

JAIL SUICIDE/MENTAL HEALTH UPDATE

(A joint project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice)

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SPECIAL ISSUE: JUVENILE SUICIDE IN CONFINEMENT — FINDINGS FROM THE FIRST NATIONAL STUDY

*In August 1999, the National Center on Institutions and Alternatives (NCIA) was awarded a contract from the U.S. Justice Department's Office of Juvenile Justice and Delinquency Prevention (OJJDP) to conduct the first national survey on juvenile suicide in confinement.¹ The primary goal of the project was to determine the extent and distribution of juvenile suicides in confinement (i.e., juvenile detention centers, reception centers, training schools, ranches, camps, and farms); as well as to gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the juvenile facility which sustained the suicide. The project has been completed and it is hoped that the findings and recommendations from the recently released report will be utilized as a resource tool for both juvenile justice practitioners in expanding their knowledge base, and juvenile correctional administrators in creating and/or revising policies and training curricula on suicide prevention. A summary of **Juvenile Suicide in Confinement: A National Survey** is offered below.*

I INTRODUCTION

A) The Problem

At the age of 14, Brian Malone had been in and out of the local juvenile justice system.² Beginning four years earlier, he had been arrested for trespassing, theft, and assault. Several of the arrests had resulted in brief confinement in the county juvenile detention center. His parents were divorced, and Brian was being raised by a father who had few parenting skills. Not surprisingly, the youngster did poorly in school and was suspended on several occasions for disruptive behavior and smoking marijuana. Brian was also assaultive to both siblings and peers.

In early March 1997, Brian agreed to seek counseling. The initial weekly group sessions seemed helpful, and he appeared to be making progress with both his overall behavior and abstinence from drugs. By the end of the month, however, Brian became increasingly quiet, apathetic and despondent. Following one session on April 2, the youngster confided to Amy Wilson, a counselor with the local mental health center, that he felt suicidal and "was considering cutting his wrists." Crisis intervention was provided, and Brian gave assurances that he would alert Ms. Wilson of any future suicidal ideation. The counselor, however, remained concerned about Brian and contacted his probation officer several hours later. She related the incident in which Brian had expressed suicidal ideation. The probation officer informed Ms. Wilson that the youngster had been arrested an hour earlier for an alleged sexual assault on his younger brother. Brian was being transported to the county juvenile detention center.

Built in 1961, the juvenile detention center comprised 23 single rooms. The one-story facility was in poor condition and scheduled to be replaced. It was also poorly managed and lacked any regular mental health services. On average, youth spent approximately 15 days in the detention center. Although there had never been a suicide in the facility, staff seemed both unprepared and untrained

in the area of suicide prevention. When Brian Malone entered the detention center on April 2, staff did not administer any intake health screening. They seemed unaware that Amy Wilson had contacted Brian's probation officer about her concern of the youngster's suicidal ideation.

During the next two weeks, Brian's stay at the detention center was uneventful. He stayed out of trouble and generally participated in required programming. Then, a sudden change in behavior occurred. On April 16, the facility's cook noticed that the youngster had begun to refuse meals. The following day, Brian was notified by his probation officer that his detention had been extended 30 more days for a probation violation. During their conversation, the officer noticed that Brian seemed depressed, lethargic and incoherent, sounding as if he had a "mouth full of mush." For unexplained reasons, this unusual behavior was not reported to facility staff. On April 18, Brian confided to another resident that he had attempted suicide by slashing his wrists. The cuts were superficial but visible. Staff did not seem to notice. He again refused most of his meals during the next few days. On April 20, Brian's father arrived at the detention center to visit his son. Mr. Malone was refused admission because he was not on the approved visitor list. Later that evening, Brian again engaged in high-risk behavior

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when he placed a sweat shirt around his neck and persuaded two other residents to pull on the sleeves until he passed out. The two other youth soon became scared and stopped, and Brian never lost consciousness. The incident was not observed by, or reported to, staff.

At approximately 1:00 pm April 21, Brian was sitting in the day room with other residents who were eating lunch. He had refused his meal and appeared to be trying to sleep by laying his head on the table. Brian was warned several times by staff that sleeping in the day room was prohibited. He appeared tired and listless, and again placed his head on the table. As a result of his refusal or inability to stay awake, Brian was placed on "room confinement" for the remainder of the day and escorted to his room. According to Linda Maples, a detention officer at the facility, "throughout the next few hours, I intended to go talk with Brian about his behavior and let him know how long he would be in his room. I never did get the opportunity to do that."

At 5:30 pm on April 21, Brian was found hanging from a bed sheet in his room. Staff were unable to initiate cardiopulmonary resuscitation because of rigor mortis. The youth had been left unobserved for over four hours. At the time of his death, Brian Malone was one week shy of his 15th birthday.

B) Prevalence

Brian Malone's death is only one of an unknown number of suicides that occur each year in public and private juvenile facilities throughout the country. According to the Surgeon General of the United States, youth suicide in the general population is a national tragedy and a major public health problem (U.S. Department of Health and Human Services, 1999). The suicide rate of young people (ages 15 to 24) has tripled from 2.7 per 100,000 in 1950 to 9.9 per 100,000 in 2001 (Arias, Anderson, Kung, Murphy & Kochanek, 2003). More teenagers die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease *combined* (U.S. Department of Health and Human Services, 1999). In addition, a recent national survey found that over 3 million youth are at risk for suicide each year in the community, with 37% of surveyed youth reporting that they attempted suicide during the previous 12 months (Substance Abuse and Mental Health Services Administration, 2001).

Despite the fact that youth suicide in the general population is considered a major public health problem, as well as the fact that there have been several national studies conducted regarding the extent and nature of suicide in jail and prison facilities (Hayes, 1989; Hayes 1995), there has *not* been any comparable national research conducted to date regarding juvenile suicide in confinement.

C) Self-Injurious Behavior

Although there has been little prior research conducted regarding youth suicide in custody, there is information available to suggest a high prevalence of self-injurious behavior in juvenile correctional facilities. For example, according to one national study, more than 11,000 juveniles are estimated to engage in more than 17,000 incidents of suicidal behavior in juvenile facilities each year (Parent, Leiter, Kennedy, Livens, Wentworth & Wilcox, 1994). In another national survey, a modified version of the Centers for Disease Control's Youth Risk Behavior Surveillance System (YRBSS) survey was administered

to over 1,800 confined youth in 39 juvenile institutions throughout the country in 1991 (Morris, Harrison, Knox, Tromanhauser, Marquis & Watts, 1995). The study found that almost 22% of confined youth seriously considered suicide, 20% made a plan, 16% made at least one attempt, and 8% were injured during the previous 12 months.

Other studies found that large percentages of detained youth had prior histories of suicide attempts (Dembo, Williams, Wish, Berry, Getreu, Washburn & Schmeidler, 1990) and current suicidal behavior (Robertson & Husain, 2001, Shelton, 2000; Davis, Bean, Schumacher & Stringer, 1991; Woolf & Funk, 1985). In fact, Robertson and Husain (2001) found that 31% of confined youth self-reported a prior suicide attempt, and 9% were currently suicidal with either ideation and/or a plan to act on suicidal thoughts. Finally, Chowanec, Josephson, Coleman and Davis (1991) found higher rates of self-harm behavior among incarcerated male youth than in the general adolescent community population.

With regard to race, Caucasian youth appear to attempt suicide in confinement at a higher rate than African American youth (Kempton & Forehand, 1992; Alessi, McManus, Brickman & Grapentine, 1984), although Morris, et. al. (1995) found that Native American (29%) and Caucasian (25%) youth reported higher rates of suicidal ideation than Hispanic (15%), Asian (12%) and African American (8%) youth. Other researchers have reported similar findings of high rates of suicidal behavior (Duclos, LeBeau & Elias, 1994) and psychiatric disorders (Duclos, Beals, Novins, Martin, Jewett & Manson, 1998) among Native American youth confined in juvenile facilities.

Several studies have consistently reported high rates of suicidal behavior for incarcerated youth based upon pertinent risk factors. For example, researchers have reported that confined youth with either major affective disorders or borderline personality disorders had a higher degree of suicidal ideation and more suicide attempts than adolescents in the general population (Alessi, McManus, Brickman & Grapentine, 1984); male incarcerated youth whose parents had affectionless bonding styles reported more suicidal ideation and/or attempts (McGarvey, Kryzhanovskaya, Koopman, Waite & Canterbury, 1999). Findings from a recent study indicated that over half (52%) of all detained youth self-reported current

*The full report of
Juvenile Suicide in Confinement:
A National Survey*

*can be accessed through the
National Criminal Justice Reference Service's
website at:*

virlib.ncjrs.org/JuvenileJustice.asp
(and scroll down to report)

or

ncjrs.org/pdffiles1/ojjdp/grants/206354.pdf

or through the NCIA website:

ncianet.org/cjjsl.cfm

suicidal ideation, with 33% having a history of suicidal behavior (Esposito & Clum, 2002). The researchers concluded that a history of “sexual abuse directly affects the development of suicidal ideation and behavior in incarcerated adolescents (p. 145).”

In addition, a study of youth confined in a juvenile detention facility found that suicidal behavior in males was most significantly associated with depression, major life events, poor social connections, and past suicide attempts; whereas suicidal behavior in females was associated with impulsivity, current depression, instability, and younger age (Mace, Rohde & Gnau, 1997; Rhode, Seeley & Mace, 1997). The most common correlate between both males and females was not living with a biological parent before detention, and suicidal behavior of a friend was significantly associated with past and current suicidal ideation among boys, but not girls (Rhode, Seeley & Mace, 1997). Finally, a recent study of confined youth referred for psychiatric assessment found that 30% reported suicidal ideation/behavior, and 30% self-mutilative behavior while incarcerated (Penn, Esposito, Schaeffer, Fritz & Spirito, 2003). These youth reported more depression, anxiety, and anger than non-suicidal confined youth.

D) Provision of Mental Health Services in Juvenile Facilities

The overall mental health status of confined youth, as well as general conditions of confinement within juvenile correctional systems, has increasingly come under scrutiny. Much of the recent attention has been limited to investigations of specific jurisdictions and anecdotal information on tragic outcomes throughout the country. (Amnesty International, 1998; Burrell, 1999; Coalition for Juvenile Justice, 1999, 2000; Puritz & Scali, 1998; Rosenbaum, 1999; Sullivan, 1995; Twedt, 2001a; Twedt, 2001b; Warren, 2004).

In 1994, the U.S. Justice Department’s Office of Juvenile Justice and Delinquency Prevention (OJJDP) released a landmark study regarding the conditions of confinement in juvenile facilities (Parent, Leiter, Kennedy, Livens, Wentworth & Wilcox, 1994). The *Conditions of Confinement: Juvenile Detention and Corrections Facilities* study included a survey of 984 public and private detention centers, reception and diagnostic centers, training schools, and ranches throughout the country. On a daily basis, these facilities held almost 65,000 juveniles or 69% of youth confined in the United States. Substantial and widespread problems in living space, health care, security, and the control of suicidal behavior were found in the surveyed facilities.

With regard to the state of mental health services for confined youth throughout the country, a 1983 national survey of health care delivery in juvenile correctional facilities found deficiencies in certain key areas: only 60% of facilities were conducting initial health screening and less than 50% were providing ongoing mental health services (Anno, 1984). Fifteen years later in 1998, a national survey on the availability of mental health services in juvenile facilities found increased availability, but remaining gaps: 64% of facilities provided initial mental health screening, 74% provided a clinical evaluation by mental health staff, 82% had provisions for psychotropic medication, and

69% provided on-site access to psychiatrists, psychologists and/or master’s level social workers (Goldstrom, Jaiquan, Henderson, Male & Manderscheid, 2001).

II. JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY

A) Phase 1

In August 1999, the National Center on Institutions and Alternatives (NCIA) was awarded a contract from the U.S. Justice Department’s Office of Juvenile Justice and Delinquency Prevention (OJJDP) to conduct the first national survey on juvenile suicide in confinement. The project was divided into three phases. During Phase 1, a one-page survey instrument and cover letter was sent to directors of 1,178 public and 2,634 private juvenile facilities in the United States.³ Each of the 3,812 facility directors was asked to complete the one-page survey if their facility experienced a juvenile suicide(s) between 1995 and 1999. Similar to OJJDP’s *Conditions of Confinement* study (Parent, Leiter, Kennedy, Livens, Wentworth & Wilcox, 1994), the project surveyed facilities that housed juveniles in more traditional types of confinement—juvenile detention centers, reception centers, training schools, ranches, camps, and farms—operated by state and local governments, and private organizations.⁴ Excluded from the project were shelters, halfway houses, and group homes which were open, physically unrestricted residential programs for juveniles.

In order to more accurately account for the total number of juvenile suicides in confinement between 1995 and 1999, survey forms and cover letters were also sent to each state department of juvenile corrections, attorney general’s office, and state medical examiner; as well as members of the National Association of Child Advocates in 47 states, child fatality review programs in 12 states, and various other state agencies (e.g., child ombudsman, licensing and regulatory services). Further, survey forms and cover letters were sent to each of OJJDP’s state advisory groups, state criminal justice councils, and state juvenile justice specialists.⁵ Finally, a newspaper clipping service was utilized to verify juvenile suicides not identified through these traditional sources.

Phase 1 resulted in the identification of 110 juvenile suicides occurring between 1995 and 1999. The suicides were distributed amongst 38 states. Table 1 provides a breakdown of data collection sources for the suicides. As can be seen, 54 (49.1%) of the deaths were identified from self-reporting of the juvenile facilities. Data obtained from state departments of juvenile corrections yielded an additional 27 (24.6%) suicides not identified through self-reporting. Of the remaining deaths, 14 (12.7%) were identified through other state agencies (i.e., those responsible for licensing and regulatory services), 10 (9.1%) through newspaper articles, and 5 (4.5%) through “other” sources.⁶ It should be noted that self-reporting was given the primary recognition for the identification of juvenile suicides. For example, if a juvenile suicide was identified by more than one source, including a self-report from the facility in which the death occurred, the source would be attributed to a self-report. Table 1, therefore, is meant to be more of a reflection of self-report accuracy rather than data collection efforts of state reporting systems.

It should be noted, however, that of the 54 suicides self-reported from facility directors, only 28 (51.8%) of these deaths were also known to any state agency (i.e., state departments of juvenile corrections, as well as other state agencies responsible for licensing and regulatory services). Further, the 15 suicides that were identified through both newspaper articles and “other” sources were also unknown to any state agency. Therefore, 39% (43 of 110) of the juvenile suicides identified in this study were unknown to any state agency (i.e., departments of juvenile corrections, as well as agencies responsible for licensing and regulatory services). Most of these suicides occurred in either county detention centers or private residential treatment centers.

B) Phase 2

Once facilities experiencing suicides during the five-year study period were identified, Phase 2 of the survey process was initiated and included dissemination of a 7-page survey instrument to directors of facilities that sustained suicides. The survey instrument was designed to collect readily available data on the: 1) demographic characteristics of each victim; 2) characteristics of the incident; and 3) characteristics of the juvenile facility.

1. **Demographic Characteristics** included, but were not limited to, age; sex; race; living status; current offense(s); prior offense(s); legal status (detained, committed, other); length of confinement; drug/alcohol intoxication at confinement; history of room confinement; substance abuse history; medical/mental health history; physical/sexual abuse history, and history of suicidal behavior.
2. **Incident Characteristics** included, but were not limited to, date, time and location of suicide; housing assignment (e.g., single/multiple occupancy); issue of room confinement; method and instrument utilized; time span between incident and finding victim; and possible precipitating factors to the suicide.
3. **Facility Characteristics** included, but were not limited to, facility type; facility ownership (e.g., state, county, private); capacity/population at time of

suicide; and the suicide prevention components - written policy, intake screening, staff training in suicide prevention and cardiopulmonary resuscitation, observation levels, safe housing, and mortality review.

In August 2000, the survey instruments and cover letters were mailed to directors of 83 facilities that sustained the 110 suicides. Initially, only 23 (20.9%) completed Phase 2 surveys were returned. By September 2001, subsequent follow-up letters and telephone contact with facility directors not responding to initial survey requests resulted in a final response/collection rate of 71.8% (79 of 110) completed Phase 2 surveys.⁷

III.

PHASE 3: DEMOGRAPHIC FINDINGS OF THE JUVENILE SUICIDE DATA

Project staff analyzed data on 79 suicides that occurred in public and private juvenile facilities between 1995 and 1999. The following demographic findings are presented in relationship to facility type. As shown below, 33 (41.8%) of the juvenile suicides took place in *Training School/Secure Facilities*, while 29 (36.7%) occurred in *Detention Centers*, 12 (15.2%) in *Residential Treatment Centers*, and 5 (6.3%) in *Reception/Diagnostic Centers*. In addition, almost half (48.1%) of the suicides occurred in facilities administered by state agencies, while 39.2% took place in county facilities, and 12.7% in private programs. Finally, the 79 suicides were distributed among 70 juvenile facilities: 65 facilities sustained a single suicide, 3 facilities each had two suicides, 1 facility had three suicides, and 1 facility had five suicides during the survey period.

A) Personal Characteristics of the Victims

1. Race, Sex, Age, and Living Status Prior to Confinement

Approximately two-thirds (68.4%) of the victims were Caucasian, with both African-American and American Indian each representing 11.4% of the victims, Hispanic comprising 6.3%, and 2% designated as Other. The finding that over two-thirds of the victims were Caucasian was not surprising given the fact that this racial group

**TABLE 1
SOURCES FOR IDENTIFYING JUVENILE SUICIDES**

SOURCE	N	PERCENTAGE
Facility Self-Report	54	49.1
State Departments of Juvenile Corrections	27	24.6
Other State Agencies	14	12.7
Newspaper Articles	10	9.1
Other Sources	5	4.5
TOTAL	110	100.0

represents over 90% of suicides that occur each year in the community (Arias, Anderson, Kung, Murphy & Kochanek, 2003). In regard to juvenile facilities, although only limited information was available, one previous study found that Caucasian youth held in detention attempted suicide at a rate approximately 3.5 times that of African-American youth (Kempton & Forehand, 1992). Of interest, however, was the fact that (according to recent *Census of Juveniles in Residential Placement-CJRP* data) although African-American and Hispanic youth comprised approximately 39% and 18%, respectively, of the confined juvenile population throughout the country (Sickmund & Wan, 2001),⁸ they represented only 11% and 6% of the victims in this study; whereas Caucasian and American Indian youth comprised approximately 38% and 2%, respectively, of the confined juvenile population throughout the country, but 68% and 11% of the victims in this study. The causes of these disproportionate relationships were outside the purview of this analysis.

The vast majority (79.7%) of the victims were male. Given the fact that over 80% of all confined juveniles throughout the country are male (Sickmund & Wan, 2001), these findings were not surprising. The study that over 70% percent of the victims were between the ages of 15 and 17. The average (mean) age was 15.7, with one victim as young as 12 and another as old as 20. These findings were also consistent with the most recent CJRP data (Sickmund & Wan, 2001). Finally, a sizable number (39.5%) of the victims were living with one parent at the time of their confinement. Only slightly less than one quarter (23.7%) of the victims were living with both parents.

2. Most Serious Offense and Confinement Status

For purposes of this study, the most serious offense was broken down into six categories.⁹ As can be seen by Table 2, the vast majority (69.6%) of the victims were confined on non-violent offenses, with the Property offense (32.9%) category accounting for the highest percentage of victims. In addition, the Public Order (10.1%), Status (12.7%), and Probation Violation (11.4%) categories combined represented over a third (34.2%) of the offenses. Person offenses accounted for 30.4% of the victims, and only 2.5% of the victims were confined on drug offenses. Of interest, approximately 40% (13 of 33) of the victims housed in a *Training School/Secure Facility* were confined for a Person Offense.

With slight variance, these findings were consistent with recent data on the confined juvenile population throughout the country. For example, Person offenses accounted for 35%, and Property offenses accounted for 29%, of all confined juveniles throughout the country (Sickmund & Wan, 2001); whereas they each accounted for 30.4% and 32.9%, respectively, in this study. However, whereas the Public Order, Status, and Probation Violation categories combined represented 27% of all confined juveniles, these categories represented 34.2% of the victims in this study, a slight increase.

Approximately two-thirds (67.1%) of the victims were being held on commitment status at the time of their death.¹⁰ This finding was significantly different than a national study on jail suicides which found that the overwhelming majority of victims were on detention status at the time of their death (Hayes, 1989). The finding was, however, somewhat consistent with national data of confined juveniles throughout the country which found that 74% of youth

were on commitment status (Sickmund & Wan, 2001). Not surprisingly, the vast majority (88.5%) of victims held in *Detention Centers* were on detention status, and all of the *Training School/Secure Facility* victims were on commitment status, at the time of their deaths.

WE'RE LOOKING FOR A FEW GOOD PROGRAMS

Future issues of the *Jail Suicide/Mental Health Update* will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility's suicide prevention policy contain, and do your practices reflect, the following critical elements?

- ◆ Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- ◆ Suicide prevention training for correctional, medical, and mental health staff;
- ◆ Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- ◆ Suicide-resistant, protrusion-free housing of suicidal inmates;
- ◆ Levels of supervision for suicidal inmates;
- ◆ Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- ◆ Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- ◆ A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an up-coming issue of the *Update*, please contact:

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**TABLE 2
MOST SERIOUS OFFENSE**

MOST SERIOUS OFFENSE	DETENTION CENTER	TRAINING SCHOOL/SECURE FACILITY	RECEPTION/DIAGNOSTIC CENTER	RESIDENTIAL TREATMENT CENTER	COMBINED N PERCENT
Person	8	13	2	1	24 (30.4)
Property	11	10	2	3	26 (32.9)
Drug	0	1	0	1	2 (2.5)
Public Order	2	3	1	2	8 (10.1)
Status	2	4	0	4	10 (12.7)
Probation Violation	6	2	0	1	9 (11.4)
TOTAL	29	33	5	12	79 (100.0)

3. Length of Confinement (Prior to Suicide)

As presented in Table 3, less than 4% of the juvenile suicides occurred within the first 24 hours of confinement (and all of these deaths occurred in Detention Centers). This finding was significantly different from a national study on jail suicides which found that over 50 percent of suicides took place within the first 24 hours, with almost a third of the deaths occurring within the first three hours (Hayes, 1989). Instead, the deaths in this national survey of juvenile suicide in confinement were

distributed fairly evenly during a more than 12-month period. For example, the same number of suicides (10) occurred within 1 to 3 days confinement as occurred in more than 12 months confinement.¹¹ The majority of suicides (31.6%) occurred during 1 and 4 months confinement. However, it should also be noted that *all* of the *Detention Center* suicides occurred within the first four months of confinement, with over 40 percent occurring within the first 72 hours; whereas the vast majority (72.7%) of *Training School/Secure Facility* suicides occurred three months or more following confinement.¹²

**TABLE 3
LENGTH OF CONFINEMENT (PRIOR TO SUICIDE)**

LENGTH OF CONFINEMENT	DETENTION CENTER	TRAINING SCHOOL/SECURE FACILITY	RECEPTION/DIAGNOSTIC CENTER	RESIDENTIAL TREATMENT CENTER	COMBINED N PERCENT
Less than 24 Hours	3	0	0	0	3 (3.8)
1-3 Days	9	0	0	1	10 (12.6)
4-6 Days	3	0	0	0	3 (3.8)
7-13 Days	3	3	0	0	6 (7.6)
14-30 Days	4	2	1	1	8 (10.1)
1-2 Months	4	4	3	2	13 (16.5)
3-4 Months	3	7	0	2	12 (15.2)
5-6 Months	0	4	0	3	7 (8.9)
7-9 Months	0	2	1	1	4 (5.1)
10-12 Months	0	1	0	2	3 (3.8)
More than 12 Months	0	10	0	0	10 (12.6)
TOTAL	29	33	5	12	79 (100.0)

4. Substance Abuse, Medical Problems, Emotional Abuse, Physical Abuse, and Sexual Abuse

A large majority (87.9%) of the victims had a history of substance abuse. Approximately one-third (32.8%) of the victims with a substance abuse history used alcohol, marijuana, and cocaine prior to their confinement. This finding was consistent with, and perhaps even higher than, other recent data suggesting that two-thirds of confined youth have one or more alcohol, drug or mental (ADM) disorders (Teplin, Abram, McClelland, Dulcan & Mericle, 2002). Also of particular interest was the large percentage of unknown (N=13) responses to this variable, particularly *Detention Centers* which accounted for most (11 of 13) of the non-responses, a finding that might relate to the efficacy of intake screening at these facilities.

A large majority (77.3%) of the victims did not have a history of medical problems. Allergies and asthma were common types of medical problems found in the few victims with such histories. Again, of particular interest was the large percentage of unknown (N=13) responses to this variable, particularly *Detention Centers* which accounted for most (10 of 13) non-responses, a finding that might relate to the efficacy of intake screening at these facilities.

A majority (58.3%) of the victims had a history of emotional abuse. The most frequent examples of this abuse were excessive punishment, neglect and/or abandonment, verbal abuse, or other types of general dysfunction within the family. Again, of particular interest was the large percentage of unknown (N=19) responses to this variable, particularly *Detention Centers* which accounted for many (10 of 19) of the non-responses, a finding that might relate to the efficacy of intake screening at these facilities.

A history of physical abuse was found in 43.5% of the victims, with an immediate family member (e.g., father or step-father) being the perpetrator of the abuse in the vast majority (20 of 27) of cases. Again, of particular interest was the large percentage of unknown (N=17) responses to this variable, particularly *Detention Centers* which accounted for many (8 of 13) of the non-responses, a finding that might relate to the efficacy of intake screening at these facilities.

A history of sexual abuse was found in 38.6% of the victims, with an immediate family member (e.g., father or step-father) being the perpetrator of the abuse in many of the cases. Again, of particular interest was the large percentage of unknown (N=22) responses to this variable, particularly *Detention Centers* which accounted for many (11 of 22) of the non-responses, a finding that might relate to the efficacy of intake screening at these facilities.

5. Mental Illness

A history of mental illness was found in 74.3% of the victims, with the vast majority (65.3%) suffering from depression at the time of their deaths. Other types of mental illness reported included attention deficit/hyperactivity disorder, conduct disorder, post-traumatic stress disorder, and psychotic disorder.¹³ Although this finding was consistent with prior research indicating that a high percentage of youth in the juvenile justice system suffered from at least one mental disorder and have higher rates of mental disorders than youth in the general population (Cocozza & Skowrya, 2000),

it should also be noted that substance abuse disorder (which accounts for a sizable percentage of psychiatric orders) was not included in this category. Again, of particular interest was the percentage of unknown (N=9) responses to this variable, particularly *Detention Centers* which accounted for *all* of the non-responses, a finding that might relate to the efficacy of intake screening at these facilities. In addition, 53.5% of the victims were taking psychotropic medication at the time of their deaths.

6. Suicidal Behavior

As presented in Table 4, a history of suicidal behavior was found in 71.4% of the victims. The most frequent type of suicidal behavior was suicide attempt(s) (45.5%), followed by suicidal ideation and/or threat (30.9%) and suicidal gesture and/or self-mutilation (23.6%). Although prior research summarized earlier in this report showed a notable percentage (varying widely between 8 and 52%) of confined youth had a history of suicidal behavior, the finding from this national survey would seem to suggest that the vast majority of confined youth who commit suicide have a higher percentage of prior suicidal behavior than those confined youth who engage in suicidal behavior but do not commit suicide. Of particular interest was the lower percentage (55.5%) of *Detention Center* victims with *known* histories of suicidal behavior, a finding that might relate to the efficacy of intake screening at these facilities to inquire about such history.

7. History of Room Confinement

For purposes of this study, *room confinement* was defined as a "behavioral sanction imposed on youth that restricted movement for varying amounts of time. It included, but was not limited to, isolation, segregation, time-out, or a quiet room." Room confinement did *not* include a youth assigned to their room during traditional sleeping hours. The study found that 62 percent of victims had a history of room confinement. The circumstances that lead to room confinement included threat/actual physical abuse of staff or peers (40.5%), threat/actual verbal abuse of staff or peers (26.2%), failure to follow program rules/inappropriate behavior (26.2%), and other (7.1%).¹⁴

B) Suicide Incident Characteristics

1. Date and Time

The suicides were equally distributed during the five-year study period of 1995 through 1999; and distributed throughout the year, although January and May accounted for more than 30% of all the reported deaths. Contrary to common belief, certain seasons of the year and holidays did *not* account for a higher number of suicides. Further, there was not any statistically significant difference regarding the day of the week in which the suicides occurred.

Research in the area of adult jail suicide has found that deaths were more prevalent when staff supervision was reduced. For example, less than 20% of all deaths in a national study of jail suicides occurred during the six-hour period between 9:00am and 3:00pm, a major portion of the day shift (Hayes, 1989). In contrast, and as shown in Table 5, findings from this study indicated that 70.9% of suicides occurred during traditional waking hours (7:01am to 9:00pm),

**TABLE 4
SUICIDAL BEHAVIOR**

SUICIDAL BEHAVIOR	DETENTION CENTER	TRAINING SCHOOL/SECURE FACILITY	RECEPTION/DIAGNOSTIC CENTER	RESIDENTIAL TREATMENT CENTER	COMBINED N PERCENT
Yes	15	26	5	9	55 (71.4)
No	12	7	0	3	22 (28.6)
TOTAL	27	33	5	12	77 (100.0)

Unknown = 2

whereas 29.1% of suicides occurred during traditional sleeping hours (9:01pm to 7:00am). In addition, approximately half (50.6%) of all suicides occurred during a six-hour period of 6:01pm and midnight, and almost a third (29.1%) of *all* suicides sustained between 6:01pm and 9:00pm.

2. Method, Instrument and Anchoring Device

The study found that all but one victim (98.7%) chose hanging as the method of suicide.¹⁵ The vast majority (71.8%) of the victims utilized bedding (e.g., sheet, blanket, etc.) as the instrument to hang themselves. Clothing, excluding belts and shoelaces, was utilized to a lesser degree. The victims utilized a variety of anchoring devices to commit suicide, including door hinge/knobs (21.1%), air vents (19.7%), bed frames (19.7%), and window frames (14.5%). Other devices included closet rods, toilets, sinks, and television stands.

3. Intoxication

In perhaps the most surprising finding of the study, *none* of the 79 victims were under the influence of alcohol and/or drugs at the time of their suicides. This finding is in stark contrast to a national study on jail suicides which found that over 60 percent of the adult

suicide victims were intoxicated at the time of their suicides (Hayes, 1989).

4. Room Assignment and Time Span (Between Last Observation and Finding Victim)

At the time of the suicides, the data indicated that 74.7% of the victims were assigned to single occupancy rooms, whereas 25.3% were assigned to multiple occupancy rooms. There were no significant differences between room assignments and the types of facilities where the suicides occurred. The study found that 41% of the respondents stated that staff found the victim in less than 15 minutes following the last observation of the youth. However, slightly more than 15% of the victims were reported to be found after more than an hour following the last observation, including several victims found after 3 hours.

5. Room Confinement (at the Time of Suicide)

As shown in Table 6, approximately 50% of all suicide victims were on room confinement status at the time of their deaths. Further, compared to other facility types, a much smaller percentage (16.6%) of suicide victims housed in *Residential Treatment Centers* were on room confinement status at the time of their deaths.

**TABLE 5
TIME OF SUICIDE**

TIME OF SUICIDE	DETENTION CENTER	TRAINING SCHOOL/SECURE FACILITY	RECEPTION/DIAGNOSTIC CENTER	RESIDENTIAL TREATMENT CENTER	COMBINED N PERCENT
12:01 a.m.-3:00 a.m.	1	2	0	0	3 (3.8)
3:01 a.m.-6:00 a.m.	1	1	0	1	3 (3.8)
6:01 a.m.-9:00 a.m.	1	1	1	0	3 (3.8)
9:01 a.m.-12:00 p.m.	5	5	0	1	11 (13.9)
12:01 p.m.-3:00 p.m.	2	3	1	1	7 (8.9)
3:01 p.m.-6:00 p.m.	5	5	0	2	12 (15.2)
6:01 p.m.-9:00 p.m.	8	9	2	4	23 (29.1)
9:01 p.m.-12:00 a.m.	6	7	1	3	17 (21.5)
TOTAL	29	33	5	12	79 (100.0)

**TABLE 6
ROOM CONFINEMENT**

ROOM CONFINEMENT	DETENTION CENTER	TRAINING SCHOOL/SECURE FACILITY	RECEPTION/DIAGNOSTIC CENTER	RESIDENTIAL TREATMENT CENTER	COMBINED N PERCENT
Yes	16	18	4	2	40 (50.6)
No	13	15	1	10	39 (49.4)
TOTAL	29	33	5	12	79 (100.0)

In addition and of particular interest, 85% of victims who committed suicide while on room confinement status died during waking hours (7:01am to 9:00pm), a percentage found to be higher than those victims who committed suicide during waking hours but not on room confinement status (70.9%). The circumstances that lead to room confinement included failure to follow program rules/inappropriate behavior (47.3%), threat/actual physical abuse of staff or peers (42.1%), and other (10.6%).¹⁶

6. Suicide Precaution Status

Only a small percentage (16.5%) of youth were on suicide precaution status at the time of their deaths. Of the 13 victims on suicide precaution status, 10 were required to be observed at 15-minute intervals, with the remaining youth allegedly observed at continuous, 5-minute and 60-minute intervals. In addition, despite their identified risk of suicide, almost half (6 of 13) of these victims were found to be last observed in *excess* of 15 minutes prior to the suicide.

7. Assessment and Last Contact by Qualified Mental Health Professional

Separate from initial intake screening, national juvenile correctional standards and standard correctional practice indicates that all confined youth should be assessed as soon as possible by a qualified mental health professional (National Commission on Correctional Health Care, 1995, 1999; Roush, 1996; Underwood & Berenson, 2001), with Performance-based Standards requiring an assessment within 7 days of entry into the facility (Council of Juvenile Correctional Administrators, 2003).¹⁷ For purposes of this study and consistent with national standards, *qualified mental health professional* was defined as “an individual by virtue of their education, credentials, and experience that is permitted by law to evaluate and care for the mental health needs of patients. May include, but is not limited to, a psychiatrist, psychologist, clinical social worker, and psychiatric nurse.”

The study found that the vast majority (69.6%) of victims were assessed by a qualified mental health professional (QMHP). In addition, compared to other facility types, a much smaller percentage (34.5%) of suicide victims housed in *Detention Centers* received mental health assessments prior to their deaths. It should be noted, however, that slightly over half (51.7%) of all *Detention Center* victims committed suicide within the first 6 days of confinement, thus possibly precluding the opportunity for assessment.

Of those victims receiving a mental health assessment prior to their deaths, almost half (49.1%) had a contact visit with a QMHP within 6

days of their deaths. However, the data also showed that 20% of the assessed victims had not been assessed by a QMHP within 30 days of their death and, combined with those victims that were never assessed by a QMHP, suggested that slightly less than half (44.3%) of *all* victims in the study either had never been assessed by a QMHP or had not been assessed by a clinician within 30 days of their deaths.

C) Juvenile Facility Characteristics

1. Facility Type and Population

As previously indicated, this national survey of juvenile suicide in confinement found that 41.8% of the juvenile suicides took place in *Training School/Secure Facilities*, while 36.7% occurred in *Detention Centers*, 15.2% in *Residential Treatment Centers*, and 6.3% in *Reception/Diagnostic Centers*. In addition, almost half (48.1%) of the suicides occurred in facilities administered by state agencies, while 39.2% took place in county facilities, and 12.7% in private programs.

Further, the vast majority (71.6%) of suicides occurred in facilities with populations of 200 youth or less, with 44.6% of all deaths in facilities with 50 or less youth.¹⁸ The study did *not* find any evidence to suggest that overcrowding was a contributing factor to juvenile suicide. In fact, the data indicated that the majority (67.6%) of facilities were either at, or below, bed capacity at the time of the suicides, with an additional 9.5% slightly over (less than 10%) capacity.

2. Written Suicide Prevention Policy

National juvenile correctional standards and standard correctional practice indicate that all juvenile facilities should have a written suicide prevention policy that details the identification and management of suicidal youth (American Correctional Association, 1991; Council of Juvenile Correctional Administrators, 2003; Hayes, 1999; National Commission on Correctional Health Care, 1995, 1999; Roush, 1996). The vast majority (78.5%) of respondents reported that their facilities maintained a written suicide prevention policy at the time of the suicide, although *Detention Centers* maintained suicide prevention policies to a lesser degree (62%).

Intake Screening

The vast majority (70.9%) of respondents reported that they maintained an intake screening process to identify suicide risk of youth entering the facility, although less than half (48.2%) of the *Detention Centers* maintained an intake screening process to identify suicide risk. This finding is very consistent with recent OJJDP data

suggesting that approximately 70% of all confined youth are screened for suicide risk (OJJDP, 2002).

Training

More than half (56.9%) of respondents reported that they provided suicide prevention training to all of their direct care staff. In addition, of those respondents who provided suicide prevention training at the time of the suicide, the vast majority (66.7%) provided annual instruction. However, only 42.1% of *Training Schools/Secure Facilities* that provided suicide prevention training did so on an annual basis. Of those respondents who provided suicide prevention training, but *not* on an annual basis, furnished it either on a pre-service and/or periodic basis. Finally, only 37.9% (30 of 79) of *all* facilities that experienced a suicide provided annual suicide prevention training to its direct care staff.

The vast majority (65.7%) of respondents who provided suicide prevention training to all direct care staff offered the instruction in a 1- or 2-hour block. A full day (7-8 hours) of suicide prevention instruction was offered in only 8.6% of facilities providing such training, as well as only in 3.8% (3 of 79) of *all* facilities that experienced a suicide.

The vast majority (68.4%) of respondents reported that all direct care staff had received certification in cardiopulmonary resuscitation (CPR) at the time of the suicide, although to a lesser degree (54.5%) in *Training Schools/Secure Facilities*.

Suicide Precaution Observation Levels

The overwhelming majority (89.9%) of respondents reported that their facilities maintained a suicide precaution protocol for the observation of youth (excluding closed circuit television monitoring) at the time of the suicide. Less than half (48.6%) of the respondents indicated that constant observation was the highest level of suicide precaution in the facility, with a sizable number (37.1%) of facilities listing observation at 15-minute intervals as the highest suicide precaution level. Of interest, only 29.1% (7 of 24) of *Detention Center* respondents indicated that constant observation was the highest level of suicide precaution in their facilities.

Housing

The study found that less than half (45.6%) of respondents indicated that the facility had a housing process by which a suicidal youth would be assigned to a safe and protrusion-free room. In fact, although the majority (60%) of both *Training Schools/Secure Facilities* and *Reception/Diagnostic Centers* provided safe and protrusion-free housing for suicidal youth, only 34.4% of *Detention Facilities* and 25% of *Residential Treatment Centers* provided such housing

Mortality Review

National juvenile correctional standards recommend that a mortality review be conducted following each serious suicide attempt (i.e. requiring hospitalization) and suicide (Hayes, 1999; National Commission on Correctional Health Care, 1995, 1999; Roush, 1996). For purposes of this study, *mortality review* was defined as “a multidisciplinary committee process that examined the

events surrounding the death to determine if the incident was preventable. The review process might include recommendations aimed at reducing the opportunity of future deaths.” The process also attempts to identify any possible precipitating factors which may have caused the victim to commit suicide.

The majority (64.6%) of respondents in this study reported that a mortality review was conducted following the juvenile suicide, although *Detention Centers* conducted mortality reviews to a lesser degree (51.7%). In addition, more than half (58.8%) of the respondents who conducted mortality reviews reported a wide variety of possible precipitating factors to the deaths, including the following: fear of waiver to adult system, transfer to a more secure juvenile facility, or pending undesirable placement (including home) [10 cases]; recent death of a family member [6 cases]; failure in the program [5 cases]; contagion (from another recent suicide in facility) [3 cases]; parent(s) threat of/failure to visit [2 cases]; and other (loss of relationship, close proximity to birthday, suicide pact with peer, ridicule from peers) [4 cases].¹⁹

Finally, however, it should also be noted that of the 79 suicides reported in this study, possible precipitating factors for the deaths were offered by respondents in *only* 30 (or 37.9%) of the cases.

IV.

SPECIAL CONSIDERATIONS

A) Comprehensive Suicide Prevention Programming

National juvenile correctional standards and standard correctional practice require that all juvenile facilities have a written suicide prevention policy that includes a variety of components (American Correctional Association, 1991; Council of Juvenile Correctional Administrators, 2003; Hayes, 1999; National Commission on Correctional Health Care, 1995, 1999; Roush 1996). In OJJDP’s *Conditions of Confinement* study, researchers evaluating suicide prevention practices used four specific assessment criteria (written procedures, intake screening, staff training, and close observation), and found that 89% of the juveniles were housed in facilities with a written suicide prevention plan; 72% in facilities that screened juveniles for suicide risk at admission; 75% in facilities where staff were trained in suicide prevention; and 50% in facilities that monitored suicidal youth at least four times per hour. However, the OJJDP study found that *only 25% of confined juveniles were in facilities that conformed to all four suicide prevention assessment criteria* (Parent, Leiter, Kennedy, Livens, Wentworth & Wilcox, 1994).

And although the OJJDP study could not assess the quality of each of the four criteria operating within the juvenile facilities because most of the data was self-reported, other findings were equally revealing. For example, the data showed that: 1) facilities which conducted screening for suicide risk at admission and trained their staff in suicide prevention had lower rates of suicidal behavior among their residents; and 2) while written policies to provide close observation of suicidal residents did not appear to significantly reduce the rate of suicidal behavior, it could be very important in reducing completed suicides because many times the policy is implemented after the risk and/or attempt are recognized (Parent, Leiter, Kennedy, Livens, Wentworth & Wilcox, 1994).

For purposes of this national survey of juvenile suicide in confinement, data were collected to determine whether facilities sustaining a suicide had comprehensive suicide prevention programming in place at the time of the death. Consistent with national juvenile correctional standards, comprehensive suicide prevention programming included the following *seven* critical components: written policy, intake screening, training, CPR certification, observation, safe housing, and mortality review (Hayes, 1999). As previously indicated, the vast majority of respondents in this study indicated they had a written suicide prevention policy at the time of suicide. However, as shown in Table 7, *only 20.3% of facilities had written policies encompassing all seven suicide prevention components at the time of the suicide.* The degree to which facilities had all seven suicide prevention components varied considerably by facility type: *Detention Centers* (10.3%), *Training Schools/Secure Facilities* (24.2%), *Reception/Diagnostic Centers* (40.0%), and *Residential Treatment Centers* (25.0%)

Consistent with OJJDP’s *Conditions of Confinement* study, these findings suggest that, although there was a higher rate of compliance with individual suicide prevention components, few facilities that sustained a suicide had all components of a comprehensive suicide prevention program.

B) Room Confinement

No one still seems to understand. I don’t want to be alone. I can’t seem to trust anyone, and I am afraid of my own self. I just want to die. I wish I could stop the pain. I am lonely every day, trapped in my own hell that I created. I probably won’t ever go home. I miss my old life. To think I gave it up for a man. Pathetic! I’ll probably never forgive myself. I don’t believe this is my life. I just want out... anyway possible. I feel if I had a roommate... someone to express my self to. When I start feeling bad, it could help me and prevent

anything happening to me. I think that’s my only problem... is being alone. Does any one hear my cries? God! I’ve only failed myself. I hate being me. In a giant rat race to the final battle... death. Forget it, you’ll never win. Forsake this bashful tear, bring my life back to you.

The 16-year-old girl who authored the above letter committed suicide shortly after her placement on “off-program” status, a sanction requiring room confinement of four hours duration for failure to attend school. Isolation and segregation, terms commonly utilized in the adult corrections field, are rarely heard in the juvenile corrections system, perhaps because of their harsh tones. Instead, isolation in a juvenile facility is often referred to as “room confinement,” a term that has many faces, including time-out, quiet time, restriction, adjustment, conflict resolution, room lock, and off-program. Youth who are removed from the room in which they normally sleep are often held in seclusion, exclusion, separation, and special management. In addition, an entire housing unit may be confined to their rooms at various parts of a day (under the umbrella of “large group lockdown,” “marathon,” “freeze,” or “suspension”) due to staff shortages, staff convenience, or to punish an entire group for the actions of a few non-conforming youth. All these protocols could be considered hidden forms of isolation, the basic separation from both staff and peers.

In addition, although room confinement is often utilized as a behavioral sanction resulting from assaultive and/or disruptive behavior, as well as a form of quarantine for newly arrived residents and/or those in need of protective custody, it is also used for suicidal youth. For example, a recent investigation of conditions of confinement within a state juvenile correctional system by the U.S. Department of Justice found that:

Girls in the SIU (Special Intervention Unit) at Columbia are punished for acting out or being suicidal by being placed in a cell called the ‘dark room.’ The ‘dark room’ is

**TABLE 7
SUICIDE PREVENTION COMPONENTS**

SUICIDE PREVENTION COMPONENTS	DETENTION CENTER	TRAINING SCHOOL/SECURE FACILITY	RECEPTION/DIAGNOSTIC CENTER	RESIDENTIAL TREATMENT CENTER	COMBINED N PERCENT
0	2	0	0	0	2 (2.5)
1	2	0	0	1	3 (3.8)
2	2	3	0	1	6 (7.6)
3	4	2	0	1	7 (8.8)
4	4	8	1	3	15 (19.0)
5	6	5	1	1	13 (16.5)
6	6	9	1	2	17 (21.5)
7	3	9	2	3	16 (20.3)
TOTAL	29	33	5	12	79 (100.0)

a locked, windowless isolation cell with lighting controlled by staff. When the lights are turned out, as the girls reported they are when the room is in use, the room is completely dark. The room is stripped of everything but a drain in the floor which serves as a toilet.

Most girls are stripped naked when placed in the 'dark room.' According to Columbia staff, the reason girls must remove their clothing before being placed in the room is that there is metal grating on the ceiling and the cell door which could be used for hanging attempts by suicidal girls. (U.S. Department of Justice, 2003, p. 7).

And while room confinement and isolation can be effective behavioral management tools when appropriately utilized for short durations which are both closely monitored and clearly documented (see National Commission on Correctional Health Care, 1999), the concern is overuse and abuse. In fact, the mere presence of a separate isolation unit within a juvenile facility may provide an environment in which there is likely to be an over-reliance on isolation as the primary behavior management strategy (Mitchell & Varley, 1990). Other recent federal investigations of several juvenile correctional systems throughout the country have found both excessive and unjustified use of isolation and room confinement (*United States v. State of Georgia*, 1998; *United States v. Commonwealth of Kentucky*, 1995; *United States v. States of Louisiana*, 2000; *United States v. Commonwealth of Puerto Rico*, 1997). In one example, the U.S. Department of Justice found that:

The use of isolation rooms at the facilities is improper and potentially abusive. Staff isolate youth far too frequently and isolation practices are generally outside the requirements of residential treatment or facility security. Due process procedures are significantly lacking and youth are isolated for extended periods of time to suit the staff. One youth was isolated for fifteen days 'for acting out and planning an escape.' Another youth was isolated for three days for being 'sarcastic with a smart mouth.' In practice, staff use the isolation rooms to excessively punish youth or simply when the staff are tired of dealing with a specific youth (U.S. Department of Justice, 1995, p. 3).

Nationally, Parent, et. al. (1994) found although the use of isolation varied considerably among facility types, during a 30-day period, there were 57 incidents per 100 youth of isolation for less than 24 hours and 11 incidents per 100 youth of isolation for more than 24 hours.²⁰ A more recent national census found that approximately 17% of confined youth spend more than four hours per month in room confinement (OJJDP, 2002). In addition, an assessment of conditions of confinement in one juvenile detention facility found that approximately 10% of confined youth were on disciplinary room confinement status on any given day, often for relatively minor incidents such as horseplay and being disrespectful to staff (John Howard Association, 1998). As a result of subsequent litigation, the facility entered into a consent decree requiring that:

...room confinement for therapeutic purposes will be employed only upon written order of a...qualified mental

health professional...who has personally observed and examined the resident and has clinically determined that the use of room confinement is necessary to prevent the recipient from causing imminent physical harm to himself or others, and that no other less restrictive intervention is appropriate...disciplinary room confinement is used only when no less restrictive form of punishment is appropriate, and that youth who are confined to their rooms are permitted to rejoin the general population when capable of doing so without further disruption to the detention operations... (*Jimmy Doe, et. al. v. Cook County, et. al.*, 2002, at pp. 23, 34-35).

Data from this national survey of juvenile suicide in confinement appeared to show a strong relationship between juvenile suicide and room confinement — 62% of victims had a history of room confinement prior to their deaths and 50% percent of victims were on room confinement status at the time of their deaths. Perhaps more importantly, 85% of victims who committed suicide while on room confinement status died during waking hours

Although the relationship between suicide and isolation is well documented in the adult inmate suicide literature (Bonner, 1992; Hayes, 1989), the issue has not been previously explored in depth regarding juvenile suicide. However, Liebling (1993) did find that suicidal youth in confinement appeared to feel more isolated, received fewer visits, wrote fewer letters, and missed loved ones more than non-suicidal youth in custody. Parent et. al. (1994) found that 77% of all confined youth were in facilities that permitted the use of isolation, and that rates of suicidal behavior appeared to be higher for youth who were isolated from their peers or assigned to single room housing. Porter (1996) theorized that suicides were more likely to occur in juvenile correctional facilities when youth are further removed from each other, were more alienated, and lacked social integration. Facilities officials that promoted these policies were clearly more likely to experience higher rates of suicidal behavior. Likewise, policies and practices that lessened the degree to which confined youth were allowed contact and interaction with one another could increase a facility's risk of experiencing higher rates of suicidal behavior (Porter, 1996). In conclusion, as one clinician succinctly noted: "When placed in a cold and empty room by themselves, suicidal youth have little to focus on — except all of their reasons for being depressed and the various ways that they can attempt to kill themselves" (Boesky, 2002, p. 210).

C) Corrective Action

The building was haunted with death. The insulated room at the far end of the moldering basement had once been the morgue for the hospital next door. In March, a year before I came, fourteen-year-old George Dunbar hanged himself upstairs on a pipe in Room 205. A poor black youngster. Alive and well and waiting for his breakfast at 7:00am shift change. Hanging dead, with a sheet around his neck at 7:12am. Few people noticed. Maybe Officers Ed Deitrick and Greg Lyons, who found him there. The prosecutor. A delegation from the National Council of Jewish Women who came to investigate sat stunned in their cars. They said that the building spoke to them: the

Children’s Shelter, a place where floors sparkled but where children never sparkled (Previte, 1994, p. 9).

Thus began the introduction to *Hungry Ghosts* and Mary Taylor Previte’s description of the sentinel event in 1973 that transformed the Camden County Children’s Shelter into a humane environment for throwaway youth.

This national survey of juvenile suicide in confinement also found that suicide was a sentinel event for many facilities. As previously reported, approximately two-thirds of respondents reported that a mortality review was conducted following the juvenile suicide. In addition, the vast majority (86.3%) of respondents who conducted mortality reviews reported multiple recommendations promulgated to reduce the likelihood of future suicides in the facility. The most frequent recommendations included: developing/revising suicide prevention policies (20 cases); removing room hazards (20 cases); increasing suicide prevention training (18 cases); fostering better internal communication among staff and/or external communication with outside agencies (11 cases); increasing supervision of youth (10 cases); hiring additional direct care staff (9 cases); increasing on-site qualified mental health professionals (QMHP) and/or daily assessment of suicidal youth (8 cases); and providing critical incident stress debriefing to staff and youth (6 cases). In three cases, facility staff were either disciplined or fired; in two other cases, the facilities were closed.

During a 16-month period from October 1996 through January 1998, one facility sustained five juvenile suicides, three of which occurred during a two-week period. As a result of the deaths, the facility underwent dramatic changes, including, but not limited to, the following: for several weeks during and after the crisis, lights in all resident rooms were left on 24 hours a day and all youth were observed at 15-minute intervals; critical incident stress debriefing was given to all staff and youth; the number of direct care staff and QMHP were dramatically increased; basic suicide prevention training was increased to 8-hours instruction, and a 2-hour annual refresher training was developed; housing units were renovated to ensure that they provided better staff visibility of youth and were free of obvious protrusions and hazards to suicide; and suicide prevention policies and screening/assessments forms were revised. In April 1998, an oversight committee of the state legislature met in special session and appropriated approximately \$2 million to fund the corrective action measures. Finally, the facility faced and subsequently settled civil litigation arising out of four of the five suicides.

It is not unusual for corrective action measures to be implemented following a death or litigation (Hayes, 1994). For example, in March 2003, the Civil Rights Division of the U.S. Department of Justice entered into a settlement agreement with the State of Arkansas regarding conditions of confinement (including two suicides) at one of its juvenile detention facilities. The agreement required several substantive remedial measures including, but not limited to, increased suicide prevention training for staff, better communication among staff in managing suicidal youth, and “revisions in the facility’s suicide prevention policy to appropriately clarify what type of staff can place a juvenile on suicide precautions, specify what type of staff can remove a juvenile from such precautions, and provide for sufficient and appropriate daily interactions between qualified mental health personnel and every

juvenile on suicide precautions” (*United States v. State of Arkansas*, 2003, p. 4). Similar corrective action for juvenile suicide prevention programming has been agreed to through settlement agreements in Georgia (*United States v. State of Georgia*, 1998), Kentucky (*United States v. Commonwealth of Kentucky*, 1995), Louisiana (*United States v. States of Louisiana*, 2000), and Puerto Rico (*United States v. Commonwealth of Puerto Rico*, 1997).

V. CONCLUSION AND FINAL THOUGHTS

While youth suicide in the community has been identified as a major public health problem, juvenile suicide in confinement has received little attention. The primary goal of this project was, for the first time, to determine the extent and distribution of juvenile suicides in confinement, as well as to gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the juvenile facility which sustained the suicide. In the end, the study compiled significant data on juvenile suicides throughout the country, and it is hoped that these findings can be utilized as a resource tool for both juvenile justice practitioners in expanding their knowledge base, and juvenile correctional administrators in creating and/or revising sound policies and training curricula on suicide prevention.

A) Comprehensive Suicide Prevention Programming

The findings suggested that, although there was a high rate of compliance with individual suicide prevention components, few juvenile facilities that sustained a suicide had all components of a comprehensive suicide prevention program. Consistent with national correctional standards and practices, all juvenile facilities, regardless of size and type, must have a detailed written suicide prevention policy that addresses each of the following critical components: training, identification/screening, communication, housing, levels of supervision, intervention, reporting, and mortality review.

B) Future Training Efforts

Although findings from this study suggested that some type of suicide prevention training was conducted in most facilities, only a third of all facilities experiencing a suicide provided annual training and very few facilities provided a full day of training to its personnel. Coupled with recent census data indicating that almost a quarter of all intake screening for suicide risk in juvenile facilities throughout the country is conducted by untrained personnel (OJJDP, 2002), it would be prudent for administrators to ensure that all direct care, medical and mental health personnel receive regular and comprehensive instruction in suicide prevention.

Further, for the most part, current suicide prevention training curricula utilized in juvenile facilities throughout the country relies on information gathered from *adult* inmate suicide. Findings from this study clearly demonstrate that there are several differences between adult inmate suicide and juvenile suicide including, but not limited to, confinement status, intoxication, length of confinement prior to suicide, and time of day. These significant differences should give pause to utilizing training curricula from the adult correctional field in the

prevention of suicide in juvenile facilities. Although there is common ground to suicide prevention in *all* types of correctional facilities, it would appear that the differences between juvenile and adult inmate suicide warrant development of separate training curricula targeted to suicide prevention within juvenile facilities.

At the minimum, basic suicide prevention training for all direct care, medical, and mental health personnel who work in juvenile facilities should include, but not be limited to, the following: discussion on why facility environments are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, warning signs and symptoms, identification of suicide risk despite the denial risk, high-risk periods, components of the facility's suicide prevention policy, instruction regarding the proper role of staff in responding to a suicide attempt (includes a mock drill), critical incident stress debriefing, liability issues, and general discussion about recent serious suicide attempts and/or suicides within the facility/agency.

Staff are at a distinct disadvantage in both the identification and management of suicidal youth if they have received little, or no training in suicide prevention. Bluntly stated, young lives will continue to be lost and jurisdictions will incur unnecessary liability from these tragic deaths if administrators do not create and maintain effective training programs.

C) Detention Centers

Findings from this study indicated that a high percentage of unknown responses to survey questions relating to several personal characteristics of the victim (including histories of substance abuse, medical problems, emotional abuse, physical abuse, sexual abuse, and mental illness) came from detention center respondents.²¹ In addition, suicide victims housed in detention centers had a lower percentage of reported histories of suicidal behavior. Finally, although the study found that many facility types lacked comprehensive suicide prevention programming at the time of the suicide, detention centers had the lowest percentage (approximately 10%).

According to the National Juvenile Detention Association (NJDA), *juvenile detention* is defined as being “the temporary and safe custody of juveniles who are accused of conduct subject to the jurisdiction of the court who require a restricted environment for their own and the community’s protection while pending legal action” (National Juvenile Detention Association, 1990). Due to the lack of available community resources, detention centers often bare the responsibility for troubled youth because of their unique ability to provide physical custody. In addition, few would disagree that juvenile detention centers are both ill-equipped and under-resourced to provide anything more than basic health care services on a short-term basis. However, while the “temporary” nature of the detention center experience may help to explain some of the survey findings regarding these types of facilities, such a distinction should not be viewed as a mitigating factor for suicide prevention. All juvenile facilities, regardless of size and mission, have a responsibility for the safety of its youth, particularly those at risk for self-harm.

The findings from this study lend support to the NJDA’s position that although youth with severe mental illness should

be provided services in “the appropriate therapeutic environment...when juvenile detention facilities are forced to house youth with severe mental health issues, NJDA promotes the provisions of adequate services by appropriately trained and licensed specialists” (National Juvenile Detention Association, 2001). More importantly, these findings suggest that the significant deficiencies in the scope of not only intake screening, but overall suicide prevention programming within detention centers experiencing suicides, warrant immediate attention. Resources need to be channeled to all juvenile facilities throughout the country, particularly detention centers, to ensure that any agency housing a juvenile provides basic, yet comprehensive suicide prevention programming.

D) Data Limitations

Given the epidemiological data regarding youth suicide in the community, coupled with the increased risk factors associated with confined youth, the reported number of suicides in this study would appear low. However, this study did identify more deaths per year than a recent national census of juvenile facilities (OJJDP, 2002), and many experts believe that the current “self-reporting” of juvenile suicide in custody is under-reported (Sullivan, 1995, Twedt, 2001b). Despite concerted efforts by project staff to locate all possible juvenile suicides during the five-year study period, it remains uncertain as to whether every death was identified.

Further, approximately 13% of the reported suicides in this study were identified through non-traditional sources (including newspaper articles and the project director’s consultation with facilities sustaining the deaths). In addition, *more than one-third of the reported suicides were unknown to any state agency* (e.g., departments of juvenile corrections, as well as agencies responsible for licensing and regulatory services). Most of the deaths that were unknown to state agencies occurred in either county detention centers or private residential treatment centers.²² Many of the reported suicides in this study were also unknown to many child advocacy agencies. *The fact that any suicide occurring within a juvenile facility throughout the United States could remain outside the purview of a regulatory agency should be cause for great concern within the juvenile justice community.*

E) More Research Needed

This study was simply the first attempt to collect data on the extent and distribution of suicide within juvenile facilities throughout the country. More research is clearly needed in this area. For example, possible precipitating factors to the suicides reported in this study were found in only slightly more than one-third of the cases; an indication of either uncertainty of the term, inadequate review of the circumstances surrounding the death, limited knowledge of the victim’s background, and/or all of the above. Regardless of the reason(s), further inquiry of possible precipitating factors to juvenile suicide is critically important to our further understanding of the problem.

In addition, although it appeared very significant that approximately half of all victims in this study were under

conditions of room confinement at the time of their deaths, further research is necessary to explore the perceived relationship between suicide and isolation. Further, despite the fact that youth were alone in their rooms between the hours of midnight and 6:00am, with ample opportunity and privacy to engage in self-injurious behavior, few suicides took place during this six-hour period. Instead, approximately half of all deaths occurred during a six-hour period of 6:01pm and midnight, with almost a third sustained between 6:01pm and 9:00pm. Perhaps more importantly, the vast majority of victims who committed suicide while on room confinement status died during waking hours. These are time periods in which youth are normally either involved in programming or back on their housing units, interacting with staff and peers, as well as perhaps more likely to become involved in confrontations and/or behavior that resulted in room confinement. Again, further research is needed to explore this issue.

Finally, although only a smaller percentage of victims committed suicide following more than 12 months of custody, the average length of confinement prior to suicide for these youth was quite high (i.e., approximately 22 months), suggesting that prolonged confinement might have been one of the precipitating factors in the suicides. This issue is also worthy of further study.

F) The Challenge

In conclusion, findings from this study create a formidable challenge for both juvenile correctional and health care officials, as well as their respective staffs. For example, although room confinement remains a staple in most juvenile facilities, it is a sanction that can have deadly consequences and will need to be closely scrutinized and utilized judiciously. In addition, because data also showed that suicides can occur at any time during a youth's confinement, with the same number of deaths occurring within the first few days of custody as in more than a year of confinement, intake screening for the identification of suicide risk upon entry into a facility should be viewed as time-limited. Instead, because youth can be at risk at any point during confinement, the challenge for those who work in the area of juvenile detention and corrections will be to conceptualize the issue as requiring a continuum of comprehensive suicide prevention services aimed at the collaborative identification, continued assessment, and safe management of youth at risk for self-harm.

Juvenile Suicide in Confinement: A National Survey will appear as an OJJDP publication in the near future. The report, however, can currently be accessed through the National Criminal Justice Reference Service's website at: <http://virlib.ncjrs.org/JuvenileJustice.asp> (and scroll down to report), or <http://www.ncjrs.org/pdffiles1/ojjdp/grants/206354.pdf>, or through the NCIA website: <http://www.ncianet.org/cjjsl.cfm>

Due to space limitations, citations for references were omitted from this article. They appear in the full report.

FOOTNOTES

¹The project was directed by Lindsay M. Hayes of NCIA. He was assisted on the project by two prominent national juvenile justice organizations

(the National Juvenile Detention Association and Council of Juvenile Correctional Administrators), as well as a consultant team comprised of four prominent juvenile justice practitioners and researchers (G. David Curry, Ph.D., Robert E. DeComo, Ph.D., Barbara C. Dooley, Ph.D., and David W. Roush, Ph.D.). In addition, Cedrick Heraux, a doctoral student at Michigan State University, provided both data entry and data analysis support to the project.

²In order to ensure complete confidentiality, names of the facility, staff, and suicide victim have been changed. No other modifications have been made.

³Facilities were identified through OJJDP's *Census of Juveniles in Residential Placement* (1999). A small percentage of facilities were subsequently found to be either closed or could not be located, and thus presumed to be closed.

⁴By definition, *detention centers* hold juveniles for short terms in a physically restrictive environment pending juvenile court action, or following adjudication pending disposition, placement, or transfer. *Reception Centers* are short-term facilities that hold juveniles committed by courts and which do screening and assessment to assign them to appropriate facilities. *Training schools* are long-term facilities in which treatment and programming is provided in an environment that provides strict physical and staff control. *Ranches, camps, and farms* are long-term residential facilities which do not require the strict confinement of a training school, often allowing them greater contact with the community. This last category includes "residential treatment center" and "boot camp."

⁵Unfortunately, most of OJJDP's state advisory groups, state criminal justice councils, and state juvenile justice specialists proved to be either non-responsive and/or unable to provide the requested information. The following typified the common response from these agencies: "I'm the director of a child advocacy organization and the chair of my state's advisory group for OJJDP funding. I do not have information about specific suicides in specific facilities."

⁶"Other" sources were from the project director's expert witness consultation and/or technical assistance to facilities that sustained these deaths.

⁷Of interest, the response rate for this study (71.8%) was lower than that found in the project director's two previous national studies of

UPDATE ON THE INTERNET

Recent issues of the *Jail Suicide/Mental Health Update* are now available on the Internet at:

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hpub.com/journals/crisis/1997

www.nicic.org/jails/default.aspx

www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm

www.ncjrs.org/html/ojjdp/jjnl_2000_4/sui.html

www.pbstandards.org/resources.aspx

www.gainsctr.com

jail suicide (82% for 1981 study, 85% for 1988 study). Several reasons were cited by juvenile facility directors for not fully participating in the study, including litigation and advice from legal counsel, sensitivity of the subject matter, issues of confidentiality, time and/or manpower constraints, as well as at least two officials who argued that because victims had died in hospitals following the suicide attempts in their facilities, the suicides should not be categorized as juvenile facility deaths. Further, in three cases, facilities were closed shortly after each death, thus agency officials were not available to cooperate. Finally, in two other cases, the deaths were identified following the final Phase 2 deadline, and, in another case, a five-year investigation by the department's internal affairs division had continued to delay release of victim's case file. Also of interest, although 27% of the total number of suicides (N=110) occurred in private facilities, many of which were residential treatment centers, approximately two-thirds (67%) of all non-responses to survey requests came from private facilities.

⁸For comparative purposes, data collected from OJJDP's *Census of Juveniles in Residential Placement* (CJRP) was limited to the following: gender, age, race, placement authority, most serious offense charged, and adjudication status.

⁹*Person* offenses included murder, negligent manslaughter, armed robbery, rape, indecent assault, assault, battery, sexual assault, aggravated assault, and kidnapping; *Property* offenses included burglary, grand larceny, petty larceny, auto theft, robbery (other), receiving stolen property, shoplifting, arson, breaking and entering, entering without breaking, counterfeiting, forgery, embezzlement, vandalism, and carrying a concealed weapon; *Drug* offenses included possession, use, and distribution of any control dangerous substance or narcotic; *Public Order* offenses included alcohol-related charges (intoxication, liquor law violation, driving under the influence), resisting arrest, prostitution, disorderly conduct, sex offenses (other), vagrancy, unauthorized use of a motor vehicle, and minor traffic offenses; *Status* offenses included running away, truancy, incorrigibility, curfew violation, and loitering; and *Probation Violation* offenses included any technical violation of the terms of probation and/or parole.

¹⁰*Committed* juveniles included those placed in a facility as part of a court-ordered disposition. *Detained* juveniles included those held awaiting a court hearing, adjudication, disposition, and/or placement.

¹¹It should be noted, however, that the average length of confinement for the 10 victims who committed suicide after more than 12 months in custody was 21.8 months.

¹²For comparative purposes, although lengths of stay within juvenile facilities throughout the country varied considerably, prior OJJDP research has shown the average length of stay in the four facility types as follows: Detention Center (15 days), Training School/Secure Facility (7.5 months), Reception/Diagnostic Center (34 days), and Residential Treatment Center (6.5 months) (see Parent, Leiter, Kennedy, Livens, Wentworth & Wilcox, 1994).

¹³It should be noted that, for the most part, survey respondents did not report the victims' mental illness according to Diagnostic and Statistical Manual (DSM) III or IV editions.

¹⁴Other included two cases of youth involved in gang activity, and one case of a standard protocol for new intake.

¹⁵The only other method of suicide was absconding from the facility and running in front of a passing train.

¹⁶Other included two cases of standard procedure for new intake, one case of court-ordered confinement, and one case of group confinement during a shift change.

¹⁷In 1995, recognizing that existing standards failed to ensure that critical outcomes related to safety, security, health, and other programming were being achieved, OJJDP contracted with the Council of Juvenile Correctional Administrators to develop, field test, and implement performance-based standards for juvenile correctional and detention facilities. The Performance-based Standards Project offers a systematic method for facilities to measure outcomes and provides guidance for facilities to review their practices and make corrective action.

¹⁸This finding is somewhat consistent with a prior OJJDP research finding that approximately 72% of juveniles are housed in facilities with 250 or less beds, although only 21% are housed in facilities with 50 or less beds (see Parent, Leiter, Kennedy, Livens, Wentworth & Wilcox, 1994).

¹⁹In several cases, more than one precipitating factor was listed. As such, only the perceived leading factor is listed.

²⁰It is important to note that Parent, et. al. (1994) could not calculate the incidence of "time-out" or other forms of room confinement that occurred for durations of less than one hour because its use was frequently *not* documented, although it was theorized that such a practice was common (and perhaps greatly overused) in juvenile facilities.

²¹Communication amongst agencies also appeared to be a problem in several cases. Surveys were received from several Detention Centers in which respondents complained that they had been temporarily "holding" the victim for another jurisdiction (e.g., state correctional facility, probation office, etc.) and knew little, if anything, about the youth. As one facility director stated, "I do not know the answers to some of these questions because the child was not from our county. He was being housed here in a state-contract bed."

²²Perhaps not surprisingly, although the study found that 27% of the total number of suicides (N=110) occurred in private facilities, many of which were Residential Treatment Centers, approximately two-thirds (67%) of all non-responses to survey requests came from private facilities. □

NEWS FROM AROUND THE COUNTRY

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

Washington, DC

At a U.S. Senate Governmental Affairs Committee hearing held on July 7, 2004 and entitled "Juvenile Detention Centers: Are They Warehousing Children with Mental Illness," Senator Susan Collins from Maine and Representative Henry Waxman of California released a report indicating that almost 2,000 youth are incarcerated throughout the country each day because community mental health services are not available. In 33 states, despite the fact youth have not been charged with any crime, they are often confined in detention facilities to await treatment. The report — *Incarceration of Youth Who are Waiting for Community Mental Health Services in the United States* — was prepared by the Special Investigations Division of the U.S. House of Representative's Committee on Governmental Reform (Minority Staff).

Senator Collins released the following statement regarding the hearing and investigative report:

"Throughout the nation, children as young as seven years of age are being held in juvenile detention centers. But many of these children are not serving sentences for crimes; their only 'crime' is having a mental illness.

According to a survey that I commissioned with Representative Henry A. Waxman, during a recent six-month period, nearly 15,000 children were incarcerated while they were waiting for mental health services. In 33 states—Maine was not among them—the youth had no charges against them of any kind. All too often, these mentally ill children are simply left to languish in juvenile detention centers, which are ill equipped to meet their needs. The survey also estimates that juvenile detention facilities are spending an estimated \$100 million—at taxpayers’ expense—each year simply to warehouse these children and teenagers while they are waiting for mental health care.

Tragically, many children with mental illnesses end up in juvenile detention facilities because their families believe they have no other choice to obtain treatment for them. During a series of Senate Governmental Affairs Committee hearings I held, mental health care advocates and families described their personal struggles to find mental health services for their severely ill children. They discussed the limitations in both public and private insurance coverage, the shortage of mental health providers, and the long waiting lists for desperately needed mental health services. They told the Committee of the lack of coordination and communication among the various agencies and programs that serve children with mental health needs. And, most disturbingly, they said that some parents are advised that the only way to get the intensive care and services that their children need is to relinquish custody and place them in the child welfare or juvenile justice system.

This is a wrenching decision that no family should be forced to make. No parent should have to give up custody of his or her child just to get the services that the child needs. Unfortunately, this problem is more common than it seems. Serious mental illness afflicts millions of our nation’s children and adolescents. It is estimated that as many as one in five American children under the age of 17 suffers from a mental, emotional or behavioral illness. What is even more disturbing is the fact that two-thirds of all young people who need mental health treatment are not getting it.

When a child has a serious physical health problem like diabetes or cancer, the family turns to its doctor. When the family includes a child with a serious mental illness, it is often forced go to the child welfare or juvenile justice system to secure treatment. Yet neither system is intended to serve children with serious mental illness. Child welfare systems are designed to protect children who have been abused or neglected. Juvenile justice systems are designed to rehabilitate children who have committed criminal or delinquent acts. While neither of these systems is equipped to care for a child with a serious mental illness, in far too many cases, there is nowhere else for the family to turn. In some extreme cases, families feel forced to file charges against their child or to declare that they have abused or neglected them in order to get the care that they need. As one family advocate observed, ‘Beat ‘em up, lock ‘em up, or give ‘em up,’ characterizes the choices that some families face in their efforts to get help for their children’s mental illness.

According to a General Accounting Office (GAO) study that I requested, parents placed more than 12,700 children into the child welfare or juvenile justice systems in 2001 so that these children could receive mental health services. Of these 12,700 children,

JAIL MENTAL HEALTH SERVICES INITIATIVE FROM THE NATIONAL INSTITUTE OF CORRECTIONS (JAILS DIVISION)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail’s community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division’s mental health initiative includes the following services:

- ◆ **On-site Technical Assistance:** This assistance usually consists of an assessment of a jail system’s mental health needs, *but also can be targeted at suicide prevention issues in the jail;*
- ◆ **Newsletter:** The NIC Jails Division funds the *Jail Suicide/Mental Health Update*, a newsletter which is distributed free of charge on a quarterly basis;
- ◆ **Information Resources:** The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division’s mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

9,000 entered the juvenile justice system. This is just the tip of the iceberg, since 32 states—including the five states with the largest populations of children—did not provide the GAO with any data. Other studies indicate that the problem is even more pervasive. A 1999 survey by the National Alliance for the Mentally Ill found that 36 percent of the families surveyed placed their children in the juvenile justice system to access mental health services that otherwise were not available to them.

Like custody relinquishment, inappropriate detentions are a regrettable symptom of a much larger problem, the lack of available, affordable, and appropriate mental health services and support systems. There are actions that we can take to address these challenges. A first step would be for Congress to pass a bipartisan bill that I introduced last year, the Keeping Families Together Act. My bill would authorize \$55 million for grants to states to develop more coordinated systems of care for children with serious mental illnesses and their families.

Congress should also approve three other measures that I have co-sponsored. The Family Opportunity Act would allow states to create a new eligibility category for Medicaid to cover children with physical or mental illness whose family income exceeds state requirements. States could require families to pay monthly premiums for these services, based on their income levels. The Mental Health Equitable Treatment Act of 2003 would require insurers to cover mental illness in the same way that they cover a physical illness. And to address the shortage of mental health providers, the Child Healthcare Crisis Relief Act includes incentives, such as scholarship and student loan forgiveness programs, to help recruit and retain child mental health professionals. It also would expand and create programs to train child mental health professionals.

My hope is that by heightening public awareness of the difficult problems confronting these children and their families, these hearings will advance legislative and administrative reforms at both the federal and state level to reduce the barriers to care for children who suffer from mental illness. No children who are in need of mental health care should be left to languish in juvenile detention centers without the proper treatment they deserve.”

The report — *Incarceration of Youth Who are Waiting for Community Mental Health Services in the United States* — can be accessed on the U.S. House of Representative’s Committee on Governmental Reform (Minority Staff) website: www.reform.house.gov/min

Arizona

In early 2004, the U.S. Justice Department announced the results of its investigation into the conditions of confinement at three juvenile facilities administered by the Arizona Department of Juvenile Corrections (ADJC) — Adobe Mountain School in Phoenix; Black Canyon School in Phoenix; and Catalina Mountain School in Tucson. The Justice Department found substantial and deeply troubling civil rights violations at all three facilities.

Through the course of its investigation, the Justice Department discovered credible evidence that sexual abuse of youth by both

staff and other juveniles occurred frequently at the Adobe Mountain School, and that the institution’s management had done little to effectively address this serious problem. The investigation also concluded that physical abuse, including unjustified physical force, was similarly prevalent. Even basic services, such as medical and mental health care, failed to satisfy constitutionally minimum standards.

“The conditions in these facilities are extremely troubling,” said R. Alexander Acosta, Assistant Attorney General for the Justice Department’s Civil Rights Division, in January 2004 press release. “However, the state of Arizona has cooperated fully with our investigation and we are confident that together we will continue to work cooperatively to remedy these deficiencies.”

Three youth committed suicide at the Adobe Mountain School between April 2002 and March 2003. The investigation revealed inadequate suicide prevention measures and inadequately trained staff throughout the facilities. “Our investigation revealed that the Adobe suicides are emblematic of the inadequate suicide prevention measures and practices throughout the facilities,” the report stated.

Investigators were particularly concerned about the issue of communication and management of suicidal youth:

The communication failures within ADJC are exemplified by the July 11, 2002 suicide of a youth at Adobe. On June 25, 2002, this youth was placed on close observation status based upon his high suicide ideation rating. We found no indication of any formal mental health assessment or in-house physical assessment by a psychiatrist of this youth. While his mental health records were reviewed by a psychiatrist on June 26, there was no indication that the youth’s close observation status was communicated to the psychiatrist. The youth was not seen by mental health staff until July 3, when he was seen by a psychology intern.

Between July 3 and July 11, ADJC’s Community Family Services Division conducted an in-home evaluation and discovered that this youth had previously threatened and/or attempted suicide. In addition, his court file, which accompanied him to Adobe, contained information regarding his attempted suicide while he was in detention. This information, which could have assisted in addressing this youth’s mental health needs, was not communicated to, or reviewed by, staff. On July 11, this youth committed suicide.

The Department’s findings and recommendations are documented in a report from Assistant Attorney General Acosta to Arizona Governor Janet Napolitano and Arizona Attorney General Terry Goddard. The report can be accessed on the Justice Department’s website: http://www.usdoj.gov/crt/split/documents/ariz_findings.pdf

“We are fully committed to resolving these issues...(and) committed to the safety and security of all the youth that we serve,” Patti Cordova, legislative liaison for the ADJC, told the *Arizona Republic* on January 27, 2004. She said that the agency is working with the

Governor's Office to respond to 16 remedial measures that the Justice Department said must be taken at the three state juvenile facilities to avoid a lawsuit. Officials from both the ADJC and Governor's Office believe that several of the findings have already been addressed. "The governor feels like we have made progress to address the deficiencies inherited from the last administration, but obviously we have work to do," said Jeanine L'Ecuyer, spokeswoman for Governor Napolitano. For its part, the state legislature appropriated over \$5 million this past fiscal year toward ADJC's efforts to create safe housing for suicidal youth, as well as to hire and train additional staff.

During the last several months, attorneys the Justice Department's Civil Rights Division and officials from both the ADJC and Governor's Office have worked to formalize a settlement agreement based upon the investigative findings. On September 15, 2004, the parties entered into a comprehensive "memorandum of agreement." The 25-page agreement outlines the specific provisions for corrective action in the areas of suicide prevention, abuse, special education, medical care, and mental health care. The ADJC's compliance with the agreement will be monitored and enforced by a team of independent experts. The agreement can be accessed on the Justice Department's website: http://www.usdoj.gov/crt/split/documents/split_az_schools_8_26_04.pdf

Texas

In May 2004, the parents of a 15-year-old boy who committed suicide while in custody of the Smith County Juvenile Attention Center filed a lawsuit against the county and detention center employees. The lawsuit claimed that the actions and inactions of the defendants were deliberately indifferent to their son's known serious medical and mental health needs, including a known risk of suicide.

According to the lawsuit, while confined in the Tyler facility, Trey Christopher was rarely, if ever, seen by his probation officer, and the facility failed to provide him with mental health services as recommended by mental health professionals on both November 26, 2001 and January 11, 2002. "By March 2002, (Christopher's) despair over the length of his detention increased to the point that he threatened suicide for the first time," the lawsuit alleged. On March 24, he was placed on suicide precautions, observed at 5-minute intervals, and subsequently required to sign a "no-harm contract" agreeing not to engage in any self-injurious behavior. Christopher remained on this level of observation until March 26, when alleged pressure by a supervisor resulted in his removal from suicide precautions. Although Christopher threatened suicide again, facility staff failed to take any precautionary actions, according to the lawsuit.

On Saturday, May 18, 2002, Christopher was placed on room confinement for an alleged rules violation. He showed his anger by yelling and banging on his cell door throughout the day. He was also allegedly heard screaming that he would kill himself by other parents visiting their children at the facility. Christopher then requested to speak with mental health staff, but was told he would have to wait until the following Monday.

As reflected on the medical log, Christopher was given his medication at 7:30pm on May 18. Although youth on room confinement status were required to be observed at 15-minute intervals, with those observations documented on a log sheet, the last documented check of the youth occurred when he received his medication. Approximately one hour later at 8:30pm, a staff member turned on the light in Christopher's room and found the youth had used the mattress cover to hang himself from a metal crossbar on the window in his room. He was subsequently pronounced dead.

California

Vowing to end a practice dubbed inhumane by critics, the interim director of the California Youth Authority (CYA) told a state senate committee on August 4, 2004 that juveniles who break institutional rules will no longer be isolated 23 hours a day in barren segregation cells. Walter Allen, III offered no specific details of how officers will manage these youth who are now placed on lockdown status and deprived of most privileges for an average of 60 to 90 days. But after members of the Senate Rules Committee called the practice "barbaric," Director Allen said that, "As of today.... it is over. We are going to change our way of doing business. We're going to change the conditions of confinement."

Director Allen's comments came as the committee met to consider whether to confirm him as director of the CYA, which houses 4,300 juveniles in 11 facilities and camps on an annual budget of approximately \$391 million. Following an hour-long hearing, the panel voted 4 to 0 to endorse his appointment by Governor Arnold Schwarzenegger. The committee's action means that he is all but certain to win endorsement by the full senate in the near future.

Juvenile justice advocates and civil rights attorneys who had previously demanded an end to the lockdown sanction said they were encouraged by Mr. Allen's announcement, but uncertain what change it would bring. "If he means that kids are no longer going to be locked up for very long, both in terms of hours in their cell and number of days, then it's a good thing," stated Donald Specter, an attorney with the Prison Law Office, a non-profit firm in San Quentin that has sued the state over conditions in the CYA. "But you have to have some plan to deal with inmates creating problems. The question is, will their approach be punitive or therapeutic?" he told the *Los Angeles Times*.

The segregation cells are just one area of controversy plaguing the agency. Once considered a national model, the CYA has come under increasing fire during the last year from legislators, parents and activists for failing to rehabilitate juveniles — or even tend to their basic medical needs and keep them safe from violence. The criticism was fueled by the January 19, 2004 suicides of two juvenile cellmates in CYA's Preston Youth Correctional Facility in Ione. At the time of their deaths, 18-year-old Durrell Feaster and 17-year-old Deon Whitfield were on "23 and 1" status, occupying the same type of segregation cell that became the focus of the state senate's recent confirmation hearing of Mr. Allen (see *Jail Suicide/Mental Health Update*, Volume 12, Number 4, Spring 2004, pp. 19-20).

Florida

In March 2004, a Broward County Circuit Court jury needed only 70 minutes of deliberations to convict Sandra Trotter, a former staff member at the Lippman Family Center in Oakland Park, of child neglect for not providing any life-saving measures to Anthony Dumas. Four years earlier on June 12, 2000, Ms. Trotter had found the 15-year-old youth hanging from a bunk bed by his leather belt. Instead of cutting the ligature and initiating cardiopulmonary resuscitation (CPR) to the youth, she began taking photographs of the victim and waited several minutes before calling the police. Anthony Dumas subsequently lapsed into a coma and died four months later.

During a police investigation of the death, as well as at her criminal trial, Ms. Trotter offered several conflicting explanations as to why she failed to initiate CPR. She first told investigators that she did not help the youth because “there were no CPR masks available,” as well as feared being held liable “for causing more damage to him by removing him from the belt.” Ms. Trotter also initially stated she took photographs of the victim as an attempt to assist police in determining whether there was any foul play, but then told other staff she took the pictures for the facility’s own records.

During her trial, Ms. Trotter testified that she did everything she could to save Anthony’s life. She stated two other employees of the facility abandoned her. (In fact, the investigation showed that the other staff went into shock and left the facility. All three employees were subsequently terminated.) Ms. Trotter also testified that she disobeyed a supervisor’s order not to touch the boy. “I couldn’t let him just stay there, I had to try,” she said. She testified she made three attempts to loosen the belt around Anthony’s neck and ran out of the room at one point in an unsuccessful effort to get a knife or scissors. Ms. Trotter also testified that she escorted other youth back to their rooms during the chaotic situation, and she took the photographs to show the position of the Anthony’s body “for Lippman or whatever purpose they could be used for.”

Assistant State Attorney Dennis Siegel argued during the trial that the defendant’s testimony was unbelievable. There was no way Ms. Trotter could have done everything she said she did, including taking the photographs, in the few minutes it took for police to respond to the facility, he argued.

The suicide attempt occurred only 19 days following Anthony’s arrest for shoving his mother during a heated argument. Records indicated that within his first few hours of entering the facility, Anthony told a youth worker he had attempted suicide a few days earlier and planned to hang himself with his belt in the facility. On the day of the suicide, Anthony was placed on room confinement for misbehavior. A few hours later, he was found hanging.

In May 2004, Sandra Trotter was sentenced to 12 months of house arrest and four years probation to include 500 hours of community service and a stipulation that she never again be employed by an agency serving youth or disabled adults. The family of Anthony Dumas still has a lawsuit pending against the state Department of Juvenile Justice and reached a confidential, out-of-court settlement with Lutheran Services Florida, the Tampa-based non-profit organization that runs the Lippman Family Center, a 28-bed shelter for runaway and delinquent youth. □

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)’s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

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Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)

National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)

Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-12)

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