

	State of Indiana Indiana Department of Correction Division of Youth Services	Effective Date 4/1/2022	Page 1 of 14	Number 4.06Y
HEALTH CARE SERVICES DIRECTIVE-YOUTH SERVICES Manual of Policies and Procedures				

Title SUICIDE AND SELF-INJURY PREVENTION
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Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidance regarding the identification and management of youth who are at risk for suicide or self-injurious behavior.

II. DEFINITIONS:

- A. FACILITY STAFF: Any individual assigned or permitted by the Warden to perform a job, including volunteers.
- B. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of youths' needs.
- C. QUALIFIED MENTAL HEALTHCARE PROFESSIONAL (QMHP): A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians, psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.
- D. SELF-INJURIOUS BEHAVIOR: An intentional, self-inflicted act of bodily harm. Risk of lethality can range from small cuts with low lethality, head banging, swallowing foreign objects, insertion of foreign objects into the body, starvation, not complying with medical treatment for chronic conditions or allowing wounds to heal; to serious life-

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threatening mutilation and amputation. Self-injurious behavior may result in suicide, either intentionally or unintentionally. Youth who engage in self-injury must be evaluated by a QMHP who shall use their clinical judgment to determine appropriate treatment. Tattoos, decorative piercing, and similar markings are not considered self-mutilation for the purpose of this HCSD. Self-injurious behavior which requires emergency medical treatment, such as the level of care provided in a hospital or emergency department, will be considered a serious self-injury.

- E. **SERIOUS SUICIDE ATTEMPT:** Self-injurious behavior by a youth which emergency medical treatment such as the level of care provided in a hospital emergency department.
- F. **SUICIDE PREVENTION COORDINATOR:** A staff member assigned or appointed by the Warden or the Warden's designee to chair the Suicide Prevention Committee.
- G. **SUICIDE WATCH:** The enhanced supervision or precautions taken for a youth who is at increased risk of suicidal behavior. One of two levels of suicide watch shall be implemented for a youth at risk of suicidal behavior; close or constant.

III. GENERAL GUIDELINES (See Facility Directive):

- A. Suicide prevention is the responsibility of all staff. All threats gestures of suicide must be taken seriously. Active suicidal intent is an emergency and should be reported to physical and mental health staff immediately.
- B. Each facility must develop a written suicide prevention plan as a facility directive which includes all components of this HCSD as well as addressing the unique needs of the facility including the facility-specific process and chain of command for implementing safety measures as well as the responses to, and evaluation of, attempted and actual suicides. In addition, the facility-specific plan shall include a schedule for regular maintenance and inspection of safety smocks, blankets, and tools used to intervene in suicide attempts. The warden or designee must review the facility-specific suicide prevention plan annually.
- C. All facility staff in direct contact with youths must receive training regarding suicide prevention at the inception of employment and through annual in-service training. Facility staff must receive training on the facility's suicide and emergency plans as well as job-specific training

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regarding the responsibilities for suicide prevention and monitoring activities appropriate for the staff's assigned duties.

- D. Whenever there is imminent danger of self-harm, a shift supervisor or physical health care staff trained in suicide-risk assessment may order a continuous watch until the youth is evaluated by a QMHP or until a QMHP can be consulted and provide instructions by phone.
- E. All facility staff in direct contact with youths must be trained in standard first aid and cardiopulmonary resuscitation (CPR) in accordance with HCSD 1.04Y, "Credentialing of Employees," and HCSD 1.06Y, "Health Related Training for Youth Developmental Specialists." All housing units must contain an emergency response bag that includes a first aid kit, pocket mask, latex gloves and an emergency rescue (cut down) tool. Emergency bags maintained by health services staff must contain an Ambu bag and oxygen. An Automated External Defibrillator (AED) shall be readily available.
- F. In accordance with HCSD 1.19Y, "Emergency Plan," the facility shall conduct an annual mock drill in accordance with and activate the facility's emergency response plan when the suicide attempt is life threatening.
- G. All equipment necessary for medical emergencies shall be inspected and maintained in accordance with HCSD 1.13Y, "Health Care Equipment Maintenance." The following supplies must be readily available in every housing unit or in a common area immediately adjacent to every housing unit: a cut down tool or rescue tool, gloves, and a pocket mask for CPR. These supplies shall be inventoried daily.
- H. When a suicide attempt occurs, staff must not assume the youth is deceased. Staff must always provide first aid or CPR if appropriate while waiting for facility health care staff or external emergency services to arrive. Scene preservation will be secondary to the provision of immediate life-saving measures.
- I. Every serious suicide attempt and suicide shall be reviewed in accordance with HCSD 2.24Y, "Clinical Critical Incident Review."
- J. Close observation shall be implemented when a QMHP determines there is a clinical need for observation based on a youth's statement or presentation that they may be suicidal or may engage in self-injurious behavior that could result in death. QMHPs may use their clinical

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discretion to decide whether to place an offender on close observation, but the evaluation must occur and a treatment plan must be devised.

- K. When a youth is on suicide watch, the Shift or Housing Area Supervisor shall make visits to the area where the youth is on watch at a minimum of once each shift to ensure that the youth is being appropriately monitored and that monitoring forms are being used and accurately completed.
- L. Each incident involving a youth who engages in self-injurious or suicidal behavior, or who dies by suicide must be reported to the Chief Medical Officer (CMO), Executive Director of Behavioral Health, Director of Mental Health, Health Services vendor's Regional Director of Behavioral Health and Regional Director of Mental Health within twenty-four (24) hour of the incident.

IV. STAFF TRAINING:

All facility staff with direct youth contact shall be trained, in pre-service orientation and annually, in the identification, referral, and monitoring of potentially suicidal youths. Training must address:

- A. The reasons the environment of correctional facilities is conducive to suicidal behavior including the demographic and cultural parameters of suicidal behavior; and,
- B. Identifying the situations, warning signs, and symptoms of impending suicidal behavior as well as how to access help for the youth including:
 - 1. Incidence and variations in precipitating factors;
 - 2. Understanding the demographic and cultural parameters of suicidal behavior, including incidence and precipitating factors;
 - 3. High risk suicide periods;
 - 4. Responding to suicidal and depressed youth;
 - 5. Improving communication between Correctional and Health Services staff;
 - 6. Referral procedures;
 - 7. Housing observation and Suicide Watch levels, procedures and requirements;
 - 8. Procedures for initiating Close or Constant Observation;
 - 9. Communication and referral procedures between Custody staff, Unit Staff, Nursing, and Mental Health staff;
 - 10. Reporting and notification procedures;
 - 11. Follow-up monitoring of youth who make a suicide attempt;

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12. Population-specific factors; and,
13. Review procedures.

The curriculum used for training must be approved by the Executive Director of Behavioral Health Services

V. CLINICAL SERVICES:

A. Identification at Intake

All youths shall be screened for suicide risk at Intake immediately upon arrival in accordance with HCSD 4.03Y, "Mental Health Services." In addition, facility staff receiving the new youth will also obtain information regarding conduct and demeanor during transport from the transporting officer or staff. Facility staff in the Intake area must not rely exclusively on a youth's denial that they are suicidal; any behavior or actions which suggest the youth is at risk of suicide must be documented and nursing staff notified.

Mental health trained nursing staff will assess each youth and complete the suicide potential screening template on the nursing intake section, on the suicide / BH screen template in the electronic medical record (EMR). Whenever, a youth responds "yes" to any bolded question or whenever the youth has answered "yes" responses to 5 or more questions, the nurse will immediately contact the designated QMHP for guidance regarding management.

No youth shall be assigned to a housing unit until the Intake suicide risk assessment has been completed.

B. Identification and Referral

A youth may become suicidal at any time and facility staff should not assume that a youth's ability to successfully function in general population eliminates any risk of suicide. Facility staff that interact with youths must be cognizant at all times while on duty of increased suicide risk.

Suicide precautions must be implemented by any facility employee who:

- Observes self-injurious, suicidal, or unusual behavior which is believed to present a credible risk of self-injurious behavior
- Hears a youth make suicidal statements or threats

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- Is made aware of a youth's verbal comments expressing a desire or intent to commit suicide
- Observes a youth displaying or engaging in any other concerning or unusual behavior which is believed to present a credible risk for injury to themselves or others.

Facility staff will maintain the youth under direct supervision until the Shift Supervisor or designated Health Services staff contacts the QMHP and the QMHP gives orders for supervision. The on-call system should be used to contact the QMHP after normal business hours, on weekends and holidays. Telephone contact with the on-call QMHP should be limited to the initial placement on either close or constant observation, maintenance of current level of observation, or on the decision to raise the observation level from close to constant observation. No youth will be downgraded and/or discharged from suicide observation without a face-to-face assessment by a QMHP.

QMHPs will provide mental health evaluation and treatment to youth with suicidal ideation or behaviors. When notified by facility staff that a youth is suicidal, a QMHP must complete a suicide evaluation within the time frames required by HCSD 2.01Y, "Access to Care" but no later than the next business day.

VI. EVALUATION:

Whenever there is imminent danger of self-harm, a Shift Supervisor or Health Services staff trained in suicide-risk assessment may order a constant observation until the youth is evaluated by a QMHP.

When a youth has been determined to be at risk of suicide, evaluation and treatment by a QMHP is indicated. The QMHP shall assess the youth's:

- Behavior or factors resulting in the referral
- Mental health status
- Current suicide risk:
 - Ideation
 - Intent to end life
 - Plans
 - Lethality of plan
 - History of suicidal behavior

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- How often
 - When
 - Precipitating stressors
 - Method used or contemplated
 - Circumstances surrounding rescue
 - Consequences of prior attempts/gestures
- Recent Stressors and other pertinent social or family history
 - Likelihood of further self-harm in the short-term

The QMHP must determine the youth's level of suicide risk, the level of supervision required, and the type of treatment that is needed including transfer to a facility with on-site health services 24 hours per day if necessary.

A consultation with a psychiatrist and/or other staff shall be obtained to assist in the evaluation as needed.

The youth must be reassessed daily to identify any change in condition which would necessitate a change in level of supervision or a transfer to another facility. This reassessment shall be documented in the EMR and the results of this communicated to the multidisciplinary treatment team.

VII. HOUSING:

The level of suicide risk will guide housing unit placement. Youths will be housed in the least restrictive environment as indicated by the level of suicide risk including general population close to staff or specific areas of designated housing units.

Before any youth at risk of self-injurious behavior is housed in a cell, the cell should be inspected using the Safe Cell Check List. (Attachment) When a cell does not meet all of the conditions listed on the Safe Cell Check List, staff must identify and plan for accommodations or special precautions which will be taken, up to and including Constant Observation.

Regardless of who identifies a youth as being at an increased risk of self-injurious behavior or suicide, from the moment the risk is identified until the youth is placed in a cell that has been inspected using the Safe Cell Check List, the youth shall be directly and continuously monitored by a staff person.

Removal of any items shall be avoided whenever possible, except for items that could easily be used for hanging. When it is necessary to remove clothing from a suicidal youth, the youth must be issued a safety smock or other protective clothing that is more durable and relatively suicide resistant. If the youth

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demonstrates ongoing risk to self and danger is imminent due to destroying the safety smock, protective clothing, or bedding, a QMHP or Shift Supervisor may order all clothing and bedding removed. Upon taking such measures, a same-sex staff member will be assigned to constantly observe the youth.

The Shift or Housing Area Supervisor shall make visits to the housing units containing youths on suicide precautions once per shift to ensure that observation is being performed appropriately and monitoring forms are being used, accurately completed, and reviewed daily.

VIII. MONITORING:

Interventions and monitoring should be based on the youth's individual level of risk. Two levels of increased supervision shall be used for suicidal youths: close observation and constant observation. Other aids such as closed-circuit television monitoring, may never substitute for staff observations.

If approved by mental health staff, the youth on suicide precautions shall continue to be provided with educational services, showers, visits, etc. commensurate with the youth's security level and treatment plan. Toileting and bathing may or may not be visually supervised, depending on the provisions of the safety plan.

The Shift Supervisor or designee may raise the observation level of a youth if circumstances warrant until the QMHP is consulted. Only a licensed QMHP may discontinue close observation or constant watch.

A suicidal youth must remain on suicide precautions, until they are removed from this status by a licensed QMHP. Once a youth has been released from suicide watch, the youth will remain on the mental health caseload, and unless justified otherwise in an assessment, should receive follow-up assessments by mental health staff after discharge from suicide precautions documented in the EMR:

- A. Daily for five days (on non-business days this may be accomplished by mental health trained nursing staff conducting a mental status review and telephonic contact with a mental health provider);
- B. Once a week for two weeks; and,
- C. Once a month until release

IX. LEVELS OF OBSERVATION:

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A. Close Observation

At this level of observation, staff must conduct regular visual checks at staggered intervals not to exceed 15 minutes (e.g., 5, 11, 8 minutes). Camera surveillance may be used to supplement staff monitoring but not replace it. When cameras are used, regular checks must still be conducted at regular random intervals no longer than 15 minutes apart. All visual checks must be documented. All completed forms shall be returned to Suicide Prevention Coordinator.

The youth on close observation shall be provided with the usual bed and bedding.

One set of clothes without belts, shoe laces, or similar item(s) that can be easily used for hanging may be provided. The youth may have no additional personal property unless authorized by the QMHP in writing.

Regular meals shall be provided unless the QMHP specifies an alternative diet order. Water shall be offered every 2 hours if the water has been turned off due to intentional flooding or the observation area or cell has no water in it.

Re-evaluation by a QMHP must be done within 24 hours. Orders to continue close observation must be updated daily. When QMHPs are not on-site and are contacted by telephone regarding a suicidal youth, the youth will not be downgraded and/or discharged from suicide precautions without a face-to-face assessment by a QMHP. The telephone contact with the on-call QMHP should be limited to the initial placement on either close or constant observation, maintenance of the current level of watch, or on the decision to raise the observation level from close to constant observation.

B. Constant Observation Suicide Watch

Constant observation must be used whenever the youth has engaged in an act of suicide or when there is an imminent danger of self-harm.

Staff must perform continuous, one-to-one in line-of-sight direct visual observation. Behavioral observations and statements shall be documented on the suicide observation form every 15 minutes.

Unless otherwise specified by the QMHP, youth on constant observation may not have personal property or clothing other than a safety smock for modesty. The cell must be empty and stripped with only a mattress

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and approved suicide blanket. Other safety measures including therapeutic restraints may be necessary. When such restraints are required to protect the youth from harm, they must be applied in accordance with applicable procedures and directives.

When nursing staff are on site, vital signs and a mental status assessment must be obtained and documented in the EMR every shift.

Regular meals will be provided unless the QMHP specifies an alternate diet order like no packaging/no utensils diet. When sack meals or alternate diet order is necessary, the number of calories must be equal to the regular juvenile diet. Water will be offered every 2 hours while awake. QMHP must evaluate the youth at least once every twenty- four hours. Suicide watch precautions may not be discontinued or downgraded in the absence of a face to face evaluation by a QMHP. On non- business days when the QMHP is not on site, consultation and orders to continue constant observation suicide watch may be done by telephone by the QMHP after contact with a nurse who has completed a mental status assessment.

X. INTERVENTION:

Any facility staff that discovers a youth attempting suicide must respond immediately by activating the facility's emergency response plan, alerting other staff to call for the facility's nursing staff if available and bring the emergency response bag to the cell. When no nurse is on duty, facility staff must contact 911 and access external emergency medical services. The exact nature of the emergency (e.g., "hanging attempt") and location of the emergency must be communicated to facility nursing staff and EMS personnel

Once the responding staff has radioed for assistance, the responding facility staff shall immediately enter the cell and provide first aid and CPR if necessary. Facility staff must never wait for nursing staff or external emergency services to arrive before entering a cell and initiating appropriate life saving measures.

If a youth is hanging, facility staff must use measures necessary including using the cut down tool to release the youth from the ligature. Facility staff must assume a neck/spine cord injury and stabilize the neck with a cervical collar or other means (e.g., rolled blankets) and the spine with a backboard. All life-saving measures must be continued by facility staff until on site nursing staff or external emergency medical personnel assume care.

When external emergency services are necessary, the shift supervisor or designee must ensure emergency services personnel have unimpeded access to

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the youth.

A youth attempting suicide should receive a comprehensive psychological assessment as soon as it is medically feasible.

Each youth attempting suicide or otherwise placed on suicide precautions shall have an Individualized Treatment Plan.

XI. COMMUNICATION:

All facility staff must share pertinent information and make appropriate referrals to health services staff whenever a youth is suicidal or suspected to be at increased risk for self-injurious behavior.

Facility staff must use their training and skills when engaging with a youth who is suicidal including active listening, being a nonjudgmental and caring contact, being mentally present during their interaction with the youth, and staying with the youth if they are at an imminent risk of self-injurious behavior or suicide.

Each facility must have a mechanism to notify the Warden, health care staff, and incoming shift custody staff of the status of each youth on safety precautions. Officers transporting a youth to another jurisdiction or to another facility should also be advised of a youth's self-injurious behavior or suicide risk.

When a youth returns to the facility following transfer to another facility or local hospital for self-injurious or suicidal behavior, the shift supervisor must contact medical and mental health staff to obtain direction regarding what measures or observation is necessary.

All incidents of suicidal behavior including authorizations for suicide precautions, reassessments, and any changes in suicide watch must be documented on the suicide monitoring forms and in the EMR.

The status of any youth on suicide precautions will be discussed in the multidisciplinary team meetings in accordance with the parameters of HCSD 4.03Y, "Youth Mental Health Services."

XII. NOTIFICATION AND REPORTING:

All appropriate facility staff including the Warden, nursing staff, and QMHP shall be notified of a youth's self-injurious behavior or suicide attempt. Parents or community caretaker should be notified of a serious suicide attempt that results in an inpatient hospital admission. Central Office staff who should be notified of a youth's self-injurious behavior or suicide attempt include the Chief

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Medical Officer, Executive Director of Behavioral Health Services, Director of Mental Health, the Health Services vendor's Regional Director of Behavioral Health, and Regional Director of Mental Health.

For a completed suicide, the youth's family, the Department executives including the Executive Director of the Division of Youth Services, Chief Medical Officer, Executive Director of Behavioral Health Services, Director of Mental Health, Health Services vendor's Regional Director of Behavioral Health, and Regional Director of Mental Health must be notified in accordance with applicable procedures and directives.

XIII. DOCUMENTATION:

All facility staff involved in assessing suicide risk and suicide watches must record their observations and interventions on applicable forms and on appropriate templates in the EMR. At a minimum, staff must record:

- Youth's name and identifying data
- Date, time, location of events
- Description of behaviors of concern
- Identification of staff and youths who were present or participated
- Identification of QMHPs involved and direction received
- Interventions provided
- Youth's response to interventions
- Updated orders

Personnel carrying out close or constant observation suicide watch must document the checks as they are done or as soon as possible after the check is completed. Staff must not defer documentation to the end of a shift and record all checks simultaneously.

In addition, QMHPs are expected to provide documentation of:

- Date, time, location of situation
- Chronological account of the development and handling of the crisis
- Description of offender or youth behavior and mood of concern
- Information gathered from other staff involved
- Psychiatric history review
- Rationale for the crisis status placement
- Current mental health status
- Individual Treatment Plan with clearly stated and relevant problems, goals, objectives, interventions, time frames, and staff responsible
- Orders

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XIV. REVIEW:

Critical Incident Stress Debriefing or Defusing (CISD) provides affected staff an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. In the event of a serious suicide attempt or suicide, all affected staff shall be offered CISD. For maximum effectiveness, the CISD process and other appropriate support services shall occur within 24 to 72 hours of the critical incident but may be approved after that time when necessary.

Youth who are affected by another youth's self-injurious behavior, suicide attempt, or suicide will be offered support by Health Services staff.

Every suicide, as well as serious suicide attempt, shall be examined in accordance with procedures established by HCSD 2.24Y, "Clinical Critical Incident Review."

Facility Health Services staff shall conduct a mortality review and psychological autopsy.

XV. SUICIDE PREVENTION COMMITTEE:

Each facility shall establish a suicide prevention committee which will review the adequacy and effectiveness of the facility's suicide prevention program including but not limited to:

- Quality and extent of suicide prevention training;
- Quality and thoroughness of the mental health evaluations;
- Completeness of observation records for any youth who had been on observation; and,
- Quantitative measures and outcomes of Close and Constant Observations.

Facility committees shall consist of the facility's Lead QMHP (chair), the Suicide Prevention Coordinator, and at least two (2) individuals appointed by the Warden from various services in the facility including Correctional Officers, Unit Team staff, Chaplains, programs staff, other Health Services personnel, and volunteers.

Meetings shall be held minimally on a quarterly basis or more frequently as needed. Minutes of the meetings will be maintained by the Suicide Prevention Coordinator and a copy forwarded to the Warden and the site's Quality Assurance Manager.

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XVI. APPLICABILITY:

This HCSD is applicable to all Division of Youth Services facilities.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date