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Position Statements

Prevention of Juvenile Suicide in Correctional Settings

Introduction

Adolescent suicide in the general population is a national tragedy and a major public health problem (Carmona, 2005). The suicide rate among people aged 15 to 24 tripled from 2.7 per 100,000 in 1950 to 9.9 per 100,000 in 2001 (Arias, Anderson, Kung, Murphy, & Kochanek, 2003), and more teenagers die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined (U.S. Public Health Service, 1999). Available information suggests a high incidence of suicidal behavior in juvenile correctional facilities; however, until recently, current national data has been lacking. Although the number of reported suicides appears low, significant numbers of juvenile justice clinicians believe the problem is underreported (Penn, Esposito, Schaeffer, Fritz, Spirito, 2003). **In addition, the placement of youth adjudicated as adults raises concern as to what effect the adult correctional environment may have on this problem.**

The U.S. Justice Department's Office of Juvenile Justice and Delinquency Prevention in 2004 released the National Center on Institutions and Alternatives' national survey on juvenile suicide in confinement (Hayes, 2004). The study found several significant differences between adult suicides and suicide by juveniles in confinement. Significant findings regarding juvenile correctional suicides included the following:

Timing of Suicides: Except in detention centers, deaths were evenly distributed over a period of more than 12 months, with the same number occurring within the first 1 to 3 days of confinement as 12 months or more later. Contrary to adult suicides in jails, few suicides occurred within the first 24 hours. Most (71%) juvenile suicides occurred during traditional waking hours (7 a.m. to 9 p.m.). Half occurred from 6 p.m. to midnight, and almost a third between 6 p.m. and 9 p.m.

Room Confinement Status: Consistent with other recent research (Gallagher & Dobrin, 2006) half of victims were on room confinement status (i.e., time-out, segregation, quiet room, separation) at the time of death. The reasons for such confinement included failure to follow program rules, inappropriate behavior, and threat of or actual physical abuse by staff or peers.

Prior Suicidal Behavior: 71% of those who committed suicide had a history of suicidal behavior, most commonly suicide attempt, followed by verbalizing a suicidal ideation and/or threat, suicidal gesture, and self-mutilation.

Comprehensive Suicide Prevention Programming and Training: Although 79% of reporting facilities had a written suicide prevention policy at the time of the suicide, only 20% (10% among detention centers) had comprehensive programming at that time. Most facilities lacked an adequate suicide prevention curriculum, suggesting lack of commitment to such training.

Suicide Prevention

This position statement is not a comprehensive guide to suicide prevention for youth in correctional settings. Different national organizations parse out essential elements for suicide prevention programs. The most comprehensive list appears in standard Y-G-05 Suicide Prevention Program in NCCHC's *Standards for Health Services in Juvenile Detention and Confinement Facilities* (2004). However, all programs have a common goal: to prevent suicide, and, if a suicide occurs, to guide evaluation of the event to enable learning that will improve care and enhance preventive actions.

This statement presents seven components of a successful suicide prevention program that focuses on recent research and the implications for improved suicide prevention.

Position Statement

NCCHC recommends that all juvenile facilities, regardless of size or type, develop and implement a comprehensive suicide prevention program that takes into consideration the unique characteristics of juvenile suicide risk in correctional settings. Necessary revisions to current policies and procedures should be based on the implications of the recent research. **The recommendations below apply to all correctional facilities housing adolescents, including adult jails or prisons. The legal status of a youth does not change his or her health needs.**

1. Staff Training in Suicide Prevention

Nationwide, suicide prevention training curricula in juvenile facilities primarily rely on information extrapolated from adult inmate suicides. Although there are common elements in such training across all types of correctional facilities, the differences between juvenile and adult inmate suicides support the development of suicide prevention training targeted specifically to juvenile facilities and based on the latest research regarding juvenile suicide. In initial and refresher juvenile suicide prevention training, all direct care, medical, and mental health personnel should receive comprehensive training in the program components outlined in this position statement.

2. Ongoing Identification of Risk

Youth can become suicidal at any time during their confinement. Thus, continuous assessment of all juveniles is critical to prevent suicides. Suicide risk screening and assessment needs to be part of the admission process, but it is not a single event and vigilance should be ongoing. The intent of a suicide prevention program should not be "zero" juveniles on precautions, but rather to provide a systemwide process of ongoing identification, management, and stabilization of at-risk or suicidal juveniles. A continuous assessment process alerts staff to consider critical components for identifying and managing risk on a day-to-day basis. The following points are especially helpful when working with adolescents:

! A prior history of suicide attempts and related behaviors is strongly related to future risk. Information should be obtained about the need for suicide precautions during a previous confinement and a history of suicidal behavior or other risk factors while in the community.

! Juveniles who have required special precautions during their current confinement should continue to be assessed frequently, even after active suicide precautions have been removed.

! Staff should not rely solely on the statements of juveniles who deny they are suicidal nor solely on "contracts for safety" because these contracts are unreliable. Research has found that youth who appear manipulative may also be suicidal, and at a minimum suffer from an emotional imbalance that requires a multidisciplinary treatment plan (Dear, Thomson & Hills, 2000). It is crucial to understand that feigned suicide attempts can and have resulted in death.

3. Communication

Certain behavioral signs exhibited by incarcerated juveniles may indicate a risk for suicide. The likelihood of a suicide can be reduced by using a multidisciplinary approach and communicating to all staff that signs of risk are present. Communication in preventing suicide involves all categories of staff, for example, between arresting/transporting officers and correctional/direct care staff, among facility staff (including medical and mental health staff), and between facility staff and the at-risk juvenile.

4. Housing

Half of all juvenile suicides occur among youth on room confinement status. Further research is necessary to explore the relationship between suicide and isolation.

Despite the fact that youth are alone in their rooms overnight, with ample opportunity and privacy to engage in self-injurious behaviors, the vast majority of suicides among youth on room confinement occur during waking hours. During these time periods, youth are usually involved in programming or are interacting with staff and peers. These interactive situations provide an opportunity for youth to become involved in confrontations and inappropriate behavior, resulting in room confinement.

Youth on room confinement status must be closely observed and receive frequent mental status assessments by qualified mental health personnel. Facility officials should also explore alternatives to room confinement.

Safe physical environments are critical to prevent juvenile suicides. The vast majority of these suicides occur by hanging, using bedding attached to a variety of anchoring devices, including door hinges/knobs, air vents, and window frames. Housing units and cells must be suicide resistant, and officers must have cutting tools readily available to remove the ligature within seconds of discovering the youth.

5. Levels of Monitoring

The monitoring of at-risk juveniles should be based on their individual clinical needs and not simply on the resources that are said to be available. Medical evidence suggests that brain damage due to strangulation caused by a suicide attempt can occur within 4 minutes, and death within 5 to 6 minutes. Although various levels of monitoring may be used, generally facilities maintain three levels of special observation based on assessment of the immediacy of the suicide risk.

Constant Observation: This 1:1 monitoring is used when suicide risk is high. It occurs on a continuous, uninterrupted basis for a juvenile judged to be at imminent risk for suicide. These juveniles may also be assessed as in need of psychiatric hospitalization. In such cases, the one-on-one, constant observation is maintained until the transfer occurs.

Intermediate Observation: This monitoring is used for juveniles assessed as being at moderate risk for suicide. It occurs at staggered intervals not to exceed 5 minutes.

Close Observation: This monitoring is used for juveniles assessed to be at low risk for suicide. It occurs at staggered intervals not to exceed 15 minutes.

Since facilities may differ in how they define the requirements for monitoring, it is critical that staff know what is required.

Aids, such as closed-circuit television, can be used to supplement, but never substitute for, staff monitoring. Mental health staff should assess and provide timely interventions at least daily for suicidal juveniles.

6. Intervention

A sound and comprehensive suicide prevention program provides early identification and intervention for at-risk and suicidal youth. Mental health clinicians new to the correctional setting should be oriented to the unique challenges that a suicidal adolescent presents. Multidisciplinary treatment plans, while specifically tailored to monitor and stabilize the juvenile, need to be revised and updated as the youth improves. An aspect of intervention often overlooked is the development of long-range goals. Even youth that appear stable need intermittent follow-up to monitor progress.

7. Mortality and Morbidity Review

Every completed suicide and serious suicide attempt (e.g., requiring hospitalization) should be examined through a morbidity/mortality review process. Ideally, this review is conducted by a multidisciplinary team including representatives of both line and management correctional staff, as well as medical and mental health personnel. A psychological autopsy is also recommended. NCCHC's juvenile standard Y-A-10 Procedure in the Event of a Juvenile Death is one source of further information.

***Adopted by the National Commission on Correctional Health Care Board of Directors
October 14, 2007***

Additional Resources

Council of Juvenile Correctional Administrators. (2003). *Performance-based Standards (PbS) for youth correction and detention facilities: PbS goals, standards, outcome measures, expected practices and processes*. Braintree, MA: Author.

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