

Suicide Prevention and Response

	DIVISION OF CHILD AND FAMILY SERVICES Juvenile Justice Services STATEWIDE POLICY
SUBJECT:	Suicide Prevention and Response
POLICY NUMBER:	DCFS/JJS 400.01
EFFECTIVE DATE:	October 1, 2021
APPROVED BY:	Kathryn Roose, Deputy Administrator – Division of Child and Family Services
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APPROVED BY:	Ross Armstrong, Administrator – Division of Child and Family Services
DATE:	July 9, 2021
REFERENCES:	NRS 62B.625; National Youth Screening & Assessment Partners (nysap.us/maysi2/index.html); The Columbia Lighthouse Project (cssrs.columbia.edu/); Quality Assurance (DCFS/JJS 100.11); Documentation Standards (DCFS/JJS 100.13); Performance-based Standards (DCFS/JJS 100.14); Use of Force (DCFS/JJS 300.02); Incident Reporting (DCFS/JJS 300.07); Searches of Youth (DCFS/JJS 300.14); Mental Health Treatment Plan (DCFS/JJS 400.06); Screening and Evaluation (DCFS/JJS 500.18)
ATTACHMENTS:	Attachment A: Columbia Protocol Triage Screen Attachment B: C-SSRS Risk Assessment Attachment C: C-SSRS Risk Checklist Attachment D: Safety Plan Attachment E: Suicide Observation Log

I. SUMMARY

The Division of Child and Family Services (DCFS) Juvenile Justice Services considers the health and safety of the youth in its custody top priorities. DCFS staff shall screen youth for suicidal ideation and behavior, prevent suicidal behaviors, and provide for the proper care and observation of youth expressing suicidal ideation or engaging in behaviors related to suicidality.

II. PURPOSE

To establish clear guidelines and procedures to assist staff in the identification, assessment, treatment, and ongoing protection of youth who may be suicidal or at risk for suicide.

III. DEFINITIONS

As used in this document, the following definitions shall apply:

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- A. Acute: A clinical judgement determined after evaluation based upon the presentation of significant symptoms, behavior, and mental status. Youth needing immediate treatment or stabilization due to severity of symptoms and the inability to keep themselves safe.
- B. Clinical Supervisor: A DCFS staff who directly supervises Mental Health Counselors and makes clinical decisions.
- C. Columbia Protocol: Also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain-language questions which anyone can ask. Mental health training is not required.
 - 1. Columbia Protocol Triage Screen used as a rapid screening tool
 - 2. C-SSRS Risk Assessment used as a suicide risk assessment
 - 3. C-SSRS Risk Checklist used as a quick review or reassessment
- D. Critical Incident Report (CIR): The document to report an event involving abuse, death/suicide, lost/missing person, runaway/elopement, serious injury, threat or hostage situation, public health emergency, health facility emergency, or fire/natural disaster.
- E. Determination of Risk: A process used to identify youth with mental illness, substance use, or those at risk of suicide, self-harming behaviors, or reckless behaviors, using one or more screening tools.
- F. Levels of Observation:
 - 1. **General Observation** – Direct observation at irregular intervals at least every 15 minutes. This level of observation shall be used with youth assessed at low risk or no risk for suicide.
 - 2. **Close Observation** – Observation at irregular intervals no longer than 5 minutes apart. This level of observation shall be used with youth not actively suicidal but who may be expressing suicidal ideation, such as a wish to die. This level may also be used for youth who may directly deny suicidal ideation but display other concerning behavior. This is associated with moderate risk of suicide.
 - 3. **Constant Observation** – Constant, continuous, and uninterrupted observation of a youth, at a staff-to-youth ratio of 1:1. This is associated with high or acute risk of suicide.
- G. Massachusetts Youth Screening Instrument, Second Version (MAYSI-2): A behavioral health screening tool to assess immediate needs of youth in a secure setting. The MAYSI-2 is a standardized reliable, 52-question true or false method for screening youths aged 12 to 17 entering the juvenile justice system, to identify potential behavioral health problems in need of immediate attention. The MAYSI-2 is a validated mental health screening tool approved for statewide use by the Juvenile Justice Oversight Commission (JJOC) pursuant to NRS 62B.625.
- H. Medical Staff: All full-time, part-time, and contracted staff authorized to provide medical services within a state facility.
- I. Mental Health Counselor (MHC): A DCFS staff authorized to deliver mental health services. Also referred to collectively as mental health staff.
- J. myAvatar: The collection of interdisciplinary data relating to a child's/youth's treatment and the Health Insurance Portability and Accountability Act (HIPAA) electronic billing information management system which supports the mental health services provided by DCFS programs.

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- K. Serious Suicide Attempt: A suicide attempt which would have been lethal had it not been for the provision of rapid and effective emergency treatment.
- L. Tyler Supervision: The web-based case management software system utilized by DCFS.

IV. STAFF TRAINING

- A. All staff, including direct care, medical, mental health, supervisory, and administrative staff shall be trained in suicide awareness, suicide prevention, and the management of youth at risk for suicidal behaviors.
- B. Initial training for new staff shall be conducted within 90 days of hire and shall consist of a classroom-based training consisting of the following:
 - 1. Correctional facilities and suicidal behavior general overview
 - 2. Staff attitudes and beliefs related to suicide
 - 3. Risk factors and red flags
 - 4. Screening tools utilized by the facility
 - 5. Policy review
 - 6. Liability associated with juvenile suicide
 - 7. Incident reporting process
 - 8. Referral process for the facility medical or mental health staff
 - 9. Levels of observation based on risk
 - 10. Identification of emergency tools for use in an active suicide attempt, such as a cutting device in the instance of a hanging attempt
- C. Medical and mental health staff shall receive additional training to include:
 - 1. Evidence-based treatment approaches for working with suicidal and self-injurious adolescents.
 - 2. Treatment planning for youth assessed at moderate and high risk of suicide, to include how often contact with clinical staff and youth shall be made.
 - 3. Process for clinical evaluation and recommendations prior to the removal of any privileges (e.g., clothing, hygiene, school, or recreational activities) for disciplinary purposes.
 - 4. Process for comprehensive mental health evaluations or appointments with a contracted psychiatrist.
 - 5. Process for referral and transfer for those youth assessed as acute.
- D. All direct care staff and any additional staff designated by the facility Superintendent shall complete an annual refresher training on suicide prevention.
 - 1. Refresher training shall include a review of:
 - a. Any policy changes which have occurred in the past year
 - b. Screening tools
 - c. Levels of observation and facility operations
 - d. Suicide attempts or completions which have occurred in the past year within the facility

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2. Initial and refresher curriculum shall be approved by the Director of Nursing or a Clinical Supervisor and be presented by a mental health clinician, the facility Training Officer, or other designee.
 3. The Superintendent may approve additional training venues, such as web-based training.
- E. Staff responsible for administering the Columbia Protocol shall receive training prior to administering the tool.
1. Training is located at <https://cssrs.columbia.edu/training/training-options/>.
 2. The online training module is the minimum requirement; additional trainings may be required by the Juvenile Justice Programs Office or a Clinical Supervisor.
 3. The facility Training Officer shall document completed training for any staff responsible for administering the C-SSRS.
- F. All training, including initial and refresher training, shall be documented in staff training files.
1. The facility Superintendent or designee shall periodically review training files to ensure trainings are up to date for all staff.

V. DETERMINATION OF RISK/REFERRAL

- A. The admission of new youth to a facility shall be coordinated with the sending jurisdiction.
1. The facility intake staff shall receive the youth from the transportation staff and ask transportation staff about any concerning behavior during the transport, including indications the youth may want to harm themselves.
- B. The facility intake staff shall verbally notify mental health and medical intake staff of any concerning behavior.
- C. The facility intake staff, Mental Health Counselor (MHC), and a nurse shall be assigned to assist the youth through the intake and screening processes.
- D. The assigned MHC or trained facility staff shall administer the Columbia Protocol Triage Screen (Attachment A) on all newly admitted youth within one hour of the youth's arrival.
1. A Clinical Supervisor shall be notified within 24 hours when a new intake has been screened as high risk and shall review and sign off on the Columbia Protocol Triage Screen (Attachment A) on newly admitted youth assessed as high risk within one business day.
 2. Youth who score moderate or high on the Columbia Protocol Triage Screen shall be provided the C-SSRS Risk Assessment (Attachment B).
 3. The C-SSRS Risk Checklist (Attachment C) may be completed any time as a review or reassessment and may be used daily while a youth is on constant observation.
- E. The MHC or trained facility staff shall complete the MAYSI-2 on all newly admitted youth within one hour of a youth's arrival.

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1. The MAYSI-2 addresses six areas including suicide ideation and is part of the mental health evaluation required by Performance-based Standards (DCFS/JJS 100.14). Refer to Mental Health Screening and Evaluation (DCFS/JJS 500.18).
 2. When a youth scores a *Caution* or *Warning* on the *Suicide Ideation* scale of the MAYSI-2, the MAYSI-2 Second Screening – Suicide Ideation may be completed immediately, based on clinical judgement, in Tyler Supervision.
- F. The determination of risk shall be identified as low, moderate, high, or acute by an MHC or Clinical Supervisor based on the results of the Columbia Protocol and the MAYSI-2.
1. If an MHC determines a youth's suicide risk is high or acute, the MHC shall immediately notify the following:
 - a. Clinical Supervisor
 - b. Shift Supervisor
 - c. Head Group Supervisor
 - d. Assistant Superintendent
 - e. Superintendent
 - f. Youth's parent or guardian
 - g. Assigned Youth Parole Counselor
- G. Only an MHC or a Clinical Supervisor may adjust a youth's determination of risk.
1. The MHC or Clinical Supervisor shall consult other staff members, including direct care and medical staff when there is a reduction in a youth's observation level.

VI. ACUTE RISK

- A. Youth assessed as acute risk may require immediate referral to medical or acute hospitalization services.
1. The MHC shall act as the lead and assist in such referrals, working in conjunction with administration, mental health, medical, and Youth Parole.
 2. Determination of acute hospitalization shall include, but is not limited to, consideration of:
 - a. Youth presenting a clear danger to self and others or has a clear suicide plan
 - b. The degree of lethality and intentionality used by the youth
 - c. Presence of severe psychosocial dysfunction which precludes maintaining the youth in a lower level of care
 3. In cases where a youth is referred to acute hospitalization, the Superintendent shall be responsible for notification to the Deputy Administrator of Residential Services, youth's parent or guardian, Chief of Parole, and the assigned Youth Parole Counselor.
- B. Youth assessed as acute shall be kept in an area identified in the facility Standard Operating Procedures on constant observation until such time as they are transferred to acute hospitalization.
- C. Youth may be returned to the facility after they are stabilized and shall be given a Safety Plan

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(Attachment D) and Mental Health Treatment Plan. Refer to Mental Health Treatment Plan (DCFS/JJS 400.06).

VII. HIGH RISK

- A. Youth assessed as high risk shall have a Safety Plan (Attachment D) developed by an MHC and the youth within 24 hours.
- B. Youth assessed at high risk shall be placed on constant supervision.
- C. Youth assessed as high suicide risk shall be seen daily by a MHC (or designee on MHC scheduled days off or after hours). The MHC or designee shall:
 - 1. Assess youth daily regarding current thoughts, feelings, and behaviors
 - 2. Review Safety Plan (Attachment D) with youth daily
 - 3. Complete a C-SSRS Risk Checklist (Attachment C) with youth daily
 - 4. Document clinical observations and youth's current status in myAvatar
 - 5. Notify the Clinical Supervisor, medical staff, and Superintendent of the youth's status
- D. Youth assessed as high suicide risk shall be seen daily by medical staff (or designee on medical staff scheduled days off or after hours) to assess any changes in medical condition.
- E. Youth assessed as high risk shall be referred to the facility's contracted Psychiatrist.

VIII. MODERATE RISK

- 1. Youth assessed as moderate risk shall have a Safety Plan (Attachment D) developed by an MHC and the youth within 24 hours.
- 2. Youth assessed as moderate risk shall be placed on close observation.

IX. LOW RISK

- 1. No additional action is required for youth assessed as low risk.

X. SAFETY PLANNING

- A. Any youth assessed as moderate or high risk shall participate in the development of a Safety Plan (Attachment D) with an MHC within 24 hours of risk determination.
 - 1. The purpose of the Safety Plan is to identify triggers, coping strategies, external supports, and reasons for living.
- B. MHCs shall review or revise the Safety Plan for youth assessed as high risk at every therapy session, and less often (based on clinical judgement) for those assessed as moderate risk.
- C. Safety Plans may be updated following any updated assessment or clinical judgement.
- D. All facility staff responsible for caring for youth with a Safety Plan must review the youth's Safety Plan prior to each shift for any updates.

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1. Any staff member identified as an external support must be made aware of their role in the Safety Plan by the MHC.

E. Any ongoing Safety Plans shall be transferred to the next level of care at youth's discharge.

XI. LEVELS OF OBSERVATION (DIRECT CARE STAFF)

A. Youth shall be on varying levels of observation based on suicide risk.

B. All direct care staff shall be confidentially informed of the level of observation of every youth they are responsible for at the beginning of every shift.

C. **General Observation:** All youth at low or no risk are placed on general observation. Youth shall be directly observed through general rounds at irregular intervals of no longer than 15 minutes.

D. **Close Observation:** All youth at moderate risk are placed on close observation. Youth on close observation shall be observed by staff at staggered intervals not to exceed five minutes. In addition, medical, mental health, and supervisory staff shall make periodic visits to the youth.

1. Youth on close observation shall be placed in rooms as suicide resistant as possible, and as close to staff as possible.

- a. The Head Group Supervisor (or designee on the Head Group Supervisor's scheduled days off) shall make daily visits to check in with the youth.

- b. The Shift Supervisor or designee shall conduct a thorough room search once during each shift and remove anything from the room which may be a potential hazard to the youth. Refer to Searches of Youth (DCFS/JJS 300.14).

- i. Particular attention should be paid to making sure rooms are as suicide resistant as practicable and free of ligature points which could be used to support strangulation devices, including clothing.

2. A Suicide Observation Log (Attachment E) shall be completed for any youth placed on close observation.

- a. Documented observations shall be recorded on the log at staggered intervals not to exceed five minutes.

3. An MHC or trained designee shall complete a C-SSRS Checklist (Attachment C) within two hours of a youth being placed on close observation.

4. Youth on close observation due to suicidal ideation shall be seen by an MHC per their Mental Health Treatment Plan. Refer to Mental Health Treatment Plan (DCFS/JJS 400.06).

- a. The rate at which this is to occur shall be determined after consultation with the Clinical Supervisor, a MHC, or the facility's contract Psychiatrist.

5. Tyler Supervision shall be updated in real time for any youth placed on close observation levels due to suicidal ideation:

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- a. An incident shall be created with appropriate Suicidal Behavior incident characteristics, Suicide Ideation Attempt and/or Threat to Self.
 - b. A Suicide Observation Confinement shall be started on the youth's current booking screen and ended when the observation level returns to normal.
- E. **Constant Observation:** Constant observation shall be used for youth assessed as acute and high risk. Youth on constant observation shall be observed by staff on a continuous and uninterrupted basis at a staffing ratio of 1:1. Staff shall always maintain an unobstructed view of youth under observation. In addition, the following shall occur:
1. Youth on constant observation shall be placed in rooms as suicide resistant as practicable, and as close to staff as possible.
 - a. The Head Group Supervisor (or designee on the Head Group Supervisor's scheduled days off) shall make daily visits to check in with the youth.
 - b. The Shift Supervisor or designee shall conduct a thorough room search once during each shift and remove anything from the room which may be a potential hazard to the youth. Refer to Searches of Youth (DCFS/JJS 300.14).
 - i. Particular attention should be paid to making sure rooms are as suicide resistant as practicable and free of ligature points which could be used to support strangulation devices, including clothing.
 6. A Suicide Observation Log (Attachment E) shall be completed for any youth placed on constant observation.
 - a. Documented observations shall be recorded on the log at intervals not to exceed ten minutes.
 7. An MHC or trained designee shall complete a C-SSRS Checklist (Attachment C) within two hours of a youth being placed on constant observation.
 8. Youth on constant observation shall be seen by an MHC per their Mental Health Treatment Plan. Refer to Mental Health Treatment Plan (DCFS/JJS 400.06).
 - a. The rate at which this is to occur shall be determined after consultation with the Clinical Supervisor, a MHC, or the facility's contract Psychiatrist.
 9. Constant observation shall be documented in youth's Tyler Supervision record.
 - a. Booking Screen > Confinement > Suicide Observation
 - b. The Head Group Supervisor is responsible for ensuring documentation is completed.
 10. The C-SSRS Risk Checklist (Attachment C) may be used daily while a youth is on constant observation.
 11. Tyler Supervision shall be updated in real time for any youth placed on close or constant observation levels due to suicidal ideation.

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- a. An incident shall be created with appropriate Suicidal Behavior incident characteristics, Suicide Ideation Attempt and/or Threat to Self.
- b. A Suicide Observation Confinement shall be started on the youth's current booking screen and ended when the observation level returns to normal.

XII. BEHAVIOR INDICATORS

- A. Direct care staff may notice or identify alarming behaviors such as threats to self or others.
- B. Any staff member may place a youth on close or constant observation due to suicidal ideation after having observed behavior or receiving information to warrant such intervention.
 1. In such instances, facility mental health staff shall be notified immediately.

XIII. ADDITIONAL PRECAUTIONS

- A. For youth on close or constant observation, removal of the youth's clothing, except for shoelaces and belts, should be avoided when possible.
 1. If the youth's clothing must be removed, smocks or scrubs shall be issued when it has been determined the youth would otherwise not be safe in regular clothing.
 - a. In this instance, the Superintendent, Assistant Superintendent, Head Group Supervisor, medical staff, and Clinical Supervisor shall be notified.
- B. Restraints shall only be used for youth on constant observation who cannot be kept safe and all other interventions have failed.
 1. In this instance, a referral shall be made to Desert Willow Treatment Center or a similar facility.
 2. The length of time in restraints shall be documented. Refer to Use of Force (DCFS/JJS 300.02).
- C. When a youth is on close or constant observation, the youth shall remain in regular programming whenever possible based on the degree of crisis and at the discretion of the MHC.
- D. Living units shall contain emergency equipment including a rescue tool, first aid kit, face mask, or an Ambu-bag (manual resuscitator).
- E. Every living unit shall have posted emergency medical contact numbers.
- F. A designated facility staff member shall be responsible for checking the living units weekly to ensure all emergency equipment is present and in working order.
 1. Facilities shall maintain a log recording completed checks, including the date, time, and staff who conducted the check.

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XIV. INTERVENTION

- A. Any staff who becomes aware or discovers a youth attempting suicide shall intervene immediately to the extent which is safe to do so and make radio notification immediately.
 - 1. Staff who are alone may wait for backup prior to engagement if there is an additional threat to the staff's safety.
 - 2. In addition, staff shall:
 - a. Always assume the attempt is real
 - b. Quickly survey the scene to ensure the safety of the youth and staff
 - c. Notify other staff, including medical staff
 - 3. In all instances, life-saving procedures (CPR, first aid) shall be initiated immediately and be maintained until medical staff or emergency personnel arrive on scene.
- B. Restraint equipment is prohibited unless the youth continues self-harming behavior despite de-escalation attempts or presents a clear threat to the safety of others.
- C. Staff shall remain with the youth while waiting for additional staff support to arrive and attempt to calm the youth and engage the youth in conversation.
- D. The Shift Supervisor or designee shall coordinate the unimpeded entrance to the facility for external medical personnel.

XV. REPORTING REQUIREMENTS FOR SUICIDE OR SUICIDE ATTEMPT

- A. When a completed suicide or a serious attempt requiring medical treatment or hospitalization occurs, the Superintendent shall be responsible for making all proper notifications as quickly as possible after the event, and ensuring contact is made to:
 - 1. Deputy Administrator of Residential Services
 - 2. Youth's parent or guardian
 - 3. Youth's assigned Youth Parole Counselor, a Parole Unit Manager, and the Chief of the Youth Parole Bureau
 - 4. Youth's social worker or case worker
 - a. Each contact shall be documented in Tyler Supervision as an Activity > Facility Call – Outgoing in youth's record. Refer to Documentation Standards (DCFS/JJS 100.13).
- B. When a suicide or attempt occurs, all staff who encountered the youth during the incident shall complete a report for the incident in Tyler Supervision before the end of their shift.
 - 1. The Shift Supervisor or designee is responsible for creating the incident in Tyler Supervision and tagging all appropriate staff required to complete a report.
- C. A Critical Incident Report (CIR) shall be completed for all completed suicides and serious attempts and sent to the Administrator within four hours of the incident. Refer to Incident Reporting (DCFS/JJS 300.07).

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XVI. FOLLOW UP ACTIONS FOR SUICIDE ATTEMPT OR SUICIDE

- A. Following a suicide attempt, mental health staff shall follow up with the youth within 24 hours and complete a C-SSRS Risk Checklist (Attachment C) and develop or revise the youth's Safety Plan (Attachment D) as necessary.
 - 1. Outside referrals may be made if appropriate.
- B. The Deputy Administrator of Residential Services may require a Root Cause Analysis of any completed suicide or serious attempt.
 - 1. This shall be coordinated by the Deputy Administrator of Quality and Oversight and be completed no later than 30 days after the incident. Refer to Quality Assurance (DCFS/JJS 100.11).
- C. Morbidity/Mortality Reviews shall occur for every serious suicide attempt or completed suicide and shall be comprised of a multi-disciplinary team which includes medical, mental health, education, direct care staff, and administration.
 - 1. The Deputy Administrator of Residential Services shall be responsible for coordinating this effort in conjunction with the facility Superintendent.
 - 2. The Morbidity/Mortality Review shall:
 - a. Review all circumstances surrounding the incident
 - b. Review the facility standard operating procedures
 - c. Review staff training for all staff involved in the incident
 - d. Review the record of the youth, including but not limited to, the youth's prior record; medical history and record; medication history, and current regimen (this would include Physician and Psychiatrist's notes, Medication Administration Record, suicide screenings, mental health assessments, Safety Plans, living unit logs, case notes, inspection records)
 - e. Review and discuss precipitating and contributory factors
 - f. Make recommendations for policy and procedure changes
 - g. Make recommendations for changes in staff training
 - h. Make recommendations for enhancements in the physical plant
 - i. Make recommendations for enhancements in mental health or medical services
 - j. Require a corrective action plan addressing any deficit found in the review, when appropriate
 - k. Refer and collaborate with the DCFS Child Fatality Specialist as needed to:
 - i. Discuss the circumstances of the case
 - ii. Obtain recommendations from the regional Child Death Review Team

XVII. DOCUMENTATION

- A. All completed risk tools (Attachments A, B, C, and D) shall be uploaded to Tyler Supervision. Refer to Documentation Standards (DCFS/JJS 100.13).
 - 1. Attachments A and B shall be combined to make one document and uploaded for the corresponding Assessment.

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- a. New Assessment > Suicide Risk Assessment (date of Assessment)
2. Attachment C shall be uploaded for the corresponding Assessment.
 - a. New Assessment > Suicide Re-Assessment (date of Assessment)
3. Attachment D shall be uploaded for the corresponding Clinical Activity.
 - a. New Clinical Activity > Completed > Safety Plan (date of Assessment)
- B. Suicide Observation Logs (Attachment E) shall be available to staff on housing units.
 1. Completed Suicide Observation Logs:
 - a. Shall be uploaded as a document for the corresponding Confinement in youth's current Booking Documents.
 - b. Shall be electronically scanned and stored by year and month on facility's shared drive.

XVIII. PAROLE

- A. Prior to release, facility mental health or case management staff shall include a youth's suicide risk on their Case Plan and Discharge Summary.
 1. The Youth Parole Counselor shall utilize the Case Plan and Discharge Summary to refer the youth to appropriate community services based on acuity.
- B. The Youth Parole Counselor shall refer to a Parole MHC for determination of next steps if a youth admits or reports they are suicidal while in the Youth Parole Bureau office.
 1. A Parole MHC shall administer the Columbia Protocol Triage Screen (Attachment A) and may create a Safety Plan with the youth (Attachment D).
- C. While on community supervision, the Youth Parole Counselor shall refer the family and/or youth to community services in the event of a suicide attempt by the youth.

XIX. STANDARD OPERATING PROCEDURES

- A. Each facility shall develop Standard Operating Procedures consistent with this policy to include, but not limited to:
 1. Referral procedures from staff to mental health counselor and mental health counselor to contract psychiatrist.
 2. Training for facility staff, including specialized training for medical and mental health staff.
 3. Process for mental health staff to adjust determination of risk.
 4. Process for informing direct care staff of youth observation levels prior to each shift.

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5. Process to refer and transfer youth assessed as acute.
 - a. Process to house youth assessed as acute on constant observation until they are transferred to acute hospitalization.
 6. Process for reassessing youth.
 7. Process and designated facility staff responsible for checking the facility and living units weekly to ensure all emergency equipment is present and in working order.
 8. Process and designated facility staff responsible for adding incident and confinement status for a youth placed on close or constant observation levels due to suicidal ideation in Tyler Supervision.
 9. Roles and responsibilities for staff to complete tasks as outlined in this policy, including weekend and evening designees.
 10. Process for storing Suicide Observation Logs by year and month on facility's shared drive.
- B. The Youth Parole Bureau shall develop Standard Operating Procedures consistent with this policy to include, but not limited to:
1. How Youth Parole Counselors will determine the necessity for an in-person or virtual visit to a youth in a state facility following determination of suicide risk.
 2. How Youth Parole Counselors will determine the need for an in-person or virtual visit to a youth in a state facility following a suicide attempt.
 3. How Youth Parole Counselors will take suicide risk and attempts into consideration when planning for re-entry.
 4. The process for referring youth to a Parole Mental Health Counselor in the event they divulge suicidal talk, feelings, or ideation while on community supervision.
 5. The process for referring youth and families to community resources following a suicide attempt while on community supervision.