Interview Guide

Manuscript note: Extraneous interview guide questions have been removed. Only questions pertinent to the scope of this paper are provided.

1. What role do juvenile detention centers play in preventing suicide?

2. When a young person arrives at your center, how is level of suicide risk identified?

3. When a young person is identified as being "at-risk for suicide" walk me through how your organization handles their care.

4. What challenges have you faced in implementing suicide prevention?

Thank you for providing this overview. I'm going to follow up with specific questions about your suicide prevention practices and policies.

1. How big is your organization?
   - How many beds?

2. How many reportable incidents have there been in your detention center in the last month?

Component 1: Training

5. Can you tell me about your detention center's training in suicide prevention?
   a. Who is trained
   b. How long is the training
   c. How often is the training repeated
   d. Is it a branded training (i.e., a purchased training curricula?)
      i. If no, can you send the materials for review?
   e. If not a branded training, what is the content of the training?

Component 2: Identification, Referral, and Evaluation

2. Explain your detention center's process for screening for suicide risk
   a. Who is responsible for screening for suicide risk at intake and what is there job description?
   b. Where does the screening take place?
   c. What questions are asked during screening/is a standard measure used?
   d. How does your detention center decide who is screened?
   e. How often are youth re-screened for suicidal thoughts and behaviors?

3. Explain your detention center's process for assessing for suicide risk
   a. Who is responsible for assessing
   b. What is assessed?
      i. Do you

1. Assess for current suicidal intent or plans
2. Assess for past suicidal thoughts and behaviors
3. Assess for access to means in detention (e.g., bedding, shoelaces, sharp objects) needed to carry out the plan

4. What are some things that make it easier or more difficult to screen and assess youth for suicide risk?

5. How is the information from the suicide risk screening and assessment measures used in your detention center?
    a. How do you define "at risk"/what term do you use to label someone as at-risk (e.g., on "safety precautions")

6. What therapeutic supports are provided to youth identified as at an elevated risk while detained?
    a. How often do mental health providers interact with youth?
    b. Do staff members help the youth recognize warning signs (situations, moods, or behaviors) that immediately precede a suicidal crisis?
    c. Do staff members help the youth learn strategies, such as relaxation techniques or physical activities that they can do by themselves to take their mind off problems?

Component 4: Housing (Safe Environment)

1. Now I'm interested in hearing about how staff determines the most appropriate housing location for youth at risk for suicide.
    a. Does the facility have specific housing for youth at risk for suicide?
    b. How do staff determine when to place youth in suicide-resistant rooms? (Rooms with no blankets or anchoring devices?
    c. Under what circumstances is room confinement used for youth at risk for suicide?
    d. Under what circumstances are restraints used for youth at risk for suicide?

Component 5: Levels of Observation (Follow-up, Tx planning)

2. Tell me about the levels of observation in your detention center
    a. Which are used for youth at risk for suicide
    b. How do you decide the appropriate level

3.What are some things that make it easier or more difficult to provide youth at risk for suicide with the appropriate level of observation?

4.Tell me about treatment planning for youth at risk of suicide in your detention center while they are detained.
    a. How often is an individualized, follow-up treatment plan developed for youth for their time in detention?

5. Can you tell me about any services or resources available for discharge planning and follow up care for youth at elevated risk for suicide?

6. What are some things that make it easier or more difficult to plan for discharge for youth at risk for suicide?

Component 3: Communication

7. How is suicide risk communicated across staff?
    a. Across different staff (e.g., medical to direct care)
    b. Across different shifts

8. What are some things that make it easier or more difficult to communicate youth suicide risk?

Component 6: Intervention (Emergency Response)

9. What is the protocol if a staff member discovers a youth engaging in self-harm behaviors?

Component 7: Reporting and Notification

10. In the event of a suicide or suicide attempt, how are all the appropriate officials and staff members?

Component 8: Mortality/Morbidity Review

11. Has anyone ever died by suicide in your detention center?

Suicide Prevention Components Codebook

#	Code	Definition	Keywords/Inclusion	Exclusion	Example text 1
1	Training	References to training provided to center staff that aims to better equip staff to effectively prevent suicide among the center's youth. Training could include initial trainings, refresher courses, mock drills, use of emergency medical equipment, first-aid training, and CPR among other components.	training, course, education, drill, class, PREA, trainer, CPR/first aid	any trainings unrelated to suicide prevention or PREA	Transcription 6: "Yeah, so, um, we have training on mental health first aid, which I believe is a training that began in Australia, but there's a big push now to make it mandatory everywhere, which I think is good. Um, with, with us it's taught by Wixi. Again, the same, uh, organization that helps residents of [COUNTY] navigate mental health. Um, so they train our staff on how to respond to a mental health crisis, uh, in a first aid style. Um, we have training from our county's behavioral health department in terms of suicide prevention... Like identifying, like looking at red flags, um, how to talk to kids that you think might be at risk, how to listen to them, um, physical signs to look for stuff like that."
2	Identification, referral, and evaluation	References to the initial intake screening process to assess for suicide risk among youth entering the center, referral procedures to a mental health clinician and/or medical staff for standard mental health evaluation as needed, ongoing screening and assessment of youth to evaluate suicide risk, and policies of constant observation of youth that staff believe are at risk for suicide until appropriate treatment services are put in place.	screening, assessment, identification, referral, evaluation, crisis response, crisis deescalation, intake, constant observation [not standard observation]	references to observation once it has been clinically indicated by a provider's assessment of a youth (this should be coded as Levels of observation, follow-up, treatment planning).	Transcription 11: "Um, from the time that they come in at the intake phase, um, we have a screening tool in which we're asking questions about suicidal behavior, any suicidal past incidents. Um, as well as self-injury attempts or gestures. Um, we also inquire about history of sexual abuse, a history of aggressive or violent behavior. We ask about mental health treatment or counseling and this is all coming in the door. Um, as soon as we take the handcuffs off, our juveniles counselors are instrumental in, um, following our kids' responses, our residents' responses. Um, and you know designating them appropriately."
3	Communication	References to the following three levels of communication in relation to their roles in suicide prevention: (1) between arresting/transporting officer, direct care staff, and youth's family; (2) between center staff; and (3) between center staff and youth.	communication, information, briefing, empathy, logbook, documentation, contact, intake	communication unrelated to suicide prevention and intake information transfer	Transcription 11: "...we want to make sure we treat all our children with dignity and respect. Uh, making sure we're establishing a rapport with our children to make sure they can feel comfortable with disclosing anything. Um, as far as, uh, there's their low self esteem or maybe victimization or right now we're seeing a sex trafficking, um, coming in or human trafficking coming in and to our centers. So, uh, you know, our role is basically to provide a safe environment and make the child feel safe, um, with disclosing any issues that, that might be negative in your life."

4	Housing	References to the center's policies that seek to create and maintain safe housing environments for youth who are at risk for suicide. These policies may include avoiding use of isolation as often as possible (instead, housing in general population, or if needed, in mental health unit or medical infirmary), avoiding removal of youth's clothing (excluding belts and shoelaces), avoiding use of physical restraint (only employed as last resort), and assigning of housing aims to maximize staff interactions with youth (in contrast with depersonalizing confinement).	isolation, general population, physical restraint, safety blanket, housing assignment, segregation, hazard, confinement	housing external to the facility (e.g., psychiatric placements or residential treatment centers)	Transcription 9: "If it's just a concern that we have but they haven't attempted anything but they've talked about it, there's certain items that they're allowed in the room and not allowed in the room, we would go to a safety blanket instead of a regular blanket so now we would provide them with a safety blanket and they're specially made to be able to keep the kids from using them in any way to harm themselves, uhm, they would be on five-minute room checks while they're awake in the room, and I should say, first of all, they're not isolated into their room or anything-they're still with the general program area."
5	Levels of observation, follow-up, treatment planning	References to the center's policies regarding levels of observation for youth at risk for suicide, treatment planning with follow-up services for youth on suicide precautions, and continuned mental health services until youth are discharged from the center.	close observation, constant observation, treatment plan, suicide precautions, follow-up services, specific clinical roles, staff to youth ratio, therapy, safety planning, safety contract	references to observation when it is used as an emergency measure until youth can be assessed by authorized personnel OR observation that may result from a youth's initial intake assessment and evaluation completed by a clinician (these should be coded as Identification, referral, and evaluation).	Transcription 4: "So we have two levels. Um, we have insensitive supervision, um, where their doors will be closed during shift change in sleeping hours, but we'll do seven minute checks. Normally the kids on, um, they're not on any type of watch. We do 15 minute checks when they're in their rooms, anytime they're in the rooms, but at an increased super intensive supervision will to seven minute checks and we'll document them. Um, they will be given suicide blankets. They will not have any sheets or pillow cases. Um, and staff will situate themselves outside of that kid's door, not like right on their door, but so they can hear what's going on in between their seven minute checks. Um, if we have to enhance that, we have an enhanced intensive supervision, um, and sometimes we get crisis involved. Um, and those, um, the residents door can be closed. But again, staff are going to situate themselves outside the kid's door and they're going to do three minute checks."
6	Intervention (emergency response)	References to a center's emergency policies and practices related to suicide prevention. Examples could include the utilization of crisis services or any immediate actions staff are directed to take after a youth's suicide attempt (e.g., beginning first aid and CPR if needed).	first-aid, CPR, emergency response, medical personnel, crisis services, 302, hospitalization, bed	mentions of crisis services outside of intervention contexts (e.g., "We contract with local crisis service"); mentions of first aid/CPR outside of intervention contexts (e.g., "We have a first aid kit in every unit")	Transcription 11: "I told you we call or utilize crisis services for that 302 mental health assessment when we have a plan or a physical act. What I didn't tell you is we also call if the child requests. The child might say, hey I want a crisis services assessment. And sometimes it's a manipulation. In my history here, I've seen kids want to do that because they think they can go to the mental health hospital and they'll be able to abscond. Uhm, you know, it's kind of like a manipulation technique. But when they ask for it we don't even assume that they're manipulating- we just call. We let them make the assessment once they get here if the child needs that type of service or not."

7	Reporting and notification	References to documentation of youth suicide attempts and suicides in the center. Policies related to such documentation could include alerting all appropriate officials through the chain of command, immediately notifying the youth's family and the appropriate external authorities, and requiring all staff who came into contact with the youth prior to the attempt or suicide to submit a statement about the youth and incident.	notification, statement, report, reportable incident, critical incident reporting, mandated reporting, documentation, documentation	other reporting not related to critical incidents (e.g., financial reporting)	Transcription 3: "Um, so, you know, yeah, they usually, it's usually, and we're not required to report, um, a reportable for suicidal, um, thoughts or gestures. It's only for attempts. Um, yeah. So, yeah, I can't remember the last time we had. Now we do have, you know, we have them for, um, placing a kid in a psych hospital because what frequently will happen is, as I said, if we feel a kid is at that high level of risk, we will get crisis services involved. We will get them, um, into a psych placement and then that will result in a reportable incident, um, relating to suicidal ideation. Um, and as opposed to an attempt, and I would say maybe that's one or two times a year that we would have a reportable for a psychiatric placement."
8	Mortality-morbidity review	References to a center's policies for responding to a "serious suicide attempt" or suicide. These policies could include a mortality-morbidity review and active crisis management, including identifying center youth and staff in significant distress due to the traumatic event and providing them with individualized support and treatment.	mortality-morbidity review, crisis management, critical incident, post-traumatic stress	NA	Transcription 11: "And we train our staff on self care, making sure you take care of yourself. We do have a debriefing, a procedure if they witness a suicide or if we had a child that died out in the community and we cared for that child. And once upon a time we make our, our counselors get debriefed. They have to go to a counseling session. Um, just to give them an opportunity to process what has occurred. A lot of people expect people to be robots in this, in this, um, build. And, you know, we're working with children. It's not hamburgers, it's not Walmart. So it's kinda more important than that. And we just try to keep that up."

Suicide Prevention Quality Indicator Codebook

#	Component	Quality Indicators	Exemplar Quote *SITE #*
1	Training	Completed by all staff with regular contact with youth	
		Initial 8-hour suicide prevention training	
		Content for initial training: administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, why the environments of juvenile facilities are conducive to suicidal behavior, potential predisposing risk and protective factors related to suicide, high-risk suicide period, juvenile suicide research, warning signs of suicide, identification of suicidal youth despite the denial of risk, components of the facility's suicide prevention policy, liability issues associated with juvenile suicide	
		Annual 2-hour refresher training	
		Content for refresher training: administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, review of predisposing risk and protective factors related to suicide, warning signs of suicide, identification of suicidal youth despite the denial of risk, review of any changes to the facility's suicide prevention policy, general discussion of any recent suicides and/or suicide attempts in the facility	
		Mock drills included in both initial and refresher trainings	

		First-aid, CPR, and emergency equipment (located in each housing unit) training	
2	Identification, referral, and evaluation	Intake screening of all youth	
		Intake screening determines the following: Was the youth a medical, mental health, or suicide risk during any prior contact and/or confinement within this facility? Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the youth is a medical, mental health, or suicide risk now? Has the youth ever considered suicide? Has the youth ever attempted suicide? Is the youth now being treated (or ever been treated) for mental health or emotional problems, such as depression or anxiety? Has the youth recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)? Has a family member/close friend of the youth ever attempted, or died by, suicide? Does the youth feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)? Is the youth thinking of hurting and/or killing him/herself?	
		Youth's verbal responses during intake process are used in conjunction with youth's behavior and previous confinement history to assess for suicidality	
		Screening process must include referral procedures to qualified mental health and/or medical personnel for a more thorough and complete assessment when appropriate	

		If staff hear a youth verbalize a desire or intent to kill his/herself, observe a youth engaging in any self-harm, or otherwise believe a youth is at risk for suicide, a procedure is in place that requires staff to take immediate action to ensure that the youth is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained	
		Any youth assigned to room confinement or any form of isolation/segregation receives a written assessment for suicide risk by medical or mental health staff upon admission to the placement	
3	Communication	Layer 1: between the arresting/transporting officer and direct care staff	
		Layer 1: between the family members of youth and direct care staff	
		Layer 2: between and among facility staff - shift supervisors inform direct care staff of status of youth placed on suicide precautions	
		Layer 2: between and among facility staff - multidisciplinary team meetings to discuss status of youth on suicide precautions	
		Layer 2: between and among facility staff - authorization for, changes in, and observation related to those on suicide precautions documented on designated forms and distributed to appropriate staff	
		Layer 3: between facility staff and youth (e.g., active sympathetic listening, staying with youth if suspect immediate danger)	

4	Housing	Housing assignments based on ability to maximize staff interaction with the youth and not on decisions that heighten depersonalizing aspects of confinement	
		To every extent possible, suicidal youth should be housed in the general population, mental health unit, or medical infirmary and located close to staff	
		Removal of a youth's clothing (excluding belts and shoelaces) and the use of physical restraints avoided whenever possible and only used as a last resort when youth physically engaging in self-destructive behavior	
		Rooms designated to house suicidal youth should be as suicide-resistant as is reasonably possibly, free of all obvious protrusions, and provide full visibility	
		Each housing unit should contain various emergency equipment (first-aid kit, pocket mask or face shield, Ambu-bag, and rescue tool)	
		Emergency equipment in each housing unit checked by staff daily	
5	Levels of observation, follow-up, treatment planning	Close observation (1 of 2 levels of supervision) - reserved for youth who aren't actively suicidal but who express suicidal ideation, have a recent history of self-destructive behavior, or demonstrate other concerning behaviors (through actions, current circumstances, or recent history)	
		Close observation (1 of 2 levels of supervision) - youth observed in a protrusion-free room at staggered intervals not to exceed every 10 minutes	
		Constant observation (2 of 2 levels of supervision) - reserved for youth who are actively suicidal	
		Constant observation (2 of 2 levels of supervision) - staff observe youth on a continuous, uninterrupted basis	

		Suicidal youth assessed by mental health staff on a daily basis	
		Individualized treatment plan (with follow-up services) developed for each youth on suicide precautions	
		All youth discharged from suicide precautions remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody	
6	Intervention (emergency response)	If a staff member discovers a youth engaging in a suicide attempt, they "immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary"	
		Direct care staff "never presume that the victim is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel"	
		Function of all emergency equipment in the facility checked on a daily basis	
7	Reporting and notification	Post incident, "all appropriate officials should be notified through the chain of command"	
		Victim's family immediately notified	
		External authorities immediately notified	
		All staff who came into contact with victim before incident required to submit statement including their full knowledge of victim and incident	

8	Mortality-morbidity review	Active crisis management including identifying staff and youth in significant distriss (due to traumatic event) and providing them with individualized support/treatment	
		Multidisciplinary mortality-morbidity review process coordinated by external agency	
		Review should include inquiry of the circumstances surrounding the incident, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services/reports involving the victim, possible precipitating factors leading to the suicide or serious suicide attempt, recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures	

Note. To save space, we only included space for one Exemplar Quote. However, when using this codebook, we identified three.

Comparison of Suicide Prevention Implementation, Leadership Perceptions of Role in Suicide Prevention, Crisis Stabilization Calls, and Critical Incidents between the Highest and Lowest Suicide Prevention Implementation Quality Facilities

	HIGH-PERFORMING SITE		LOW-PERFORMING SITE		
FACILITY CHARACTERISTICS	**# crisis calls**	**6-12 per year**	**# crisis calls**	**55 per year**	
	# of critical incidents	**5 per year**	**# of critical incidents**	**27 per year**	
	Size Classification	**Large facility (~35 beds)**	**Classification**	**Small facility (~15 beds)**	
SUICIDE COMPONENT DOMAIN	**SUICIDE PREVENTION QUALITY RATING (PER COMPONENT)**	**SUMMARY**	**SUICIDE PREVENTION QUALITY RATING (PER COMPONENT)**	**SUMMARY**	**INTERPRETATION**
IDENTIFICATION	**83.3%**	Utilized 5 screening tools and multiple "layers" of screening, including contact with youth's probation officer and family.	**33.3%**	Utilized a single screening tool; no contact with probation officer or family.	High-performing facility used more screening tools and had multiple "layers" of screening.
HOUSING	**33.3%**	Rigorously adhered to state-mandated guidance on safety regulations. Had procedures for removing items that could be used for self-harm or suicide.	**0%**	No comments regarding protocols or procedures for ensuring a safe housing environment.	High-performing facility had rigorous adherence to safety regulations, including procedures for fostering a safe housing environment.

OBSERVATION	**42.9%**	Low-level observation includes continuous observation. High-level observation includes 5-minute checks and observation logs, as well as constant 1:1 supervision.	**14.3%**	Low-level observation includes continuous observation. High-level observation includes 5-minute checks, though high-risk youth may be left unattended during interim.	High-performing facility provided 1:1 observation for high-risk youth and did not permit high-risk youth to be left unattended.
INTERVENTION	**33.3%**	Immediate referral to crisis services and potential psychiatric placement. Also had explicit protocols around psychiatric and medical intervention in the event of a crisis incident.	**0%**	Although this facility had limited procedures for intervention during crisis incidents, they did explicitly state procedures for (1) immediately alerting relevant staff, (2) performing CPR/first aid, (3) or regularly confirming the functionality of first aid equipment on-site.	While both facilities had the ability to make referrals to crisis services and psychiatric placements, the high-performing facility had clearer and more adherent procedures for intervening during crisis incidents.
COMMUNI-CATION	**100%**	Established avenues of communication to youth's probation officer and family; clear communication across staff; warm and empathetic communication with youth.	**66.7%**	No mention of communication with probation officer or family; minimal communication across staff; warm and empathetic communication with youth.	High-performing facility appeared to place greater emphasis on comprehensive pathways for communication, including with youths' probation officers and families.
MORTALITY-MORBIDITY REVIEW	**0%**	Not discussed.	**0%**	Not discussed.	No difference between the facilities.

REPORTING	**25%**	High-performing facility had procedure for reporting incidents to higher-ups and medical staff.	**25%**	Little to no information provided about process for reporting incidents.	High-performing facility had streamlined and collaborative process for reporting incidents.
TRAINING	**85.7%**	Required all staff to have B.A./B.S. at minimum; required at least 40 hours of comprehensive annual training on mental health and suicide prevention.	**0%**	No requirements regarding staff education; unclear how frequently or intensive mental health and suicide prevention trainings are.	High-performing facility had requirements in place for staff credentialing and extensive annual training.