Preventing Suicide in Regions 1 and 2

Suicide Prevention in Juvenile Justice and Correctional settings

June 6, 2005

Commonwealth of Massachusetts

Suicide Prevention Task Force

May 17, 2005

Suicide Prevention Task Force History

- Following two tragic completed suicides in a juvenile justice setting, the Secretary of Health and Human Services established a task force, composed of suicide prevention experts, state agency representatives, private providers, researchers and family members to examine all avenues of suicide prevention for any youth in 24-hour residential care.

Subcommittees of the Task Force

- Facility Safety Review
- Data
- Crisis Response
- Policies and Procedures
- Training

- **Facility Safety** conducted facility safety assessments at state contracted programs
- **Data** reviewed current data systems and recommended a new way to track and measure suicide attempts
- **Crisis Response** visited programs and interviewed staff to examine prevention and response protocols
- **Policies and Procedures** conducted on-site reviews of program operations
- **Training** reviewed regulations and best practice guidelines to inform new recommendations

Suicide Prevention Task Force Structure

- The Task Force was co-chaired by Massachusetts Department of Mental Health Commissioner Dr. Elizabeth Childs and nationally recognized suicide expert Dr. Robert Macy.
- Subcommittees followed the same public/ private co-chair model.
- The Task Force was a time-limited exercise, beginning in March of 2004 and ending that December.
- The subcommittees met separately and reported back to the Task Force at monthly meetings.
- Subcommittees performed site visits, conducted interviews with staff, performed literature reviews and solicited expert opinions to inform their recommendations.
- Recommendations were only made after full Task Force consensus.

Recommendation One

- The creation of a mobile training and technical assistance team.
  - A train-the-trainer model
  - Interactive website with best practice guidelines and resources
  - Two full time trainers and a half-time coordinator that will build the capacity of local residential providers to train their own staff in best practices related to risk assessment, crisis response, development and implementation of risk reduction policies and procedures, and data collection.
  - Trainings offered:
    - Statewide training
    - Smaller group trainings (by target population and/ or size of the residential program)
    - Program- specific technical assistance

Recommendation Two

- Add to existing Office of Child Care Services licensing regulations as follows:
  - The licensee shall provide training for all staff addressing suicide awareness and prevention, the content of which shall be appropriate for the population served as well as the staff's position and duties within the organization, including training in the areas of Suicide Awareness, Prevention, Assessment, and response to suicide attempts and completions. Such training shall be a part of orientation and annual refresher training.
- Include language in procurement specifications on training in suicide prevention.
  - Training requirements should also be worked into recontracting standards by agencies, for programs that are not up for reprocurement for long periods of time.

Recommendation two-procurement specifications

- Trainings include all 4 areas as defined by the subcommittee (Awareness, Prevention, Assessment, and Post-incident).
- Trainings must be participatory, not lecture-style.
- Trainings should be explicitly tailored to each level of staff, considering their duties and the populations served and responsive to the organization's assessment of individual training needs.
- Incidents should be evaluated post-incident as a teaching/ training opportunity.
- Agencies should identify training outcomes, specifying the competencies to be enhanced.
- Trainings must use current, state-of-the-art research.

Recommendation Three

- Use assessment tools to guide appropriate placements.
  - Assessment tools should be used regularly for all youth.
    - At a youth's admission to a program to assure that the child does not have problems requiring a more intensive or clinical level of care;
    - and also at discharge, to assure that a child is being discharged to an appropriate setting.

Recommendation Four

- Create a simple database with common data elements to track precise, measurable and useful information as it pertains to self-injurious behaviors, suicide attempts, and suicide completions.
  - All data fields will be drop-down menus, with no opportunity for narrative, free text.

Method of injury

Program where injury occurred

Indication of intent

Level of medical attention needed

Gender of self-injurer

Date of injury

Recommendation Five

- Notification of Physical Plant Issues.
  - The Commonwealth may choose to notify all residential programs about physical plant concerns identified as potentially problematic. Programs will be asked to perform a self-analysis of potential facility problems. Programs rating selves at high danger should be instructed to apply for funds.

Potentially Lethal Physical Plant Items

Bathroom loopables, like shower rods, exposed pipes, and showerheads.

Access to breakable glass, in mirrors or windows.

Bedroom loopables, like closet rods, clothing hooks, and HVAC grates.

Recommendation five-common "Quick Fixes"

- A number of facilities had similar problems that could be fixed for low or no money.
  - Replace bolted shower rods with velcro-adhered or tension-mounted shower rods.
  - Use velcro-adhered curtains instead of regular window treatments.
  - Shorten all wires and cords to less than 16 inches, or tube them.
  - Fill gaps in bed headboards with plywood.
  - Where possible, replace plastic trash bags with paper liners.
  - Box in exposed pipe when possible.

Recommendation Six

- Make operational changes in vendor practice, including:
  - improve staffing levels
  - improve training
  - map communication between and within agencies and providers
  - incorporate best practice models in programming
  - reconcile contracting, procurement, and regulatory standards across agencies
  - implement a system-wide programmatic protocol review

Current Action-
June 2005

- Database in development.
- Mobile Training Team to be placed at the MA Department of Mental Health for fiscal year 07.
- Suicide Prevention Training to be addressed in procurement specifications by agencies and in regulatory language by the Executive Office of Health and Human Services.
- Programs to be notified of potentially dangerous physical plant items.