

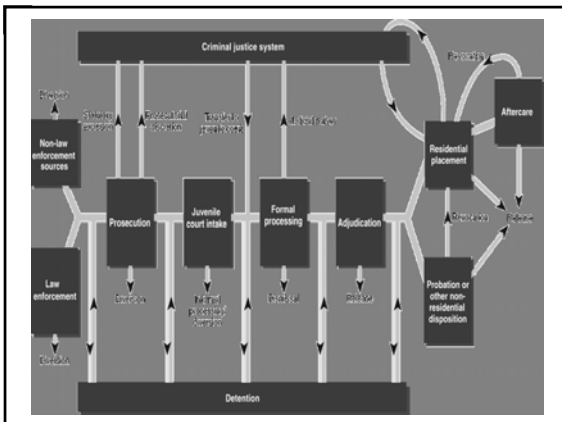
Practical Strategies For Preventing Juvenile Suicides in Confinement Settings

SAMHSA Suicide Prevention Grantee Technical Assistance Meeting
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By Judith F. Cox, MA, CCHP

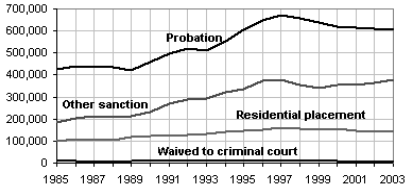
Focus of Today's Presentation

- **Suicide among youths in confinement settings**
 - Overview of facilities where juveniles are confined
 - The problem of juvenile suicides in confinement facilities
 - National strategy and standards related to suicide prevention in confinement facilities
 - Key prevention strategies



Juvenile Confinement is used Less Frequently than Probation

Disposition of delinquency cases, 1985-2003



Juveniles in Confinement Settings

Detained by **Law Enforcement** -can be held while waiting to contact a parent or guardian or to arrange transportation to a juvenile detention facility



Mid year 2003 **Adult Jails**, held 6,869 juveniles under 18 years of age

- 5,484 held as adults
- 1385 held as juveniles

Mid year 2003 Indian Country Jails (n=70) held 288 juveniles

On 10/22/03 **Juvenile Residential Facilities** held 96,655 juveniles

On 6/30/03 **State Prison** held 3,006 inmates in prisons under age 18 yrs

Large Number of Residential Facilities, Representing Small & Large facilities (OJJDP,2002)

2,964 facilities confine juvenile offenders:

- 1,651 hold between 1-20 residents
- 1,054 hold between 21-100 residents
- 171 hold between 101-200 residents
- 88 hold between 201-972 residents

Wide Range of Juvenile Residential Facilities

- detention centers
- shelter
- reception/diagnostic
- group home/halfway house
- boot camp
- ranch/forestry/wilderness camp/marine program
- training school/long-term secure facility

The Length of Stay for Most Juvenile Offenders is short

Median time in juvenile facilities was 68 days.

> After 60 days, only 21% of detained person offenders remained in custody.

> After 6 months, 45% of committed person offenders remained in custody.

•Source: OJJDP's Census of Juveniles in Residential Placement for 2003

The Prevalence of Mental Illness for Youth in Confinement is High

Teplin(2002): found two thirds of all juveniles(1,830) confined in a county juvenile detention facility found: two thirds to have one or more alcohol, drug, or mental disorder

Results of 2 comprehensive literature reviews (Otto et al, 1992 & Edens et al,1997)

Disorder	Estimated rate among youth in confinement
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- | | |
|--|---------------|
| • Conduct disorders | 50-90% |
| • Attention deficit | up to 46% |
| • Anxiety | 6 to 41% |
| • Substance abuse or dependence | 25-50% |
| • Affective disorders | 32-78% |
| • Psychotic disorder | 1-6% |
| • Co-occurring Mental Health and substance abuse | more that 50% |

Suicide Prevention for Juveniles in Confinement is Part of the 2001 National Strategy for Suicide Prevention

- **Goal 8: By 2005, for juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers**

- **Goal 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment**
 - Objectives for this goal are to ensure key gatekeepers like nurses, clergy, correctional workers obtain training to help prevent suicide

National Standards & Guidelines Address Suicide Prevention for Juveniles in Confinement
The 3 most recognized standards & Guidelines

- **National Commission on Correctional Health Care (NCCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities**

- **The American Correctional Association (ACA)**

- **The American Psychiatric Association (APA), Psychiatric Services in Jails and Prison**

Deaths in Confinement Facilities

- Suicide was the leading cause of death in residential facilities between Oct.1, 2001- September 30,2002
 - Suicides (N=10)

 - Accidents (N= 6)

 - Illness (n=6)

 - Homicide (n= 2)

 - Other n=2)
- (OJJDP 2002)

First National Survey(2004) conducted on Juvenile Suicide in Confinement

Conducted by the National Center on Institutions and Alternatives (NCIA)

- The survey identified 110 juvenile suicides occurring between 1995 and 1999. Data was analyzed on 79 cases.

• **Suicides Reported**

<u>Year</u>	<u>Number of suicides</u>
1995	9
1996	16
1997	22
1998	18
1999	14

What was the Commitment vs. Detained Status of the Suicide Victims in the NCIA Survey,2004?

- 67.1% held on a commitment status
- 32.9% detained

Where did the Suicides reported on the NCIA National Survey(2004) occur?

- Data was analyzed on 79 cases:
 - 41.8% occurred in Training School/Secure Facilities
 - 36.7% in Detention Centers
 - 15.2% in Residential Treatment Centers
 - 6.3%in Reception/Diagnostic Centers.

NCIA National Survey (2004) reported a High Prevalence of Mental Illness and History of Suicide Behavior Among Juveniles complete Suicide

- **74.3% had a history of mental illness:**
- **The vast majority (65.3%) suffered from depression at the time of their death**
- **71.4% had a history of suicide behavior (45.5% w/ prior attempt)**

Suicide Attempts Within Juvenile Facilities Occur Frequently

- OJJDP 2002 census findings: 114 facilities reported a serious suicide attempt that required hospitalization in the month prior to the OJJDP 2002 census
- A 1994 National Study found more than 11,000 juveniles in juvenile facilities are estimated to engage in more than **17,000 incidents** of suicide each year (Parent et al 1994)

Juvenile Suicide in the Adult Jail Population

- Bureau of Justice started collecting annual data on jail suicides in 2000
- This was the result of a requirement of the Death in Custody Reporting Act of 2000


Jail & Prison Inmates Under 18 have the Highest Suicide (BJS 2005)

Years old	Suicide Rate per 100,000	
	Jail	Prison
Under 18	101	52
18-24	38	14
25-34	47	14
35-44	53	14
45-54	52	13
55 yrs or older	58	13

The smallest facilities have the Highest Rates of Suicide (BJS 2005)

- Over 40% of our nation's jail are small, housing fewer than 50 inmates
- The suicide rate in small Jails = 177/100,000
- The Suicide Rate in the 50 largest Jails in the USA=32/100,000

Constitutional Right to Mental Health Care

- Jails have a constitutional duty to provide adequate levels of medical care including mental health care
- 
- This duty arises because persons in custody must rely on facility authorities to treat their medical needs

Essential Program Components to Prevent Suicides among juveniles in confinement

- Ten program components for suicide prevention in juvenile facilities can be derived from the legal cases and standards

Essential Components to Prevent Suicides

1. Identification of high risk inmates
2. Timely referral to health providers
3. Professional assessment of suicide risk
4. Treatment planning & treatment services
5. Communication among juvenile child workers or correctional officers & health staff
6. Safe housing &adequate monitoring of suicidal inmates
7. Intervention during a suicide incident
8. Review and Debriefing
9. Discharge Planning
10. Training

Identification of Suicide Risk (at Intake)

Best practices

- Suicide Screening is part of the intake process
- It includes risk reports from the courts and transporting officers & a **Structured Form** which is based upon established risk factors
- Screening is conducted when the inmate first arrives
- Screening includes a procedures that positive findings are immediately reported and safe housing/supervision provided
- Screening is conducted by trained staff & qualified staff



A word About Qualified staff?

- Health services in confinement facilities are provided via many different arrangements . Key providers include county/city/state staff, private national contractors and local providers
- Have a clear written definition of the education, license requirements and competency level of staff who provide screenings and assessments
- All inmates identified as potentially suicidal should be evaluated by professional staff. This means staff who are qualified in your State to make these assessments e.g. licensed staff



Mental Health Screening in Juveniles Residential Facilities (OJJDP 2002 Census Report)

- 2,964 facilities in the USA hold juvenile offenders-
Of these facilities 2,837 reported information on screening for suicide risk:
 - 68% said they screened all youth
 - 17 reported they screened some youth
 - 15% reported no youth screened
- 56% of the reporting facilities said screening was conducted by mental health professionals with at least a master's degree in psychology or social worker

Identification of Suicide Risk After Intake

Best practices

- Identification focuses on inmates in general population as well as inmates in special housing
- Identification always results in reporting positive findings, providing safe housing and access to health care
- Identification is a process involving the collaborative efforts of child care workers, correctional officers medical and mental health staff and the inmate population
 - Suicide questions are part of ongoing health assessments
 - Observations are part of routine rounds
 - Staff are well trained and know their roles



Identification of Suicide Risk After Intake

Precipitating factors reported in mortality reviews of juvenile offender victims of suicide

- Recent death of family member/break up of a girl/boyfriend
- Threat of or actual assault
- Parents threat of /failure to visiting
- Fear of waiver to adult system or transfer to a more secure facility
- Contagion

Referral

- Best practices
- Written Procedures are in place to refer juveniles identified as being at risk of suicide
- Staff making the referral should record their specific observations on a referral form.
- Inmates at risk for suicide are under constant supervision pending assessment findings

Housing Suicidal Inmates

Best practices

- Housing decisions are based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement
- Suicidal juveniles are not isolated & should be housed close to staff preferable in a health/mental health unit
- The inmate is fully visible when in the suicide cell

Take a Moment to Reflect the Housing of
Juveniles in Confinement Settings and Suicide

Juveniles in confinement who completed suicide
(NCIA 2004)

- 74.7 % of victims were assigned to single room occupancy
- 50% of the juveniles were on room confinement at the time of their death
- 62% of the juvenile suicide victims had a history of room confinement

Circumstances that lead to room
confinement (NCIA study continued)

- Failure to follow program rules/inappropriate behavior(47.3%)
- Threat/actual physical abuse of staff or peers(42.1%)
- Other (included two cases where it was standard procedure for new intake

Housing Suicidal Inmates

- **Suicide housing should contain tamper-proof light fixtures, smoke detectors and ceiling /wall air vents that are protrusion-free**
- **Suicide housing should not contain live electrical switches or outlets or any objects that provide an easy anchoring device(towel racks radiator vents etc.)**

Monitoring

Constant observation

The juvenile is actively suicidal threatening or engaging in suicide behavior

Communication Regarding Risk

Best practices

- Communication is established with outside sources (arresting officer, families, courts, probation officer)
- Communication occurs among child care workers and correctional staff and health care staff regarding inmates on suicide watch
 - After the decision to die a person's behavior often changes
 - either becoming agitated as if ready to act
 - or very peaceful

Staff monitoring juveniles on suicide watch are in the best position to notice these important behaviors

Intervention during a Suicide Attempt

Best practices

- Staff are current in First Aid & CPR
- Staff are trained to respond to health-related situations w/in 4 a minute response time
- Emergency equipment is available
- Policy requires staff who discover a juvenile engaging in self-harm to:
 - 1) immediately assess the severity of the emergency
 - 2) call for backup
 - 3) never presume an juvenile is dead and as appropriate provide life saving measures

Treatment Planning & Treatment Services

Best practices

- A treatment plan is developed in collaboration with the suicidal inmate. This plan addresses the underlying cause of the suicide behavior
- Treatment addresses protective factors
- Treatment addresses cultural and age factors
- Treatment plans address the cyclical nature of suicide risk and includes a strategy for relapse
- Treatment is provided consistent with the plan.
- Discharge planning and release to the community

A Word About Treatment

- **According to the Public health approach, two ways to prevent suicides are :**
 - Identify persons at risk and engage them in early and aggressive treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g. depressed mood, hopelessness, helplessness, alcohol and other drug abuse)

This includes accurate assessment of how individuals respond to significant life events, transitions and challenges to their mental and physical well-being and appropriate and timely intervention
 - Promote and support the presence of protective factors such as skills in problem solving & conflict resolution

A Word About Treatment

- Psychological autopsy studies have found a large percent of suicides victims with major depression were not receiving treatment or were receiving inadequate treatment

Discharge Planning

Best practice

- Release plans coordinated with community providers are developed for all inmates who are suicidal

- What if the juvenile is suicidal at release?

Review Following a Suicide

Best practices

- A clinical mortality & a psychological autopsy are completed within 30 days of the suicide, the results of both are reviewed with treating staff and corrective action is implemented

Critical Incident Debriefing(CID)

Best practice

- Critical Incident Debriefing is provided w/in 24 to 72 hours of the incident

Training in Suicide Prevention

Best practices

- All staff who work with juveniles should be trained to recognize verbal and behavioral cues that indicate potential suicide and how to respond appropriately
- Child Care workers and correctional officers who work in mental health units or who provide intake screening should receive more intense training to perform duties of these positions
- Medical and mental health staff should be evaluated to ensure they have required competencies

Key subject areas in Suicide Prevention Training Programs for Confinement Facilities

- First Aid and CPR
- Suicides in confinement
- Myths about Suicide
- Risk/ protective factors
- Acute suicide risk
- Substance use & suicide
- Recognizing intoxication and withdrawal
- Mental illness & suicide
- Recognizing signs of mental illness
- Responding to crisis
- What is manipulation
- Communication Skills
- Suicide Prevention Screening
- Referral procedures
- Facility suicide prevention policy & staff roles
- Psychological autopsy
- Debriefing

A Model for Thinking about Training

- Stakeholders, gatekeepers and all staff (e.g. child care workers, correctional officers, probation officers, medical and mental health) who work with juveniles have a role in suicide prevention
- In determining the training needs of these staff:
 - Define their expected roles in suicide prevention,
 - Identify the skills needed to provide these roles (eg. identification, crisis intervention medication therapies)
 - Reflect on what level of competency these staff need to have for each skill
- Measure skills attained (at least for critical areas-e.g... screening)

Exercise

You have just developed a multi-level training program that offers suicide prevention awareness to a broad level of stakeholders & competency-based training for those staff who have gatekeeper and other direct care responsibilities.

- Who did you include as **Stakeholders** (e.g.) lawyers, judges, county social services staff, health department staff and families

- Who are the **Gatekeepers**

- What other **Direct Care Staff** did you include (e.g. nurse chaplain, physician, social worker, child care workers, correctional officers)

Exercise

- Now for each of the subject areas think about knowledge and skills the stakeholders, gatekeepers and direct care staff need to facilitate suicide prevention in your system

- The Dreyfus Model of Skill Development
Novice >Advanced Beginner > Competent > Proficient> Expert

A Closing Thought!

- More than one-third of the suicides identified in the NCIA 1999 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.

Stop – additional slides for discussion

Where did the Suicides Occur? NCIA Survey

- The majority of the suicides occurred in smaller facilities:
 - 71.6 % occurred in facilities with a census less than 200 persons
 - 44.6% occurred in facilities with a census less than 50 persons
