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Performance-Based Standards for Juvenile Correction and Detention Facilities:
A Resource Guide

Suicide Prevention *in* Juvenile Correction *and* Detention Facilities

Office of Juvenile Justice and Delinquency Prevention
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CJCA Council of Juvenile Correctional Administrators

Suicide Prevention In Juvenile Correction and Detention Facilities

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SUICIDE PREVENTION IN JUVENILE CORRECTION AND DETENTION FACILITIES

I. Introduction

In 1995, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) awarded the Council of Juvenile Correctional Administrators a major grant to develop, field test and implement performance-based standards for juvenile correction and detention facilities. OJJDP recognized that existing standards failed to assure that critical outcomes related to safety, security, order, health, education and other programming were being achieved. The Performance-based Standards project offers a systematic method for facilities to measure outcomes and offers ways for facilities to review their operations and make improvements.

One of the many components of the project is to develop and distribute a series of five Resource Guides to assist facilities with the development or improvement of special programs or program components. These guides are designed to be a handy reference that reviews the background of the problem, provides a model of an ideal program, briefly summarizes research used to develop programs, lists existing programs with evaluation information as well as organizations, Internet sites and additional written materials.

Each of the guides is designed to provide facility staff and administrators with a readable and thorough summary of current information and profiles of programs that appear promising. The guides are based on expert knowledge, input from leaders in the field and a review of research and resources available. The guides are not meant to be definitive sources but a resource to help make improvements.

II. Background: Scope of the Problem

Born with fetal alcohol syndrome, Kevin had spent most of his young life in and out of state custody and foster care programs.[1] Now 13 years of age, he had an extensive history of substance abuse, mental illness and aggressive behavior. Shortly after his admittance to a private juvenile training school on February 9, 1998, Kevin was asked during the intake screening process if he felt suicidal. He responded by stating that he had often thought about death because he "didn't think life was worth it" and, although he last thought about suicide about a year ago, he "didn't feel that way now." Kevin received additional screening the following day. A counselor asked him to finish various sentences they had started. His written responses included, "I wish ...I was not born," "I want...not to live" and "The worst thing I could ever do is ...live." Despite these responses, mental health staff did not feel that suicide precautions were necessary. Kevin was, however, placed in restraints seven times during the next ten days for "out-of-control behavior."

On February 20, Kevin told a psychiatrist at the facility that he had thought about joining his adoptive father in death and was thinking of using his bed sheets to commit suicide. The psychiatrist later stated that there was too much "psychomotor retardation" for Kevin to carry out the hanging and that the youth had made a number of plans for the future which led the clinician to believe that he was not at risk of self-harm. During the evening of February 21, Kevin complained of a headache and asked a staff member to turn off the night light in his room. Because turning off the light was against facility policy, the counselor gave Kevin some Tylenol and a wet towel. The following morning, Kevin was found hanging by his bed sheets in the shower area of his room. He had not been visibly observed since before midnight the previous night and it was estimated that Kevin had been dead for more than four hours. A subsequent investigation found numerous systemic deficiencies and the facility was closed down.

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

Prevalence

Kevin'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 Centers for Disease Control (CDC), youth suicide in the community is a national tragedy and a major public health problem (CDC, 1992). The suicide rate of adolescents (ages 15 to 19) has quadrupled from 2.7 per 100,000 in 1950 (CDC, 1995a) to 11.1 per 100,000 in 1994 (Sickmund, Snyder & Poe-Yamagata, 1997). More teenagers died of suicide during 1992 than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza and chronic lung disease combined (CDC, 1995b).

While there have been several national studies conducted regarding the extent and nature of suicide in jail and prison facilities (Hayes, 1989, 1995), there has *not* been any comparable national research conducted to date regarding juvenile suicide in confinement. The only national survey of juvenile suicides in custody contained several flaws in the calculation of suicide rates (Flaherty, 1980). Re-analyses of suicide rates in that study found that youth suicide in juvenile detention centers was estimated to be more than four times greater than the general population (Memory, 1989). Still, there remains a dearth of accurate data on the total scope and rate of juvenile suicide in custody. Since 1989, the U.S. Bureau of Census has been collecting data on the number of deaths by juveniles in custody. In the first year of the survey, 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). Twenty such deaths were reported during 1994 (OJJDP, *Children in Custody*, 1995 Census of Public and Private Juvenile Detention, Correctional and Shelter-Care Facilities, machine-readable datafiles). Given the epidemiological data regarding adolescent suicide, coupled with the increased risk factors associated with detained youths, the number of "reported" suicides in custody appears very low. Most juvenile justice practitioners and experts believe the problem to be severely under-reported. To date no comprehensive study of deaths in custody has been undertaken to assess the level and sources of under-reporting.

Risk Factors

In regard to risk factors, Brent (1995) identified mental disorder and substance abuse as the most important set of risk factors for adolescent suicide in the community. Other risk factors included impulsive aggression, parental depression and substance abuse, family discord and abuse, and poor family support. Life stressors, specifically interpersonal conflict/loss and legal/disciplinary problems, were also associated with suicidal behavior in adolescents, particularly those who were substance abusers. It has been argued that many of these risk factors are prevalent in youths confined in juvenile facilities (Alessi, McManus, Brickman & Grapentine, 1984; Rohde, Seeley & Mace, 1997).

Although there is no current national data regarding the incidence of youth suicide in custody, there is information available to suggest a high prevalence of suicidal behavior in juvenile correctional facilities. According to one recent study, more than 11,000 juveniles are estimated to engage in more than 17,000 incidents of suicidal behavior in juveniles facilities each year (Parent, Leiter, Kennedy, Livens, Wentworth, and Wilcox, 1994). In addition, the limited research on juvenile suicide in custody suggests that confined youths may be more vulnerable to suicidal behavior based on current and/or prior suicidal ideation. For example, one study found that incarcerated youths with either major affective disorders or borderline personality disorders had a higher degree of suicidal ideation and more suicide attempts than adolescents in the community (Alessi, McManus, Brickman and Grapentine, 1984). Other studies have found that a high percentage of detained youths reported a prior history of suicide attempts (Dembo, Williams, Wish, Berry, Getreu, Washburn and Schmeidler, 1990); current and active suicidal behavior (Davis, Bean, Schumacher and Stringer, 1991); and prior history of psychiatric hospitalization (Waite, 1992). Two recent studies of youths confined in a juvenile detention facility found that suicidal behavior in males was associated with depression and decreased social connection, whereas suicidal behavior in females was associated with impulsivity and instability (Mace, Rohde and Gnau, 1997; Rhode, Seely and Mace, 1997). Finally, other researchers have found high rates of suicidal behavior (Duclos, LeBeau and Elias, 1994) and psychiatric disorders (Duclos, Beals, Novins, Martin, Jewett and Manson, 1998) among Native American youths confined in juvenile facilities.

Suicide Contagion in a Juvenile Correctional Facility

The Valley Youth Correctional Facility (VYCF) is a 200-bed co-educational training school.[2] The facility houses youths between the ages of 12 and 25, although over 70 percent are between the ages of 15 and 17. Approximately 50 percent of youths are committed to the VYCF for personal crimes, with 21 percent committed from the adult court system. Over two thirds of the residents are male. Not unlike youths confined in other juvenile institutions of comparable size, VYCF youths periodically engage in self-injurious behavior, with an average of 30 incidents of suicidal gestures or attempts per year. During the 16-month period of October 1996 and January 1998, five youths committed suicide at the VYCF or within a few days of discharge from the facility.

[2] The following information is based upon the writer's technical assistance to a state juvenile correctional agency that recently sustained a cluster of suicides in one of its facilities. In order to ensure complete confidentiality, the names of the facility, agency and suicide victims have been changed. No other modifications have been made.

October 4, 1996

Mark, a 14-year-old White male, was committed to the VYCF on January 4, 1996 for Unlawful Use of a Weapon, Theft, and Menacing. The youth had a history of depression, as well as a suicide attempt at age 9 (by tying a boot string around his neck). He was given a psychiatric evaluation soon after admission to the VYCF and prescribed various psychotropic medications (which he often refused). Mark was known to cottage staff as a depressed youth who exhibited rapid mood swings and unpredictable behavior. On May 6, in an apparent effort to be transferred to the state hospital, Mark was placed in a "quiet room" after inquiring to staff as to what would happen if he tried to kill himself. He was given a psychological evaluation on May 24 and diagnosed as suffering from Dysthymic Disorder, Attention Deficit Hyperactivity Disorder, and Conduct Disorder. On September 24, Mark was prescribed new psychotropic medication, but reportedly refused to take it. On September 30, he talked openly with peers and staff about "dying." A mental health professional (MHP) was notified, talked with Mark and conferred with cottage staff; but concluded that suicide precautions were not necessary. On October 2, Mark was overheard by cottage staff as saying "good-bye" to a number of his peers.

At approximately 7:20 pm on October 4, cottage staff found Mark hanging from a window screen in his room by a shoelace. Staff initiated cardiopulmonary resuscitation (CPR), but the youth died at the hospital the following day.

October 19, 1997

Anne, a 14-year-old White female, was committed to the VYCF on August 8, 1997 for Burglary, Unauthorized Use of a Motor Vehicle, Criminal Mischief, and Providing False Information to Police. The youth had a history of alcohol and drug abuse and was given a psychological evaluation on September 5, 1997 as an aid in determining her treatment needs. The evaluation revealed a history of depression and self-injurious behavior. Anne was diagnosed as suffering from Poly-Substance Dependence with Physiological Dependence, Post Traumatic Stress Disorder (from several years of both physical and sexual

abuse by family members), Conduct Disorder, and Dysthymic Disorder. On August 17, she was placed under suicide precautions in a quiet room with closed-circuit television (CCTV) surveillance by a MHP after expressing suicidal ideation. The precautions were discontinued on August 24, 1997. On September 29, Anne complained of depression, hopelessness, and hearing voices to harm others. She was started on psychotropic medication.

Progress reports from early October 1997 indicated that Anne's grandmother had recently died, she had been "dumped" by her boyfriend, and was having difficulty with her peers (particularly roommates). On October 18, Anne spoke with at least two other youths and asked them how they would feel if she were to kill herself. Because she had a reputation for lying to peers and staff, the two youths did not alert staff to Anne's threats.

At approximately 10:30 am on October 19, two youths found Anne hanging from the headboard of a bed in her room by a sheet. Staff quickly arrived and initiated CPR, but the youth died several days later at the hospital.

January 12, 1998

Nelson, a 16-year-old Native American male, was committed to the VYCF on May 24, 1996 for Sexual Assault. The youth had a long history of sexually inappropriate behavior and treatment failure in previous community programs. He had been physically abused by family members at an earlier age, and sexually abused by neighborhood youths. Nelson had an extensive history of suicidal ideation, but no prior suicide attempts. A psychiatric evaluation was conducted May 28, 1996 and he was diagnosed as suffering from Conduct Disorder and Attention Deficit Hyperactivity Disorder. He was prescribed various psychotropic medication and seen regularly by the facility's psychiatrist. On October 12, 1996, Nelson was placed on suicide precautions after scratching his arms following an altercation with other youths. He told the MHP that he often got depressed after getting into trouble and engaged in self-mutilation in response to the depression. He also admitted to scratching his arms following the recent death of a friend at the facility (Mark). Suicide precautions were discontinued several days later.

Nelson was also placed in quiet room status on several occasions during his confinement. On June 23, 1997, he was placed in a quiet room for a few hours after being deemed at risk to himself (superficial scratches on arms) and others (threatening his peers). He later told cottage staff that placement in the quiet room satisfied his need to abuse himself (e.g., punching the walls with his fist). Beginning on July 12, 1997, Nelson was placed on suicide precautions and housed in a quiet room for two days after threatening suicide because he was depressed it was his birthday and because his mother had a new boyfriend. At the request of the psychiatrist, he was seen daily by MHPs for approximately two weeks. On December 31, 1997, cottage staff referred Nelson to a MHP following concerns that he was depressed and expressing concerns as to whether "life was worth living anymore." He was also reportedly upset because of non-compliance with his sex offender treatment program and was close to being sent to another juvenile facility. The situation was exacerbated by his mother's recent decision to stop visiting him in order to encourage his participation in treatment. The MHP did not feel that suicide precautions were necessary and Nelson agreed to notify staff if he felt suicidal again.

At approximately 5:30 pm on January 12, 1998, Nelson was placed in a quiet room for disciplinary reasons (after throwing gang signs in the dining room, as well as making sexual comments about female cottage staff). He was returned to his housing cottage at approximately 6:50 pm, but appeared quiet and lonely to his peers. At approximately 10:30 pm, cottage staff found Nelson hanging from a ceiling vent in his room by a sheet. Staff initiated CPR, but the youth died at the hospital a few days later.

January 17, 1998

James, a 15-year-old White male, was committed to the VYCF on October 16, 1997 for Theft, Menacing, and Criminal Mischief. He had a traumatic childhood; his parents were divorced at his birth and he was abandoned by his mother at age 6. James then lived with his father and was later subjected to physical abuse. Most recently, he had been living with his aunt and uncle prior to confinement. James had a significant history of substance abuse, aggressive outbursts, and inappropriate sexual behavior.

On both November 3 and December 10, 1997, he was placed in a quiet room for several hours due to his aggressive behavior toward peers.

Although he had no prior history of suicidal behavior, James was referred to a MHP on January 13, 1998 after telling cottage staff "he did not feel safe" after a peer (Nelson) committed suicide in the facility several days earlier. Because he was already housed in a safety room (i.e., with large viewing windows) after an altercation with another youth, and because he agreed to alert staff if he became suicidal, the MHP felt that suicide precautions were not necessary.

At approximately 8:45 pm on January 17, 1998, cottage staff found James hanging from a ceiling electrical conduit in the room by a sheet. (Visibility into the room had been obstructed by Venetian blinds drawn closed in the windows.) Staff initiated CPR, but the youth was later pronounced dead at the hospital.

January 26, 1998

Grace, a 17-year-old Native American female, was committed to the VYCF on October 17, 1997 for Attempted Possession of a Controlled Substance ("huffing" gasoline). The youth had a long history of substance abuse, as well as physical abuse (and possible sexual abuse) by family members. As a result of one abusive incident at age 9, she tried to jump out a window but was stopped by her sister. Grace also had a history of depression and insomnia relating to years of abuse. She arrived at the facility two days prior to the suicide of Anne on October 19, 1997. Following the suicide, Grace appeared "confused" over how she should feel. She did not want to make any friends, and stated that a friend had died the previous year (in the community) under similar circumstances. After becoming involved in repeated verbal outbursts with peers, Grace was placed in a quiet room on October 23, 1997 for two days. She was later seen by a psychologist on November 7, 1997, and diagnosed as suffering from a Conduct Disorder, Poly-Substance Dependence, and Dysthymic Disorder. Grace told the psychologist that she occasionally experienced suicidal ideation and used "counter measures" to stop the ideation.

No suicide precautions were deemed necessary by mental health staff.

On January 12, 1998, her boyfriend (Nelson) committed suicide at the VYCF. Grace was seen the following day by a MHP, could not understand why her boyfriend killed himself, and promised not to hurt herself. The MHP recommended that her room light be left on at night, but did not order formal suicide precautions because Grace had a roommate and was housed in a CCTV-monitored room. Three days later on January 16, 1998, staff observed Grace in a fetal position in her room grieving her boyfriend's death. She was seen by a MHP and, although allowed to call her grandmother and sister, no suicide precautions were deemed necessary. The following day, cottage staff found her in a "rocking" position after hearing about another suicide in the facility (James) and mistakenly believed the victim was her cousin. She was again seen by a MHP, but suicide precautions were not deemed necessary.

On January 23, 1998, Grace was released from the facility for placement in a foster home. A few days later on the morning of January 26, a roommate found Grace hanging by a sheet in her room. She was later pronounced dead at the hospital.

Suicide contagion is a process by which exposure to the suicide or suicidal behavior of one or more persons triggers a cluster of subsequent suicides and/or suicidal behavior (CDC, 1994). Of an estimated 5,000 young people that commit suicide in the community each year, only 1 to 5 percent of these deaths are associated with contagion. Because it is such a rare event, there is a dearth of research available to explain the dynamics of contagion. Available research, however, suggests that suicide clusters are more prevalent among teenagers and young adults, and commonly associated with friends or acquaintances, e.g., belonging to the same school or church (Gould, 1990). It is not necessary, however, for suicide victims to have direct contact with each other and contagion can be initiated and sustained through newspaper and other media coverage of an event. Suicide clusters are also provoked by other factors, such as a shared environmental stressor (Gould, 1990; Gould, Wallenstein, Kleinman, O'Carroll, and Mercy, 1990; King, Franzese, Gargan, McGovern, Ghaziuddin, and Naylor, 1995).

With regard to the VYCF suicides, the victims shared many similarities. The five youths all had histories of depression, family problems and mental health intervention. Four of the youths were victims of either physical and/or sexual abuse during childhood. With one exception (James), all of the youths had a prior history of suicidal behavior before their arrival at the VYCF. All five victims

expressed suicidal ideation during their confinement. None of the youths were under suicide precautions at the time of their deaths. And while many other youths confined at the VYCF have histories of abuse, depression and suicidal behavior, the psycho-social problems of the five suicide victims appeared to be more pronounced than their peers.

Suicides at the Valley Youth Correctional Facility

	Mark	Anne	Nelson	James	Grace
When	10/4/96	10/19/97	1/12/98	1/17/98	1/26/98
Where	Unit A	Unit B	Unit C	Unit D	Foster Home
[redacted] Serious [redacted]e	Unlawful Use of Weapon	Burglary	Sexual Abuse	Theft	Att. Poss. Controlled Substance
Age	14	14	16	15	17
Length of Stay at VYCF (Days)	270	73	598	94	99 VYCF 3 Foster Home
Hanging From	Shoelace/ Window Screen	Sheet/ Bed Headboard	Sheet/ Ceiling Vent	Sheet/ Ceiling Electrical Conduit	Sheet/ N/A
Time Found	7:20 pm	10:30 am	10:30 pm	8:45 pm	N/A
Last Seen by Staff	7:00 pm	10:00 am	10:00 pm	8:15 pm	N/A
CPR by Staff	Yes	Yes	Yes	Yes	N/A
Mental Health History	Yes	Yes	Yes	Yes	Yes
Suicide Behav. History	Att. @ age 9, ideation days before suicide	Self-destructive behavior, suicide precautions 8/17/97	Extensive suicidal ideation, suicide precautions 10/12/96; 7/12/97	Ideation days before suicide	Att. @ age 9, recent ideation
Last Mental Health Contact Before Suicide [redacted]s)	4	14	12	5	10

N/A - Not Available

Turning to the issue of contagion and the VYCF suicides, although each of the suicides received considerable local newspaper coverage, there was no evidence to suggest that this media attention contributed to any of these deaths. In addition, although four of the suicides occurred in separate housing cottages of the same building, this common trait was probably coincidental. Information regarding the suicides was spread equally throughout all housing units of the 200-bed facility. The evidence of contagion, however, did appear in other forms. For example, although there was no evidence to suggest that the initial two suicides (of Mark and Anne) were triggered by contagion, there was information to suggest that Nelson apparently became despondent following Mark's suicide and engaged in superficial self-mutilation. In addition, Grace arrived at the VYCF two days before Anne's suicide, behaved indifferently and acted out against her peers about the death, resulting in her temporary placement in a quiet room. Grace was also the girlfriend of Nelson and was clearly despondent following his suicide. She was also upset by James' suicide, mistakenly believing the victim was her cousin. Finally, five da[redacted] before his suicide, James, with no prior history of suicidal behavior, became despondent and felt unsafe after learning of Nelson's suicide.

While no definitive conclusions can be drawn from the brief review of these cases, with more in-depth study warranted, it would appear that contagion played a significant role in these suicides. Most of the victims were predisposed to suicidal ideation, the latter victims became despondent over the earlier suicides, and learned how relatively easy it was (through opportunity and means) to commit suicide. Finally, however, it is important to realize that suicide is never the result of a single factor or event, rather it involves the interaction of many factors (Gould, 1990). Therefore, contagion cannot be considered the *sole* explanation for the VYCF suicides.

Prior to October 1996, the Valley Youth Correctional Facility had not experienced any deaths in its 83-year-old history. The recent tragedies that occurred at the VYCF clearly demonstrate that, although normally a rare event in the day-to-day routine of a juvenile institution, it is critically important for all staff to realize that suicides can occur at any time and in any type of juvenile facility throughout the country.

OJJDP's Conditions of Confinement Report

In August 1994, OJJDP released the landmark report entitled *Conditions of Confinement: Juvenile Detention and Corrections Facilities*. The research study, completed by Abt Associates, investigated several conditions of confinement within juvenile facilities, including suicide prevention practices (Parent, Leiter, Kennedy, Livens, Wentworth, and Wilcox, 1994). To evaluate suicide prevention practices, researchers used four specific assessment criteria (written procedures, intake screening, staff training, and close observation), and found that 89 percent of the juveniles were housed in facilities with a written suicide prevention plan; 72

percent in facilities that screened juveniles for suicide risk at admission; 75 percent in facilities where staff were trained in suicide prevention; and 50 percent in facilities that monitored suicide risks at least four times per hour. However, only 25 percent of confined juveniles were in facilities that conformed to all four suicide prevention assessment criteria.

Although the study could not assess the quality of each of the four criteria operating at the juvenile facilities because most of the data was self-reported, other findings were equally revealing. For example, the data suggested that: 1) facilities conducting suicide screening at admission and training staff in suicide prevention had lower incidences of suicidal behavior among their residents; 2) suicidal behavior increased for youths housed in isolation; and 3) while written policies to provide close observation of suicidal residents did not appear to significantly reduce the "rate of suicidal behavior," they may be very important in reducing "completed suicides" because many times the policy is implemented after the risk and/or attempt are recognized.

III. Critical Components of a Suicide Prevention Plan

The literature is replete with numerous examples of how jail and prison systems have developed effective suicide prevention programs (Cox and Morschauser, 1997; Hayes, 1995; Hopes and Shaull, 1986; White and Schimmel, 1995). New York continues to experience a significant drop in the number of jail suicides following the implementation of a statewide comprehensive prevention program (Cox and Morschauser, 1997). Texas has seen a 50 percent decrease in the number of county jail suicides as well as almost a six-fold decrease in the rate of these suicides from 1986 through 1996, much of it attributable to increased staff training and a state requirement for jails to maintain suicide prevention policies (Hayes, 1996). One researcher reported no suicides during a seven-year time period in a large county jail after the development of suicide prevention policies based upon the following principles: screening; psychological support; close observation; [redacted]oval of dangerous items; clear and consistent procedures; and diagnosis, [redacted]tment, and transfer of suicidal inmates to the hospital as necessary (Felthous, 1994). Although information is limited, there are examples of model suicide prevention programs operating in juveniles facilities (Hayes, 1994, 1998; Mace, Crumbley, Gnau, Leppard and Khalsa, 1994), including the Hamilton County Juvenile Court Youth Center in Cincinnati, Ohio (see Appendix A).

Comprehensive suicide prevention programming has also been advocated nationally by such organizations as the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC). Both groups have promulgated national correctional standards that are adaptable to individual jail, prison and juvenile facilities. Although the ACA standards are the most widely recognized throughout the country, they provide very limited guidance regarding suicide prevention -- simply stating that institutions should have a written prevention policy that is reviewed by medical or mental health staff. ACA's broad focus on the operation and administration of correctional facilities precludes these standards from containing needed specificity. The NCCHC standards, however, are much more instructive and offer the recommended ingredients for a suicide prevention plan: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing (NCCHC, 1995). Utilizing a combination of ACA and NCCHC standards, the author has developed a comprehensive suicide prevention plan for juvenile facilities that addresses specific key components. These elements are not simply a series of discrete and disconnected procedures. On the contrary, the following components form a continuum of care aimed a minimizing suicidal behavior within juvenile detention and correctional facilities.

Staff Training

[redacted] The essential component to any suicide prevention program is properly trained staff, who form the backbone of any juvenile facility. Very few suicides are

actually prevented by mental health, medical or other professional staff because suicides are usually attempted in resident housing units, and often during late evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by direct care staff who have been trained in suicide prevention and have developed an intuitive sense about the youths under their care. Direct care staff are often the only personnel available 24 hours a day; thus, they form the front line of defense in preventing suicides.

All direct care, medical, and mental health personnel, as well as any staff who have regular contact with youths, should receive eight hours of initial suicide prevention training, followed by *two* hours of refresher training each year. The initial training should include why the environments of juvenile facilities are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, components of the facility's suicide prevention policy, and liability issues associated with juvenile suicide. The two-hour refresher training should include a review of predisposing risk factors, warning signs and symptoms, and review of any changes to the facility's suicide prevention plan. The annual training should also include general discussion of any recent suicides and/or suicide attempts in the facility.

In addition, all staff who have routine contact with youths should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff. (See Section IV, Additional Resources for available training curricula.)

Intake Screening/Assessment

Intake screening and on-going assessment of all confined youths is critical to a juvenile facility's suicide prevention efforts. Although youths can become suicidal at any point during their confinement, high-risk periods include: initial admission into the facility, after adjudication when the youth is returned to the facility from court, following receipt of bad news or after suffering any type of humiliation or rejection, confinement in isolation or segregation, and following a prolonged stay in the facility (NCCHC, 1995). In addition, although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide (Cox and Morschauser, 1997; Hughes, 1995). Research consistently reports that approximately two-thirds of all suicide victims communicate their intent some time before death and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than

those who have never made an attempt (Clark and Horton-Deutsch, 1992; Maris, 1992).

Intake screening for suicide risk may be contained within the medical screening form or as a separate form. The screening process should include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting/transporting officer(s) belief that youth is currently at risk. Specifically, inquiry should determine the following:

- o Was the youth a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?

- o Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency/facility, conversation with family member/guardian, etc.) that indicates youth is a medical, mental health or suicide risk now? (Staff ask officer before he/she departs.)

- o Has the youth ever attempted suicide?

- o Has the youth ever considered suicide?

- o Is the youth now or has h/she ever been treated for mental health or emotional problems?

- o Has the youth recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?

- o Has a family member/close friend ever attempted or committed suicide?

- o Does the youth feel there is nothing to look forward to in the immediate future (youth expressing helplessness and/or hopelessness)?

- o Is the youth thinking of hurting and/or killing himself/herself?

The process should also include referral procedures to mental health and/or medical personnel for a more thorough and complete assessment. Following the

intake process, should any staff hear a youth verbalize a desire or intent to commit suicide or hear from other staff or residents, observe a youth engaging in any self-harm, or otherwise believe a youth is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the resident is constantly observed until appropriate medical, mental health and/or supervisory assistance is obtained. A variety of intake screening and assessment forms are contained in Appendix B.

The screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in residents. This process, coupled with staff training, will only be successful if an effective method of communication is in place at the facility.

Communication

Certain behavioral signs exhibited by the youth may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most juvenile suicides can be prevented by direct care staff who establish trust and rapport with youths, gather pertinent information and take action (Roush, 1996). There are essentially three sequences of communication within the facility that prevent juvenile suicides: between the arresting/transporting officer and direct care staff; between and among facility staff (including direct care, medical and mental health personnel); and between facility staff and the suicidal youth and/or youths who may know of another youth's intention to harm himself or herself.

In many ways, suicide prevention begins at the point of arrest. During initial contact, what a youth says and how he or she behaves during arrest, transport to the facility and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the youth. Arresting officers should pay close attention to the youth during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation and previous behavior can be confirmed by onlookers such as family members, guardians and friends. Any pertinent information regarding the youth's well-being must be communicated by the arresting or transporting officer to direct care staff. It is also critically important for direct care staff to maintain open lines of communication with parents or guardians who often have pertinent information regarding the mental health status of residents.

At the facility during intake and screening, effective management of suicidal youths is based on communication among direct care personnel and other professional staff in the facility. Because youths can become suicidal at any point during confinement, direct care staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate direct care staff are

properly informed of the status of each youth placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of all residents on suicide precautions. Interdisciplinary team meetings (to include direct care, medical and mental health personnel) should occur on a regular basis to discuss the status of youths on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions and observation of youths placed on precautions should be documented on designated forms and distributed to appropriate staff. A variety of forms that could be used to communicate information regarding suicidal youths are contained in Appendix C.

During the youth's stay at the facility, staff must use various communication skills with the suicidal youth, including active listening, staying with the youth if they suspect immediate danger and maintaining contact through conversation, eye [redacted]tact and body language. Direct care staff should trust their own judgments and [redacted]servations of risk behavior and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

The communication breakdown between and among direct care, medical and mental health personnel, as well as outside entities (e.g., arresting/referral agencies, family members, etc.) is a common factor found in the reviews of many custodial suicides (Anno, 1985; Appelbaum, Dvoskin, Geller and Grisso, 1997; Hayes, 1995; Jones, 1986).

Housing

In determining the most appropriate housing location for a suicidal youth, juvenile facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (e.g., room confinement, etc.) and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the youth since the use of isolation escalates the child's sense of alienation and further removes the individual from proper staff supervision (Parent, Leiter, Kennedy, Livens, Wentworth, and Wilcox, 1994). To every extent possible, suicidal youths should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of a youth's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, straitjackets, etc.) should be avoided whenever possible and used only as a last resort when the youth is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the youth, not on decisions that heighten depersonalizing aspects of confinement.

[redacted] All rooms designated to house suicidal youths should be suicide-resistant, [redacted]e of all obvious protrusions and provide full visibility (Atlas, 1989; DeJames, 1995, 1997; Jordan, Schmeckpeper and Strope, 1987; Lester and Danto, 1993). These rooms

should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In addition, the room should not contain any electrical switches or outlets, bunks with open bottoms, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each room door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the room interior. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag and rescue tool (to quickly cut through fibrous material). Direct care staff should ensure that such equipment is in working order on a daily basis.

Levels of Supervision

In regard to suicide attempts in juvenile facilities, the promptness of the response is often driven by the level of supervision afforded the youths. Medical evidence suggests that brain damage from strangulation caused by a suicide attempt can occur within four minutes, and death often within five to six minutes (American Heart Association, 1992). Two levels of supervision are generally recommended for suicidal youths: close observation and constant observation. Close observation is reserved for the youth who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. Staff should observe such a youth at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes, etc.). Constant observation is reserved for the youth who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such a youth on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every 5 minutes. Other aids (e.g., closed-circuit television, roommates, etc.) can be used as a supplement to, but never as a substitute for, these observation levels. Finally, mental health staff should assess and interact with (not just observe) suicidal youths on a daily basis.

Intervention

Following a suicide attempt, the degree and promptness of the staff's intervention often foretells whether the victim will survive. National correctional standards and practices generally acknowledge that a facility's policy regarding intervention should be threefold. First, all staff who come into contact with youths should be trained in standard first aid procedures and cardiopulmonary resuscitation (CPR). Second, any staff member who discovers a youth engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. Third, staff should never presume that the youth is dead, but rather should initiate and continue appropriate life-saving

measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Finally, although not all suicide attempts require emergency medical intervention, all suicide attempts should result in immediate intervention and assessment by mental health staff.

Reporting

In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement including their full knowledge of the youth and incident.

Follow-up/Administrative Review

A juvenile suicide is extremely stressful for both staff and residents. Staff may also feel ostracized by fellow personnel and administration officials. Following a suicide, misplaced guilt is sometimes displayed by the direct care worker who wonders: "What if I had made my room check earlier?" Residents are often traumatized by critical events occurring within a facility. Such trauma may lead to suicide contagion. When crises occur in which staff and residents are affected by the traumatic event, they should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, comprised of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy and mental health personnel), provides affected staff and residents an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms and develop ways of dealing with those symptoms (Meehan, 1997; Mitchell and Everly, 1996). For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment and/or hospitalization), should be examined through an administrative review process. If resources permit, clinical review through a psychological autopsy is also recommended (Spellman and Heyne, 1989). Ideally, the administrative review should be coordinated by an outside agency to ensure impartiality. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should 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; and 5) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services and operational procedures.

IV. Additional Resources

There are several resources available to assist juvenile facilities in the development of comprehensive suicide prevention plans. These resources include:

Dangerous Acts of Mentally Ill Offenders: Self-Mutilation and Suicidal Behaviors in Juvenile Detainees (1994), Jana Ewing, Ph.D. (training video)

Desktop Guide to Good Juvenile Detention Practice (1996), David W. Roush, Ph.D., Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Jail Suicide/Mental Health Update. Mansfield, MA: National Center on Institutions and Alternatives. (quarterly newsletter)

The NJDA Juvenile Detention Careworker Curriculum (1995), Richmond, KY: National Juvenile Detention Association.

Training Curriculum on Suicide Detection and Prevention in Juvenile Facilities (1999), Mansfield, MA: National Center on Institutions and Alternatives, forthcoming.

Training Curriculum on Suicide Detection and Prevention in Jails and Lockups - 2nd Edition (1995), Mansfield, MA: National Center on Institutions and Alternatives.

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Council of Juvenile Correctional Administrators
Stonehill College
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(508) 238-0073; Fax (508) 238-0651
E-Mail: emailcjca@aol.com

National Juvenile Detention Association
Eastern Kentucky University/301 Perkins Building
Richmond, Kentucky 40475
(606) 622-6259; Fax (606) 622-2333
E-Mail: njdaeku@aol.com

Websites

The following websites provide general information on suicide prevention:

American Association of Suicidology
http://www.suicidology.org

American Foundation for Suicide Prevention
http://www.afsp.org

Council of Juvenile Correctional Administrators
http://www.corrections.com/cjca

Crisis: The Journal of Crisis Intervention and Suicide Prevention
http://hhpub.com/journals/crisis

Justice Information Center
http://www.ncjrs.org

Office of Juvenile Justice and Delinquency Prevention
http://www.ncjrs.org/ojjcorr.htm

Suicide Prevention Advocacy Network
http://www.spanusa.org

U.S. Department of Justice, National Institute of Corrections
http://www.nicic.org

APPENDIX A

JAIL SUICIDE/MENTAL HEALTH UPDATE

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

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Model Suicide Prevention Programs Part II: Juvenile Facilities

Although there is no national data available on the incidence of suicide in juvenile facilities, recent reports of such deaths would suggest cause for concern. Since the beginning of 1998, at least seven suicides in juvenile facilities have been reported by local media throughout the country. For example, a 15-year-old youth hanged himself with a sweatshirt tied to his cell door at a juvenile detention center in Ohio in early January. Sparked by contagion, three youngsters committed suicide in Oregon's juvenile justice system during a two-week period in late January. In February, a 13-year-old youth hanged himself with a bed sheet thrown over a shower wall at a private juvenile training school in Colorado. The death sparked numerous investigations and ultimately resulted in closure of the facility (see article on pages 8 and 9 of this issue). In March, a 14-year-old youth hanged herself with a bed sheet tied to a shower brace at a juvenile training school in Washington (State). And in April, a 17-year-old youth hanged himself with a bed sheet at a juvenile detention facility in Mississippi.

According to the Centers for Disease Control (CDC), youth suicide in the community is a national tragedy and a major public health problem (CDC, 1992). Suicide is the third leading cause of death for youth aged 15 to 24. In addition, the suicide rate of adolescents (ages 15 to 19) has quadrupled from 2.7 per 100,000 in 1950 to 10.8 per 100,000 in 1992 (CDC, 1995a), and more teenagers died of suicide during 1992 than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined (CDC, 1995b).

Despite the fact that only limited information is available on juvenile suicide in custody, a 1994 national survey of conditions of confinement in various types of juvenile facilities found that only 25 percent of confined juveniles were in facilities that conformed to four basic suicide prevention assessment criteria — written procedures, intake screening, staff training, and close observation (Parent, Leiter, Kennedy, Livens, Wentworth, and Wilcox, 1994). Survey data also showed that: 1) facilities which conducted suicide screening at admission and trained their staff in suicide prevention had lower rates of suicidal behavior among their residents; 2) suicidal behavior rates increased for youth housed in isolation; and 3) while written policies to provide close observation of suicidal residents did not appear to significantly reduce the rate of suicidal behavior, it may be very important in reducing completed suicides because many times the policy is implemented after the risk and/or attempt are recognized.

In our last issue, the *Update* began a special four-part series on model suicide prevention programs operating in correctional systems of varying sizes throughout the country. In this issue, we turn our attention to juvenile facilities. Programs have and will be evaluated (and on-site case studies conducted) according to extended incident-free periods of suicide and on the following suicide prevention components:

- Suicide prevention training for correctional, medical and mental health staff;
- Identification of suicide risk through intake screening;
- Procedures for referral to mental health and/or medical personnel; reassessment following crisis period;

INSIDE...

- Effective communication between correctional, medical and mental health staff when managing a suicidal inmate;
- Supervision and safe housing options for suicidal inmates;
- Timely medical intervention following a suicide attempt;
- Proper reporting procedures following an incident; and
- Administrative and/or clinical review of suicide; availability of critical incident debriefing to staff and inmates.

We continue our special series by highlighting the suicide prevention program currently operating within the Hamilton County Juvenile Court Youth Center in Cincinnati, Ohio.

Hamilton County Juvenile Court Youth Center

Opened in November 1995, the Hamilton County Juvenile Court Youth Center sits on a five-acre site in an historic section of Cincinnati, Ohio. The facility replaced a 30-year-old linear detention center plagued with numerous physical plant problems, including three suicides during a six-year period in the 1980s. The new 160-bed Youth Center was designed based on a unit management approach in which juveniles reside under direct staff supervision in one of eight housing units. Each housing unit consists of two pods linked to a shared multi-purpose room. Each pod contains 10 single-occupancy rooms and is supervised by at least one staff member per shift. Most services are decentralized and brought to the residents, including meals, education, counseling and visitation. Youth leave their housing units for exercise, court visits, and medical treatment. The average length of stay in the Youth Center is 10 days, and no juvenile is detained longer than 90 days. During 1997, the facility had 7,427 total admissions or approximately 20 per day.

In addition to providing secure housing, the Youth Center maintains a 24-hour complaint area, hearing rooms used primarily for court arraignments, Psychology Clinic, and an intervention clinic for counseling non-resident juveniles and their families. The Psychology Clinic is the only state-certified program housed in a county detention facility in Ohio. Clinic staff include a director (part-time), three psychological assistants (two of whom are full-time), and two intake clinicians (both full-time). All Clinic staff have at least masters-level qualifications. The Clinic provides diagnostic assessment services, crisis intervention and treatment recommendations for both youth residing in the community and referred to the Hamilton County Juvenile Court as well as residents of the Youth Center. In addition, intake clinicians conduct suicide risk assessments on selected Youth Center residents, provide regular management and monitoring of all residents identified at risk for suicide, and render short-term individual counseling and crisis intervention services to referred youth. The Medical Department is directed by a full-time nurse practitioner and seven nurses provide 24-hour coverage in the facility.

Robert J. Dugan has worked in the Hamilton County juvenile court system for over 25 years, and has been superintendent of the Youth Center for 22 of those years. Following two suicides in 1980 and another in 1986, all in the old facility, the agency has not had a subsequent death in nearly 12 years. As shown by Table 1, almost 70,000 juveniles were admitted to the Youth Center during this time period. When asked why the Youth Center has such a lengthy incident-free period of suicide, Superintendent Dugan reflected briefly and then told the *Update*: "The cumulative impact of the three worst days of my career, those three days during and after the suicide of Dennis D. in our facility. I was at the hospital and witnessed Dennis' parents being informed by hospital staff that Dennis had died. The agony I witnessed in the face of his parents and the sense of guilt and failure that I felt as superintendent regarding his death will be something I will carry with me for the rest of my life."

Table 1
Hamilton County Juvenile Court Youth Center
Annual Admissions and Suicides
1986 to 1997*

YEAR	ADMISSIONS	SUICIDES
1986	4,167	1
1987	4,623	0
1988	4,659	0
1989	4,504	0
1990	5,268	0
1991	5,368	0
1992	5,335	0
1993	6,327	0
1994	6,953	0
1995	7,803	0
1996	7,190	0
1997	7,427	0
1986-1997	**69,624**	**1**

*Source: Hamilton County Juvenile Court Youth Center

Dennis D.'s Suicide: The Impetus for Change

by
Robert J. Dugan, Supt. and
Jeffrey P. Schellinger, Assistant Supt.

Dennis D., a 16-year old White male, was admitted to the Youth Center on October 8, 1986 for a charge related to absconding from a court-ordered residential treatment

program. It was his seventh admission to the facility. At intake, staff completed an intake assessment interview and Dennis was assessed as a *moderate* risk of suicide based upon prior history. Although the youth had never attempted suicide either in the facility or community, a review of the prior assessment interview forms suggested several incidences of suicidal ideation in the community.

At the time, youth identified as a *moderate* risk of suicide received no special services or restrictions except for the requirement that staff complete a short narrative each shift summarizing the resident's adjustment to quickly discern the need to upgrade or downgrade their risk level and/or provide additional services if necessary. Youth identified as *high* risk were assigned rooms closest to the staff desk and referred to mental health staff for assessment. In addition, staff completed a facility adjustment report each shift and imposed activity restrictions to limit access to harmful contraband. Youth identified as *low* risk were monitored on a regular basis, but no other special precautions were taken. The procedures did not make any distinction in the monitoring requirements between the three risk levels. Monitoring, conducted and recorded every 15 minutes, consisted of visually checking each youth whenever they were in their room.

Between October 8 and 18, 1986, adjustment reports for Dennis did not reflect anything unusual or reflective of depression, suicide threats or suicidal gesturing. On October 18, Dennis ate breakfast, participated in recreational activities in the gym and then ate lunch. After lunch, he began to argue with staff over access to an FM radio and, when denied, he cursed and threw a chair at staff which resulted in his being assigned to room restriction. Dennis was assigned to a single room approximately halfway down the hallway of a 15-bed linear design housing unit. During monitored checks of his room every 15 minutes, Dennis was found to be asleep on his stomach between 2:00 pm and 3:45 pm. At 3:55 pm, when staff went to make the next check, Dennis was found hanging by his bed sheet from a light fixture in the room. First aid resuscitation efforts were unsuccessful and Dennis was later pronounced dead at a local hospital.

The impact that this suicide had on staff and facility was profound and multifaceted. First, while our training program had clearly emphasized that written suicide prevention procedures were no guarantee that there would never be another death, staff diligence and good intentions were shaken by Dennis' death, as well as the stark realization of a tragedy that was truly not within the scope of their control. In addition, our staff experienced the same emotional cycle as anyone else enduring such a loss. The cycle was one of denial, grief, anger, and eventual acceptance. The acceptance of Dennis' death resulted in a cathartic impact and a commitment of continual quality improvement. This commitment resulted in developing a cultural commitment to consider the safety of residents to be as critical to our function as the ability to maintain a secure environment. Immediately after Dennis' death, we began

We're Looking for a Few Good Programs

Future issues of the ***Jail Suicide/Mental Health Update*** will be devoted to model suicide prevention programs that are currently operating within jails throughout the country. Does your facility have an extended incident-free period of suicides ***and*** the following suicide prevention components?

- Suicide prevention training for correctional, medical and mental health staff;
- Identification of suicide risk through intake screening;
- Procedures for referral to mental health and/or medical personnel; reassessment following a crisis period;
- Effective communication between correctional, medical and mental health staff when managing a suicidal inmate;
- Supervision and safe housing options for suicidal inmates;
- Timely medical intervention following a suicide attempt;
- Proper reporting procedures following an incident; and
- Administrative and/or clinical review of suicide; availability of critical incident debriefing to staff and inmates.

If you believe your jail facility operates a model suicide prevention program, and would like it to be considered as a possible case study in an upcoming issue of the ***Jail Suicide/Mental Health Update,*** please send a brief summary of your program and pertinent materials (e.g., suicide prevention policy and screening forms) to:

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an investigation to review our policies and procedures, as well as to scrutinize any staff practices that might have contributed to the suicide. Ultimately, Dennis' family filed a lawsuit against our agency and several employees. Although a time-consuming and agonizing process, the preparation and defense of this litigation allowed us and others to critique everything we had done correctly, as well as areas in which we had deficiencies.

The lawsuit was eventually settled in 1992, but the impact of Dennis' death continued to be felt at the Youth Center. The most immediate impact occurred in revision of the facility's policies and procedures, specifically in the areas of information flow, risk levels and monitoring, and clinical support. In regard to information flow, a review of Dennis' case indicated that psychological reports and social history summaries from other agencies were not available or made available to Youth Center staff at the time of intake. Access to these documents may have resulted in Dennis' placement at a higher risk level. As a result, procedures were revised to aggressively solicit pertinent information (in writing and by telephone) from parents and casework staff at the time of admission.

In retrospect, making no distinction in the frequency of monitoring low, moderate or high risk youth did not appear consistent with the increased risk that these youth posed, particularly moderate or high risk residents. In addition, the moderate risk category appeared awkward and confusing to staff. Eventually, the moderate risk category was dropped, and youth assessed at high risk were required to be monitored at 5-minute random intervals, while low risk youth were required to be monitored at 15-minute random intervals. Finally, the availability of mental health staff at the Youth Center was revised to ensure that high risk youth, as well as those residents experiencing a noticeable change in mood and behavior, were seen on a regular basis. A policy revision was also made to ensure that only mental health staff were authorized to downgrade a resident's risk level.

A serious impediment to ensuring the safety of residents from self-harm in the Youth Center was the poor physical plant. In 1989, in the midst of litigation from Dennis' suicide, we started the programming phase for a new facility. Because his death was still in the forefront of our minds, facility design and planning issues were always centered on a design that would create a safe environment for the type of youth that we house. From the first meeting with the design team, a critical priority would be that the facility design and finishes meet the highest standards to safely house an adolescent population that often exhibits dangerous and self-destructive behavior. Areas that received special consideration were the types and location of light fixtures (the anchoring device used by Dennis) and sprinkler heads in resident rooms. The location and design type of the supply and air return ducts in the housing units, shower rooms and holding rooms were also of special concern. In order to allow for staff to visually observe residents at night in their rooms, a night light fixture was added to the design. Plumbing fixtures, towel hooks, mirrors and furnishings and finishes were designed to eliminate sharp edges.

One of the most critical components in any suicide prevention program is the ability to monitor youth consistent with their assessed risk level, as well as the ability to establish clear documentation as to the consistency of the prescribed monitoring period. Throughout the course of programming and the design of our new facility, considerable time was spent in locating a system of available technology that would allow us to verify staff monitoring of low and high risk youth housed in either holding or resident rooms. The system that was eventually implemented, "Youth Center Guard Tour Monitoring System," was designed so that each room in the facility could be electronically set to verify monitoring of the room by staff. Through the use of lexan panels, each room can be set to be either a high (5-minute check) or low (15-minute check) risk room. Once a panel has been set, staff monitor youth by viewing them through the door window, ensuring that a resident is safe and secure. While doing the check, staff simultaneously depress the night light button, which activates a signal in the data base that a room check was done at that date, time, unit, pod, risk level and any amount of time that exceeded the risk monitoring period. If a room check was not done one minute before the high risk monitoring period of five minutes or two minutes before the low risk monitoring period of 15 minutes, the panel would audibly alarm locally in the housing pod. This feature was provided to prompt staff to make the checks as opposed to a system that would sound an alarm after staff had failed to make the checks. Data from monitoring system is reviewed by facility managers approximately nine times per day. The data base is also reviewed daily to determine if any room monitoring checks by staff exceeded the maximum monitoring periods. A graduated disciplinary system, ranging from a warning to termination of employment, was developed to ensure staff compliance.

In summary, the suicide of Dennis D. was a tragedy that became the catalyst for many valuable changes in policy and practice at the Youth Center. The need for a better flow of information regarding youth entering the facility, designating appropriate risk levels, increased availability of mental health staff, sound physical plant and effective monitoring of at-risk youth have proven very effective at saving lives. While a suicide in custody is always a tragedy, it can provide the impetus for a facility to engage in self-evaluation, change and an institutional commitment to preserving life.

The Program

During the past decade, the Hamilton County Juvenile Court Youth Center has developed and continued refined their suicide prevention program. According to Superintendent Dugan: "The diligence and dedication of our staff have sustained the quality of the program." Indeed, as observed by ***Update*** staff, the program is a

uniquely collaborative effort of Administrative, Housing Unit, Psychology Clinic and Medical Department staff. Although the agency has implemented all of the critical elements for an effective program, four key areas — training, screening/assessment, supervision, and administrative review form the backbone of the facility's "Suicide Assessment and Management Policy."

Training

The Youth Center developed an ambitious staff training program that includes over 160 hours of instruction. The program includes an eight (8) hour workshop on suicide prevention, and includes discussion of potential predisposing factors to juvenile suicide, high-risk suicide periods, warning signs and symptoms, and components of the Center's suicide assessment and management policy. All direct care personnel, including Unit managers and [redacted] Intake and Reception/Release staff, Medical and [redacted]ology Clinic staff, and Recreation staff receive the training. A two (2) hour annual refresher course was recently initiated. In addition, all staff receive an eight (8) hour cardiopulmonary resuscitation (CPR) course, as well as an eight (8) hour standard first aid course. The CPR course is repeated annually and the first aid course is provided to staff every three years. Staff are also trained in the proper intervention techniques for responding to a suicide attempt, including instruction on the proper use of a 911 Rescue Tool (used to quickly cut through fibrous material and located in each housing unit) and safety packs (worn by all direct care staff and containing mouth shields, latex gloves and other items). Finally, mock drills are held quarterly and used to test the emergency responsiveness of staff to suicide attempts.

Screening/Assessment

The Youth Center provides several layers of screening and assessment to identify potentially suicidal behavior in residents. Upon arrival to the facility, an intake officer completes the *Intake Acceptance/Refusal Form* which, although not specifically referencing suicide risk, lists several variables relating to the overall general health of the youth. In the Reception/Release Department, staff complete the *Interviewer's Assessment Form* (containing a section on current and prior suicide risk) and the *Residential Care Information Sheet* (which contains several areas of inquiry for parents/legal guardians, referral agency or transporting staff, including "Has this child or any family member threatened or attempted suicide?" and "Has youth demonstrated any suicidal or homicidal threats or gestures?") During this reception process, staff also consult a computerized database to determine whether the resident has previously been confined in the Youth Center and placed under suicide risk precautions. At the end of this process, reception staff make a determination as to whether [redacted]outh is either a low or high risk for suicide. The youth [redacted]bsequently seen in the Medical Department where nursing staff complete an *Entrance Health Screening Form* (which also contains inquiry regarding suicide risk). Should any direct care staff observe a resident displaying signs and symptoms of potentially suicidal behavior, a *Referral for Evaluation Form* is completed and forwarded to the Psychology Clinic for action.

Finally, all high risk (and a random sample of low risk) residents are interviewed by one the Clinic's intake clinicians within 24 hours of their arrival at the Youth Center. The clinician will complete a two-page *Suicide Assessment Form* containing various areas of inquiry, including demographic information, prior mental health treatment (e.g., hospitalization, counseling, medication), suicide ideation (e.g., current and prior thoughts, gesture or attempts, family history), signs of depression and several miscellaneous areas (e.g., education background, abuse history). Based upon this assessment, the clinician will determine whether suicide precautions are necessary.

Supervision

All residents confined in the Youth Center are required to be observed by Unit staff at intervals that do not exceed every 15 minutes. In essence, all residents are considered to be at least at *low risk* for potentially suicidal behavior. In addition, those residents who are assessed as having an increased potential for engaging in suicidal threats, gestures or attempts are classified as *high risk* and observed by staff at all times while on the unit and at 5-minute staggered intervals while in their rooms. Currently, an estimated 20 percent of the Youth Center population is on high risk status for suicidal behavior each day. As previously offered, verification of these monitoring levels is assured through the computerized Youth Center Guard Tour Monitoring System. Finally, *constant and continual* supervision, entailing the assignment of staff to provide one-on-one direct observation, is utilized in situations in which a resident is temporarily placed in a restraint chair, awaiting transport for an emergency evaluation or immediately following a suicide attempt.

Administrative Review

Any suicide attempt at the Youth Center, regardless of whether injury occurs, results in an administrative review. The inter-agency review entails over 20 self-critical lines of inquiry, including:

- Was the resident properly monitored at the assessed and assigned risk level?
- Were proper intervention methods used?
- Was the suicide attempt properly communicated to appropriate staff?
- Had the resident been seen recently by a clinician prior to the incident?
- Was the resident seen post-suicide attempt by Psychology Clinic staff with a revised or

validated risk level reflecting present psycho/emotional presentation?

- Was coverage, staffing configuration or relief by programmers attributable in any manner to the failure of any monitoring sequences (from the lexan panels) or management of the known risk level of the resident?

- Was the Medical Department notified and did they respond immediately and assess resident's health condition or the possibility of 911 notification?

As a result of the administrative review process, several outcomes are possible, including disciplinary action for staff found to be in non-compliance with policies or procedures, enhanced training and skill development, placement of the youth on automatic high risk status during any future admission, and/or revision of policies and procedures.

The recent case of Kelly R. (a pseudonym) is indicative of the suicide prevention practices at the Hamilton County Juvenile Court Youth Center.

Kelly R.: A Case Study
by
Melissa Dunphy and Burke Neville
Intake Clinicians

Kelly R. is a 14-year-old White female who was admitted to the Youth Center on December 7, 1997 on a violation of court order/runaway charge. Kelly has numerous prior admissions to the Youth Center, with charges ranging from aggravated burglary to a violation of court order/placement. She is the oldest of two children and her parents were divorced several years ago following the incarceration of her father. Kelly has lived in several placements outside of her home. Both of her parents have documented substance abuse problems and there is also evidence of mental illness in the family. Kelly indicated that she was sexually abused on two occasions when she was four and nine years old. Since the age of six, she has had a history of self-mutilation, suicidal threats and attempts, and has been hospitalized twice for suicidal ideation. A psychiatric evaluation conducted in 1995 indicated that Kelly has received several different diagnoses, including oppositional defiant disorder, conduct disorder, major depression and possible panic disorder.

Upon Kelly's admittance to the Youth Center, the *Intake Acceptance/Refusal Form* was completed by Intake staff. Documents from the arresting police officer, legal guardian and prior Youth Center admissions were reviewed. She was not thought to be in immediate crisis and was, therefore, accepted for admission and transported to the Reception area for processing. Kelly was then interviewed by Reception staff to determine whether she was either a high or low risk of suicide. The *Interviewer's Assessment Form* and *Residential Care Information Sheet* were completed. During this process, Kelly stated that "I want to be dead" and displayed other signs of depression. Staff also verified her prior history of suicidal behavior. She was placed under high risk status and Reception staff completed a *Referral for Evaluation Form* so that Kelly could be further assessed by the Psychology Clinic. She was then seen by Medical staff who administered an *Admission Health Screening Form* in which her previous suicide attempts were again verified and documented. A recommendation was made to maintain Kelly under the high risk category until she was assessed by Clinic staff. She was then placed in a female housing unit.

Kelly was evaluated by an intake clinician from Psychology Clinic the following morning and a *Suicide Risk Assessment Form* was completed. Following the assessment, the clinician alerted Unit staff that Kelly still presented signs of depression, active thoughts of suicide and would remain on high risk status. Her hygiene pack was also removed from her room.

Kelly remained on high risk status and was observed daily by intake clinicians. On December 15, Unit staff contacted the Psychology Clinic after Kelly was seen displaying unusual behavior. When evaluated by a clinician, Kelly revealed that she was hearing voices since before her admission to the Youth Center. She also reported that the voices were becoming more intrusive and frightening. The clinician consulted with a psychological assistant and then

asked the Clinic director to assess Kelly to determine possible hospitalization. The Clinic director evaluated Kelly the following day and determined that an emergency psychiatric evaluation was appropriate. In coordination with Administrative, Medical, Housing Unit and Psychology Clinic staff, Kelly was transferred to the psychiatric unit at a local hospital for evaluation (and subsequent in-patient treatment). In addition, her legal guardian was contacted and apprised of her condition. Kelly remained hospitalized until December 23 at which time she returned to the Youth Center. She was again placed on high-risk status and maintained on psychotropic medication that had been initiated during her hospitalization.

On December 24, Unit staff observed Kelly pacing and rocking back and forth. An immediate referral was made to Psychology Clinic staff. She was assessed by a clinician and maintained on high risk status. Two days later on December [redacted]lly requested to speak to Psychology Clinic staff [redacted]se she was concerned about the way her new medication was affecting her. She complained of nausea and feeling excessively tired. The clinician counseled Kelly as to the possible side effects of the medication, and a referral to the Medical Department was not seen as necessary. She continued to be seen on a regular basis by the intake clinicians.

On January 1, 1998, Unit staff observed Kelly attempting suicide by tying a string from her blanket around her neck. The string was tied so tight that staff used a 911 Rescue Tool to cut it from her neck. Medical and Psychology Clinic staff were notified and responded immediately. Medical staff examined Kelly and found no serious injuries. Psychology Clinic staff observed her to be agitated and crying uncontrollably. A decision was then made to upgrade her monitoring status from high risk to "constant and continual" supervision. Kelly was monitored at this extreme level until the following day when Clinic staff determined that she was no longer actively suicidal. Kelly's risk level was downgraded to high risk status and she was maintained at this risk level until her discharge from the Youth Center on January 8.

Although the high level of our intervention with Kelly R. was unique and time-consuming, her case illustrates the collaborative effort necessary from all staff to ensure the safety of residents at the Youth Center.

Maintaining Enthusiasm in the Absence of Crisis

by

Paul Deardorff, Ph.D., M.B.A., Clinic Director,
Brian Griffiths, Psychological Assistant and
Melinda McDonald, Training Supervisor

Perhaps the most challenging aspect of maintaining an [redacted]fficient suicide prevention program is avoiding [redacted]se. Institutions which have suffered a recent suicide [redacted] understandably alert, even hypervigilant, for any signs of an impending suicide attempt. When the fallout from that suicide clears, however, even the most well trained staff can become lackadaisical. That tendency would only be exaggerated by staff turnover as new employees unfamiliar with the stress generated by the previous suicide enter the work force. Maintaining a highly effective prevention program requires management to maintain an energetic and focused staff. Business professionals have long recognized the importance of creating a mission and vision which front-line workers endorse. In a *Harvard Business Review* article on transformation efforts, Kotter (1995) outlined eight steps required to transform an organization. As shown below, these steps were intuitively followed by the Hamilton County Juvenile Court Youth Center as it began to develop a comprehensive suicide prevention program.

Establishing a Sense of Urgency

Although the Youth Center was not operating in a crisis mode, its superintendent created a sense of urgency by establishing a suicide prevention team whose sole purpose was identifying and discussing possible crisis situations. Critical incident reports were routinely reviewed with the superintendent repeatedly asking "what if?" to provoke challenging discussions. An emphasis was placed on identifying opportunities for improving the efficiency of the suicide prevention program. Although there was no actual crisis, the superintendent induced a sense of urgency by occasionally focusing on procedural errors or lapses in the system. By doing so in a no-nonsense manner, he left no doubt that the team was to recognize the very serious nature of its charge.

Forming a Powerful Guideline Coalition

The superintendent assembled a work group whose members had responsibilities in each area of the suicide prevention program. The Psychology Clinic was heavily represented, as its intake clinicians were responsible for both the initial assessment of suicide potential and the first response to possible emergency situations. The Operations director was involved because of the role Intake and Reception/Release staff play in the initial assessment, identification and risk level assignment of newly admitted youth. The Housing Unit director was involved, as that individual supervised the front-line staff interacting with the residents on a daily basis. The Training Department was involved, as their responsibility was to ensure that each member of the work force was adequately trained in suicide prevention policies and procedures. Finally, the Medical Department was involved because they serve as liaison between the local hospitals and the Youth Center. The superintendent clearly indicated that he expected a state of the art suicide prevention program. Further, his demeanor left little doubt that he believed he had assembled a staff capable of creating that program.

In another *Harvard Business Review* article, Ralph Stayor of the Johnsonville Sausage Company stated that, "People want to be great. If they aren't, it's because management won't let them be" (Stayor, 1990). Like Stayor, the superintendent of the Youth Center clearly communicated his belief that he had assembled a staff capable of meeting

the challenge of creating a model suicide prevention program. Additionally, by assigning tasks relevant to each staff member's competence, he communicated his confidence in each individual team member. As Stayor indicated, "The actions of managers shape expectations." By sharing his expectation of each team member, the superintendent clearly shaped the expectations of the team as a whole.

Creating a Vision

The vision of suicide prevention team was shaped during its first few meetings. It was clear that a zero tolerance policy would be the norm for the facility. Further, the team recognized that when that goal was attained, it would then be necessary to share the appropriate procedures with other institutions. As a result, the team vision included development of a training program for other institutions along with development of a standardized, psychometrically sound suicide assessment instrument. In short, the team maintained its sense of enthusiasm by striving to be not just a good program, but a model program.

Communication of the Vision

Various staff members were sent to workshops on suicide prevention. The Psychology Clinic gathered pertinent training materials. By utilizing such formal and informal training methods, the vision of the group was continually refined. As the program developed, the Training Department developed curricula to heighten the staff awareness and skill level in responding to and managing suicidal behavior.

Empowering Others to Act on the Vision

By identifying obstacles which might hinder the acceptance by the work force of the zero tolerance policy, the superintendent further elucidated the importance of the suicide prevention program. Staff members who became lackadaisical in their approach were disciplined. Staff members who contributed suggestions which improved the system were recognized. By aligning incentives with the mission, its importance remained clear.

Planning for and Creating Short-Term Wins

In meetings with the suicide prevention team, statistics are reviewed on a monthly basis. By focusing on the number of children viewed as high risk and the reasons for downgrading those youngsters, goals were established. While there have not been any suicides in several years, the staff can take pride in its quick response time and in its ability to become more accurate in identifying high risk youngsters. Burn-out is avoided by identifying success.

Consolidating Improvements and Producing Still More Change

Unlike administrators in many juvenile detention facilities, the experiences of our superintendent have made him vigilant on this topic. Further, his exposure to total quality improvement principles has led to a continued focus on improving the system.

Institutionalizing New Approaches

The suicide prevention team developed a very thorough policy and procedures manual. It is clear, however, that the manual is more than a binder on a shelf. The team focuses on the behavior of staff members to ensure that their behavior reflects the stated policies. By continually monitoring and measuring the efforts of the program, staff members maintain enthusiasm.

Conclusion

When walking away from the Hamilton County Juvenile Court Youth Center, it is easy to be impressed by the enthusiasm and pride displayed by staff. It is among the most capable and dedicated groups professionals that *Update* staff have observed. As Superintendent Dugan offered, "After Dennis' suicide, I promised myself that I would do everything possible to proactively reduce the odds of our facility ever experiencing another suicide." He and his staff have kept that promise for more than 12 years. For more information on suicide prevention efforts at the Hamilton County Juvenile Court Youth Center, contact Robert J. Dugan, Superintendent, Hamilton County Juvenile Court Youth Center, 2020 Auburn Avenue, Cincinnati, Ohio 45219, (513/946-2644; 513/946-2675-Fax).

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APPENDIX B

INTAKE SCREENING FORM

Youth's Name | Date of Birth | Sex | Date | Time

Most Serious Charge | I.D. Number | Screening Officer

Was youth a medical, mental health or suicide risk during any prior contact and/or confinement within this facility? Yes___No___ If Yes, explain:_____

Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency/facility, family member/guardian, etc.) that indicates youth is a medical, mental health or suicide risk now? Yes___No___ If Yes, explain: _____

STAFF OBSERVATION

Yes	No		Yes	No	
___	___	Assaultive/Violent Behavior	___	___	Crying/Tearful
___	___	Loud/Obnoxious Behavior	___	___	Confused
___	___	Any Noticeable Marks/Scars	___	___	Uncooperative
___	___	Bizarre Behavior	___	___	Passive
___	___	Alcohol/Drug Withdrawal	___	___	Intoxicated
___	___	Unusual Suspiciousness	___	___	Scared
___	___	Hearing Voices/Seeing Visions	___	___	Incoherent
___	___	Observable Pain/Injuries	___	___	Embarrassed
___	___	Other Observable Signs of Depression	___	___	Cooperative

Explain_____

MEDICAL HISTORY

Yes	No	
___	___	Are you injured? If Yes, explain:_____
___	___	Are you currently under a physician's care? If Yes, explain:_____
		_____
___	___	If female, are you pregnant?
___	___	Are you currently taking any medication? If Yes, list type(s), dose(s), and frequency:_____
		_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

Yes	No		Yes	No	
___	___	Hepatitis	___	___	Heart Disease
___	___	Shortness of Breath	___	___	Chest Pains(s)
___	___	Abdominal Pain(s)	___	___	Asthma
___	___	High Blood Pressure	___	___	Venereal Disease
___	___	Tuberculosis	___	___	Diabetes
___	___	Alcohol Addiction	___	___	Drug Addiction
___	___	Epilepsy/Blackouts/Seizures	___	___	Ulcers
___	___	Other Medical Problems and/or Diseases	___	___	AIDS (Optional)

Explain:_____

SUICIDE RISK ASSESSMENT

Yes No

___ ___ Have you ever attempted suicide? If Yes. When?_____ Why?_____
_____ How?_____

___ ___ Have you ever considered suicide? If Yes. When?_____ Why?_____
_____

___ ___ Are you now or have you ever been treated for mental health or emotional problems? If Yes.
When?_____ In-Patient:_____Out-Patient:_____Both:_____

___ ___ Have you recently experienced a significant loss (relationship. death of family member/close friend, job. etc.)? If Yes. explain:_____
_____
_____

___ ___ Has a family member/close friend ever attempted or committed suicide? If Yes. explain._____
_____
_____

___ ___ Do you feel there is nothing to look forward to in the immediate future (youth expressing helplessness and/or hopelessness)? If Yes. explain:_____
_____
_____

___ ___ Are you thinking of hurting and/or killing yourself? If Yes. explain:_____
_____
_____

Additional Remarks:_____
_____

DISPOSITION

___ General Population

___ Special Observation
1) Supervision Levels: CLOSE (5-15 Minutes)_____ CONSTANT_____ OTHER_____
2) Housing Assignment: Infirmary _____ Mental Health Unit _____ Room # _____
3) Other Precautions Taken (removal of clothing, issuance of paper gown. bedding, etc., if appropriate)
_____

___ Local Hospital. If youth is later returned to facility, list any special observation recommendations: _____
_____

___ Mental Health Provider. If youth is later returned to facility, list any special observation recommendations: ___
_____

___ Other Disposition/ Referral/Transfer:_____

FAILURE TO ANSWER/REFUSAL OF TREATMENT

Youth refused to answer (circle) or unable to answer (circle and state why) verbal response sections of this form.

I, _____(print name) refuse any type of medical treatment.

SIGNATURES: Youth: _____

Screening Officer:_____ Supervisor: _____

SUICIDE CONSULTATION SHEET

YOUTH'S NAME:_____ **I.D. NUMBER:**_____
(Last) (First) (M.I.)

DOB:_____ **AGE:**___ **SEX:**___ **INITIAL ASSESSMENT:**___ **REASSESSMENT:**____ **DATE:**_____

SUICIDE WATCH DURING PRIOR CONFINEMENT:
YES___**(MOST RECENT DATE**_____**) NO**____

REASON FOR REFERRAL:_____

SUICIDAL INDICATORS (Check all that apply):

Suicide Attempt___	Suicide Ideation/Gesture___	Self-Mutilation___
Depressed____	Agitated____	Mood Change____
Hostile/Aggressive___	Sleep Problems____	Recent Loss____
Lethargy____	Excessive Weight Gain/Loss___	Isolation/Withdrawal____
[redacted]ving Away Possessions____	Intoxicated___	Hopeless/Helpless____
[redacted]raid/Fearful___	Bizarre Behavior (Explain Above)___	Other (Explain Above)___

TYPE OF THREAT/ATTEMPT: Hanging____Cutting___Jumping___Ingestion__Overdose__Other___

PREVIOUS PSYCHIATRIC/SUICIDE HISTORY:_____

CURRENT MEDICATIONS:_____

ASSESSMENT OF LETHALITY: Low (1)_____ Medium (2)_____ High (3)_____

DIAGNOSIS:

Schizophrenia____	Major Depression____	Generalized Anxiety Disorder___
Borderline Personality___	Panic Disorder____	Bi-Polar Disorder____
Substance Abuse Disorder___	Other_____	

FINDINGS/RECOMMENDATIONS:_____

ACTIONS:

Suicide Watch Authorized: Yes_____ No____

Level: **CLOSE** (Physical checks at staggered intervals not to exceed every 15 minutes)___
CONSTANT (Continuous, uninterrupted observation)____
OTHER (Specify)_____

Medical Restraints: Yes_____ No____

Paper Gown: Yes_____ No____

Items Allowed (Check): Clothing___Undergarments___Blankets___Mattress___Pillow___
Reading Materials___Toiletries__Other_____

Housing Assignment:_____

Transfer Recommendation:_____

Other Referrals/Recommendations:_____

SIGNATURE/TITLE: _____ **TIME:**_____
(Qualified Mental Health Professional)

Developed by the NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES

OREGON YOUTH AUTHORITY
Institution Mental Health Review

Youth Name:_____ Case Number:_____

Living Unit: _____Treatment Manager:_____Facility:_____

Directions: *Each youth's mental health treatment needs must be reviewed and updated on a quarterly basis. Recommendations resulting from the review should be distributed to living unit treatment manager (for inclusion in 90-day case review), institution psychiatrist/psychologist, and other health services staff as appropriate.*

Today's Date: _____ Date of Last Review: _____

1. Placements in isolation since last review? ☐Yes, number of times_____; ☐ No

2. Mental health interventions since last review? ☐Yes, number of times_____; ☐ No

3. Currently receiving ongoing mental health services? ☐Yes ☐No

Treatment Needs Review and Recommendations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

QMHP Signature:

_____

Distribution: medical file, psychiatrist/psychologist, living unit treatment manager

YA 4412 (10/98)

OREGON YOUTH AUTHORITY
MENTAL STATUS ASSESSMENT

Examiner: _____ Date: _____

Youth Name: _____ DOB: _____

Institution: _____

Examiner: Please refer to Form YA 4409A for guidance in completing this assessment..

1. Appearance: _____ neat/age appropriate _____ disheveled _____ odd/eccentric

other: _____

2. Stated Mood: _____ happy _____ sad _____ angry _____ anxious _____ calm

other: _____

3. Affect: _____ blunted _____ flat _____ labile

_____ appropriate _____ inappropriate

4. Speech _____ normal _____ pressured _____ slowed _____ slurred

_____ halting _____ stuttering _____ volume (appropriateness)

5. Orientation _____ date _____ time _____ place _____ person _____ situation

6. Memory: _____ recent _____ remote

7. Thought: Structure _____ normal _____ confused _____ loose associations _____ bizarre

8. Hallucinations: _____ none _____ auditory _____ visual _____ other

9. Other psychotic phenomena: _____

_____

_____

10. Delusions: _____

_____

_____

11. Intellect: _____ below average _____ average _____ above average

12. Insight: _____

File: Medical file, mental health file

13. Judgment: _____

14. Appetite: _____ decreased _____ increased _____ same _____ binge eating _____ purging

15. Sleep: _____ OK _____ can't fall asleep _____ sleeps all the time

_____ nightmares

16. Activity Interests: _____

_____

17. Suicide/Self abuse history: _____

_____

_____

18. Current suicidal ideation: _____

_____

Plan: _____

19. Psychiatric History: _____

_____

20. Assault/Violence: _____

_____

21. Substance Abuse: _____

_____

Last Use: _____ Withdrawal symptoms: _____

22. Recent significant loss: _____

_____

23. Suicidal history of a friend or family member: _____

_____

24. Support system: _____

_____

_____

25. Source of Information: _____

26. OUTCOME: _____ LEVEL I: STRICT SUICIDE PRECAUTION

File: Medical file, mental health file

YA4409 (7/98)

_____ LEVEL II: SUICIDE WATCH

_____ LEVEL III: CLOSE WATCH

_____ LEVEL IV: INCREASED RISK — ENHANCED SUPERVISION

_____ LEVEL V: REGULAR RISK — STANDARD SUPERVISION

OREGON YOUTH AUTHORITY
MENTAL STATUS ASSESSMENT INTERVIEW GUIDELINE

This clinical interview guideline is designed to be used with the Form YA 4409 Mental Status Assessment, the numbers of which correspond to those listed below. The purpose of the guide is to assist OYA facility mental health professionals determine a youth offender's current mental status and appropriate level of supervision/housing restrictions based upon potential suicide risk. All assessments should be reviewed by the facility's child psychiatrist or psychologist.

1. Appearance: Please comment on the peculiarities of appearance and dress, including, but not limited to, poor hygiene, unusual physical or facial characteristics, eccentric dress, gang attire, disheveled unkempt appearance, or any other features of note.

2. Stated Mood: Characterize the youth's stated mood.

3. Affect: Characterize the youth's affect throughout the entire interview.

4. Speech: Characterize the quality of the youth's speech.

5. Orientation: Assess orientation in all spheres.

6. Memory: Assess recent as well as remote memory structure.

7. Thought structure: Characterize the youth's thought.

8. Hallucinations: Assess the youth for auditory, visual, olfactory, and somatic hallucinations.

9. Other Psychotic phenomena: Assess whether the youth is or has been afflicted with a psychosis.
Possible questions include:

- Have you ever felt that you weren't real or that what you were seeing wasn't real?
- Have you ever felt as though you were living in a dream?
- Have you heard voices when no one was there?
  Where were the voices coming from? Inside your head or outside your head?
  Were the voices frightening? What sorts of things did they say to you?
- Have you ever seen things that other people don't see?
  Were you doing LSD or any other kind of drug when this happened?
- Do you ever feel that you can read other people's minds?
- Do you ever feel that someone else can read your mind?
- Have you ever gotten messages from the radio, the television, or music that were just for you?
- Do you ever feel as though you are being controlled by something or someone outside of you?

10. Delusions: Attempt to determine if the youth has ever experienced delusion ideation (i.e., false, fixed idiosyncratic beliefs) while not under the influence of a substance.

11. Intellect: Assess the youth's intellectual potential, based upon the clinical interview.

12. Insight: Attempt to determine the youth's level of insight into his or her situation.

13. Judgment: Determine the youth's level of judgment, based upon several situations.

14. Appetite: Assess disturbance of appetite, including weight loss or gain. (See #18, below.)

15. Sleep: Assess disturbance of sleep pattern. (See #18, below.)

16. Activity Interests: Explore the youth's areas of interests and activities.

17. Suicide/Self Abuse History: Thoroughly assess the youth's history of suicidal thought and prior suicidality. Look for signs of self-mutilation. Pose questions:

- How do you feel right now? Could you rate your mood on a scale of 0 to 10, where 0 would be the worst you have ever felt and 10 being the best you have ever felt?
- How are you dealing with being "locked up"?
- Have you ever felt like hurting yourself?
  - Has that been recently?
  - What did you think about doing?
- Have you ever intentionally hurt yourself?
  - Were you intending to kill yourself or were you trying to release your anger?
- Have you ever tried to commit suicide?
  - When?
  - What did you do?
  - Was it on an impulse or did you think about it for awhile?
  - Why didn't it work?
  - Were you sorry that it didn't work?
  - Did you ask for help?

18. Current Suicidal Ideation: Thoroughly assess whether the youth may be having current thoughts of attempting suicide. Pose questions such as:

- Are you having any thoughts of hurting yourself right now?
  - What are you thinking of doing? (*Attempt to establish a contract with the youth not to harm him or herself*)
- Do you sleep well at night?
  - Do you ever have trouble going to sleep or staying asleep?
- Is your appetite good?
- Do you have a normal amount of energy?
  - Do you have much energy during the day?
- What do you do for fun?
  - Have these activities been fun recently?

19. Psychiatric History: Assess the youth's family history and the youth's possible perpetration/victimization of sexual abuse. Suggested interview questions include:

Family History

- To your knowledge, has anyone in your family (including grandparents and aunts and uncles) been diagnosed with a mood disorder?
- Has anyone in your family attempted to commit suicide? If so, how?
- Has anyone in your family died violently?

Parental Divorce, Separation, or Incarceration

- Are both of your parents living at home? If not, where is the absent parent?
- Are they divorced?
  - How old were you when they split up?
- Are either of your parents in jail or prison now?
- Have either of your parents ever been in prison?

Firesetting

- [redacted] you like to watch fires burn?
- [redacted]ve you ever started a fire to watch it burn?
- Have you set fires which destroyed property?

Perpetrates Sexual Abuse

- Has there ever been a time when you had sex with someone a lot younger than you?

- Have you ever forced someone to have sex with you?

Victim of Sexual/physical Abuse

(*Look at the youth for signs of physical abuse.*)

- To your knowledge, have any reports of physical or sexual abuse been filed on parents or other adults living in your home?
- How are you disciplined at home?
- Who disciplines you, generally?
- Why were you disciplined?
- Have you ever been physically hurt by your parents or other adults in your home? When?

19. Psychiatric History: continued.

- Have you had sex with any adults in your home?
  - Did you feel forced to have sex?
  - How long ago did this happen?
  - What age were you?
  - How long did it go on?
  - Do you have flashbacks of the experience?
  - Do you have bothersome thoughts about it?
  - Do have nightmares about the experience?

(*If the youth responds positively to unreported sexual or physical abuse, you must report the disclosure to the local office of the State Office for Services to Children and Families.)*

20. Assaultiveness/Violence: Assess the youth's history of assaultiveness and violence. Pose questions such as:

- Have you ever tried to hurt anyone? Recently?
- Have you ever tried to kill someone? When? How?

21. Substance Abuse: Obtain a substance abuse history, including last use and withdrawal symptoms.

- Do you smoke cigarettes or pot?
  - How much pot do you smoke weekly?
- Do you use "crank"? How often?
- Do you use cocaine? How often?
- Have you ever tried LSD? If so, how many times? Do you still use? How often?
- Do you "huff" things like gas, paint thinner, or aerosol sprays?
- Do you drink alcohol?
  - Everybody drinks at parties. Do you like beer, wine coolers or hard liquor best?
  - How much and how often do you drink?
  - Do you have bad hangovers?
- Have you ever used tranquilizers or sedatives? If so, how often?
- Have you used heroin? How often?
- Have you used I.V. drugs?
  - Do you share needles?
- If you don't use alcohol or drugs, is it hard to resist the pressure to do so?

22. Recent Significant Loss: Determine if the youth has had any significant losses.

23. Suicidal History of a Friend or Family member: Determine if the youth has experienced the suicide of a friend or family member (including extended family).

24. Support System: Thoroughly assess the student's social support system in the community as well as in the institution.

26. Outcome: Assign the youth to an appropriate suicide risk level, based upon your clinical interview and observations of the youth's overall mental status. For discussion of each risk level and the supervision protocols to be observed, refer to the document *Oregon Youth Authority Suicide Prevention Protocols, dated 08/11/98*

APPENDIX C

AUTHORIZATION FOR SUICIDE WATCH

YOUTH'S NAME:_____ **I.D. NUMBER:**_____
(Last) (First) (M.I.)

REASON FOR OBSERVATION (Provide details):_____

SUICIDE WATCH LEVEL:

____ **CLOSE** (Physical checks at staggered intervals not to exceed every 15 minutes)
____ **CONSTANT** (Continuous, uninterrupted observation)
____ **OTHER** (Specify)_____

HOUSING ASSIGNMENT:_____

Medical Restraints: Yes____ No_____
Paper Gown: Yes____ No_____
Items Allowed (Check): Clothing___Undergarments___Blankets___Mattress___Pillow____
Reading Materials____Toiletries___Other_____
Transfer Recommendation:_____
Other Referrals/Recommendations:_____

SIGNATURE/TITLE: _____ **TIME:**_____ **DATE:**_____

REASSESSMENT OR CHANGE IN SUICIDE OBSERVATION LEVEL

I AM REQUESTING THAT RESIDENT_____ I.D. NUMBER_____ BE:

_____**TRANSFERRED FROM CONSTANT (continuous, uninterrupted) OBSERVATION TO CLOSE OBSERVATION STATUS (physical checks at staggered intervals not to exceed every 15 minutes).**

_____**TRANSFERRED FROM CLOSE OBSERVATION TO CONSTANT OBSERVATION.**

_____**CONTINUED ON CLOSE OBSERVATION STATUS (physical checks at staggered intervals not to exceed every 15 minutes).**

_____**RELEASED FROM CLOSE OBSERVATION STATUS.**

_____ **RELEASED FROM CONSTANT OBSERVATION STATUS (May only be authorized following face-to-face consultation with a psychiatrist or psychologist).**

RATIONALE:_____

HOUSING ASSIGNMENT:_____

FOLLOW-UP RECOMMENDATIONS:_____

SIGNATURE/TITLE:_____ **DATE:**_____ **TIME:**_____

APPROVED BY (Signature):_____ **DATE:**_____ **TIME:**_____
(Psychiatrist or Psychologist)

Developed by the NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES

SUICIDE WATCH OBSERVATION SHEET

YOUTH'S NAME:____ **I.D. NUMBER:**_________
(Last) (First) (M.I.)

START DATE:____________ **START TIME:**___________ **ROOM LOCATION:**__________________

SUICIDE WATCH LEVEL:

- **CLOSE** **(Physical checks at staggered intervals not to exceed every 15 minutes, e.g., 5, 12, 10 minutes)**_______
- **CONSTANT** **(Continuous, uninterrupted observation)**____
- **OTHER** **(Specify)** ______

MEDICAL RESTRAINTS: (Y)_____(N)_____ **PAPER GOWN: (Y)_____(N)_____**

CODE FOR RESIDENT BEHAVIOR AND STAFF INTERVENTIONS

A. Self-Injurious Behavior	F. Quiet/Seclusive	K. Sleeping	P. Yelling/Screaming
B. Assaultive Behavior	G. Self-Contained Activity	L. Medical	Q. Telephone Call
C. Destructive Behavior	H. Social Activity/Program	M. Mental Health	R. Visit
peractive	I. Medication	N. Eating	S. Incoherent
ctive	J. Toilet/Shower	O. Crying	T. Other_________

TIME	CODES	STAFF NAME	TIME	CODES	STAFF NAME	TIME	CODES	STAFF NAME

SHIFT SUPERVISOR SIGNATURE:______________________________ **TIME:**______ **DATE:**__________

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