



JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY

by
Lindsay M. Hayes
Project Director
National Center on Institutions and Alternatives

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Forward

It is my pleasure to present to you the report *Juvenile Suicide in Confinement: A National Survey*. This study, commissioned by the Office of Juvenile Justice and Delinquency Prevention in 1999, is the first comprehensive effort to determine the scope and distribution of suicides by youth confined in our public and private juvenile facilities throughout the country. In many ways, this report closely supports two prior initiatives funded by this office, both *Conditions of Confinement: Juvenile Detention and Corrections Facilities* and the *Performance-Based Standards Project*. This report should be viewed as a working companion to those landmark OJJDP initiatives.

The results of this research present many challenges to both direct care and health care personnel who work with confined youth on a daily basis, as well as for administrators who have the responsibility for providing safety and security to this very vulnerable population. Suicide prevention is a primary goal for all of us who work in and manage juvenile facilities. At a minimum, however, we must ensure that each death within our facilities is accounted for, comprehensively reviewed, and provisions made for appropriate corrective action. It is my hope that the data and insights offered in this comprehensive first national survey will provide motivation for continued efforts at reducing the opportunity for suicide within our public and private juvenile facilities throughout the country.

J. Robert Flores
Administrator
Office of Juvenile Justice and Delinquency Prevention

Acknowledgments

Collaboration amongst staff is perhaps the single most important ingredient to any successful suicide prevention program. The task of completing the first national survey of juvenile suicide in confinement could not have been accomplished without the collaborative efforts of a project team comprising prominent juvenile justice practitioners and researchers. I was fortunate to assemble such a team and it included G. David Curry, Ph.D. (Department of Criminology, University of Missouri-St. Louis), Robert E. DeComo, Ph.D. (Director of Research, National Council on Crime and Delinquency), Barbara C. Dooley, Ph.D. (former Director, Madison County (TN) Juvenile Court Services), Cedrick Heraux, Ph.D. candidate, School of Criminal Justice, Michigan State University), and David W. Roush, Ph.D. (Director, Center for Research and Professional Development, Michigan State University). The project team was instrumental to the design of the data collection instruments, data analysis, and review of the draft report. And as she has done on so many prior occasions, Alice Boring of our agency brought the report together to its final form.

In addition, two consulting agencies, the Council of Juvenile Correctional Administrators (CJCA) and the National Juvenile Detention Association (NJDA) provided invaluable assistance to myself and the team in both endorsing the project and encouraging juvenile facility directors to participate in the survey process, as well as reviewing the draft report. Special thanks is extended to CJCA's Edward J. Loughran, Kim Godfrey, and Robert Dugan, as well as NJDA's Earl L. Dunlap and Michael A. Jones.

I would also like to thank several officials and staff at the Office of Juvenile Justice and Delinquency Prevention (OJJDP) for their support during this long and arduous project, particularly former administrator Shay Bilchik for his encouragement and support of my pursuing this project, and to current administrator J. Robert Flores for his continued patience during the project. Special thanks is also extended to the two OJJDP program managers on our project, Karen Stern and Phelan Wyrick.

On a final note, it should be said that this project was both frustrating and rewarding on several fronts. It was not only disconcerting to review the circumstances surrounding the suicides of so many young people in confinement (many of which were preventable), but, quite frankly, frustrating to encounter some resistance to our data collection efforts. We found more than a handful of facility directors who chose not to participate in the survey process, citing time and/or manpower constraints, litigation and advice from legal counsel, sensitivity of the subject matter, or perceived confidentiality issues. Fueling this frustration was the fact that more than a third of all suicides we identified were unknown in any state agency, thus limiting our ability to gather collaborative data. As stated in the report, 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.

In the end, however, I feel the project more than accomplished its primary mission, that is, to provide relevant data on juvenile suicide that can be utilized as a resource tool for both practitioners in expanding their knowledge base, and administrators in creating and/or revising policies and training curricula that will ultimately reduce the opportunity for suicide in both public and private juvenile facilities throughout the country.

Lindsay M. Hayes
Project Director
National Center on Institutions and Alternatives

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Executive Summary

While youth suicide in the community has been identified as a major public health problem, juvenile suicide in confinement has received little attention. 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 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 study identified 110 juvenile suicides occurring between 1995 and 1999. Data was analyzed on 79 cases. Of these suicides, 41.8% occurred in Training School/Secure Facilities, 36.7% 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. Highlights of the data included findings that:

- ◆ 68.4% of the victims were Caucasian.
- ◆ 79.7% of victims were male.
- ◆ Average (mean) age of victims was 15.7, with over 70% between the ages of 15 and 17.
- ◆ 37.9% of victims were living with one parent of time of confinement.
- ◆ 69.6% of victims were confined on nonviolent offenses.
- ◆ Approximately two-thirds (67.1%) of all victims were held on commitment status at time of death, with 32.9% on detained status; not surprisingly, however, the vast majority (88.5%) of victims held in Detention Centers were on detained status.
- ◆ 78.5% of victims had a history of prior offenses, most (72.7%) were of a nonviolent nature.
- ◆ With the exception of Detention Centers, deaths were evenly distributed during a more than 12-month period, with the same number

of suicides occurring within the first 1 to 3 days of confinement as occurring in more than 12 months of confinement; only 4% of all suicides occurred within the first 24 hours of confinement.

- ◆ All Detention Center suicides occurred within the first four months of confinement, with over 40% occurring within the first 72 hours.
- ◆ 73.4% of victims had a substance abuse history; 18.9% of victims had a medical history; 44.3% of victims had emotional abuse history; 34.1% had physical abuse history; and 27.8% had sexual abuse history.
- ◆ 74.3% of victims had a history of mental illness (with most thought to be suffering from depression at the time of death); 53.5% of victims were taking psychotropic medication.
- ◆ 69.6% of victims had a history of suicidal behavior, with suicide attempt(s) being the most frequent type of suicidal behavior (45.5%), followed by suicidal ideation and/or threat (30.9%), and suicidal gesture and/or self-mutilation (23.6%).
- ◆ Approximately half (50.6%) of suicides occurred during a six-hour period of 6:01 p.m. and midnight, and almost a third (29.1%) sustained between 6:01 p.m. and 9:00 p.m.; 70.9% of suicides occurred during traditional waking hours (7:01 a.m. to 9:00 p.m.), with 29.1% sustained during non-waking hours (9:01 p.m. to 7:00 a.m.).
- ◆ 98.7% of suicides were by hanging; 71.8% of victims utilized their bedding (e.g., sheet, blanket, etc.) as the instrument; a variety of anchoring devices were utilized in the hangings, including door hinge/knob (20.5%), air vent (19.2%), bed frame (19.2%), and window frame (14.3%).
- ◆ None of the victims were under the influence of alcohol and/or drugs at the time of the suicide.
- ◆ 74.7% of victims were assigned to single-occupancy rooms.
- ◆ Approximately 41% of victims were found in less than 15 minutes following the last observation of the youth, however, slightly more than 15% of victims were found after more than one hour of last being seen alive.

- ◆ 50% of victims were on room confinement status at the time of death (and 62% of victims had a history of room confinement); the circumstances that lead to room confinement at the time of death included failure to follow program rules/inappropriate behavior (47.3%), threat/actual physical abuse of staff or peers (42.1%), and other (10.6%); only 16.6% of Residential Treatment Center victims were on room confinement status at the time of death.
- ◆ 85% of victims who committed suicide while on room confinement status died during waking hours (7:01 a.m. to 9:00 p.m.), a percentage found to be higher than those victims who committed suicide during waking hours but not on room confinement status (70.9%).
- ◆ 16.5% of victims were on suicide precaution status at the time of their deaths, most of whom were required to be observed at 15-minute intervals. Despite their identified risk of suicide, almost half of these victims were found to be last observed in *excess* of 15 minutes prior to the suicide.
- ◆ 69.6% of victims were assessed by a qualified mental health professional (QMHP) prior to their death (although only 34.5% of Detention Center victims received such assessments); slightly less than half (44.3%) of all victims either had never been assessed by a QMHP or had not been assessed by a clinician within 30 days of their deaths.
- ◆ Only 37.9% of facilities that experienced a suicide provided annual suicide prevention training to its direct care staff.
- ◆ Although the vast majority (78.5%) of respondents reported that their facilities maintained a written suicide prevention policy at the time of the suicide, only 20.3% of facilities had *all* seven suicide prevention components (written policy, intake screening, training, CPR certification, observation, safe housing, and mortality review) 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%).

The study offered several recommendations, including, but not limited to, the following:

- ◆ 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 follow-up/mortality review.
- ◆ Young lives will continue to be lost and jurisdictions will incur unnecessary liability from these tragic deaths unless juvenile administrators create and maintain effective training programs, as well as ensure that all direct care, medical and mental health personnel receive both pre-service and annual instruction in suicide prevention.
- ◆ Suicide prevention training curricula utilized in juvenile facilities has historically relied on information gathered from adult inmate suicide, as well as on youth suicide in the community. Given the findings from this study demonstrating differences between adult inmate suicide and juvenile suicide, development of separate training curricula targeted to suicide prevention within juvenile facilities appears warranted.
- ◆ Significant deficiencies in intake screening, as well as overall suicide prevention programming within detention centers experiencing suicides, warrants 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, including intake screening for suicide risk.
- ◆ More than one-third of the suicides identified in this study were unknown to many agencies responsible for the care and advocacy of confined youth. 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. At a minimum, we must ensure that each death within our juvenile facilities is accounted for, comprehensively reviewed, and provisions made for appropriate corrective action.
- ◆ Future research efforts should be directed at determining additional precipitating factors to juvenile suicide, the perceived relationship

between suicide and room confinement, and the effect, if any, of prolonged confinement on suicidal behavior.

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.

Introduction: Literature Review

A) The Problem

At the age of 14, Brian Malone had been in and out of the local juvenile justice system.¹ 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

¹In order to ensure complete confidentiality, names of the facility, staff, and suicide victim have been changed. No other modifications have been made.

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 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. The only national survey on the incidence of juvenile suicides in custody contained several flaws in the calculation of suicide rates (Flaherty, 1980). Reanalysis of suicide rates in that survey found that youth suicide in juvenile detention centers was estimated to be more than four times greater than the general population (Memory, 1989).

C) Risk Factors

Brent (1995) has identified mental disorder and substance abuse as the most important set of risk factors for adolescent suicide in the general population. Other risk factors included impulsive aggression, parental depression and substance abuse, family discord and abuse, and poor family support. Life stressors, specifically interpersonal conflict and loss, as well as legal and disciplinary problems, were also associated suicidal behavior in adolescents, particularly those who were substance abusers. It has been argued that many of these risk factors are prevalent in youth confined in juvenile facilities (Alessi, McManus, Brickman & Grapentine, 1984; Rohde, Seeley & Mace, 1997). Recently, Sanislow, et al. (2003) found that high levels of depression, hopelessness, and acute situational stress of incarceration by confined youth might explain why they had levels of psychological distress similar to those of severely disturbed adolescents hospitalized on an acute psychiatric inpatient unit. Therefore, if all youth are to some degree at risk for suicide, it could be argued that juveniles in confinement are at greater risk because they have life histories that predisposes them to suicide (e.g., mental disorders and substance abuse, physical, sexual and emotional abuse, and, perhaps most importantly, current and prior self-injurious behavior).

1. Mental Disorders and Substance Abuse

The prevalence of mental disorders among confined youth has recently been studied in several states. In California, for example, one study showed that 32% of confined male juveniles met the criteria for post-traumatic stress disorder (PTSD), and these PTSD youth had increased levels of distress, anxiety, depression, while exhibiting lower levels of restraint, impulse control and suppression of aggression (Steiner, Garcia & Matthews, 1997). In Mississippi, a recent study found that at least 66% of confined youth met the DSM-IV diagnostic criteria for a mental disorder, with over half of the youth suffering from multiple disorders including conduct and substance abuse (Robertson & Husain, 2001). In Maryland,

approximately 57% of confined youth self-reported a prior mental health history (Shelton, 2000). In Virginia, over 60% of youth admitted to the state's juvenile reception and diagnostic center were identified with a mental health treatment need (McGarvey & Waite, 2000). In Georgia, 61% of confined youth were found to have mental health disorders (Marsteller, Brogan, Smith, Ash, Daniels, Rolka & Falek, 1997). In comparing rates of mental disorder for juveniles in confinement with rates for youth in the general population, the Georgia researchers also found substantially higher rates for juveniles (61% versus 22% for any disorder, 30% versus 11% for anxiety disorders, and 13% versus 4% for depression). In Texas, researchers recently found that detention center youth had a high prevalence of psychiatric disorders, usually undiagnosed, and that comorbidity was common (Domalanta, Risser, Roberts & Risser, 2003).

Perhaps the most ambitious and reliable study is an on-going longitudinal analysis of mental disorders among 1,830 youth confined in a county juvenile detention center in Illinois. The preliminary data suggests that two-thirds of the youth have one or more alcohol, drug or mental (ADM) disorders, thus projecting that over 670,000 youth processed into the juvenile justice system throughout the country each year would meet the diagnostic criteria for one or more ADM disorders (Teplin, Abram, McClelland, Dulcan & Mericle, 2002).

In sum, following two comprehensive reviews of the literature (Otto, Greenstein, Johnson & Friedman, 1992; Edens & Otto, 1997), it has been estimated that the following rates of mental disorders are experienced by youth in confinement: 50 to 90% for conduct disorders, up to 46% for attention deficit disorders, 6 to 41% for anxiety disorders, 25 to 50% for substance abuse or dependence, 32 to 78% for affective disorders, 1 to 6% for psychotic disorder, and more than 50% for co-occurring mental health and substance abuse disorders. As shown above, high rates of mental disorders, particularly conduct disorder, have been consistently reported for youth in confinement. It should be noted, however, given the fact that the DSM-IV criteria for conduct disorder includes "aggressive conduct that causes or threatens physical harm to other people or animals, non-aggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rule" (American Psychiatric Association, 2000, p. 94), high rates of this disorder among incarcerated youth are not surprising. In conclusion, two facts appear undisputed: a high percentage of youth in the juvenile justice system have a diagnosable mental disorder, and these juveniles have higher rates of mental disorders than youth in the general population (Cocozza & Skowrya, 2000).

2. Physical, Sexual and Emotional Abuse

Juveniles in confinement also have higher rates of physical, sexual and emotional abuse than adolescents in the community. Shelton (2000) found high rates of both self-reported physical (35%) and sexual (18%) abuse of confined youth in Maryland; whereas lower rates of physical abuse (11%) and sexual abuse (10%) were found for detained juveniles in

Connecticut by Chapman, et al. (2000). More recently, Esposito and Clum (2002) found even higher rates of both self-reported physical (58%) and sexual (24%) abuse for confined youth. With regard to suicide, confined youth who reported a history of sexual abuse had a 43% incidence of suicidal ideation and a 35% incidence of one or more suicide attempts, compared to those youth who reported no history of sexual abuse and had an 18% suicidal ideation rate and 12% rate of suicide attempts (Morris, Harrison, Knox, Tromanhauser, Marquis & Watts, 1995).

3. 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, et al. (1991) found higher rates of self-harm behavior among incarcerated male youth than in the general adolescent community population.

With regard to race, White 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 White (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 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 on-going 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).

E) Surveillance Data on Adult and Juvenile Suicide

Suicide continues to be a leading cause of death within *jails* throughout the country. More than 400 inmates take their lives each year and the suicide rate is estimated to be approximately five times greater than that of the general population (Bureau of Justice Statistics, 2001). Most jail suicide victims are young White males arrested for non-violent offenses and intoxicated upon arrest. Many are isolated and dead within 24 hours of incarceration. The overwhelming majority of victims are found hanging by either bedding or clothing. Most jail suicide victims are not adequately screened for potentially suicidal behavior upon entrance into the facility (Hayes, 1989).

Suicide ranks third (behind natural causes and AIDS) as the leading cause of death in *prisons* (Bureau of Justice Statistics, 2000). Close to 200 inmates commit suicide in state and federal prisons each year (Criminal Justice Institute, 2000), and the rate of suicide within prisons is far below that for jail suicides but greater than that of the general population (Hayes, 1995). Most research on prison suicide has found that the vast majority of victims are convicted of personal crimes, housed in single cells, and had histories of suicides attempts and/or mental illness (Bonner, 1992; He, Felthous, Holzer, Nathan & Veasey, 2001; White & Schimmel, 1995).

While there have been several national studies conducted regarding the extent and nature of suicide in jail and prison facilities, there has *not* been any comparable national research conducted to date regarding juvenile suicide in confinement.

The 1988 Amendments to the Juvenile Justice and Delinquency Prevention Act of 1974 established an annual requirement for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to provide a detailed summary and analysis of the most recent available juvenile custody data on the number and individual characteristics of juveniles taken into custody, rates at which they are taken into custody, number of juveniles who died in custody, and *circumstances of their deaths*. In response to this mandate, OJJDP established the Research Program on Juveniles Taken into Custody in 1989. The survey program included

data collected from the *State Juvenile Corrections System Reporting Program* and the *Children in Custody (CIC) Census*. In the first year of the CIC survey, state juvenile officials self-reported 17 suicides occurring in public detention centers, reception/diagnostic centers, and training schools throughout the country during 1988 (Krisberg, DeComo, Herrera, Steketee & Roberts, 1991), and 14 such suicides were reported during 1993 (Austin, Krisberg, DeComo, Rudenstine & Del Rosario, 1995). In addition, other than listing gender of the victim, facility type and region of the country, the OJJDP census was unable to collect data on the circumstances surrounding these self-reported suicides. As clearly stated by the authors as a preface to one of the survey reports:

...information available on characteristics of juveniles admitted is inadequate. While most facilities record specific demographic, legal, and other information for administrative or operational purposes, no mechanism exists to collect and synthesize these data on a national level for research, policy, or program development purposes (DeComo, Tunis, Krisberg, Herrera, Rudenstine & Del Rosario, 1995, p. 1).

In 1997, OJJDP inaugurated a successor to the *Children in Custody Census* series, which included both a *Census of Juveniles in Residential Placement (CJRP)* and a *Juvenile Residential Facility Census (JRFC)*. The goal of the JRFC was to collect information on facility environments and services, including facility ownership, security features, bed space and crowding, staffing, physical and mental health care, education and substance abuse programming, and deaths in custody. According to the 2000 JRFC, there were 10 juvenile suicides reported during the most recent 12-month reporting period (OJJDP, 2002).² Similar to the CIC series, the JRFC was unable to collect data on the circumstances surrounding these self-reported suicides.

The current CJRP and JRFC research programs remain the only source of data available regarding juveniles in custody. Given the limitations described above, there remains no national data source currently available to document the extent and nature of juvenile suicide in confinement.³

²The reporting period was from October 1, 1999 to September 30, 2000.

³It should be noted that vital statistics mortality data, collected annually by the National Center for Health Statistics, Centers for Disease Control, does *not* separate out data between the community and custodial institutions, *nor* does it collect data on the circumstances, characteristics and precipitating causes of suicide. In addition, although the *Deaths in Custody Reporting Act of 2000* became Public Law No. 106-297 on October 13, 2000, the collected data is cursory, gathered on a voluntary basis, and is limited to the cause, date, time, and place of death; and age, sex, race, legal status of the victim.

Juvenile Suicide in Confinement: A National Survey

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.⁴ 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. A report of the survey's findings would 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) Phase 1

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.⁵ 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 (see Appendix A).⁶ 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

⁴NCIA 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.

⁵Facilities 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.

⁶In order to encourage a high rate of response, the cover letter was co-signed by officials of both the National Juvenile Detention Association and Council of Juvenile Correctional Administrators, and business reply envelopes were enclosed with the survey instruments.

organizations.⁷ 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.⁸ 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.⁹ 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.

⁷By 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."

⁸Unfortunately, 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."

⁹"Other" sources were from the project director's expert witness consultation and/or technical assistance to facilities that sustained these deaths.

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

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 (see Appendix B). 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 be 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 be 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 be limited to, facility type; facility ownership (e.g., state, county, private); capacity/population at time of suicide; and suicide prevention components — written policy, intake screening, staff training in suicide prevention and cardiopulmonary resuscitation, observation levels, safe housing, and mortality review.

The survey instruments and cover letters were mailed to directors of 83 facilities that sustained the 110 suicides. The process was initiated in August 2000 and initially resulted in the completion and return of only 23 (20.9%) Phase 2 surveys. Subsequent follow-up letters and telephone contact with facility directors not responding to initial survey requests occurred in October and December 2000, as well as February 2001.¹⁰ These persistent efforts resulted in the completion and return of an additional 52 (47.2%) surveys. A final request letter by both OJJDP and the National Juvenile Detention Association in June 2001 resulted in an additional 4 (3.6%) completed surveys. Despite repeated verbal and written assurances that — “Data provided will be coded and held in the strictest confidence. Results of this study will be presented in summary fashion, therefore, victim and facility names will not appear in any project report” — full cooperation from facility directors was somewhat disappointing. In September 2001, data collection efforts were concluded with a final response/collection rate of 71.8% (79 of 110).¹¹

¹⁰During this follow-up process, the project director was assisted by staff of the Council of Juvenile Correctional Administrators.

¹¹Of interest, the response rate for this study (71.8%) was lower than that found in the project director’s two previous national studies of 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.

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

As can be seen by Table 2, 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 2.5% designated as Other. The finding that over two-thirds of the victims were Caucasian was not surprising given the fact that this racial group represents

TABLE 2
RACE

Race	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Caucasian	17	25	3	9	54	(68.4)
African-American	6	1	1	1	9	(11.4)
Hispanic	2	1	1	1	5	(6.3)
American Indian	3	5	0	1	9	(11.4)
Other	1	1	0	0	2	(2.5)
TOTAL	29	33	5	12	79	(100.0)

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),¹² 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.

2. Sex

As presented in Table 3, 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.

TABLE 3
SEX

Race	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Male	23	27	5	8	63	(79.7)
Female	6	6	0	4	16	(20.3)
TOTAL	29	33	5	12	79	(100.0)

3. Age

Table 4 indicates that over 70% 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).

¹²For 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.

TABLE 4
AGE

Age	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
12	1	0	0	0	1	(1.3)
13	0	1	0	2	3	(3.8)
14	5	6	0	1	12	(15.2)
15	10	6	2	5	23	(29.1)
16	3	8	3	1	15	(19.0)
17	9	6	0	3	18	(22.7)
18	1	4	0	0	5	(6.3)
19	0	1	0	0	1	(1.3)
20	0	1	0	0	1	(1.3)
TOTAL	29	33	5	12	79	(100.0)

4. Living Status Prior to Confinement

As presented in Table 5, a higher number (37.9%) of the victims were living with one parent at the time of their confinement. Only slightly less than one quarter (22.7%) of the victims were living with both parents.

TABLE 5
LIVING STATUS PRIOR TO CONFINEMENT

Living Status	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Self Only	0	1	0	1	2	(3.1)
One Parent	13	10	3	4	30	(37.9)
Both Parents	7	8	1	2	18	(22.7)
Other Relatives	3	3	0	1	7	(8.8)
Foster Parent/ Guardian	2	3	0	1	6	(7.5)
Adoptive Parents	0	3	0	1	4	(5.0)
Community Placement	3	4	0	2	9	(11.3)
Unknown	1	1	1	0	3	(3.7)
TOTAL	29	33	5	12	79	(100.0)

5. Most Serious Offense

For purposes of this study, the most serious offense was broken down into six categories.¹³ As can be seen by Table 6, 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%,

TABLE 6
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)

¹³*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.

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.

6. Additional Charges

In regard to additional charges, 39.2% of the victims had a second charge at confinement. Property offenses (51.7%) accounted for the majority of the charges, followed by Person offenses (19.4%). The Public Order, Status, and Probation Violation categories combined represented 28.9% of the second charges at confinement.

7. Confinement Status

As presented in Table 7, approximately two-thirds (67.1%) of the victims were being held on commitment status at the time of their death.¹⁴ 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.

TABLE 7
CONFINEMENT STATUS

Confinement Status	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Detained	23	0	0	3	26	(32.9)
Committed	6	33	5	9	53	(67.1)
TOTAL	29	33	5	12	79	(100.0)

¹⁴*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.

8. Most Serious Prior Offenses

The vast majority (78.5%) of victims had a history of prior offenses within the juvenile justice system. Of the victims who had a history of prior offenses, most (72.7%) of these were of a non-violent nature, with the Property offense (50.0%) category accounting for the highest percentage of victims. In addition, and as can be seen by Table 8, the Public Order (3.2%), Status (17.7%), and Probation Violation (1.8%) categories combined represented 22.7% of the most serious prior offenses; Person offenses accounted for 22.5% of the victims.

TABLE 8
MOST SERIOUS PRIOR OFFENSE

Most Serious Prior Offense	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Person	5	9	0	0	14	(22.5)
Property	12	13	1	5	31	(50.0)
Drug	0	0	0	0	0	(0.0)
Public Order	1	1	0	0	2	(3.2)
Status	5	4	0	2	11	(17.7)
Probation Violation	0	1	0	0	1	(1.8)
Unknown	1	0	1	1	3	(4.8)
TOTAL	24	28	2	8	62	(100.0)

9. Length of Confinement (Prior to Suicide)

As presented in Table 9, 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.¹⁵ The majority of suicides

¹⁵It 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.

(31.7%) 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.¹⁶

TABLE 9
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)

10. Substance Abuse

As presented in Table 10, a large majority (73.4%) 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. As previously stated,

¹⁶For comparative purposes, although lengths of stay within juvenile facilities throughout the country vary 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).

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.

TABLE 10
SUBSTANCE ABUSE

Substance Abuse	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	15	29	5	9	58 (73.4)
No	3	2	0	3	8 (10.2)
Unknown	11	2	0	0	13 (16.4)
TOTAL	29	33	5	12	79 (100.0)

11. Medical Problems

As presented in Table 11, a large majority (64.5%) 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.

TABLE 11
MEDICAL PROBLEMS

Medical Problems	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	5	9	1	0	15 (18.9)
No	14	23	4	10	51 (64.5)
Unknown	10	1	0	2	13 (16.6)
TOTAL	29	33	5	12	79 (100.0)

12. Emotional Abuse

As presented in Table 12, a history of emotional abuse was found in 44.3% of the victims. 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.

TABLE 12
EMOTIONAL ABUSE

Emotional Abuse	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	11	15	2	7	35 (44.3)
No	8	12	2	3	25 (31.6)
Unknown	10	6	1	2	19 (24.1)
TOTAL	29	33	5	12	79 (100.0)

13. Physical Abuse

As presented in Table 13, a history of physical abuse was found in 34.1% 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.

TABLE 13
PHYSICAL ABUSE

Physical Abuse	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	7	15	1	4	27 (34.1)
No	14	13	2	6	35 (44.3)
Unknown	8	5	2	2	25 (37.6)
TOTAL	29	33	5	12	79 (100.0)

14. Sexual Abuse

As presented in Table 14, a history of sexual abuse was found in 27.8% 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.

TABLE 14
SEXUAL ABUSE

Sexual Abuse	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	3	12	3	4	22 (27.8)
No	15	14	1	5	35 (44.4)
Unknown	11	7	1	3	22 (27.8)
TOTAL	29	33	5	12	79 (100.0)

15. Mental Illness

As presented in Table 15, a history of mental illness was found in 65.8% 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.¹⁷ 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.

¹⁷It 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.

In addition, 53.5% of the victims were taking psychotropic medication at the time of their deaths.

TABLE 15
MENTAL ILLNESS

Mental Illness	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	14	23	4	11	52 (65.8)
No	6	10	1	1	18 (22.7)
Unknown	9	0	0	0	9 (11.5)
TOTAL	29	33	5	12	79 (100.0)

16. Suicidal Behavior

As presented in Table 16, a history of suicidal behavior was found in 69.6% 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 should 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.

TABLE 16
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 (69.6)
No	12	7	0	3	22 (27.8)
Unknown	2	0	0	0	2 (2.6)
TOTAL	29	33	5	12	79 (100.0)

17. 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 non-waking hours.

As presented in Table 17, 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%).¹⁸

TABLE 17
HISTORY OF ROOM CONFINEMENT

History of Room Confinement	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Yes	18	20	3	8	49	(62.0)
No	11	13	2	4	30	(38.0)
TOTAL	29	33	5	12	79	(100.0)

B) Suicide Incident Characteristics

1. Date

Table 18 shows the distribution of juvenile suicides during the five-year study period of 1995 through 1999. The fact that 1997 accounted for the highest number (and 1995 the lowest number) of suicides was not found to be statistically significant. For example, it was theorized that the reporting of only 9 suicides during 1995 had more to do with the inability of respondents to collect data that was several years old and/or the possibility that, given high staff turnover in many facilities, survey respondents were not employed at the facility during the earlier suicides.

In addition, suicides were 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.

¹⁸Other included two cases of youth involved in gang activity, and one case of a standard protocol for new intake.

TABLE 18
YEAR

Year	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
1995	4	3	0	2	9	(11.4)
1996	3	11	1	1	16	(20.3)
1997	10	6	2	4	22	(27.8)
1998	6	8	1	3	18	(22.8)
1999	6	5	1	2	14	(17.7)
TOTAL	29	33	5	12	79	(100.0)

2. Time

Research in the area of adult jail suicide has found that deaths are 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

TABLE 19
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)

major portion of the day shift (Hayes, 1989). In contrast, findings from this study indicated that 70.9% of suicides occurred during traditional waking hours (7:01am to 9:00pm), whereas 29.1% of suicides occurred during traditional non-waking hours (9:01pm to 7:00am). In addition and as shown in Table 19, 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 were sustained between 6:01pm and 9:00pm.

3. Method, Instrument and Anchoring Device

The study found that all but one victim (98.7%) chose hanging as the method of suicide.¹⁹ As shown in Table 20, 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. Other included towel and bag.

**TABLE 20
INSTRUMENT**

Instrument	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Bedding	23	22	3	8	56	(71.8)
Belt	1	1	0	2	4	(5.1)
Clothing	5	4	0	1	10	(12.9)
Shoelace	0	3	1	0	4	(5.1)
Other	0	2	1	1	4	(5.1)
TOTAL	29	32	5	12	78	(100.0)

As shown in Table 21, the victims utilized a variety of anchoring devices to commit suicide, including door hinge/knobs (20.5%), air vents (19.2%), bed frames (19.2%), and window frames (14.1%). Other included toilets, sinks, and television stands.

¹⁹The only other method of suicide was absconding from the facility and running in front of a passing train.

TABLE 21
ANCHORING DEVICE

Anchoring Device	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Air Vent	7	6	2	0	15	(19.2)
Bed Frame	7	5	1	2	15	(19.2)
Closet Rod	0	2	1	4	7	(8.9)
Door Hinge/ Knob	6	6	0	4	16	(20.5)
Sprinkler Head	2	3	0	1	6	(7.6)
Window Frame	6	5	0	0	11	(14.1)
Other	1	3	1	1	6	(7.6)
Unknown	0	2	0	0	2	(2.9)
TOTAL	29	32	5	12	78	(100.0)

4. 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).

5. Room Assignment

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.

6. Time Span (Between Last Observation and Finding Victim)

As presented in Table 22, approximately 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.

TABLE 22
TIME SPAN

Time Span	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Less than 15 Minutes	14	9	1	8	32	(40.5)
15-30 Minutes	6	14	2	1	23	(29.1)
30-60 Minutes	5	2	2	2	11	(13.9)
1-3 Hours	2	5	0	0	7	(8.8)
More than 3 Hours	2	3	0	0	5	(6.3)
Unknown	0	0	0	1	1	(1.4)
TOTAL	29	33	5	12	79	(100.0)

7. Room Confinement (At the Time of Suicide)

As shown in Table 23, approximately 50% of all suicide victims were on room confinement status at the time of their deaths. As previously indicated, 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 non-waking hours (9:01pm to 7:00am). 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.

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%).²⁰

²⁰Other 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.

TABLE 23
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)

8. Suicide Precaution Status

As can be seen by Table 24, 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.

TABLE 24
SUICIDE PRECAUTION STATUS

Suicide Precaution Status	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	7	5	0	1	13 (16.5)
No	22	28	5	11	66 (83.5)
TOTAL	29	33	5	12	79 (100.0)

9. Assessment 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).²¹ 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.”

As shown in Table 25, 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 (see Table 9).

TABLE 25
QMHP ASSESSMENT

QMHP Assessment	Detention Center	Training School/Secure Facility	Reception/ Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	10	29	5	11	55 (69.6)
No	19	4	0	1	24 (30.4)
TOTAL	29	33	5	12	79 (100.0)

Of those victims receiving a mental health assessment prior to their deaths, Table 26 indicates that 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.

²¹In 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.

TABLE 26
LAST CONTACT WITH QMHP

Last Contact with QMHP	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Less than 24 Hours	2	3	1	3	9	(16.4)
1-3 Days	5	3	1	3	12	(21.8)
4-6 Days	1	4	0	1	6	(10.9)
7-13 Days	0	8	2	2	12	(21.8)
14-30 Days	1	3	0	1	5	(9.1)
1-2 Months	1	2	0	0	3	(5.5)
3-4 Months	0	0	0	0	0	(9.9)
5-6 Months	0	1	0	0	1	(1.8)
7-9 Months	0	1	0	0	1	(1.8)
10-12 Months	0	1	0	1	2	(3.6)
More than 12 Months	0	3	1	0	4	(7.3)
TOTAL	10	29	5	11	55	(100.0)

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. Table 27 displays the facility population at the time of the juvenile suicides. As shown, two-thirds (67%) of the suicides occurred in facilities with populations of 200 youth or less, with 41.7% of all deaths in facilities with 50 or less youth.²² The study did *not* find any evidence to suggest that overcrowding was a contributing

²²This 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).

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.

TABLE 27
FACILITY POPULATION

Facility Population	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
50 or Less Youth	20	4	1	8	33	(41.7)
51-200 Youth	7	9	2	2	20	(25.3)
201-500 Youth	1	11	1	0	13	(16.4)
501-1,000 Youth	0	7	0	0	7	(8.8)
More than 1,000 Youth	0	1	0	0	1	(1.5)
Unknown	1	1	1	2	5	(6.3)
TOTAL	29	33	5	12	79	(100.0)

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). As shown in Table 28, the vast

TABLE 28
WRITTEN SUICIDE PREVENTION POLICY

Suicide Prevention Policy	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Yes	18	30	4	10	62	(78.5)
No	11	3	1	2	17	(21.5)
TOTAL	29	33	5	12	79	(100.0)

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%).

3. Intake Screening for Suicide Risk

According to Table 29, 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).

TABLE 29
INTAKE SCREENING FOR SUICIDE RISK

Intake Screening	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Yes	14	29	5	8	56	(70.9)
No	15	4	0	4	23	(20.1)
TOTAL	29	33	5	12	79	(100.0)

4. Suicide Prevention Training

As shown by Table 30, more than half (56.9%) of respondents reported that they provided some type of (pre-service, annual, and/or periodic) suicide prevention training to all of their direct care staff.

TABLE 30
SUICIDE PREVENTION TRAINING

Suicide Prevention Training	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Yes	16	19	4	6	45	(56.9)
No	13	14	1	6	34	(43.1)
TOTAL	29	33	5	12	79	(100.0)

According to Table 31, 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.

Only 37.9% (30 of 79) of *all* facilities that experienced a suicide provided annual suicide prevention training to its direct care staff.

TABLE 31
ANNUAL SUICIDE PREVENTION TRAINING

Annual Suicide Prevention Training	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	13	8	4	5	30 (66.7)
No	3	11	0	1	15 (33.3)
TOTAL	16	19	4	6	45 (100.0)

As shown by Table 32, the majority (51.1%) 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 6.6% of facilities providing such training, as well as only in 3.8% (3 of 79) of *all* facilities that experienced a suicide.

TABLE 32
DURATION OF SUICIDE PREVENTION TRAINING

Duration of Suicide Prevention Training	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
1-2 Hours	11	8	2	2	23 (51.1)
3-4 Hours	3	1	2	1	7 (15.5)
5-6 Hours	0	1	0	1	2 (4.6)
7-8 Hours	1	2	0	0	3 (6.6)
Unknown	1	7	0	2	10 (22.2)
TOTAL	16	19	4	6	45 (100.0)

5. Certification in Cardiopulmonary Resuscitation

As shown by Table 33, 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.

TABLE 33
CERTIFICATION IN CARDIOPULMONARY RESUSCITATION

Certification in Cardiopulmonary Resuscitation	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Yes	23	18	4	9	54	(68.4)
No	6	15	1	3	25	(31.6)
TOTAL	29	33	5	12	79	(100.0)

6. Suicide Precaution Protocol

As shown by Table 34, the overwhelming majority (89.9%) of respondents reported that their facilities maintained a suicide precaution protocol for the observation of youth (excluding close circuit television monitoring) at the time of the suicide.

TABLE 34
SUICIDE PRECAUTION PROTOCOL

Suicide Precaution Protocol	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Yes	25	32	5	9	71	(89.9)
No	4	1	0	3	8	(10.1)
TOTAL	29	33	5	12	79	(100.0)

As shown by Table 35, less than half (47.8%) of the respondents indicated that constant observation was the highest level of suicide precaution in the facility, with a sizable number (36.6%) of facilities listing observation at 15-minute intervals as the highest suicide precaution level. Of interest, only 28% (7 of 25) of Detention Center respondents indicated that constant observation was the highest level of suicide precaution in their facilities.

TABLE 35
HIGHEST FREQUENCY LEVEL OF OBSERVATION

Highest Frequency Level of Observation	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Constant	7	18	3	6	34	(47.8)
Every 5 Minutes	3	1	1	2	7	(9.8)
Every 10 Minutes	0	1	0	0	1	(1.4)
Every 15 Minutes	12	12	1	1	26	(36.6)
Every 30 Minutes	2	0	0	0	2	(3.0)
Unknown	1	0	0	0	1	(1.4)
TOTAL	25	32	5	9	71	(100.0)

7. Safe Housing

As shown by Table 36, 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

TABLE 36
SAFE HOUSING

Safe Housing	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N	Percent
Yes	10	20	3	3	36	(45.6)
No	19	13	2	9	43	(54.4)
TOTAL	29	33	5	12	79	(100.0)

8. 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. According to Table 37, the majority (64.6%) of respondents reported that a mortality review was conducted following the juvenile suicide, although Detention Centers conducted mortality reviews to a lesser degree (51.7%).

TABLE 37
MORTALITY REVIEW

Mortality Review	Detention Center	Training School/Secure Facility	Reception/Diagnostic Center	Residential Treatment Center	Combined N Percent
Yes	15	21	4	11	51 (64.6)
No	14	12	1	1	28 (35.4)
TOTAL	29	33	5	12	79 (100.0)

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].²³

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.

²³In several cases, more than one precipitating factor was identified. As such, only the perceived leading factor is listed above.

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 in this report (Table 28), 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 38, *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%)

TABLE 38
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	7	1	3	15	(19.0)
5	6	5	1	1	13	(16.5)
6	6	8	1	2	17	(21.5)
7	3	8	2	3	16	(20.3)
TOTAL	29	33	5	12	79	(100.0)

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 myself 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 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 that although the use of isolation varied considerably among facility types, 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 during a 30-day period.²⁴ 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

²⁴It 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.

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 percent 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. Facility 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 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 QMHPs 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).

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 (Council of Juvenile Correctional Administrators, 2003; Hayes, 1999, 2000; National Commission on Correctional Health Care, 1999; Roush, 1996):

- 1. Training:** All facility, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by a minimum of two (2) hours of annual training. Training should include, but not be limited to, predisposing factors, high-risk periods, warning signs and symptoms, and components of the facility's suicide prevention policy.
- 2. Identification/Screening:** Intake screening for suicide risk must take place immediately upon confinement and prior to housing assignment, and include inquiry regarding: current and past suicidal behavior; prior mental health treatment; recent significant loss; suicidal behavior by family member/close friend; suicide risk during prior contact/confinement with agency; and arresting/transporting officer(s) believes youth is currently at risk.

The policy must include procedures for referral to mental health personnel for further assessment.²⁵

- 3. Communication:** At a minimum, facility procedures must enhance communication at three stages: 1) between the arresting/transporting officer(s), family members, and facility staff; 2) between and among facility staff (including medical and mental health personnel); and 3) between facility staff and the suicidal youth.
- 4. Housing:** Isolation should be avoided; whenever possible, suicidal youth should be housed in general population, mental health unit, or infirmary, in close proximity to staff. Youth must be housed in suicide-resistant, protrusion-free rooms. Removal of clothing (excluding belts and shoelaces), as well as use of restraints should be avoided whenever possible, and only utilized as a last resort for short periods of time in which the youth is engaging in self-destructive behavior.
- 5. Levels of Supervision:** Two levels are normally recommended for suicidal youth: *close observation*, reserved for the youth who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior and is now viewed as potentially suicidal, requires supervision at staggered intervals not to exceed every 15 minutes. *Constant Observation*, reserved for the youth who is actively suicidal (threatening/engaging in the act), requires supervision on a continuous, uninterrupted basis. In addition, an intermediate level of supervision can be utilized with observation at staggered intervals not to exceed every 5 minutes. Other supervision aides (e.g., closed circuit television, companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels.

²⁵There are several intake screening and assessment forms available for the identification of suicide risk, including the "Intake Screening Form/Suicide Risk Assessment" (Hayes, 1999), the recently developed "Juvenile Suicide Assessment" (Galloucis and Francek, 2002) and the Massachusetts Youth Screening Instrument-MAYSI-2 (Grisso and Barnum, 2000).

6. Intervention: A facility's policy regarding intervention should be threefold: 1) all staff should be trained in standard first aid and CPR; 2) any staff member who discovers a youth attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin life-saving measures; and 3) staff should never presume that the youth is dead, but rather initiate and continue appropriate life-saving measures until relieved by medical personnel. All housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material).

7. Reporting: In the event of a suicide attempt or suicide, all appropriate facility officials should be notified through the chain of command. All staff who came into contact with victim prior to the incident (or in responding to the incident) should be required to submit a statement as to their full knowledge of the youth and incident.

8. Follow-up/Mortality Review: All staff (as well as youth) involved in the incident must be offered critical incident stress debriefing. If resources permit, a psychological autopsy is recommended. Every completed suicide, as well as serious suicide attempt (i.e., requiring hospitalization), should be examined by a mortality review process. Ideally, the review should be coordinated by an outside agency or facility to ensure impartiality. The mortality review, separate and apart from other formal investigations that may be required to determine the cause of death, must be multidisciplinary (i.e., involve correctional, mental health and medical personnel) and include a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide; and 6) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

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 of all 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 both pre-service and annual 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, as well as on youth suicide in the community. 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.

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 unless administrators 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.²⁶ 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 intake screening, as well as overall suicide prevention programming within detention centers experiencing suicides, warrants 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.

²⁶Communication 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.”

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.²⁷ 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 housed under conditions of room confinement at the time of their deaths, further research is necessary to explore the perceived relationship between suicide and

²⁷Perhaps 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.

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.

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Appendix A

JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY PHASE 1

NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES
Acting as Collecting Agent for the
OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION
U.S. DEPARTMENT OF JUSTICE

Dear Facility Director:

On behalf of the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, the National Center on Institutions and Alternatives is conducting the first national survey of juvenile suicide in confinement. The goal of this two-phase project, which is being conducted with the full support and assistance of both the National Juvenile Detention Association and Council of Juvenile Correctional Administrators, will be to gather descriptive data on demographic characteristics of suicide victims, characteristics of the incident, and characteristics of the facility sustaining the suicide. A report of the findings will be available 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.

During Phase 1, we are sending this survey to all public and private juvenile detention centers/homes, training schools/secure facilities, reception/diagnostic centers, residential treatment centers, and ranches, camps and farms in the country. *On the reverse side of this form, we are asking whether your current or former facility had a suicide and/or critical suicide attempt during the five-year period of January 1, 1995 through December 31, 1999.*

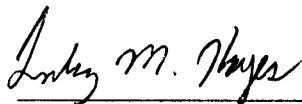
We ask that you complete and return this form within 30 days *only* if your current or former facility sustained a suicide and/or critical suicide attempt during this time period. A self-addressed, business reply envelope is enclosed for your convenience.

PARTICIPATION IN THIS SURVEY PROCESS IS VOLUNTARY. DATA PROVIDED WILL BE CODED AND HELD IN THE STRICTEST CONFIDENCE. RESULTS OF THIS STUDY WILL BE PRESENTED IN SUMMARY FASHION, THEREFORE, VICTIM AND FACILITY NAMES WILL *NOT* APPEAR IN ANY PROJECT REPORT.

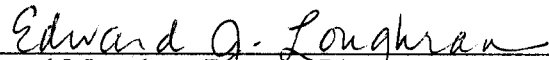
Should you have any questions or concerns regarding completion of this form or our study, please contact Lindsay M. Hayes, Project Director, National Center on Institutions and Alternatives (NCIA), 40 Lantern Lane, Mansfield, Massachusetts 02048, 508/337-8806, e-mail: LHayesta@aol.com, or 508/337-3083 (fax).

Your cooperation and support of this project are greatly appreciated.

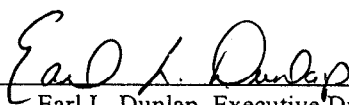
Sincerely,



Lindsay M. Hayes, Project Director
National Center on Institutions and Alternatives



Edward J. Loughran, Executive Director
Council of Juvenile Correctional Administrators



Earl L. Dunlap, Executive Director
National Juvenile Detention Association

DEFINITIONS

SUICIDE: Any death of a youth resulting from a self-inflicted act. (*Note: For purposes of this study, a youth who attempts suicide in the facility yet later dies enroute to, or at, a hospital or other health care provider, is classified as a "juvenile facility suicide" and should be reported below.*)

CRITICAL SUICIDE ATTEMPT: Any self-inflicted act by a youth that results in transport out of the facility to a hospital or other health care provider for medical attention and hospitalization.

DETENTION CENTER/HOME: A short-term facility that provides custody in a physically restricting environment pending adjudication or, following, adjudication, pending disposition, placement, or transfer.

TRAINING SCHOOL/SECURE FACILITY: A long-term facility for adjudicated youth typically under strict physical/staff controls.

RECEPTION/DIAGNOSTIC CENTER: A short-term facility that screens youth committed by courts and assigns them to appropriate facilities.

RANCH, CAMP, or FARM: A long-term residential facility for youth whose behavior does not require the strict confinement of a training school, often allowing them greater contact with the community. Includes "residential treatment facility" and "boot camp."

PUBLIC FACILITY: A facility under the direct administrative and operational control of a state or local government.

PRIVATE FACILITY: A facility (either profit or non-profit making) subject to governmental licensing but under the direct administrative or operational control of a private enterprise. May include facilities that receive public and private funding.

RESIDENT: Any youth, either classified as a delinquent, status offender, or non-offender (dependent, neglected, abused, etc.) that resides in a public or private facility.

QUESTIONS

Please indicate below the total number of SUICIDES and/or CRITICAL SUICIDE ATTEMPTS that occurred in your current/former facility during the five-year period of January 1, 1995 through December 31, 1999. *Complete this form only if your facility had a suicide(s) and/or critical suicide attempt(s) during this time period.*

1. Our facility had the following incidents by residents:

____ SUICIDE(S) and/or ____ CRITICAL SUICIDE ATTEMPT(S) in 1995
____ SUICIDE(S) and/or ____ CRITICAL SUICIDE ATTEMPT(S) in 1996
____ SUICIDE(S) and/or ____ CRITICAL SUICIDE ATTEMPT(S) in 1997
____ SUICIDE(S) and/or ____ CRITICAL SUICIDE ATTEMPT(S) in 1998
____ SUICIDE(S) and/or ____ CRITICAL SUICIDE ATTEMPT(S) in 1999

2. Our facility is: ____ PUBLIC ____ PRIVATE

3. Our facility is best described as a:

____ DETENTION CENTER/HOME
____ TRAINING SCHOOL/SECURE FACILITY
____ RECEPTION/DIAGNOSTIC CENTER
____ RANCH, CAMP or FARM
____ OTHER (Explain): _____

THE FOLLOWING WILL BE USED FOR INTERNAL PURPOSES ONLY:

4. Completed by (name/title): _____
5. Name of Facility: _____
6. Address: _____
City: _____ State: _____ Zip Code: _____
7. Telephone: _____
8. Date Completed: _____

**PLEASE RETURN THIS COMPLETED FORM IN THE ENCLOSED
BUSINESS REPLY ENVELOPE WITHIN 30 DAYS TO:
NCIA • 40 Lantern Lane • Mansfield, MA 02048
or Fax to 508/337-3083**

APPENDIX B

PHASE 2
JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY
 NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES
 Acting as Collecting Agent for the
 OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION
 U.S. DEPARTMENT OF JUSTICE

Items contained in this questionnaire refer to a suicide that occurred in your facility between January 1, 1995 and December 31, 1999 as identified during Phase 1 of the Juvenile Suicide in Confinement study. Please complete the following questionnaire by checking the appropriate boxes and/or filling in the blanks. Definitions for certain terms used in this questionnaire appear on page 7.

DATA PROVIDED WILL BE CODED AND HELD IN THE STRICTEST CONFIDENCE. RESULTS OF THIS STUDY WILL BE PRESENTED IN SUMMARY FASHION, THEREFORE, VICTIM AND FACILITY NAMES WILL NOT APPEAR IN ANY PROJECT REPORT.

We ask that you complete and return this questionnaire within 30 days. A self-addressed, business reply envelope is enclosed for your convenience. Should you have any questions or concerns regarding completion of this questionnaire, please contact Lindsay M. Hayes, Project Director, National Center on Institutions and Alternatives (NCIA), 40 Lantern Lane, Mansfield, Massachusetts 02048, 508/337-8806, e-mail: LHayesta@aol.com, or 508/337-3083 (fax).

NAME OF FACILITY _____ STATE _____

PART A: PERSONAL CHARACTERISTICS OF VICTIM

- 1) **Victim's Name (or any other identifiable notation):**

Last	First	Middle
------	-------	--------

- 2) **Race/Ethnicity:**
- | | |
|----------------------------|---------------------------------|
| (1) _____ Caucasian | (4) _____ American Indian |
| (2) _____ African-American | (8) _____ Other (Specify _____) |
| (3) _____ Hispanic | (9) _____ Unknown |

- 3) **Sex:**
- | | |
|----------------|------------------|
| (1) _____ Male | (2) _____ Female |
|----------------|------------------|

- 4) **Date-of -Birth:** ____ / ____ / ____ or ____ Years-Old

- 5) **Living Status:**
- | | |
|------------------------|----------------------------------|
| (1) _____ Self | (5) _____ Foster Parent/Guardian |
| (2) _____ One Parent | (8) _____ Other (Specify _____) |
| (3) _____ Both Parents | (9) _____ Unknown |
| (4) _____ Relatives | |

- 6) Please specify **Current Charge(s)** for which the victim was confined at time of suicide and whether victim was being **Detained** or had been **Committed** on those charge(s).

<u>Charge(s)</u>	<u>Detained</u>	<u>Committed</u>
_____	(1) _____	(1) _____
_____	(2) _____	(2) _____
_____	(3) _____	(3) _____

7) Did the victim have a record of **Prior Arrests**?

(1)____ Yes (2)____ No

8) If the victim had a prior arrest record, specify the **Prior Charges**.

<u>Prior Charge(s)</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

9) What was the total **Length of Confinement** that the victim had been in your facility prior to his/her death? (If less than two days, indicate in hours.)

_____ Hours _____ Days _____ Months _____ Years

10) Did the victim have a history of **Substance Abuse** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

11) If the victim had a history of substance abuse, briefly **Describe Substance Abuse**. _____

12) Did the victim have a history of **Medical Problems** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

13) If the victim had a history of medical problems, briefly **Describe Medical Problems**. _____

14) Did the victim have a history of **Emotional Abuse** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

15) If the victim had a history of emotional abuse, briefly **Describe Emotional Abuse**. _____

16) Did the victim have a history of **Physical Abuse** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

17) If the victim had a history of physical abuse, briefly **Describe Physical Abuse**. _____

18) Did the victim have a history of **Sexual Abuse** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

19) If the victim had a history of sexual abuse, briefly **Describe Sexual Abuse**. _____

20) Did the victim have a history of **Mental Illness** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

21) If the victim had a history of mental illness, briefly **Describe Mental Illness**. _____

22) Did the victim have a history of taking **Psychotropic Medication** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

23) If the victim had a history of taking psychotropic medication, briefly **Describe Psychotropic Medication** (e.g., date, type, dose, and frequency) _____

24) Did the victim have a history of **Suicidal Behavior** either in the facility and/or in the community?

(1)____ Yes (2)____ No (9)____ Unknown

25) If the victim had a history of suicidal behavior, briefly **Describe Suicidal Behavior**. _____

26) Did the victim have a history of **Room Confinement** (e.g., isolation, segregation, time-out, quiet room, etc., see definitions on page 7) while in the facility?

(1)____ Yes (2)____ No

27) If the victim had a history of room confinement, briefly **Describe Types and Circumstances of Room Confinement**. _____

PART B: SUICIDE INCIDENT CHARACTERISTICS

- 28) What was the **Date** and **Time** of the victim's suicide?

Date: ____/____/199__ **Time (found):** ____ a.m. ____ p.m.

- 29) What was the **Method** of suicide and the **Instrument** used?

Method

Instrument

- | | | |
|---|---------------------------------|-----------------|
| (1) ____ Hanging (from ____) | (01) ____ Shoelace | (08) ____ Knife |
| (2) ____ Overdose | (02) ____ Belt | (09) ____ Glass |
| (3) ____ Cutting | (03) ____ Other Clothing | (10) ____ Drugs |
| (4) ____ Shooting | (04) ____ Bedding | Specify _____ |
| (5) ____ Jumping | (05) ____ Towel | |
| (6) ____ Ingestion of Foreign Object(s) | (06) ____ Razor | |
| (8) ____ Other | (07) ____ Other (Specify _____) | |

- 30) At the time of the suicide, was the victim **Under the Influence** of:

- | | |
|------------------|-----------------------------------|
| (1) ____ Drugs | (4) ____ Neither Drugs or Alcohol |
| (2) ____ Alcohol | (3) ____ Drugs and Alcohol |

- 31) At the time of the suicide, was the victim assigned to a **Single** or **Multiple Occupancy** room?

- (1) ____ Single (2) ____ Multiple

- 32) What was the **Time Span** between the suicide and finding the victim?

- | | |
|------------------------------------|--------------------------------|
| (1) ____ Less Than 15 Minutes | (4) ____ Between 1 and 3 Hours |
| (2) ____ Between 15 and 30 Minutes | (5) ____ Greater Than 3 Hours |
| (3) ____ Between 30 and 60 Minutes | |

- 33) Was the victim under any type of **Room Confinement** (e.g., isolation, segregation, time-out, quiet room, etc.) at the time of the suicide?

- (1) ____ Yes (2) ____ No

- 34) If the victim was under room confinement at the time of the suicide, briefly **Describe Type and Circumstances of Room Confinement**.

- 35) Was the victim under **Suicide Watch** (see definitions on page 7) at the time of the suicide?

- (1) ____ Yes (2) ____ No

- 36) If the victim was under suicide watch at the time of the suicide, what was the **Frequency of Staff Observation** (excluding any closed circuit television monitoring)?

(1) ☐ Continuous (5) ☐ Every 30 Minutes
(2) ☐ Every 5 Minutes (6) ☐ Every 60 Minutes
(3) ☐ Every 10 Minutes (8) ☐ Other (Specify _____)
(4) ☐ Every 15 Minutes

- 37) Was the victim ever **Assessed** by a **Qualified Mental Health Professional** (see definitions on page 7) prior to the suicide?

(1) ☐ Yes (2) ☐ No

- 38) If the victim was assessed, when was the **Last Contact by a Qualified Mental Health Professional** prior to the suicide? (If less than two days, indicate in hours.)

Hours Days Months Years

- 39) Was a **Mortality Review** (see definitions on page 7) conducted following the suicide?

(1) ☐ Yes (2) ☐ No

- 40) If a mortality review was conducted, did the process offer any **Possible Precipitating Factors** (i.e., circumstances which may have caused the victim to commit suicide)? If yes, describe: _____

- 41) If a mortality review was conducted, did the process offer any **Recommendations to Prevent Future Suicides**? If yes, describe: _____

PART C: FACILITY CHARACTERISTICS

- 42) The **Facility** (see definitions on page 7) is best described as a:
- ____ DETENTION CENTER
____ TRAINING SCHOOL/SECURE FACILITY
____ RECEPTION/DIAGNOSTIC CENTER
____ RANCH, CAMP or FARM
____ OTHER (Explain): _____
- 43) The facility is **Administered** by:
- (1) ____ State (4) ____ Private Organization
(2) ____ County (8) ____ Other (Specify _____)
(3) ____ Municipality
- 44) At the time of the suicide, what was the rated **Capacity** and **Population** of the facility?
- (1) ____ Capacity (2) ____ Population
- 45) At the time of the suicide, did the facility have a **Written Suicide Prevention Policy**?
- (1) ____ Yes (2) ____ No
- 46) At the time of the suicide, did the facility have an **Intake Screening process to Identify Suicide Risk**?
- (1) ____ Yes (2) ____ No
- 47) At the time of the suicide, had *all* direct-care facility staff received **Suicide Prevention Training**?
- (1) ____ Yes (2) ____ No
- 48) If all direct-care facility staff had received suicide prevention training, what was the **Frequency** and **Duration of the Suicide Prevention Training** at the time of the suicide?
- | <u>Frequency</u> | <u>Duration</u> |
|--------------------------------|------------------------------------|
| (1) ____ Yearly | (01) ____ Hours (Specify Number) |
| (6) ____ Other (Specify _____) | (02) ____ Minutes (Specify Number) |
- 49) At the time of the suicide, had *all* direct-care facility staff received **Certification in Cardiopulmonary Resuscitation**?
- (1) ____ Yes (2) ____ No
- 50) At the time of the suicide, did the facility have a **Suicide Watch** process (excluding any closed circuit television monitoring)?
- (1) ____ Yes (2) ____ No
- 51) If the facility had a suicide watch process at the time of the suicide, what was the **Frequency Level(s) of Staff Observation**? (Check all that apply.)
- (1) ____ Continuous (5) ____ Every 30 Minutes
(2) ____ Every 5 Minutes (6) ____ Every 60 Minutes
(3) ____ Every 10 Minutes (8) ____ Other (Specify _____)
(4) ____ Every 15 Minutes
- 52) At the time of the suicide, did the facility have a **Housing** process by which a suicidal resident would be assigned to a safe and protrusion-free room?
- (1) ____ Yes (2) ____ No

THE FOLLOWING WILL BE USED FOR INTERNAL PURPOSES ONLY:

Completed by (name/title): _____
Facility/Agency: _____
Address (street): _____
City: _____ State: _____ Zip Code: _____
Telephone: _____
Date Completed: _____

Would you like to receive a copy of the survey findings?

(1) _____ Yes (2) _____ No

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DEFINITIONS

ROOM CONFINEMENT: Behavioral sanction imposed on youth that restricts movement for varying amounts of time. Includes, but is not limited to, isolation, segregation, time-out, quiet room.

SUICIDE WATCH: The level(s) of staff observation given to youth identified as being at risk of suicide. Excludes closed circuit television or any other non-staff monitoring.

QUALIFIED MENTAL HEALTH PROFESSIONAL: 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.

MORTALITY REVIEW: An interdisciplinary committee process that examines the events surrounding the death to determine if the incident was preventable. The review process may include recommendations aimed at reducing the opportunity of future deaths.

DETENTION CENTER/HOME: A short-term facility that provides custody in a physically restricting environment pending adjudication or, following, adjudication, pending disposition, placement, or transfer.

TRAINING SCHOOL/SECURE FACILITY: A long-term facility for adjudicated youth typically under strict physical/staff controls.

RECEPTION/DIAGNOSTIC CENTER: A short-term facility that screens youth committed by courts and assigns them to appropriate facilities.

RANCH, CAMP, or FARM: A long-term residential facility for youth whose behavior does not require the strict confinement of a training school, often allowing them greater contact with the community. Includes "residential treatment facility" and "boot camp."

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THANK YOU FOR YOUR COOPERATION

Please return this completed questionnaire in the enclosed business reply envelope within 30 days to:

NCIA
40 Lantern Lane
Mansfield, MA 02048
or fax to
508/337-3083