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## **SUICIDES WITHIN THE JUVENILE, JUSTICE SYSTEM: THE NEED FOR ADMINISTRATIVE OVERSIGHT**

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Suicides among youths in the United States is a national tragedy. A successful suicide by an adolescent within the juvenile justice system is both preventable and unconscionable and tends to occur as a consequence of poor or inappropriate staffing, inadequate training, and/or the lack of policy and procedure enforcement. Suicides among detained youth can and should be prevented and the role and responsibility of court and probation administrators with regard to detention facility oversight sadly have been neglected.

Unfortunately, we have not always had accurate and up-to-date data on attempted and successful suicides among youths detained in correctional facilities. According to a report prepared a couple of decades ago (Memory, 2005), it was reported that detained youths were "...four to five times more likely to be the victim of suicide than were similarly aged youths in the general U.S. population." According to Snyder (2005:84) and based on National Center for Health Statistics (NCHS) data, recent rates for suicide vary among different juvenile population groups:

The average annual suicide rate is greater for 17-year-olds than 14-year-olds (9.6 versus 3.8), greater for males than females ages 12 through 17 (17.6 versus 2.2), and greater for American Indian youths and non-Hispanic white youths ages 12 through 17 than for similarly aged Hispanic and non-Hispanic Black youths (10.8, 5.6, 3.6, and 3.4 respectively).

For adults, the leading cause of deaths in U.S. jails is suicide (Goss, J. R., 2002) while in prisons it ranks third as the primary cause (Couturier & F. R. Maue, 2000). In a study conducted in England and Wales (Fazel, et al, 2005), Standardized Mortality Ratios (SMRs) were calculated for different age groups in terms of suicides. It was found that the age-specific suicide rate for all ages for those incarcerated was 5.1. However, for detained boys ages 15 to 17, the rate was an astonishing 18. It was also found that suicide has been about five times more common among male prisoners (all ages) in England and Wales than in the general male population. Fazel, et al, (2005:2) conclude "...that this excess is...particularly striking among incarcerated boys, and it has been steadily increasing over recent decades."

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### MENTAL HEALTH DISORDERS

It has become common knowledge that many detained youths have mental health problems, which is recognized as a critical risk factor that can lead to suicides. In fact, as Grisso, et al (2001) report, while youth in the U.S. make up an average of 20 percent of those being supervised among juvenile justice agencies, their level of mental health disorders is higher and, in fact, according to Pumariega (1994), the level has even been likened to patients in mental hospitals.

Based on the research by Shelton (as quoted in Hosley, et al, 2005:23), it was found that 53 percent of youths within the juvenile justice system who had been assessed for mental health problems met criteria for diagnosable mental disorders, with 26 percent needing immediate mental health services and 14 percent requiring restrictive settings. Furthermore, as Hosley, et al (2005:23) point out:

...investigators have examined the prevalence of specific disorders among juvenile offenders, including conduct disorders (50 to 90 percent), substance abuse (50 to 80 percent), attention-deficit/hyperactivity disorder (19 to 46 percent), and mood disorders (32 to 78 percent).

Although there are other risk factors associated with suicides among detained youths (e.g., abandonment and neglect by parents and significant others, bullying by peers, generalized depression, punishments and/or misplaced disciplinary actions by caretakers, and/or extensive placements in 'quiet rooms'), it is recognized that the failure to diagnose and treat mental disorders among this population not only facilitate recidivistic behavior upon release, but suicide attempts while in a detention facility. For those youths who have borderline intellectual abilities, their ability to understand staff instructions and behavioral requirements not only can lead to anger and frustration, but self-destructive behavior (i.e., suicide attempts) as well.

### NATIONAL SURVEY OF DETAINED YOUTH

As a consequence of the inadequacy of data concerning suicides among juveniles in detention in the U.S., the Office of Juvenile Justice and Delinquency Prevention (OJJDP) commissioned the National Center on Institutions and Alternatives (NCIA) to conduct a comprehensive effort to determine the scope and distribution of suicides by youth confined in U.S. public and private juvenile facilities. In 2004, a report of findings was prepared by Lindsay M. Hayes, the project director.

The study identified 110 juvenile suicides that occurred between 1995 and 1999, but there were data on only 79 of these cases. Hayes (2004:ix) concludes:

Of these suicides, 41.8% occurred in Training School/Secure Facilities, 36.7% in Detention Centers, 15.2% in Residential Treatment Centers, and 6.3% in

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Reception/Diagnostic Centers. In addition, almost half (48.1%) of the suicides occurred in facilities administered by state agencies, while 39.2% took place in county facilities and 12.7% in private programs.

Among some of the most critical findings of the study, Hayes (2004:ix-x) reports:

- 68.4% were Caucasian
- 79.7% were male
- Average (mean) age of victims was 15.7, with over 70% between the ages of 15 and 17
- Approximately two-thirds (67.1% were held on commitment status at the time of death, with 32.9% on detained status; and 88.5% of the victims held in Detention Centers were on detained status
- All Detention Center suicides occurred within the first four months of confinement, with over 40% occurring within the first 72 hours
- 74.3% had a history of mental illness, including depression
- 71.4% had a history of suicidal behavior, with 45.5% having had prior suicidal attempts
- Approximately half (50.6%) of suicides occurred during the six hour period of 6:01 pm and midnight, and almost a third (29.1%) sustained between 6:01 pm and 9:00 pm; and 70.9% of suicides occurred during traditional waking hours
- 74.7% of victims were assigned to single-occupancy rooms
- 15.4% of the victims were found after more than one hour of last being seen alive
- 50% of victims were on room confinement at the time of death
- 16.5% of the victims were on suicide precaution at the time of their deaths, most of whom were required to be observed at 15-minute intervals

Hayes (2004:xii-xiii) concludes:

Findings from this study create a formidable challenge for both juvenile correctional and health care officials...for example, although room confinement remains a staple in most juvenile facilities, *it is a sanction that can have deadly consequences*....In addition, because data also showed that suicides can occur at any time during a youth's confinement, with the same number of deaths occurring within the first few days of custody intake screening for the identification of suicide risk should be viewed as time-limited. Instead, because youth can be at risk at any point during confinement, the challenge will be to conceptualize the issue as requiring a continuum of comprehensive suicide prevention services. (Emphasis added).

### THE CASE FOR LIABILITY

It has been over a decade since the U.S. Supreme Court's ruling of *Farmer v. Brennan* [511 U.S.825 (1994)]. Although concerned with the liability of jail officials, the decision has significant implications for the management of juvenile facilities as well. As Robertson (2004:1) explains: "This decision mandated a subjective form of deliberate indifference, in which liability for a

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constitutional tort arises when ‘the official [actually] knows of and disregards an excessive risk to inmate health and safety’.” He goes on to state (p.2): The *Farmer* Court operationalized the “actual knowledge” requirement as follows:

- To incur liability, “the official must *both* be aware of the facts from which the inference could be drawn that a substantial risk of serious harm exists, *and* he must also draw the inference.”
- When awareness can be inferred from circumstantial evidence, especially when the risk is “obvious,” the trier of fact can conclude that the official “must have known” of the danger.”
- While ignorance of obvious risks will remain a defense, “[the] official would not escape liability if evidence showed he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to be exist.

Robertson (2004:2) also concludes: “The Court handed inmate Farmer a victory of sorts by ruling that his failure to inform prison staff of the dangers facing him did not preclude a finding of actual knowledge.”

### CORRECTIONAL STAFF RESPONSIBILITIES

In addition to examining detained youths at the time of intake to identify risks for such problems as mental illness and suicidal ideation, among others, the failure to continue to observe, case manage, diagnose where indicated, train staff appropriately on suicide prevention techniques, and constantly observe youth can lead to disaster, including successful suicides. This also holds true for various policies and procedures that are commonly found in institutional settings, including leaving youth unattended or unobserved, the over-use of quiet rooms where youths are alone and sometimes without direct supervision, and such a ‘stupid’ approach to youth with suicidal ideation who are placed in suicide prevention rooms with shoelaces and/or belts!

Court and correctional administrators are obliged not only to train staff appropriately in suicide prevention techniques, they also sometimes fail to ensure that medical and correctional staffs regularly communicate with each other. No one should require a youth care worker to ‘diagnose,’ but it is incumbent upon clinical staff to train line-level staff to “observe and report” any changes in a youth’s demeanor or behavior that *may* be symptomatic of underlying suicidal ideation, mental illness, and/or the side effects of various drugs not only at the time of intake, but throughout the youths’ detention. Care worker staff are – or should be – in constant observation of youths – always within sight or sound of them. Except for the child who first comes into the facility, these workers truly get to know the children under their supervision and, therefore, should be acutely aware of changes that may signal problems.

Additionally, proper training should alert these line workers as well as their supervisors to the research findings about suicide, such as when they are likely to occur, the reasons why some

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children respond negatively to events outside of their control, peer bullying, existing depression, self-mutilation and prior suicide attempts, histories of physical and sexual abuse, the use of illicit substances, the failure of parents to visit or the death of a significant other, adverse responses to certain drugs, existing mental illness, and/or a sense of hopelessness regarding future institutionalization or the potential (unwanted) disposition of their cases, among others. (See, for e.g., Rowan & Hayes, 1995; Prison Health Services, 2001, & Pima County Sheriff's Department, n.d.)

As the *Farmer v. Brennan* ruling indicates, the failure of administrators and supervising staff to be sensitive to the potential of suicides among residents and/or the specific knowledge staff may have about a youth's realistic likelihood of suicide attempts and such staff not taking appropriate action unquestionably will lead to litigation when a successful suicide does occur.

### THE ROLE OF THE JUVENILE COURT JUDGE

The history of juvenile justice clearly reveals that the role of the judge is one not only that is concerned about hearings and trials, etc., it is one that also requires advocacy for the well being of those juveniles coming before the court. Additionally, while the judge may or may not have administrative responsibility for managing probation and/or detention services, it should be his or her responsibility to hold staff for ensuring that all youths are treated fairly, humanely, and according to constitutional, civil, and human rights. Where there is a court administrator, this becomes his or her derivative responsibility, as well as it should for the chief probation officer.

It is also incumbent upon these administrators to ensure that a detention facility in his or her community is staffed with appropriately trained personnel, that the detention center has explicit policies and procedures that are enforced by top-level staff, and that there is routine and constant monitoring of programmatic activities. This also means that administrators, as advocates, should ensure that the detention facility has the necessary and appropriate resources, including mental health staff, to accomplish its assigned duties and responsibilities. There should also be procedures in place to make sure that these juvenile facilities guarantee the safety of the youths in confinement, particularly those at risk for self-harm.

What Hayes (2004:48) concludes about training for correctional staff unquestionably has significance for the role an administrator should have with regard to ensuring that such training occurs:

Staff are at a distinct disadvantage in both the identification and management of suicidal youth if they have received little or no training in suicide prevention. Bluntly stated, young lives will continue to be lost and jurisdictions will incur unnecessary liability from these tragic deaths unless administrators create and maintain effective training programs.

### SUICIDE PREVENTION PROGRAMMING

Hayes (2004:45-46) suggests that all juvenile correctional facilities achieve total compliance

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with the following eight suicide prevention components:

1. **TRAINING:** Eight (8) hours of initial training in suicide prevention followed by a minimum of three (3) hours of annual, in-service training.
2. **IDENTIFICATION/SCREENING:** Intake screening immediately upon confinement and prior to housing assignment with an appropriate form indicating risk factors, with referral for mental health assessment where indicated.
3. **COMMUNICATIONS:** Enhanced communications between transporting officers and family, between and among facility staff, and between facility staff and the suicidal youth.
4. **HOUSING:** Isolation is to be avoided and youths always should be within proximity to supervising staff.
5. **LEVELS OF SUPERVISION:** Two levels are recommended: (1) *close observation* reserved for youth not actively suicidal at staggered intervals not to exceed 15 minutes; and (2) *constant observation*, reserved for the youth who is actively suicidal and at intervals not to exceed every five minutes.
6. **INTERVENTION:** Intervention should be threefold: (1) all staff trained in CPR and first aid, (2) an immediate response when a youth is found to be attempting suicide with an immediate call to medical, and (3) staff should never presume the youth is dead, so life saving measures should be instituted immediately.
7. **REPORTING:** When there is an attempt or an actual suicide, appropriate officials should be notified immediately and all involved staff should be required to submit written incident reports.
8. **FOLLOW-UP/MORTALITY REVIEW:** All involved staff (as well as youths) must be offered critical incident debriefing and a "psychological autopsy" should be conducted to identify factors that contributed to the suicide. This should be done to determine what factors contributed to the suicide, including personnel behavior, organizational policies and procedures, and what changes in protocols are indicated.

### SUMMARY

In the final analysis, while it may never be possible to eliminate suicide attempts and gestures among detained youth, there is hardly an excuse for a successful suicide if appropriate policies, procedures, and training are in place and are enforced with proper supervision. It is inevitable that some youth unfortunately believe that life is not worth living, while others may attempt suicide in a manipulative manner as an effort to gain attention. Moreover, if staff are properly trained and constantly alert to possible precipitating (risk) factors, successful suicides can and

should be averted. Therefore, supervisory personnel must hold all staff accountable for ensuring all youths are constantly monitored and all appropriate policies and procedures regarding suicide prevention are implemented.

While court administrators and chief probation officers may not have ultimate responsibility for the administration of detention services, they should accept the task of providing oversight to ensure that detention facilities are appropriately programmed and administered in a manner that ensures youth safety, human and civil rights are protected, and that with appropriate advocacy

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that ensures the facility has sufficient resources to accomplish its assigned duties. This also holds true for statewide facilities that may be located within the community and to which the court commits youth.

By working in concert, top-level court staff together with detention facility staff should collectively be able to guarantee a level of youth safety that leads not only to well-managed operations, but also to an organization that is committed to the elimination of successful suicides by detained youth and the litigation that is likely to ensue as a consequence.

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