recommendations for Prevention</i>	<i>Suicide Prevention Policy Section</i>	<i>Suicide Prevention Procedure Section</i>
Access to mental health services.	II, III, V	II(A)(4), III(A)(1),(3),(4), (6), (7), (9),(10), (11)
Do not rely on minor’s denial of suicidal thoughts.	II	VI(A), (D) & (I)
Consider prior risk of suicide.	II, III	VI(D), IX(A)
An assessment completed by mental health staff on all minors referred for any suicidal or self-injurious behavior within 14 days of admission.	II	IX(D)
Medical & Mental Health staff should have unimpeded access to each other’s patient charts for review and progress note charting.	III	III(A)(11)
Minor’s entire probation mental health file be sent with the minor whenever a transfer to another facility occurs.	III	III(A)(11)
All minor’s on SOS, regardless of which level, be reassessed by mental health staff on a daily basis on regular work days.	V	III(A)(4),VII(A)(4), VII(B)(4) & VII(C)(6)
“Step-Down” Level of Observation from most restrictive levels of suicide observation.	See Procedure	III(A)(12)

After release from SOS, minor should remain on a mental health caseload & be assessed periodically by mental health staff until minor is released from custody.	See Procedure	III(A)(10)
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# **Suicide Prevention Policy Attachment B (Lexipol 5-12-20).pdf**

**SUICIDE PREVENTION POLICY/PROCEDURE  
ATTACHMENT B**

CONSULT SERVICES/BEHAVIORAL HEALTH PROCESS STATUS

Regarding Section b, #3 (d) and (g):

These two Screening steps have not been implemented as of the writing of this policy.

(D) Use of a Psychometric Assessment is pending approval. Furthermore, it has not yet been determined who (i.e.: a PCO, Consult Services, etc) specifically will administer this assessment.

(G) Completion of a mental health assessment on all minors referred for any suicidal or self-injurious behavior within 14 days of admission. Administration is currently in the process of collaborating with the Department of Behavioral Health to develop an Memorandum of Understanding (M.O.U.) with the Probation Department.