In Harm's Way

A Primer in Detention Suicide Prevention

The Lane County Model
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Dedication

This manual is dedicated to the spirit of nurse practitioner Ginny Gnau. Ginny, in her honesty and care of youth, showed us all the way to make detention a safer place. Her patience, courage and steadfast insistence on the best for detained youth created a legacy that those who knew her are now blessed to carry on. Thank you Ginny.

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I, your name, having been trained in suicide prevention, do hereby accept responsibility for the safety of the youth under my care in facilities name. I pledge to be the staff who makes a difference and keeps the youth safe. I pledge to follow my hunches, use good my judgment and caring concern in keeping the youth under my care safe from self harm.

Preface

This primer is written to benefit those who work in juvenile detention and residential settings. It is not an academic study, although we have reviewed much of the available research. It encompasses the lessons learned in providing a safe setting for youth for many years in a county detention center and is primarily based on empirical data and not on controlled scientific studies. We hope, as such, the practitioner "in the trenches" will find it useful in the safe operation of their facility(s).

In the mid 1980's our detention center was a mess. We were chronically overcrowded and understaffed. In a facility built for 36 we routinely had 50-60 youth. Youth were housed in our small gym, in our dayroom and even the classrooms were turned into dormitories after school was over.

Because of this overcrowding we had the emergence of several serious safety issues related to inability to deliver adequate supervision and attention to the youth under our care. We had a dramatic increase in physical altercations (typically between youth) and we had a dramatic rise is suicide attempts.

As a result of the latter problem we began searching out detention appropriate suicide prevention programs. We also began asking the experts and attending the trainings they presented. We found there were very few resources for dealing with suicide prevention in a detention setting. There was (at that time) no research in our area and the professionals uniformly told us we had the most dangerous type of setting for youth suicide. This was not heartening to say the least. We promptly set out to invent our necessary wheel.

Ginny Gnau, detention NP, was the first to stand up to the difficulties we were having in detention in terms of the need for a coherent suicide prevention program. She contacted David Mace, contract psychologist for the Department of Youth Services, and Jim Leppard, then head of training and programs at DYS. They initially started looking into the problems. Quickly added to the group were Viriam Khalsa, detention manager and John Crumbley, intake mental health specialist. These 5 staff formed the initial core group.

Ginny later retired and shortly thereafter passed away. Jim Leppard was promoted to management of the Intake Unit. His wisdom and concepts continue to be seen throughout the suicide manual.

The prevention panel expanded and included Billy Mihaloew, MA, and John Aarons, MA and eventually Wally Harms, LCSW, Mike Thompson, MA, Martin Starr LCSW, and Frank Feuille MA.

One of the first things the initial panel did was to contact Dr. Peter Lewinsohn at the Oregon Research Institute. He introduced us to a bright new psychologist named Dr. Paul Rhody who provided us with research and program development in this area for more than a decade.

Once an intern with DYS, Janelle Jorgenson, MA, joined the team at ORI and has been instrumental in helping to develop treatment programs.

The resulting program has thus been a compilation of a host of different sources with an eye to practical application. We are indebted to the many staff at the department of Youth Services who added their expertise to this suicide prevention effort.

We had strong support from Steve Carmichael, LCSW, now retired Director of Youth Services and Chuck Ryer, MA, JD., past Assistant Director of Youth Services. We continue to have the same support from Lisa Smith, current Director of Youth Services and Lynne Schroeder MA, JD., Assistant Director.

This program would not have succeeded without the support and involvement of several "generations" of Juvenile Court Judges. Starting with Judge Hargreaves, who understood the issues and was a strong advocate for youth, Judge Ann Aiken, now on the federal bench, who provided a clear voice on the need for youth safety in detention, Judge Pierre Van Rysselburgh, who provided insight and a strong understanding of case law, and now with Judge Kip Leonard who has consistently supported, promoted, and provided strong leadership in youth services. Although they are judges, they are also some of the best social workers and problem solvers I have met.

The Lane County Commissioners, throughout the 12 years we have worked on this, have provided additional funding even during tough times, as well as policy support.

The psychology interns that we have had have also added a lot over the years. This included Dr. Heather Scott, Dr. Nick Hong, and Dr. Jody Knott. Dr. Vickie Curry was generous in contributing much of the material in the manual on stabilization functions.

Ginny Gnau, NP, did the initial work on adding the medical sections of the manual, which we could not find anywhere else. Lynnette Kline, PA, Anita Mace, RN and Patti Guthrie, RN, have supplemented the medical material.

An important part of the suicide prevention team has been the many detention Groupwork staff that operate detention and provide direct care to the youth. We want to note the outstanding skill and dedication of the detention staff. They are the real cornerstones of this program.

The best advice we received in this project was from the youth in detention. Without them this program would not exist. We continue to be amazed at how helpful and cooperative the youth are in assisting us to address the safety of youth in detention. They cared not only for their own safety but the welfare of their peers.

The many 2 am phone calls summoning us to provide psychological support to a youth who had just been intercepted from an attempted suicide are (fortunately) very rare these days. Prompt communication to the legal and County administration provided a cap on our detention population. Funds were eventually provided for physical changes in our

setting that reduced the available means for youth to hurt themselves. The process of experimentation, review and redesign of the suicide prevention and intervention program gradually produced a workable and tested system. Support from all levels of county and youth services administration guaranteed that the changes were not just cosmetic but "stuck" and became part of the detention way of doing things, part of the culture.

Policies

Adolescent Suicide Prevention and Staff Support

LANE COUNTY
DEPARTMENT OF YOUTH SERVICES

TO: Staff

FROM: Lisa Smith

DATE: December 12, 2001

RE: *Adolescent Suicide Prevention and Staff Support*

Dealing with high-risk youth, especially when they are suicidal, can add stress to our lives in doing our job. It is important to keep in touch with any levels of depression we may have ourselves and any sense of hopelessness that might result. All of the supervisors at Department of Youth Services are understanding and supportive of emotional distress. If you feel that you need help, the following resources are available:

1. Going to your supervisor for support.
2. The county has an Employee Assistance Program called Directions. Each employee is permitted up to six visits for each personal concern. A referral is made if additional treatment is necessary.
3. Staff medical plans consist of:
    a. Blue Cross - $2,000 outpatient mental health counseling for a 24 - month period.
    b. CHC - $2,000 outpatient mental health counseling for a 24-month period.

    Coverage is 80% and must be pre-authorized.

Lane County Department of Youth Services

Policy Bulletin # 800
November 1990

Suicide Prevention

The Department of Youth Services is responsible for the welfare of youth committed to Detention. This responsibility includes protecting the youth against suicide. The most effective measure is accurate identification of suicide risk, and effective prevention.

To achieve these ends, the Department of Youth Services adopts attachment A, attached hereto and made a part hereof, as standard rules of procedure for evaluating suicide risk In cooperation with Oregon Research Institute, the Department has conducted comprehensive research toward development of a precise suicide risk inventory.

The attachments provide a set of questions and a method for evaluating the answers. The answers must be obtained and rivaled on **every case entering Detention.** If the information is already on file, it shall be dated to reflect present circumstances.

Youth held in secure custody at intake should be evaluated as soon as possible after admission. The evaluation shall be conducted by the counselor on duty in the intake control room, or other trained staff. If the youth enters detention directly from court, the evaluation shall be conducted by the Groupworker who does the admission processing.

Chapter 1 - Suicidology

History of Suicidology

The word suicide itself has an interesting history. According to Edwin Shneidman, who did the most prominent work in terms of Suicidology in the twentieth century, the word "suicide" did not appear until the 16th century. "In this etymological sense, it was not possible, before about 1635, to commit suicide. One could, of course, do harm to oneself, starve oneself to death, throw oneself upon one's sword or off one's roof, or into one's well – but one could not 'commit suicide'." Suicide and its interpretation is difficult because it has to be looked at from a religious standpoint, a philosophical one, a medical one, legal issues, sociology, as well as psychological. One's philosophy of what happens after death has been debated over the last two millennia. Early in Christianity, being a martyr for one's moral values simply released life from the body to be transformed into the spirit. The concept of sin in relationship to taking one's own life was provided at the beginning of the 5th century, by St. Augustine, but related only to the narrow area of martyrdom due to zealous religious beliefs. "Suicide by reason of physical or emotional suffering, old age, altruism toward others, personal honor, illness, and the like – in short, the very reasons with which 99.9 percent of suicides committed nowadays are associated, were not targeted by Augustine's writing." (Battin, 1982) (Definitions of Suicide, Shneidman, p. 31). In 693, the Council of Toledo resolved that acts of suicide could result in excommunication. St. Thomas Aquinas, in the 13th century, upped the stakes for killing oneself to being a mortal sin. Although there have been interpretations of the Bible that support suicide being wrong, there is nothing directly in translation in the Old or New Testament that forbids suicide. The debate, in terms of classifying suicide, its history, and all the philosophical complications is summarized in Shneidman's 1985 book, Definitions of Suicide.

The scientific study of suicide started with the publication of Le Suicide, by Emile Durkheim, in 1897. Durkheim tried to break suicidal acts into four types. The first is the altruistic suicide, which is where the society itself requires the death. This includes hara kiri, where the customs require an honorable death. The main kind of suicide that would be seen in the United States was the egoistic. This is where the individual kills himself because the ties to the community are weak and the demands to live are minimized. The third type is anomic, which Durkheim explains as a special kind of estrangement from previous ties, which are suddenly disrupted. This shock of immediate loss, as of a job, friends, family, brings on the suicide. The last is the fatalistic suicide, where the person feels they have no personal freedom or hope for a future.
Shneidman, himself, in 1968, tried to break down suicidal acts into three categories. The egotic was based on intra-psychic debates, which he called a "struggle in the mind". At this point, relationships and any connectedness with one's environment are lost. The next is a dyadic suicide, in which there is a sense of unfulfilled needs dealing with significant others. These kinds of suicides are primarily social and involve the breaking of those

social ties. The third is the agenerative suicide, which results in the individual feeling a loss of membership "in the march of generations", or basically a loss of a sense of belonging. This affects a person when they cannot developmentally grow and mature with age.

In 1984, the American Psychiatric Association came up with six classifications of why people would want to kill themselves. The first is the rational, which is basically to escape pain. The reactive follows the loss of something important in one's life. The vengeful is to punish someone, or the basic "I'll show you, I'll kill myself." The fourth is the manipulative, which is mainly used to get one's way from others, and as will be talked about later, can often have fatal consequences. There is the psychotic, which fulfills the delusion of the individual, and the accidental suicide, which happens all too often, where the person has decided to kill themselves, but at the point that death is arriving, reconsiders.

There is a large cross-section of definitions of what suicide actually means. They range from the direct or intentional taking of one's life, to a more complex definition that Shneidman contributes to the "Western world", "Suicide is a conscious act of self induced annihilation, best understood as a multi-dimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution."

The vocabulary dealing with suicide can also be interesting to investigate. The term "suicide" basically refers to a death that was self - inflicted. An attempted suicide is where the individual had full desire to kill himself, and should have, but for some reason unintentionally survived. Para-suicide or Quasi-suicide is basically a type of attempted suicide in which the means were not lethal. Quasi-suicidal actions are more suicidal gestures, or actions that would appear to be suicidal, but in actuality, the individual has no interest in bringing about death. There is also a whole array of sub-intentional deaths, which are mainly high-risk activities. In sub-intentional death, the person may not actually intend to kill themselves, but they put themselves at high risk for losing their life. This is often at an unconscious level. We often label this as self destructive or high-risk behavior.

The study of suicidology can be both complex and controversial, intermixing with our own belief systems and a desire to understand death. It is important to break past these scientific and philosophical inquiries when dealing with the issues of suicide by an individual. Perhaps Shneidman also best summarizes this when he writes that categorizing of suicides "is of practically no use in the clinic, where the task is saving lives." You will find when you are working with the children and teenagers that we spend a good deal of our day with, that each is unique, and needs to have interactions with others that are real, and not academically structured.

Rates of Suicide

The research on rates of suicide is in itself complex in that not only do you have to define what a suicide is, but determine that one actually took place. When the act of suicide has implications for families in terms of their religious beliefs, it is easy for the findings to become something else that can help the family cope with their loss. It is also very hard to determine what was on a person's mind in terms of intention. Was a drug overdose due to a loss of cognitive faculties, or as a result of an initial intention to kill oneself? Different countries are tied into different social patterns where the record keeping varies. It is also hard to decide how old one has to be before they can understand the concept of death. Is a child of five who runs into traffic aware of the risk that he is placing his life at? The eight year old who gets a response from his parents because he threatens to kill himself, likely has little understanding of the concept of death itself. There are, nonetheless, some trends that we see in terms of demographics, that help our understanding of why people may want to kill themselves.

Note: Compare the 1980 studies with a more recent one through the World Health Organization in terms of trends in this area

Suicide Rates (per 100,000)

(most recent year available, as of October 2000)

Country	Year	Males	Females
Albania	1993	2.9	1.7
Argentina	1996	9.9	3.0
Armenia	1997	3.4	0.8
Australia	1995	19.0	5.1
Austria	1998	30.0	9.2
Azerbaijan	1997	2.3	0.5
Bahamas	1995	2.2	0.0
Bahrain	1988	4.9	0.5
Barbados	1995	9.6	3.7
Belarus	1998	63.4	10.1
Belgium	1994	31.2	11.4
Belize	1995	12.1	0.9
Brazil	1992	5.6	1.6
Bulgaria	1998	26.2	10.6
Canada	1997	19.6	5.1
Chile	1994	10.2	1.4
China (mainland)	1994	14.3	17.9

China (Hong Kong SAR)	1996	15.9	9.1
Colombia	1994	5.5	1.5
Costa Rica	1995	9.7	2.1
Croatia	1997	31.5	10.8
Cuba	1996	24.5	12.0
Czech Republic	1998	25.3	6.5
Denmark	1996	24.3	9.8
Ecuador	1995	6.4	3.2
Egypt	1987	0.1	0.0
El Salvador	1993	10.4	5.5
Estonia	1998	59.4	10.5
Finland	1996	38.7	10.7
France	1997	28.4	10.1
Georgia	1990	5.4	2.0
Germany	1998	21.5	7.3
Greece	1997	6.2	1.0
Guatemala	1984	0.9	0.1
Guyana	1994	14.6	6.5
Hungary	1998	51.1	14.7
Iceland	1995	16.4	3.8
India	1995	11.4	8.0
Iran	1991	0.3	0.1
Ireland	1996	19.2	3.5
Israel	1996	8.2	2.6
Italy	1996	12.4	4.2
Jamaica	1985	0.5	0.2
Japan	1997	26.0	11.9
Kazakhstan	1997	51.0	9.4
Kuwait	1997	1.4	2.4
Kyrgyzstan	1998	18.4	3.7
Latvia	1998	59.8	12.2
Lithuania	1998	73.7	13.7
Luxembourg	1997	29.0	9.8
Macedonia FYR	1997	11.5	4.0

Mexico	1995	5.4	1.0
Netherlands	1997	13.5	6.7
New Zealand	1996	23.4	5.9
Nicaragua	1994	4.7	2.2
Norway	1995	19.1	6.2
Panama	1987	5.6	1.9
Paraguay	1994	3.4	1.2
Peru	1989	0.6	0.4
Philippines	1993	2.5	1.7
Poland	1996	24.1	4.6
Portugal	1998	8.7	2.7
Puerto Rico	1992	16.0	1.9
Republic of Korea	1997	17.8	8.0
Romania	1998	21.3	4.2
Russian Federation	1997	66.4	12.3
Singapore	1997	14.3	8.0
Slovak Republic	1995	23.4	4.6
Spain	1996	12.8	4.3
Sri Lanka	1991	44.6	16.8
Sweden	1996	20.0	8.5
Switzerland	1996	29.2	11.6
Syrian Arab Republic	1985	0.2	0.0
Tajikistan	1992	5.1	2.3
Thailand	1994	5.6	2.4
Ukraine	1998	51.7	10.6
United Kingdom	1997	11.0	3.2
United States of America	1997	18.7	4.4
Uruguay	1990	16.6	4.2
Uzbekistan	1993	9.3	3.2
Venezuela	1994	8.3	1.9
Yugoslavia	1990	21.6	9.2
Zimbabwe	1990	10.6	5.2

World Health Organization, Geneva, October 2000

Top 10 Suicide Rates (per 100,000)

(Most recent year available, as of October 2000)

Country	Year	Males	Females
Lithuania	1998	73.7	13.7
Russian Federation	1997	66.4	12.3
Belarus	1998	63.4	10.1
Latvia	1998	59.8	12.2
Estonia	1998	59.4	10.5
Ukraine	1998	51.7	10.6
Hungary	1998	51.1	14.7
Kazakhstan	1997	51.0	9.4
Sri Lanka	1991	44.6	16.8
Finland	1996	38.7	10.7
*For reference United States of America	1997	18.7	4.4

Highway of Life

Risk Factors

Primary Risk Factors

There have been a number of research studies which have tried to identify risk factors with adolescent suicide attempts. Research dealing with actual suicides and the use of psychological autopsies are more difficult to quantify. What we tried to do was look over these studies and find the areas that had the most agreement. The following is a list of those factors:

1. Age, gender and race- societal factors can change, and in fact have in the United States. Generally by age fifteen, youths are just as likely to commit suicide as anyone of other ages, at least until the increase that is seen with the elderly. There are differences between men and women in terms of attempted suicides, although a lot of this is caused by the manner in which they go about doing it, and even those patterns have been changing. There have been racial issues showing that Caucasian Americans are at higher risk than Hispanic or African Americans. Part of the rationale for this is that issues of poverty require youths from minorities to learn to be more resilient.

2. Precipitants. It was noted that three days prior to a suicide the following events could occur – A. Arguments – 15 percent,
   B. Relationship break-ups – 9 percent,
   C. Disappointments – 9 percent,
   D. Work problems – 8 percent,
   E. School problems – 6 percent,
   F. Threats of separation – 5 percent,
   G. Victims of assault – 2 percent.

3. Depression – This spans the range between being sad about being in detention to a deep-rooted major depression. This topic will be reviewed more extensively later.

4. Hopelessness and lack of coping skills – Regardless of intelligence or academic background, most of the kids that we see in detention have a significant lack of problem solving or coping skills. Hopelessness can result. It is important to differentiate hopelessness from helplessness. In helplessness the teenager feels that they cannot do things or work through problems themselves. When hopelessness sets in, the feeling becomes that no one else can help them either and this provides for a more desperate or trapped feeling.

5. Conduct disorders – We use this term in the broader sense to include oppositional defiance and in general any behavior that would result in one's breaking the law.

6. Substance abuse – Generally we don't consider cigarette smoking as part of this, but it certainly ranges from someone who will drink alcohol with his or her friends on the weekend to an intravenous drug user.

7. Exposure to others suicidal acts – Has any friend or family member, or anyone in close association tried to or committed suicide?

8. Prior suicide attempts – Is suicidal behavior already present as a way of trying to solve problems?

9. Dysfunctional family patterns - This has become a rather broad term, perhaps best defined here as family patterns that have lacked the structure and support that a child needs to develop appropriately within our society.

Note: Will expand on each of these briefly in terms of research studies

Secondary Risk Factors

Secondary risk factors, or those factors that are reported in some studies but perhaps not on a consistent basis are:

1. Personality – What are the attributes of personality that are more likely to provide for either a suicide attempt or suicide? Teenagers are still developing their personality, and there is always caution in terms of dealing with personality disorders with teenagers. A lot of the work in this area deals with Borderline Personality Disorders in adults, or attributing borderline types of behavior to teenagers. Especially personalities that are very volatile in terms of their emotions.

2. Previous mental health treatment – If mental health treatment has not alleviated feelings of depression and frustration in dealing with life, this may add to a sense that the teenager cannot be helped.

3. Physical illness – It is not just the physical disability that an illness or impairment can bring, but an impulsive desire to end whatever pain or limitations are associated with it.

4. Firearm availability – The main problem with firearms is that they are a very quick and often impulsive ways to commit suicide.

5. Completed suicide by family members – Is there a family pattern?

6. Low seratonin levels – What extent does the biochemistry of the brain play in a person's taking an action?

7. Time of day and season – The blues and gray depressions. How holidays and seasonal memories play on our moods. A lot of this is individual.

8. Anger and resentment - Adolescents that are seen in detention facilities often will deny depression, while readily showing anger, frustration, and boredom. When is this resentment generalized to life itself?

9. Mass media reports of suicide – On one case this can have a significant affect, and with others it can be almost meaningless. It is always important that whenever you are dealing with the media to insist that they present the community's emergency suicide numbers and resources.

10. Pregnancy issues – This affects both boys as well as girls.

11. Runaway behavior – There are a lot of different ways of running away and that includes death.

The studies dealing specifically with suicidal behavior and conduct disorders and the demographical studies that were done by the Oregon Research Institute in collaboration with the Lane County Juvenile Department will be discussed toward the end of this chapter.

Detention Risk Factors

When the initial group on the Suicide Prevention Panel met over a decade ago, we started to draw some basic conclusions about suicide risks in detention, which unfortunately still are prevalent. These four conclusions are:

1. When the primary factors for adolescent suicide are reviewed, all the teenagers in secure programs are at moderate to high risk.
2. There is little research dealing with high risk populations outside of psychiatric hospitals
3. Assessment devices are currently defined between normal and at risk populations
4. Although completed suicides are unlikely to occur in detention, brief therapy interventions need to be developed to prevent future attempts after release.

When you look at the primary and secondary risk factors as well as precipitants, you have pretty much described the typical kid that comes to a juvenile corrections facility. It is difficult to actually do research within a juvenile corrections facility without making compromises to the actual research design. The need to develop new methodologies has been a central issue as we try to understand the dynamics of suicidal thinking with these children. Peter Lewinsohn has done extensive work with assessment devices in terms of depression and suicidal behavior, and in consulting with him, it was very clear that there was nothing to differentiate within this population. We took several different devices over the years, and found that they were pretty accurate in letting us know that our best-case scenario was that we had a high-risk teenager on our hands. There are completed suicides in detention facilities and state training schools. Our aim in this manual is not to talk about completed suicides that occur while children are home or in non-secure

settings, in that this presents a different set of issues. Although Lane County has not had a completed suicide within its detention facility, this certainly has not been the case in facilities throughout the state of Oregon, or in the United States. They often appear in clusters, and one institution, a few years ago, had as many as five within a little over a year. What can we do to prevent them? How do we identify someone who is more likely than not to try to commit suicide? Our best answer is that we are trying to learn, and we are trying to make facilities for incarcerated youths safer, not only in terms of design, but in our ability to respond to the needs of these youths so that other alternatives besides suicide will be used by them.

Methods of Suicide (Risk Analysis)

Methods of suicide can vary significantly, not only on the basis of gender, but also the socialized background and access that each individual has. One study dealing with ages 10 to 24 showed that 25% of males, and only 17% of females used firearms, although the ingestion of chemicals and drugs was only 8% for males but 31% for females. Over the last decade, the use of firearms has become more acceptable to women in our society as a means of committing suicide. At one point, 52% of children under the age of 15 completed suicides by hanging. It is likely that this percentage is even higher in terms of detained youths for hanging or suffocation. Deaths that have occurred because of ingestion have decreased, but this is primarily due to medical intervention. Most poisons take time to react, which gives an individual an opportunity to reconsider and seek help, or to be discovered. Firearms are certainly more lethal, and even when someone survives from an intended fatal gunshot wound, it is often to the head, and results in permanent disabilities.

In detention facilities, the methods of suicide have to be reviewed in terms of an understanding of the creativity that these youths have. It is not that any facility can be made completely safe, but if a child, while in detention, needs to use ingenuity, that takes thinking time and lessens the impulsive nature of the act. The main area that needs to be addressed is to remove the ability to harm oneself impulsively. Second to that, we need to be able to respond to those areas in which a youth can provide self harm in our delivery of medical attention. This is why it is so important to have camera observations as well as window checks. Be particularly observant of the kinds of behavior that would appear to be rehearsal. Anything in which the child would be tying something around their neck or beginning to do even light head banging, should be of concern. The simple infliction of pain is not necessarily suicidal. The pain that is caused by carving on oneself may be inversely related to actual suicide attempts, yet this behavior can cause harm even if not at a lethal level.

Since hanging appears to be the most used method for completed suicide in detention, care has been taken in all the rooms to try to minimize the accessibility of anything to hang from. One of the reasons for the concrete slabs is that one of the initial cases that was worked with by the panel dealt with a boy who hung himself underneath the bed, despite the fact that there was only approximately an 18 inch space there. He was found in the act, but had already reached the point of unconsciousness. If not discovered, he

would have died. It is not required for someone to be suspended to actually hang himself or herself, but only to put themselves in a situation where there is sufficient pressure against the throat to interfere with the ability to breathe.

Another major concern is ingestion. Close accountability for anything that might be toxic needs to be maintained at all times. Wherever possible, non-toxic chemicals have been substituted for use in cleaning and other purposes. When somebody is on risk level 3 or 4, they should always be closely supervised, and preferably never allowed to be around toxic chemicals.

There are a variety of things that can be used for cutting one's wrists, and this includes everything from smuggled in razor blades to sharpened pencil leads, and even a good set of fingernails. Although we restrict items like pencils in the rooms of levels 3 and 4, it is always important to remember that all of these children are at high risk for possible suicide attempts. It is therefore necessary to be observant in terms of both any changes of mood as well as accessibility to items like paper clips and staples, which could be used for cutting. It is unlikely that the slicing of one's wrists would be fatal, and even a small amount of blood in one of the cells, has the appearance of a major wound.

Can we eliminate any methods that these teenagers have in trying to harm or kill themselves? The answer clearly is no, but we can minimize its likelihood. It is important to note that most of the time, which somebody is actively suicidal; this is usually associated with a deep depression that can interfere with cognitive processes. Unfortunately, when somebody has resolved himself or herself to commit suicide, there tends to be a drop in their depression. Again, every one of these cases is different, and every one of these youths has time to think things through and can make a well thought out plan to get by us. Our best answer to those kinds of suicidal directions is to insure that they have access, during this thought process, to talk with staff and perhaps seek out some help.

Larry, Moe, Curly

Cognitive States in Suicide

Thinking Patterns in Suicide

A more thorough discussion of this was included in the book on adolescent suicide (reference). It is easy to look at these patterns as being "thinking errors", but one of the reasons that most people can relate to them is that we tend to do at least some of these, if not all of them, at some point in our lives. It is important to be aware of how these processes go, and the solution is not simply to tell you "hey, you're doing a thinking error and need to stop doing that." There is a need to discover insight into how they are thinking and guide them to more constructive thinking patterns, which will provide a longer lasting solution for them. This section is closely intermixed with the development of coping skills and how to deal with stress in one's life.

This particular area is covered in a variety of coping programs, like Options to Anger, as well as Coping with Life. Some examples of the pattern of negative thinking that we often hear are, "Why should I know?" "I never get this stuff."; "This is just like school." "I suck at school." "I'm never getting out of here anyway." "My PO never comes to visit." "He's out to get me." "Life sucks." "You suck." "I hate this stuff." "I might as well be in my room." "I hate my room…" All of us who have worked with children know, when they get into negative thinking they can really get on a roll.

Some of the more specific patterns to be aware of are:

1. Negative thoughts – this is somewhat of a general category of just feeling anything, but in the negative and without any constructive stance. "I hate …" or "It sucks."
2. Exaggerated thoughts – this is basically making a mountain out of a molehill. "I've been in detention for years, and none of the staff will ever talk to me." Although this is certainly possible, it is not likely.
3. Low Self Esteem – this is generally putting oneself down. "I'm such a loser."
4. Self-defeating thoughts – this is the anticipation that no matter what you do it is just not going to work out the way you want to. "No matter how hard I study I always flunk the test." "No matter what I do, they always find something to blame me for."
5. A gloomy worldview – this is basically the belief that even if I'm OK the rest of you aren't. "They system sucks", or "Unless you're born with money you can't get the opportunities to be successful." This is usually taking the negatives and projecting them onto your environment.
6. All or nothing thinking – this provides for absolutes and tends to negate compromise, "If I'm not out of detention by Friday, I'll be here forever." "If I can't have a Rolls Royce, I can't drive a car."
7. Overgeneralization – this is taking one incident and expanding on it. "You weren't able to talk to me right now, therefore you don't like me."
8. Disqualifying positives – this is not giving oneself credit for even the things that go right. "Yeah I know we won this game, but we'll never win the next one."

9. Catastrophizing – "I have no future." "Everybody knows I've been arrested and in here." "All my hopes are gone."
10. Personalization – this is where something, which is basically out of your control, is assumed to be under your control. This is often seen in sports fans that feel that their team would have won if they had just cheered longer, or that they jinxed the team by being present.
11. Rigid thinking – this is basically a thinking style that doesn't allow for any additional input. "I've got the answer." "You don't need to tell me what to do."
12. Social Isolation – this is not only in terms of words but also of actions, where one just places themselves in a position where there is nobody around to provide them with assistance. "I just don't want to talk, leave me alone."
13. Not goal oriented – it is important to live in the present, but it is also necessary to have a direction in one's life. "Not now."

Negative thinking patterns are common with all of us. It is not that we shouldn't do "thinking errors", but it is part of normal behavior and we try to have these adolescents understand that negatives need to be balanced with positives and to try to be aware of the logic about why they are feeling upset. It is important to understand where these youths are coming from when they use repeated negative statements. They want to be heard and to have their emotions understood. Try not to rush into being judgmental. "You say you're really sad, and because you're in detention you have nothing to look forward to in your life?" The first step therefore is to get the youth to understand that his desperation is heard, even if it is in the negative, and then you can work toward rephrasing or redirecting him to a broader and more logical insight. There is no fixed formula on what to say, but at least initially, being understanding goes a lot further than being judgmental. There are times where it is beneficial for a teenager to just verbally let off some steam, as long as they maintain being behaviorally in control. A summation can be as simple as "Now that you've got all that out, do you feel better?"

The area that we want to concentrate on is when any of these negatives address harming others or self. Many times a statement along the line of "I just as soon be dead", or "You'll be sorry I'm in here" will be made and needs to be taken seriously. It is important not to mistake a genuine cry for help that is stated in a negative as simply being a "thinking error".

Reality Check

Motivational Patterns in Suicide

(reference) Trying to be objective when reviewing a child for possible suicidal intent is very trying, even for clinicians. Parents and teachers are often the last to recognize depression and suicidal ideation in their teenagers. There are three basic clusters of motivational patterns that usually show suicidal behavior:

1. **The avoidant function** – generally in suicide attempts where the person should have died but for some unexpected circumstance, the stated intent is not death. Many of the people that I have talked with, both adults and youths, have simply wanted to sleep or put themselves in a position of not having to deal with the stresses in their lives. This *escape from stressful situations* is a compelling motivator when no other options are seen as being available. They *feel overwhelmed* by problems that they are having in their lives, or the perceptions of problems. These events are not only depressive, but can deal with "psychologically painful events" that at least help aggravate the depression. They end up with a *lack of perceived control* in dealing with those stresses in any adaptive manner. Basically they can't handle the current circumstances in their lives and find no other alternatives that are under their control.

2. **The control function** – this amounts to a *perceived loss of contingent reinforcement* where the things that make life important to us have been taken away, or at least seem to be gone. These are generally major crises of faith, security, and relationships. This is a factor in why people can become suicidal after losing their job, having someone close to them die, divorcing, or other major changes in one's life that are not under the individual's control. At first this provides a sense of "helplessness" which is basically that they are unable to come up with any means of regaining control in their lives. They see themselves as inept at handling their problems. This turns into a sense of "hopelessness" where not only do they feel that they can't help themselves, but that no one else can either. Helplessness often directs itself into "cries for help" and seeking others out. Hopelessness ends the sense that there is any solution possible.

   3. The communication function – this is the area that often gets confused with manipulation and not warranting an actual suicidal ideation. Many suicides start as manipulative communications and end with a death. *Expressions of desperation* should always be taken seriously, and not simply as histrionics. "I wish I was dead" could just as easily be a statement of intent if help is not provided, as it could be a colloquial expression learned from their parents. There is also a revenge factor, where the intent is really to *punish another person* by perhaps one of the last means they have available to do so. This is particularly true when they are sitting in detention or a state training school, where the teenager perceives that there is someone who cares about them but in some way is responsible for their being in detention who they want to make suffer yet do not have direct access to. "You'll feel guilty because you caused me to kill myself." It is impossible to be one hundred percent accurate when trying to differentiate between manipulation and the child

effort to *influence others' actions*, and there actually being an expression of suicidal intent. The default is to assume suicidal intent. Nonetheless, trying to manipulate others and what they are going to do is often a motivation. "If you leave me in detention I'll kill myself." Taking the threat of self-harm seriously brings along the restrictions and additional attention necessary to keep these youths safe while in detention. Often the main message for communication is *seeking help* from the staff. Most of these children do want attention and have problems that they want to work through. One of these problems is how to appropriately ask for help. Regardless of whether the youth's motivation is to avoid, control, or communicate, the use of suicidal behavior in doing so needs to be taken seriously and responded to with concerns that are provided within a safe structure.

A final note on depression. Depression is generally associated with suicidal behavior, especially completed suicides. Depression can be alleviated after the point at which a person decides to actually kill himself. They have in fact found a solution that will end their stress, and this does indeed alleviate that stress. Once committed to ending life or going on an endless sleep, they no longer have to face the difficulties that they are having in their lives, including painful emotional experiences. Someone who is very depressed and all of a sudden stops being depressed should be considered as possibly contemplating a suicidal act.

Mental Health Diagnosis and Suicide

The youths in juvenile corrections are quickly labeled, although psychologists, psychiatrists, and social workers do not necessarily do this, but almost everyone will have an opinion. The complexity of the interaction of symptom patterns and the variety of diagnoses that can be attributed to a set of symptom patterns is enormous. Even with hours of testing and review by qualified licensed professionals, some of our youths go without formalized diagnoses, because their patterns are so atypical that they do not fit clearly into any pattern. You will hear the term "working diagnosis" and that is not a definitive diagnosis, but more the direction that is being used for treatment purposes. Often diagnoses will include a "rule out", which basically means that there are concerns that this diagnosis might be valid, however, there are other diagnoses that perhaps better fit the information that is currently available. There are "provisional" diagnoses meaning that this is a likely diagnosis, but there is insufficient information to meet all of the requirements. There are some diagnoses that end with a "NOS", which stands for not otherwise specified. These are often given for depression, mood, anxiety, cognitive disorders, etc., when the particular pattern does not fit a more specific diagnosis, but there is a pattern in this area that provides for a significant impairment.

DSM-IV

What is DSM IV? Basically it is the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, which was determined by a group of mental health professionals, predominantly in psychiatry, to provide a kind of shorthand, which would cluster symptom patterns into labels. The revisions not only reflect social standards and the science available at the time of each edition, but also the areas stressed by the members of those committees. Diagnoses tend to be specific to the society that defines them. For instance, concepts of schizophrenia can vary widely depending on where they are discussed in the world. The DSM-IV criteria do not fit the population in detention well. Although it is possible for someone to have a single diagnosis, which would seldom occur in a detention youth. I am going to go over some of the general groupings of diagnoses that are often attributed to our youth.

Behavioral or Conduct Disorders – this is a set of diagnoses that predominantly respond to the overt behavior of a child that is disruptive, either in terms of law violations, school, or home environment.

1. **Conduct Disorder** – for a conduct disorder itself, there needs to be pervasive or persistent behavior. There is a cluster of different activities that occur over a sustained period of time. This diagnosis is not used just because someone happens to be a thief, or a sex offender, or a fire setter. There is a more general level of disrespect for authority and rule violations.
2. **Oppositional Defiant Disorder** – this is basically the kid who isn't going to go along with anything and tends to be very argumentative. It is not that he breaks the rules; he just makes it tough to have him involved with anything

that requires submission to authority. Oppositional defiance needs to be in more than one location, so it would be an improper diagnosis for a kid who is just having trouble at school, or just having trouble with his parents. Conduct Disorder and Oppositional Defiant Disorder cannot be diagnosed at the same time. That doesn't mean that the oppositional defiance cannot be part of the cluster of symptom patterns seen in a Conduct Disorder.

3. **Disruptive Behavior Disorder NOS** – this is basically the default diagnosis when the above is not provided, and yet there is, nonetheless, criminal behavior.
4. **Child or Adolescent Anti-Social Behavior** – this diagnosis provides an overlap of the several areas including the Behavioral Disorder NOS, and the difference is basically that this particular code is used when the type of behavior may be a focus of clinical attention.

Attention Deficit Hyperactivity Disorder – this is an easy disorder to misdiagnose. The symptom patterns are often clustered with reactivity to depression and anxiety, very extroverted individuals, and a variety of cognitive disorders. It is basically difficulty in being able to attend and concentrate, and/or impulsive behavior. There are a lot of different reasons why this can occur, and that is the basis on which this diagnosis is made. Certainly providing somebody with Ritalin or Cylert who has a frontal lobe syndrome providing the same type of symptoms would be questionable. This would be same thing in terms of a person who can't concentrate because they are overly anxiety ridden, or significantly depressed.

Mood Disorders – Mood differs from affect. Affect is usually seen as appropriate or inappropriate and even can be described as flat. It is a temporary emotional state. Affect is often compared to what the weather is for the day. Mood is more the climate, and is sustained over a period of time. There can be significant episodes of deep depression, and this is often seen as associated with suicidal behavior. It is important not to get caught up with variations between Dysthymia, Major Depressions, Adjustment Disorders with Depression or Anxiety, Posttraumatic Stress Disorder, panic attacks, and all of the above basically secondary to medical and neurological problems, not to mention the side effects of medication. The main thing is to be aware of the child's state of mind emotionally, and whether or not there is variance to that state of mind that could provide for a change or unpredictability in terms of behavior. The vast majority of the kids who come into detention have had traumatic experiences, but this does not necessarily mean that they have Posttraumatic Stress Disorder. PTSD is a set of reactions to trauma. Many soldiers from World War II didn't start to feel the effects of the trauma of battle until their 50th reunion. **It is important not to project one's own issues, or how one would respond to things, over to other people.**

What should you look for in terms of mood disorder? Rely mainly on your experience of how kids normally react within this environment. It is easy to, on the more immediate side, compare and contrast them with other kids who have similar circumstances to theirs, but then after you get to know them, it is important to see variances within the individual. Changes in eating habits, increased or decreased need for associations and attention, sleep

patterns, self concepts both toward the positive and the negative, mood or agitation or lethargy, and just general negative thinking. Teenagers tend to be able to vary their emotions quickly when compared to adults. They normally switch moods at a quicker pace, and this certainly does not mean that they are bipolar. There is a confused emotional state that is generally attributed to the developmental process of going from the fantasies of childhood, to the harshness of an adult world reality. They start to question not only Santa Claus, but also the very meaning of life, without having adequate defense mechanisms with which to modulate those emotions. This creates emotional issues for most teenagers. The strongest thing in your favor when working with mood issues in teenagers is the fact that we were all teenagers once ourselves, and have some level, hopefully, of relating to them. The most critical years for parenting are the teenage years between fourteen and sixteen, when the youth really needs to rely on the mentoring and wisdom of the adults around him. Some of the teenagers that we deal with have not have effective parenting at any time in their lives, while others, at least, have been temporarily removed from having parental support on an ongoing basis. This void is potentially filled in by detention staff and probation officers. On a more productive note, although other youths will seek out peers some, unfortunately, isolate themselves. These years are critical in terms of emotional development, and for these children, this is being done at least in part, in detention.

Psychosis – This is the area of hallucinations and delusions. Schizophrenics, manic episodes, major depressions with congruent and non-congruent psychoses, and psychoses secondary to cognitive and medical issues. The main kind of psychosis seen in a detention center is generally secondary to drug use. The symptom patterns for an Amphetamine Delusion Disorder are basically indistinguishable from that of schizophrenic symptom patterns. Schizophrenics don't tend to sleep off the drugs, however, and generally in a few days you will see a significant change in terms of thought processes. Can someone with a psychosis be appropriate in detention? The answer is yes if it is a transitional state in terms of drug use, or at a level that psychiatric medications can stabilize the individual. The best place, however, to stabilize a psychosis with medication is in a psychiatric unit, where the complications from medication side effects can be better addressed. Another question asked about psychosis is whether or not the person is competent in terms of their offenses. This ties into whether or not the hallucination or delusion is directly related to the nature of the activity. Simply being psychotic does not mean that one is not competent in terms of handling their actions. Also in juvenile corrections, we will on occasion work with a teenager who on admissions showed the absence of a thought disturbance, even in testing, but developed an onset while under our care. These youths tend to have a certain level of fantasy and unconventional thinking, but a psychosis requires a move into a significant distortion. Trying to differentiate a kid who exaggerates everything to make him feel better about himself, or in the service of the ego, and that of one who is delusional, without any foundation in reality is often not easy to do. It is important for staff to be able to observe symptoms over a period of time. Can a kid fake a psychosis? Probably for a brief period of time, but pulling it off over a period of days is more than most people can manage. Feedback and staffing, especially with a professional clinical staff, is important in diagnosing these children and transferring them to an appropriate facility.

Autism, Aspergers, and Pervasive Developmental Disorders – there are different definitions, especially in terms of autism. School districts use a light set of definitions that include many children who are not clinically autistic. Many times diagnoses are done on the basis of grant and research definitions and not on DSM IV. Anyone who has worked with an autistic child can tell you that it takes very few minutes to figure out that there is a significant problem in this area. The main difference between autism and Aspergers is the development of language in the earlier years of childhood. This is further complicated by the level of functioning. Generally, autistic children will score in a Mental Retardation area, but it is hard to say if this is due to a lack of intelligence or a lack of ability to communicate. Often our youth will be diagnosed with a Pervasive Developmental Disorder NOS, in that there are a lot of autistic styles about them, but not enough to be clinically diagnosable. Probably more than anything else in this category, are kids who are at a pre-level of diagnosis, but still show significant impairment in their ability to relate to others and the world about them. This non-diagnosable gray area has been a point of concern for clinicians who work with high-risk children.

Cognitive Impairments – this is basically a cross-section of neurological disorders that stem from Fetal Alcohol Syndrome to acquired head trauma and birth defects. There is basically damage to the brain structure or in terms of altered biochemistry that affects behavior, the ability to process sensory information, or other issues like memory, attention and concentration, and reasoning. The use of neuropsychological testing and neurological testing helps in trying to determine, along with the child's history, where these problems are. Unfortunately, this is not an exact science, and symptom patterns relate to a variety of areas of brain functioning.

Learning Disorders - learning disorders are usually directed to issues of cognitive deficits, but those that relate specifically to either a distinct area of learning, or learning in general that is not caused by simple intellectual or specific brain impairment that is determined at that point. It is common to see children with dyslexia or a reading disorder in our population, and sensitivity to the issues of embarrassment and self-esteem is very important.

Mental Retardation – mental retardation is operationally defined as a score of below 70 on an IQ test like the Wechsler or Stanford-Binet, which is equated by poor adaptive or social functioning often seen on the Vineland Social Maturity Scale. This slowness generally originates at birth. Low IQs can be acquired due to head injuries or other changes. Mental retardation usually is determined when there has been no earlier level of higher functioning. Low intelligence does not mean a lack of insight or control of one's behavior.

Impulse Disorders – these are issues of more specific sexual impulsivity, fire setting, obsessive compulsiveness, and a general lack of being able to control one's actions or behaviors. These kids basically act without thinking. This is certainly symptomatic of

certain disorders such as ADHD, but the behavior may be caused by other aspects not attributed to ADHD.

Personality Disorders – although Anti-Social Personality Disorder is the only personality disorder that has an age limit of at least eighteen, personality disorders are generally not attributed to children or adolescents. Part of this is that a personality disorder is a more crystallized personality style that interferes with effectiveness in one's daily life. It is quite legitimate to say that there are concerns about a particular teenager who is developing say a Borderline personality or an Avoidant personality, but I would be reluctant to go past that and indicate that this particular set of diagnoses represents a specific teenager. The degree of narcissism or self-centeredness that an adolescent has may be inappropriate for someone in his thirties, yet quite common for a fifteen year old. There is certainly a degree of dependence that children have on their parents that would be inappropriate as an adult.

Alcohol and Drugs – these diagnoses are often specific to alcohol, Cannabis, methamphetamine, cocaine, and other drugs. Generally when there are three or more specific drugs, the use of a Polysubstance Dependence or Abuse disorder is indicated, as opposed to listing each one out separately. What is the difference between abuse and dependency? This can be somewhat of a gray area, although certainly an IV drug user would be considered to be dependent by almost everyone, and someone who only has a glass of wine at dinner would not be considered even abusive. The man who gets intoxicated once a year but gets into his car and has an accident, either causing property damage or harm to others, could be considered dependent, while another, who has two beers a night at home in the evening, but drinks every night, might be considered abusive. Any minor who uses drugs or alcohol generally is classified at least at the abuse level, in that it is illegal to do so. Care has to be taken to differentiate common experimentation in childhood and not to include someone who takes a hit from a joint at a party when they are sixteen, in the same classification as someone who is stealing to be able to buy marijuana. The overall dynamic of alcohol and drug use is important in terms of treatment recommendations, in that this can vary in the system from an educational program to intensive inpatient treatment that can last up to a year.

There are other categories that could be added to this list, each with their own set of different diagnoses that are not only in DSM IV, but discussed in journals and diagnostic books based on specific symptom patterns and etiologies. If the only thing was to try to figure out which one of these categories each one of our children fall into was required, you can see that this would still be a complicated issue. Unfortunately, most of these youths have three to five prominent mental health issues that interact in their own unique way and make treatment planning, as well as behavioral management a complex task. The more time you spend with high risk children, the more you realize how individual each one of them is, and how none of them tend to fit into a structured classification. That doesn't mean that we are not going to try to type them and try to simplify their behaviors in a more organizational construct, so that we can maximize the often limited resources that we have for them.

Filed under Misc.

Subtyping Behaviorally Disordered Youth

Attempting to try to find some typology in delinquent youth started on an empirical basis in the 1940s, and more on a theory basis in the 1950s. A more thorough background in terms of subtyping can be found in Herbert Quay's 1986 Handbook of Juvenile Delinquency, and work by Paul Frick, et al, whose article is included, and Karl Jaconos, The Clinical and Forensic Assessment of Psychopathy 2000. Quay basically used multivariate statistical studies to determine 4 major subtypes.

1. **The under socialized aggression** - which he also labeled as being psychopathic. He tends to define this as "it seems obvious that the youth's behavior that typifies this dimension is likely to be at odds with everyone in the environment, and most particularly with those who must interact with him on a daily basis to raise, education, or otherwise control him.
2. **The socialized aggression** – "this pattern seems clearly to reflect gang delinquency."
3. **The attention deficit** – this is often seen as being "the cognitive and social behavioral correlates of this pattern seems to make those representative of it susceptible to environmental influences."
4. **The Anxiety-Withdrawal-Dysphoria** - which he sees as being overlapping, "all of the various approaches to the sub categorization of delinquents include this pattern." The main dynamics are seen as "it is not difficult to see how acts considered delinquent could be motivated by a felt need to escape or avoid situations giving rise to subjectively experienced distress."

Frick, P., and Barry, C. 2000, provide a more extensive history that goes over the theory and empirical studies and also the development of how the Diagnostic and Statistical Manuals tried to classify conduct disordered youth. Some of the main factored that had been utilized included age of onset and whether the youth was considered to have aggression based on socialized or non-socialized origins. DSM IIIR tried to divide the groups between those who tended to commit crimes alone versus those who did so with other delinquent peers. The current DSM IV provides for two types, which are the *childhood onset type*, and the *adolescent onset type*. The difference is that the adolescent onset type "is defined by the absence of any criteria characteristic of conduct disorders prior to the age of ten." (DSM IV, 1994) These are further classified by levels of severity between mild, moderate, and severe. The severity factors are determined by the number of conduct problems required to make the diagnosis, and is also a qualitative judgment as to the degree of the act.

The utility of some of the subtyping, at least in the form presented, had limited utility on a practical basis in trying to understand children with behavioral disorders. On the mental health diagnostic side, we attach DSM IV labels that stack as if they are mutually exclusive of each other. Four patterns do seem to emerge that somewhat relate to the

earlier subtyping of Quay, but perhaps here are redefined in a manner that stresses more the interactional dynamics of diagnoses rather than their specific nature. Basically, all four of the types presented could have the same diagnosis, but need to be looked at in terms of the manner in which those diagnoses interact in order to understand the subtyped dynamics of the youth and treatment directions. Although this concept came from the influence of research, especially that done at Oregon Research Institute, this is based more on the practical implications of doing psychological evaluations over more than a decade for the juvenile court. This was added to with discussions by discussions with clinicians and corrections staff in terms of its practical implications. These subtypes will be presented in terms of suicidal behavior as one of the focuses.

1. ***The Psychopathic Type*** – the issues of psychopathic behavior are perhaps the most fascinating diagnostically in corrections. The work of Dr. Hare, with The Psychopathy Checklist – Revised, (PCL-R) has become the basis of an operational definition for use with adults. It is not, however, shown to be valid with youth, and reviewing the checklist would show that it would be easy to over diagnose this subtype. Frick, P., and Hare, R.D., have been trying to develop a psychopathy screening device (PSD), which is still in the research mode without current sufficient validity. Therefore, it is difficult to define this particular subtype, except that it probably only exists, in the manner in which it is presented here, in about one or two percent of the actual population that enters a detention center. Part of the difficulty may be that psychopathic adults have more crystallized personality in terms of a broader group of these individuals. There also becomes the question of whether people are born psychopathic or does the level of detachment evolve. This subtype differs from the under socialized aggression in that it is not just that their behavior is at odds with their environment but the underlying core factor that generates such a level of defiance. The psychopathic type requires the main force of narcissistic gratification that is accompanied by a lack of guilt or depression or remorse dealing with concerns of victims. As a result of the narcissistic gratification, or basically I take what I want with no concern for others or society, is that laws usually get broken. This type has a range of personalities from the charming, bright teenager who is extremely gifted in terms of social skills, to those who are just mean and overtly destructive. It is therefore the narcissistic gratification that leads to conduct, and the conduct that leads to consequences of being punished. The consequences of being punished can cause a depression, which is basically a narcissistic insult. This is not as a result of insight into one's actions and how they affect others, but rather a depression caused by not being in control of what is happening around them. Can a psychopathic type commit suicide? Yes, especially if it is in spite of the system. Taking one's life can be seen as the last method of control, preventing outside influence. This is more rare in that narcissism tends to stress self –perpetuation. Here the style of diagnosis, like alcohol and drug use, depression, suicidal behavior, and any learning or cognitive disorders are secondary to the direction of behavior caused by a prominent narcissistic gratification. Treatment is based on offsetting gains from crimes with losses in consequences. The surface patterns of other subtypes often look as if they could be psychopathic, and this would be a terrible error to make if treatment is not provided in terms of the other dynamics. For this

reason, psychopathic types are not directly stated in forensic evaluations dealing with youths. Despite this, anyone working in a detention facility knows that there are a small number of youths that come through, where there is general agreement that there is a coldness, or even dangerousness about them, even those there is a variance in personality presentations. There is no valid way, at this time, of operationally defining a psychopathic type, but they do occasionally find their way into detention facilities. None of the other treatment directions would be harmful to them, and provide for the best hope that the undercurrents are best represented by another subtype. (Insert diagram)

2. ***Socialized Type*** – this is somewhat in line with the socialized aggression type, but it is important to note that this subtype does not just include aggressive behavior, but the nature of those youths who come from an anti-social environment, be that at home or with peer groups. It is not so much that they are breaking the law, but that they are basically doing what everyone around them is doing and it appears, at least within their social structure, that this is normal and expected behavior. Even if this behavior is socialized, eventually they come up against the larger issues of society and its laws. As a result of what society feels is an interpretation of their behavior as being delinquent, they find themselves confronted with unexpected consequences, or basically being arrested and detained. As a result of these unexpected consequences, they can become depressed and anxious. Issue of alcohol and drug use is also part of the social pattern. Basically their conduct is in line with either their family or peer/gang expectations. They come from a sub-culture. The basic treatment for this type is re-socialization, as is seen in many of our programs dealing with social learning approaches. Redirecting these youths is often initiated within detention, as they need to learn new rules of social conduct and expectations. The stress basically comes from the struggle between the two sub-cultures. (Insert diagram)

3. ***Reactive Type*** – it is hard to say whether the socialized type or the reactive type is the more dominant in terms of the children that we see in detention. The reactive type of youth is seen as one whose prominent origin of behavior comes from traumatic events, neglect, poverty, adoption, and school problems stemming from learning disorders. This can certainly include disorders like Attention Deficit Hyperactivity, where it is the reactivity to having difficulty dealing with one's behavior that results in misconduct. Basically as a result of these circumstances that are beyond the control of the social structure or the individual mood issues of depression and anxiety are created. They become bored, frustrated, and/or angry. There then becomes an escapist position, which was discussed by Quay as "anxiety-withdrawal-dysphoria" type. The difficulty with previous subtyping is that all of these features can be seen in the other subtypes, but it is how they interact in terms of the causal elements. Here, the mood disturbance is painful and reactive. As a result of wanting to escape or withdraw the youth creates his/her own anti-depressant through the use of misconduct, alcohol and drug use, high-risk behavior, and suicidal behavior. Stealing a car and driving at high speed can provide the very kind of excitement that negates, at least for a short period of time, painful emotional feelings. As a result of this behavior there are consequences, and in fact, those consequences

can add to the initial stimulus and even increase the cycle as well as hopefully being therapeutic. Here the treatment issues are replacing negative behavior with socially appropriate methods. Now this may sound more in line with social learning models, or re-socialization, but here it is the development of coping skills to deal with the level of stress. A suicide will certainly end one's distress, but are there less lethal methods that would also accommodate this? Generally the reactive type's misconduct is more pervasive. These teenagers seem to be desperate to try a variety of things to escape, and they tend to get increasingly more severe in terms of the behavior. Being placed in jail for a long period of time can avoid a more threatening set of distressing events that the person sees themselves being involved in if left in the general community. (Insert diagram)

4. ***Compulsive Type*** – to a certain extent Quay discussed this with Attention Deficit Hyperactivity Disorder and the kinds of symptom patterns associated with that. Certainly a compulsive type deals with issues of impulsivity if that was more isolated. It seems though that the ADHD kids that we see in detention have a second component of either reactivity or socialization. There are those, however, who form more of the compulsive type, and this is added to other compulsive situations dealing with sex offenders, fire setters, stealing, or lying. Here the behavior is usually specific and treatment is tailored to the area of misconduct. The basis is a drive state bound with behavior and subsequent other diagnostic implications stem from that drive state. When one has a compulsion to commit an act, regardless of it being fire setting, sex offending, etc., the result of not being able to control one's actions can directly relate to depression and anxiety. This also certainly leads to breaking the law and the consequences of that. The compulsive type has a section of reactivity to it, in that the depression and anxiety can lead to the misconduct of the reactive form, but there is a higher level based on the drive state that is causing the stress initially. Suicidal behavior is often the result of the frustration of not being able to control one's drive state and trying to escape that drive state. This suicidal behavior is not always caused, in this subtype, in terms of reactivity to the emotions, but sometimes a moralistic attempt to negate one's dangerous activities. This is basically the "I have no other way to control my behavior". (Insert diagram)

Let's look at a couple of diagnoses and how they would fit in each category. I will start off with depression leading to suicidal behavior. In a Psychopathic Type we can see that this is a result of narcissistic insult. The Socialized Type could see this as an acceptable manner of handling one's circumstances, especially if such behavior is common within their social structure. The Reactive Type basically wants to escape, but for this type it is not so much the desire to die, but an avoidance of stress and what is often seen as an extended sleep state. This escape is the result of the painful emotional experiences. The Compulsive Type could also use a suicide as escape, but here the escape is less in terms of the emotional issues and more based on a sense of protection from continuation of the obsessive and compulsive behavior.

Alcohol and drugs can be seen in the Psychopathic Type, as just an experience that they like doing, and that therefore needs no further justification. With the Socialized Type,

alcohol and drug use becomes a learned behavior. Obviously, the Reactive Type uses substances as a means of escape, and as an anti-depressant. The Compulsive Type provides for more of what was once considered the "medical model", which stressed the alcohol and drugs as being the core of why other problems developed.

Last we will look at sex offender behavior. The Psychopathic Type basically feels, I want and I take. You often get socialized kids who were molested themselves and are often part of a collection of others they know who are molesting children. This is particularly seen with younger youths that seem confused on what appropriate sexual behavior is. The Reactive Type is generally in need of intimacy and connectedness that provides misguided sexual components, especially when their immaturity is attracted to a younger child. The Compulsive Type can be anything from an actual pedophile to someone with limited abilities that nonetheless has the hormonal drive state.

None of these subtypes take in aspects of misconduct that would question culpability underneath the corrections system. This would include those with cognitive limitations where they are not competent to understand the nature of their actions. There is also the issue of psychosis, where the behavior is attributed to a distortion of reality. Note that the adolescent can have an experience because of drug use, and that certainly does not render them incompetent. Psychosis can also occur during the course of detainment but the behavior that led to incarceration was caused by other issues prior to the onset of the psychosis. There are times when delusional patterns are not related to the actual behavior of breaking the law. In these cases there would not be a Conduct Disorder. The above subtyping deals with the interaction of diagnoses that include a behavioral disorder. With the youths that I have personally reviewed, and in talking to a cross-section of others, we have been unable to come up with cases that fit more than one category. Again, it is the predominance of the initiating cause that leads to the misconduct, which determines the type, and also the treatment direction. Within each of these subtypes, there is again a broad difference of individual styles and dynamics. The point that is mainly trying to be made is that children and adolescents come into detention with a wide array of backgrounds, and reasons for their being there. On occasion there are some in detention that don't fit in a corrections mode and they are temporarily out of place. Hopefully this subtyping will start you trying to think in more detail of the unique dynamics of each child and their individual needs.

Slow leak

Review of Research in Detention Centers

Conducting research in detention centers or juvenile correction facilities is difficult in terms of providing for an adequate research design. Confounding variables are basically everything that happens that you can't control, and you can see where this would be quite a jump from a university research format to the constant changes and array of environmental factors. Nonetheless, research that is done in more controlled environments has poor generalization over to the kind of environment that a detention facility provides. It therefore becomes necessary to modify designs so that the research provides information that is practical and meaningful to the staff within a detention facility. There are specific questions that we initially started out, a decade ago, to obtain answers to, however, and these answers were not available in any of the literature. We basically wanted to know what were the dynamics in terms of suicidal behavior of those youths who are detained. We started with Peter Lewinsohn, Ph.D., at Oregon Research Institute, who helped us form a team with Paul Rohde, Ph.D., and later, John Seeley, Ph.D., and Jenel Jorgensen, M.A. There were a few technical articles that were written based on statistical analysis, and in Appendix I, there is a translation in practical terms and the implications for detention. The reader is referred to the article Psychological Patterns of Depression and Suicidal Behaviors of Adolescents in Juvenile Detention Facilities, 1997, in Appendix II, of this manual. Included in the article was information that we felt was important, but did not meet the standards required for technical publications. It starts to become clear the degree to which the population of youths that we serve have not only significant mental health, but also an array of those issues where there is certainly an interactional effect. This interactional effect is discussed in subtyping, and provides for a combination of issues that are not generally seen in a standard mental health clinic. Youths with aggressive behavior, sexual misconduct, substance dependency, and other behavioral issues provide an addition to the mix of mental health diagnoses that provide for a different complexity and treatment needs.

For the last five years, the team of Department of Youth Services and Oregon Research Institute has been working toward trying to understand areas where we can provide treatment. One of the factors that seems to encompass most of the teens that we saw was a lack of social and problem solving skills. Dr. Lewinsohn had initially developed a Coping With Depression program for adults, and about fifteen years ago, Dr. Clarke adapted this, for adolescents. Mace, Rohde, and Jorgensen, with a lot of advice from Clarke, and the youths and staff in detention, started again to adapt this program within a detention facility, which is now titled Coping With Life. It was interesting that when we initially tried to use Coping With Depression, none of the kids wanted to identify with being depressed, but they had no problem with needing to have skills to negotiate through life. Similar other programs in the juvenile department are Anger Management and Responsible Decision Making. In order to research the program, it was re-developed as MAPS, or Making A Plan for Success, which concluded in the year 2000, and at the time of writing this manual, is still in data collection. What we have started to find is that regardless of intelligence, adolescents coming into a detention facility usually lack the kinds of maturity and skill development necessary to appropriately and successfully

interact with the community and the school system. Other components, from Leonard Goldstein, Ph.D., the Myers-Briggs, and moral development, were added. The direction of this current research in program development is to provide alternatives to depressive behavior that is not suicidal or anti-social. This cognitive behavioral model was designed more specifically to reactive subtypes, but also has practical therapeutic value for the other subtypes.

Over the last decade, there have been other suicide prevention programs put together in much the same manner, based on a practical basis. There is a need to gather information from various sources throughout the country to try to provide a compendium of suicide prevention assessment, management, and treatment methods. There will undoubtedly be a lack of valid research support for these programs. The problem that we face is that we cannot wait for the amount of research necessary, because our job is taking care of these children now, and that includes the prevention of self-harm behavior.

Not fooling anyone

Legal Issues/Risks

Suicidal prevention deals with a balance that provides a program not only for the safety of youth, but also for the protection of liability of the agency and staff. These two factors are not in competition with each other, in that they are mutually supportive. The Lane County Model is a proactive approach, which makes a lot more sense when you look at legal issues. We try to address problems before they develop, which we have found over the years has been time and cost effective than the more reactive approach that was used a dozen years ago. The primary direction for staff to understand in protecting their liability is to simply follow the program as drawn out in this manual. No one expects detention staff, individually, to provide the expertise on each youth that comes into detention. In fact, we don't expect anyone to be able to deal with these problems on an individual basis, and therefore, no one person is ever responsible for any decision that is made. The Lane County Model is designed specifically so that accountability is always spread over two or more people, in terms of their judgment and experience. Not only is it required to have two people who are outside of detention on the risk assessment panel, but also the panel always confers with the senior staff before lowering any kid's risk level. Even they can be overruled by anyone else associated with detention if they feel a more conservative approach is necessary. Do we make mistakes? Yes, in fact the program is designed to make mistakes, but those errors are on the conservative side. We look at all children as being at risk for suicidal behavior but we do triage them in terms of the intensity of resources provided. It would be improper for every child coming into detention to be placed in a smock and in a camera room. The standard of care, therefore, is the same for all youth, but the specific service varies in terms of several factors dealing with suicidal behavior. Liability is best handled by us working as a team.

One article written by an attorney, Darrell Ross, "Examining the Liability Issues of Suicides in Juvenile Detention Facilities", 1997, did so from the standpoint of investigating lawsuits in which judgments were awarded based on problems within detention facilities. At that time, Mr. Ross concluded that only "twenty-five percent of the respondents conformed to all four suicide prevention assessment criteria's". The assessment criteria that he found from a legal standpoint were:

1. "Develop a suicide policy/plan which directs staff in their responsibility of intervention with youths, from reception through the duration of the youth's confinement. Develop a suicide screening assessment form, which targets factors necessary to identify youth who may be suicidal. As a matter of practice all youth entering the facility must be screened for suicidal intentions. Development of a mental health form is also recommended.
2. Develop and provide training for staff in the policy and the screening instrument. Also provide all staff with training in the signs and symptoms normally associated with suicidal ideologies. Initial training should be from 4 to 8 hours. Additional refresher training of at least 4 hours should be provided every two years at a minimum.
3. Establish protocol for properly classifying youth into various types of housing while incarcerated. An operational plan should be developed which identifies the agency's

philosophy of how to respond to and to confine a suicidal youth. Operational procedures should indicate varying ranges of custodial levels which require different monitoring practices for youth who exhibit behaviors not only suggestive of suicide, but behaviors suggestive of assaultive tendencies as well. The plan must articulate how staff is to respond to a suicidal youth, how he/she will be monitored, the frequency of monitoring, and notifying emergency mental health authorities to determine proper confinement options.

4. Operational plans should be developed which guide staff in properly responding to a suicidal attempt or a completed suicide. Staff should know how to administer lifesaving procedures, how to properly extricate a hanging victim and know what medical authorities to contact in emergency situations. The policy should specify that all staff involved in the incident be required to submit a written report. Facility administrators should provide a debriefing meeting with all staff involved in the discovery and/or rescue effort and provide after incident counseling with staff as warranted." (Ross, p. 23)

Mr. Ross stresses, "Implementing these recommendations and revising operational plans for the facility to decrease the risk of suicide is imperative for detention administrators. " There is no standard detention facility, and they can range from a few beds to several hundred. Also there is a wide range between detention facilities as in Lane County, which are nestled between universities with a large number of available professionals in the community, to those in outlying rural areas where there may be no one on staff with a graduate degree, and insufficient funds for contracting the professionals that may be in the community. We therefore try to maximize resources to the best of our ability, and this is translated in terms of procedures and discussions of limitations.

The main limitation is that regardless of how much energy is put into suicide prevention, a youth, while detained, can kill him/herself. Although Lane County has never had a completed suicide, and over the last decade, since our program was put into effect, there have been very few, if any attempts made per year, we have a high respect for the creativity and level of emotional pain that these young people have when they are in our facility. We know that if someone wants to end their life, they could get by us. We want to make that as unlikely as possible. Again note that before this program was put into place, we had as many as ten suicide attempts in a week, and once four on one weekend. The program has shown that it works, not only in this facility, but other facilities, and has been the best, to this point in time, that those of us collectively working in this area along with researchers outside of DYS, have been able to come up with. The Lane County Model is constantly changing as we try to have a better understanding of the juveniles we serve.

Our system is designed so that anybody on staff, new or veteran, can raise one of our wards to a higher level of observation, and instigate further clinical review. Anyone who reduces a child from a higher risk level to a lower one, independently takes on full liability for anything that might go wrong, and would certainly have to explain themselves to administration, and possibly the courts, noting that this program is part of county policy. It is your obligation to bring forward to the suicide prevention panel

anything that you feel might improve the panel's operation or the suicide prevention program. Again this is not a definitive program, but it is the best we have been able to put together so far, and therefore it does have limitations and room for improvement.

Not to laugh

Chapter 2 - Detention Suicide Procedures

Adolescent Suicide Prevention

Suicide and the possibility of suicide is a very real problem in the Detention environment. According to current assessment tools, all teenagers in the detention environment are at a moderate to high risk for committing suicide. By its very nature, detention deals with a high risk for suicide population. Most, if not all, of the precursors for suicide, such as depression, loss of control, arguments, separation from family, drug use, etc are present in the detention population. Youth with anger problems can displace this anger inward toward themselves, thus becoming dangerous to self.
Since the Department of Youth Services is responsible for the children committed to detention, Groupwork staff has the responsibility of protecting the children against suicide.

Detention has developed procedures to protect children from suicide. All these procedures and background information are contained in *In Harms Way*, a manual available from Viriam Khalsa or Marc Swindling. This paper is a brief description of the approach Detention uses for preventing suicide.

Prevention begins with a suicide assessment that is done at the time a child enters Detention/Intake. This is a special tool that is contained on the back of the medical intake sheet. The assessment distinguishes the amount of risk a child is at for suicide. An assessment is done on every child who enters detention and each time a child enters detention.

The assessment puts youth into four different categories of risk. It is important to realize that even low risk youth are at risk in this environment. The four categories are as follows:

Imminent Risk or Risk Four This child is currently thinking of ending their life and are actively, currently suicidal. Interventions with this type of youth are 1) contacting the suicide panel immediately, 2) Keeping staff in room, 3) keeping the child in a camera room, 4) giving them only suicide smock clothing (available in nurses office) and untearable blankets (no sheets). The Johnson Unit (Sacred Heart) may be a resource via Dr. Mace. This risk 4 youth is not assigned a razor. They may not have pencils in their rooms at any time nor be in the cube recreation area alone. Risk level 4 youth may not have room mates.

Unpredictable Risk or Risk Three This child is not currently seeking suicide but may have attempted in the recent past, be emotionally unstable, and in general be a child that could become suicidal easily. Response in the detention environment includes, increased staff contact, rooming with a stable (non-risk) roommate, eliminating isolation time, providing emergency access to stabilization members at any time, develop a suicide

contract, and follow-up with psychiatric and psychological care. The risk 3 youth may not be assigned a razor.

Increased Risk or Risk Two This is a child who is currently stable but has a history of suicide attempts, or no attempts but has some de-stabilizing emotional issues that put them at increased risk. These children are often assigned roommates, have increased Groupwork contact, are placed in depression group and may consult with panel members if necessary.

Regular Risk or Risk One This child has no special programming due to suicide. They are deemed stable, have no history of suicide and claim that suicide is not an option for them. It is important to remember that a level one kid in Detention is a moderate to high risk in the general (non detained) population.

Dealing with teenagers that are at risk for suicide requires some special counseling skills. It is important to use your experience and sensitivity.

If a child reports in any way that they are considering killing themselves or are giving any hints that this is an option, this information needs to be documented and followed up on. Anytime a child is found to be suicidal the suicide panel needs to be contacted immediately.

Suicide panel members are Dr. David Mace-343-7317, the Physician's Assistant, John Aarons, Mike Thomson, Frank Feuille, or Dr John Crumbley-461-0662. Viriam Khalsa is detention liaison to the panel.

Obviously, in this area, it is important to not miss any youth who are at risk for suicide. It is much better to have many false alarms than to miss the real thing. Staff may raise a child's suicide risk level at any time if there is perceived risk. Documentation should occur whenever this done. The panel are the only people who can lower a child from a level 4 or 3. Groupwork supervisors can lower a child from a level 2 to regular risk level one.

Youth risk levels are identified on the room charts by the designation of risk 2, 3, or 4. A youth's risk history is available in JJIS.

Staff needs to be aware of youth when they are in their rooms. Isolation and room time are the most dangerous times for a child to act out suicidal thoughts. Children observed with ripped clothes or bed sheets or with anything fastened to light fixtures or windows need to be told to stop this and have their bedding and possibly clothing removed from the room. Check in with the child and ask them if they are intent on harming themselves. Regardless of the answer all this information needs to be documented and passed on the shift supervisor.

Be aware that children in detention have attempted suicide. Staff training, vigilance, good assessment and some luck have prevented a child from taking their life. With your help we will continue this excellent record.

Detention Suicide Assessment Procedure

Instructions:

Upon intake, every youth is to be asked a series of questions related to suicide. The answers to these questions are used to determine the category of suicide risk. The four categories are:

Imminent Risk or Risk Level Four
Unpredictable Risk or Risk Level Three
Increased Risk or Risk Level Two
Regular Risk or Risk Level One.

After answering the questions determine if the youth is:

Imminent Risk

If the youth is determined to be Imminent Risk (risk level 4) follow the intervention recommendations.

If the youth is:

Not Imminent Risk

Use the scoring table to determine the category of suicide risk. Based on the level of suicide risk follow the recommended interventions.

Behavior in detention (i.e. suicide gestures or attempts), or the discovery of information not previously disclosed, can change the category of suicide risk.

Questions Asked Upon Intake

Identifying Risk Related Factors

1A. A. Move you ever attempted to harm/kill yourself?

1B If "No" go to question #2

1C If "Yes" ask the following 5 questions:

a. How many times have you attempted this?

b. When did you try this?

c. How did you try and do it?

d. Did you really think that would end your life?

e. Did they have to take you to the hospital?

2. How are you feeling/doing right now? (present desire to die)

3. Has a close friend killed themselves?

4. Has anyone in your family killed themselves?

5. How much drinking/drugging have you been doing recently?

6. What do you think/feel about being in detention?

Imminent Risk

Imminent Risk exists if any of the following occurs or if the following information is discovered:

1. Present suicidal gesture;

2. Prior suicide attempt that required hospitalization;

3. Recent attempt (1 yr) where youth viewed means as lethal;

4. Counselor/detention staff subjective opinion.

Scoring Risk Factors

1. More than one prior suicide attempt	2 points
2. Past attempt using means other than ingestion	2 points
3. Presently feeling depressed/hopeless	2 points
4. Close friend committed suicide	1 point
5. Family member committed suicide	1 point
6. Use of drugs/alcohol over 3 times a week	1 point

7. Distress over entering detention	1 point
8. Extremely withdrawn/overly dramatic	2 points

Total Points _____

Total Points Determines Risk Level

A. 1-2 Points = Standard Risk (Risk Level 1)

B. 3-5 Points = Increased Risk (Risk Level 2

C. Over 6 Points = Unpredictable Risk (Risk Level 3)

Detention Policies

a) All risk level four youth in Detention and Intake will be assigned to a camera room with the light left on at all times. The only exception to this is if such a room is not available (full with other risk level 4 youth or the room is out of order).

b) All risk level four youth in their rooms shall be visually sight checked every 15 minutes (or more) by Detention and Intake staff. Checks will be recorded via proximity card on the card readers immediately adjacent to the camera rooms. Groupwork staff and practicum students (after training) may complete these checks. Obviously, if the youth is not in their room (e.g. youth is in school) the checks do not have to be done.

c) Risk level four youth shall not have room mates due to the stress and responsibility this places on the room mate.

NOTE: Supervision of youth is a staff function. While we hope all detained youth will assist by reporting concerns about peer's suicidal intentions, this is not a substitute for staff supervision and monitoring. Placement of a roommate with a risk level three youth is a detention staff decision to be made independent of risk status concerns. Under no circumstances should a roommate be used as a substitute for staff supervision and monitoring.

d) Risk level four youths will have limited access to items that may be used to inflict self-harm. This includes all risk level four cases having limited access to pencils, no access to razors, and eating utensils (finger food). When access to a pencil is permitted direct supervision is to be provided.

1) It is no longer necessary to notify a risk panel member by phone (pager) when a risk level 4 youth is detained.

The reason for this change is that risk panel members cannot legally advise treatment(s) or interventions over the phone without seeing the youth in person.
The only reason to call (page) a risk panel member is if you want them to come in to detention at that time to provide emergency stabilization and counseling for a risk level 4 youth. Having a panel member come in to detention is not expected to occur except in the most extreme cases of immediate lethal risk. The panel does not need notification of routine risk level 4 admits.

2) In lieu of panel notification Detention staff will provide our highest level of intervention with all risk level 4 youth admitted to detention. All risk level 4 youth entering detention will be placed in a camera room with the light on, be placed in an anti-suicide smock and have all sheets, pillow cases, and clothing removed from their room. They will be on finger food and receive all the other suicidal safety measures we have in place.
The panel will review these youth at the earliest possible time to evaluate risk reduction and a possible lesser level of intervention and/or risk level.

3) Youth who have a prior detention risk history but in their last stay in detention had been reduced down from risk level 4 to a lesser status during their previous stay and who do not score as a risk level 4 on the current intake suicide assessment can be admitted as a risk level 3. The panel will review these youth as a normal part of their assessment process. This is anticipated to reduce our risk level 4 population from the past practice of placing all youth "back" on risk level 4 if they were previously scored a risk level 4 in their history with detention or Intake.

4) We need to notify all responsible receiving parties that a youth is on a risk level 4 status at the time of their release from detention. Parents, counselors and other agency personnel will be the typical recipients of this information. Groupwork staff can perform this notification verbally.
Youth who are currently a risk level 4 and who are scheduled to be released from detention to their own recognizance need evaluation from a psychologist prior to release. The psychologist will determine if the youth needs to be transported as an emergency admit to the Johnson Unit. When possible we will perform this evaluation in advance to the release so the youth is not held up in detention. Fortunately, the number of risk level 4 youth that are released to their own recognizance is extremely small.

Optional Interventions

Upon the discretion of panel members additional precautions may be instituted for risk level four youth. These precautions will likely take into account the means or items necessary to carry out a developed plan of self-harm by the youth. Significant factors include what items or what means have been used previously, or if a child does not specify the means they intend to use. These precautions may include:

24 Hour (Constant) Supervision

Youth in detention who, in the perception of the panel member called to consult the case, are at risk for self harm either through emotional volatility, distrust of the detention

environment, inability to form even minimal staff or youth relationships, mental health issues beyond the presenting suicidal ideation, etc. can specify that the youth have 24 hour Groupwork direct supervision. This decision shall necessitate the detention shift supervisor to call in an additional staff per shift to provide constant supervision to the youth. Working line staff can spell the relief worker for necessary breaks and/or meals. The decision to call in additional staff to provide 24-hour supervision is reviewed by either of the Groupwork supervisors within the first 24 hours. The decision to continue or discontinue the 24-hour supervision is made by the Groupwork supervisor(s).

Supervision During Sleep Times

Youth who do not require 24 hour supervision but are volatile and at risk being alone in their rooms at night, in the perception of the panel member called to consult the case, have the option of having the youth sleep in the day room. This allows late swing shift staff, night shift staff, and early morning day shift staff to have direct observation of the youth. If this decision is made all the youth's bedding (non-tear blankets) and mattress is moved into the dayroom near but not under the large tables in the dining room.

Review for Possible Johnson Unit Referral

Youth who, in the estimation of risk panel review members, are deemed to have psychiatric problems that outweigh their criminal behavior shall be referred to the consulting psychologist for review and possible referral to the Johnson Unit or other appropriate psychiatric setting. Any panel member team can initiate the request for review process. This option has decreased in recent years due to the detention setting having more highly trained staff in suicide prevention and the setting being deemed safer than the Johnson Unit for suicidal youth.

Other Options

The suicide panel may devise or design any additional options that provide for the safety, stabilization, and effective monitoring of youth at risk for self-harm and/or suicide in detention or intake. Any such options that are not listed above shall be cleared by administrative review before implementation.

JJIS Computer Information

a) Upon Intake, all youth are screened via the suicide intake assessment. The information from this screening, and the risk level assigned, is entered into the JJIS record.

b) The suicide risk level of a youth is entered by intake into the alerts section of the JJIS file.

No U turn

Chapter 3 - Suicide Panel

Functions

The primary function of the Suicide Risk Panel is to provide for the safety of children in Intake and the detention community. The main role of the panel is to assess individual risk levels and change the risk levels as the situation warrants. This mainly applies to risk level three and four cases, but may include others. While panel members may provide stabilization or support services, their primary role is not clinical in nature. Risk recommendations are not treatment recommendations.

History

The panel usually becomes aware of a risk level four youth either via phone calls made to the panel by intake staff who have completed an intake suicide assessment or by noting that a risk level 4 youth is on the detention room chart. Sometimes Groupwork staff call when they have assigned a youth the risk level four status via a youth's actions or comment once the youth is in detention.
There exist many gradations of risk and individual circumstances that necessitate a range of options in the successful management, care and resolution of risk level cases. This proposal seeks to establish a working framework for the consistent application of interventions by the panel to maximize both youth safety from self-harm and/or suicide while in Detention and Intake. The document also seeks to ensure panel agreement and support in the application of such interventions. Lastly the document outlines when exceptions to the rule can be made and the mechanisms for such decisions by panel members.

Panel Review of Youth

Panel review of youth placed on risk level four for possible lowering of risk level is perhaps the most important decision the panel members make. Such decisions determine the level of intervention and the subjective opinion of the relative safety of a youth in detention for committing acts of self-harm and/or suicide.

Process:

a) Any decision to lower risk level three or four is only made by the panel. In assessing or reviewing cases, **the panel member with the most conservative risk recommendation will prevail** no matter who else may disagree. Any DYS staff may increase the risk level.

b) Risk level three and four youth are routinely reviewed by various panel members. Risk levels may be raised or lowered based on the current information available to the reviewing

panel members. Issues raised and documented in prior reviews are considered and addressed in making any changes in risk level. All changes in status shall be fully documented and initialed by all panel members who helped make the decision.
c) It will be the responsibility of a panel member(s) who wish to be contacted about a change in risk level to specify this on the initial SBR.

d) Panel members shall review risk level four youth as soon as possible upon the assignment of the risk level four status. This is generally considered to be the next working day.

e) The panel interview process shall consist at a minimum of a face-to-face interview with the risk level four youth and the reading of all documentation produced to that point concerning the youth's risk level.

f) The panel shall have at least 2 panel members present to review youth for possible "downgrading" of risk level status. The panel members performing this function shall document their decisions on an SBR along with the key issues and reasons justifying the recommended risk level. This SBR shall become a part of the youth's detention file. A copy of this SBR shall be provided to the counselor for the youth. All panel members participating in the review shall initial the SBR document.

Panel Re-Review of Cases

In cases where youth who are not lowered from risk level upon review by the panel, the panel members conducting the review shall document the date for the next panel review. The span of time between reviews shall not exceed one week (7 days) and may be as short as deemed necessary by panel members doing the initial review.

Panel Attempt Autopsy

The suicide prevention panel will review any and all attempts at suicide that occur within the facility. This review should be conducted as soon after the event as is practically possible. The review team should consist of (at a minimum) the staff psychologist, 2 panel members, medical, detention/department staff who dealt with the attempt, detention administrator.
The goal of this review is to find and correct possible "holes" in policy and procedure, identify training areas for staff, and change procedures if necessary.

Documentation

A JJIS entry or a Special behavioral Report will be made on every intervention done by the panel. Both panel members making the change need to be clearly identified on the document.

Special Types of Cases

Suicide Risks of Gay and Lesbian Youth

This section is devoted to suicidal risk of gay, lesbian and transgendered youth, examining the perspective of gay and lesbian youth gained through research and other information. It is an attempt to share some ideas and provoke some thoughts so that youth care workers and other professionals will give some thought to this area.

While recently participating in a workshop/conference on suicidal youth, the question was asked, "How many of you work with gay and lesbian youth that are suicidal?" Half of us raised our hands, leaving one to wonder if the others worked with adults or other beings that might be suicidal. In fact, all of the folks in the room were youth workers but only half recognized that they do currently work with, or have in the past worked with gay and lesbian youth. Having examined in the past chapters the risk factors of participants of suicide, it is a challenge to imagine that there could be a group of youth even more at risk. Certainly when we examine gay and lesbian youth this must be considered. In addition to all the ongoing factors, the experience of being ostracized from your peer group is an additional significant risk factor. To say the least, adolescence is a profound time of great change, hormonally, physically, and emotionally. As you discover your sexuality and experiment in that area, to not feel the same as others, to have different experiences, to be attracted in ways to other peers that may be culturally awkward, inappropriate or condemned, by religion, or other family mores.

Definitions of Terms

When working with gay and lesbian youth, it is common to talk about a sexual "preference". It is appropriate and accurate to talk about an "orientation". To discuss preference sounds as though one makes a choice as to whether they are gay or lesbian, or heterosexual. Rather, an "orientation" would be the feeling of affection and romance as more that a behavior or choice; and at times it is even difficult for adults to describe their feelings let alone an adolescent.

During adolescence one of the key issues is the development of identity and trying on different styles. Many of us may recall that we "tried on" different personalities, different masks to see who we are and who we were going to be.

Some youth may choose to identify as bi-sexual, which may be part of experimentation, may be easier in terms of identifying bi-sexual as opposed to gay or straight, or it may be part of a transition process from heterosexual to homosexual.

The term "gay" makes reference to the male gender, and the term lesbian makes reference to female gender. Transgender, which would include transvestites (men that wear women clothing) but are straight.

Transsexuals have an opposite sex identity, and may not fit in with either gay or lesbian circles. They may change their name from a boy name to a girl name or vice versa. It may involve high-risk behavior, such as prostitution or attempting to enter social circles as a different gender while processing.

Disclosure

Disclosure is openly acknowledging sexual orientation to another. This is not the period of discovering; revealing, or admitting, but is sharing information and disclosing.
The median age of knowing, indicated by research, is that males know about the age of 13, and females about the age of 14. As part of the process, on a 1 to 10 scale, number one is "I'm not gay, and I deny the feelings". Ten is "I am gay or lesbian, and this is a part of my life, and is integrated into my life".
When one thinks of the coming out process, that process being from understanding through acceptance and sharing, the first person one has to feel acceptance from is themselves, the first one that one comes out to is themselves.
Parents often have thoughts, feelings, impressions, concerns, worries, hopes, whatever intuition might lead them to think their child might be lesbian or gay. The question that you might ask them is what makes you think that, what indicators do you have, how are your feelings with that.

Resources

When looking at resources, it's important to know your resources in your community, such as PFLAG (Parents and Families supporting Lesbian and Gay adults and youth).
Other competency-based resources would include:

1. Acknowledging that you are competent/comfortable in working with gay and lesbian youth.
2. Staying current with trends, information in the field, resources in your community.
3. Using gender neutral language such as "do you have a partner" verses "do you have a girlfriend/boyfriend"?
4. Using current and accepted terms such as gay, bi-sexual, or lesbian.
5. Have literature in your office that speaks to creating an affirming environment.
6. If disclosure occurs with you, acknowledging it not judging it. Not all gay and lesbian youth need to be referred to counseling after they disclose they are gay or lesbian. However, the suicidal issue needs to be separated from that.
7. Acknowledging that if you are gay or lesbian it would be a safe environment to come out.
8. If you are heterosexual it would be a safe environment to talk about it.
9. Be aware of resources. This may require some research. If resources don't exist, bring that up at community meetings, with supervisors, and other professionals.
10. Don't look for stereotypical cues. Don't encourage or invite youth to come out.
11. Focus on creating a safe environment for all youth.
12. Let youth know we can talk about scary/difficult issues.

Summary

Managing yourself around gay and lesbian youth can be a challenge. Not unlike suicide, gay or lesbian issues often cross religion, in addition to any number of other cultural boundaries. If you don't feel that you can work with these issues, and be open, it's a great time to check in and get other training, support, or supervision from other staff. If you are not sure what to do, saying that may be your best ally.

In closing, my encouragement is to know yourself around these issues. Be very clear that what we are focused on in this manual is suicide, be aware that youth exploring his or her sexuality outside of the norms of the adolescent group, can be frightening, scaring, and at times very painful and ostracizing. Being sensitive, alert, and aware of those feelings. Encouraging resources, and reminding the youth that there is a place for them in this community, and respecting their courage in working in that area are all ideas which will be supported.

Panel Practices

a) Not to lower the risk level of a child when detoxing from substance use (72 hours after admission is typical). Consultation with the detention nurse practitioner is urged in such cases.

b) If a youth identifies a suicide provoking situation (i.e. being sent to MacLaren, not getting a visit etc) the provoking event will pass or be resolved before the panel will consider lowering risk level.

c) For youth whose risk level is related to integration into the detention community, their forming of relationships with peers and adults will be tracked and stable before lowering the risk level.

d) Lowering of risk level may be dependent upon the youth demonstrating alternative means of coping with difficult circumstances other than self harm. Many youth look good when not under pressure, but revert to self-harm under stress. Lowering the level of these youth may require seeing them deal with adversity prior to lowering their risk level.

e) If a panel member has a relationship with a child aside from the panel (e.g. child is on their caseload, has been in a group they have led etc) they may consult with the case but do not make the determination of the risk level. If a panel member has a personal stake in the case of any kind that panel member to shall indicate this on an SBR.

f) The suicide panel will consult with or use outside psychological or psychiatric assessments as well as other professionals when possible, or other programs assessment of imminent or unpredictable risk, but shall be responsible for setting the suicide risk level for youth within the Detention and Intake setting.

Routine Risk Panel Interview Questions for Risk Level Four Youth

a) What do you understand about being placed on Risk four?

b) Tell us what you think about killing yourself.

c) What reasons do you have for killing yourself?

d) What reasons do you have for living and not killing yourself?

e) Tell us about the last time that you tried to kill yourself. What was going on then that contributed to the idea of suicide?

f) What resources do you have for yourself in and out of detention? Which persons in your life mean the most to you? Do you have anyone, in or outside of detention, who will talk with you when things are the roughest?
g) Are there any detention staffs that you have confidence in and trust? Is there anyone on the staff you would like to know?

h) When was the last time you tried to kill yourself?

i) Did you think that this attempt was serious? If not, why were you doing it? What did you hope to achieve by attempting suicide? If the attempt was serious, how did it turn out that you lived? Are you sorry it did not turn out that you died from the attempt? If you are sorry, what are some of the most important reasons?

j) What thing or things in life could be improved so that suicide would be less an option?

k) In five years, assuming that you live, what will your life be like?

l) What plans do you have for the future?

m) Under what circumstances would you most seriously consider killing yourself?
n) Under what conditions are you most at risk for suicide?

o) If it is not bad enough for you now to think of killing yourself, what would you do if your dog died, your parents said they did not want you any more, your girl/boyfriend left you, and you were detained for another six months, pending placement in an institution? What would you do to take care of yourself?

p) What things in life do you live for?

q) How much do you use drugs and alcohol to cope with difficulties?

r) Do you have any friends in detention? Who are they?

s) How many people do you know who have killed themselves or tried to kill themselves? How do you feel about that?

t) If you were going to kill yourself in detention how would you do it?

Routine Risk Panel Interview Questions for Risk Level Three Youth

a) Why do you think you are on Risk level three? Is that a good idea or not? Why?

b) What do have in the future that looks good to you?

c) Under what circumstances would you seriously consider killing yourself?

d) Why do you want to live? Isn't suicide a good way out?

e) If your plans go astray and the Judge keeps you here for another six months until you can get into a special kind of institution or placement, what will you do to take care of yourself? What resources in detention can you use to help yourself cope? What staff will talk to you? Who on the staff would you like to know better? What kinds of things have you learned that help you get through hardships?

f) If you tried to kill yourself in the past, why did you attempt? What did you think you would accomplish then? What is different about now and then?
g) How are you feeling about yourself now? What kinds of things help you to feel worse about yourself? What do you know how to do to help yourself feel better?

h) How much do you use alcohol and drugs to cope with difficulties?

i) Tell us your present thoughts about the issue of suicide. How do these thoughts relate to you?

j) If you were thinking about killing yourself again, how would anyone know this?

k) Why do you think we should consider changing you from Risk level three?

Panel Availability

The panel can be accessed 24 hours a day via phone. Two specialized on-call Groupworkers shall be on-call to respond to emergency risk assessment and intervention.

Panel Composition

The DYS suicide panel shall be composed of at least 6 regular members and receive information and consultation from the DYS contract psychologist (on stabilization and therapy issues) and the detention Physician's Assistant (on health and medical related issues). The panel shall also have a liaison from detention administration. When at all possible, the panel will have at least on female members and representatives from all the DYS units (supervision, intake and resource).

Panel Meetings

The suicide panel shall have regularly scheduled monthly meetings. All panel members shall be expected to attend these meetings unless excused by their supervisor due to temporary work conflicts. If these conflicts exist the panel shall explore meeting at a time that allows all panel members to attend and participate. The panel shall meet on the second Tuesday of the month from 13:30 - 14:30. The normal meeting site shall be the intake conference room. The detention manager will periodically poll the panel membership to find if this time continues to be the best time to meet.

Panel Member Selection

Members of the suicide prevention and intervention panel shall be chosen upon review of available candidates from the existing DYS staff. Education, interest in the area of intervention, availability to detention, people skills and caring are some of the factors taken into consideration for review. Potential panel members are offered the panel membership and may decline if not interested. All potential panel members shall be approved by the Assistant Director of Youth Services.

Panel Member Termination

Existing panel members may end their service to the panel by notifying the panel and giving one month's notice. No panel member shall ever be made to serve on the panel against their will, inclination or ability to serve youth in crisis.

Disagreement Between Panel Members

It is anticipated that there will be some disagreement between panel members on correct interventions with suicidal youth.

All panel members are able to review the decision(s) made by other panel members and are encouraged to read all documentation produced by fellow panel members. Copies of all intervention and review documentation shall be made available to all panel members, the psychologist, Physician's Assistant and detention administrator via copies of the original SBR documents.

The decisions the panel makes are hard ones that have large potential impacts. The wider the possible discussion and review the better are the decisions individual panel members will make.

Individual case review and discussion is expected to be a part of the monthly (or more often if needed) panel meeting agenda.

In the event of disagreement of a change or alteration from policy that has the potential of altering the prescribed interventions on a particular youth, the concerned panel member(s) shall contact the panel member who made the intervention in question and discuss the concerns before taking any action. In the event the panel member who made the initial decision and wrote up the original SBR on the case is not available, the panel concerned member(s) can contact any member of the detention administrative team for review and possible change of intervention. In the event of an alternate decision being reached a thorough SBR shall document the reasons for the change and the staff and process involved in the change. If the decision they had reached was reversed upon review, a voice mail call, email message and copy of the SBR shall be left with the original panel member who made the initial decision if they could not be reached in person.

Supervision of Panel Members

Panel members need psychological and administrative supervision. These duties are carried out primarily by the detention administrative coordinator. The detention duties of the staff or contract psychologist(s) needs to include consultation for members of the suicide panel as well as involvement in setting the standards for practice and training of the panel members. This is particularly important as new members come onto the panel and begin dealing with the day to day issues of depressed and suicidal youth. The administrative supervisor attends to issues such as staff support systems, training, work load issues, recognition for panel members for the job they do and solving system issues. In our system the detention administrator bears the bulk of supervision. The panel members also have and provide peer supervision. Because the minimal qualifications for membership on the panel is possession of a master's degree the panel members help each other. The peer review nature of clinical supervision is part of the reason to have two panel members interview for possible risk level reduction. This system has worked fairly well but requires consistent communication between the psychologist and the detention administrator.

Suicide Prevention Training

Training for Detention/Intake Staff

Detention/Intake Groupworkers, detention Medical staff, Housekeeping, and any other detention staff as well as on-call Groupwork staff are trained in a mandatory 6 hour suicide prevention intervention program. Detention staff have a yearly 2 hour refresher course in suicide issues and prevention.
Detention administration also sends detention staff to outside trainings in Suicidology and prevention when they are offered.

Training for Suicide Panel Members

Once a potential panel member has been selected and has agreed to serve on the panel they shall receive a process of orientation and training to the workings of the panel process and responsibilities before becoming active in review of cases or intervention with youth.
The training process shall consist of a minimum of:
12 hours of training by panel members in segments to be mutually agreed upon by panel members and new members.
Review of selected panel cases for the past six months via written documentation and discussion of cases and decision(s) (provided by the existing panel).
Observation of 10 suicide reviews and debrief of the process with the two panel members doing the review process.
Reading this document in its entirety.
Reading of the suicide manual in its entirety.

Panel members are expected to attend 6 hours of professional training in mental health subjects per year, particularly in the suicide prevention and intervention area. Panel members may attend more than the 6 minimum hours. Typically panel members shall attend training as a group in order to be able to discuss the training and have similar backgrounds in knowledge.

Panel Disclaimer

Although we have spent over a decade in the careful design of a suicide prevention/intervention program and have confidence that the system we have arrived at is the best we could produce under the circumstances it is important to understand that despite these efforts we have not eliminated suicide risk from detention. Our system is not foolproof and at best mitigates risk in detention via a risk management model. We have had no completed suicides in detention while this program has been in place but that does not mean we are suicide proof. It is necessary to remain humble and be constantly

proactive to meet emerging issues as they come up. For a fuller exposition on this topic please see chapter 6 - Suicide Risk Mitigation.

Chapter 4 - Medical Issues in Suicide

Primary Medical Evaluation

Often in the course of dealing with high-risk youth, the detention staff will be faced with the possibility of encountering a medical emergency. It is, therefore, extremely important that all staff members are able to properly and accurately assess the physical and mental condition of a youth who may require prompt medical treatment.

An easy way to remember the steps to be taken in an initial survey is to remember that they follow the first five letters of the alphabet:

A = Airway maintenance – the airway should be opened by lifting the chin or jaw and performing a sweep of the mouth and throat to check for debris that might be blocking the youth's breathing. Remember to maintain control of the neck so as to prevent possible injury to the cervical spine. (review CPR training)

B = Breathing – staff member should expose the chest and visually assess movement. If no ventilation, begin CPR.

C = Circulation and Hemorrhage Control – the way to assess circulation is to check for a pulse (most accessible is the carotid pulse in the neck), look at the youth's skin color (is it pink, indicating good circulation, or is it gray or purple, indicating lack of circulation) and capillary refill, which is assessed by pressing on an area of the skin and watching to see if there is blood return to the area. (see Classification of Hemorrhages)

D = Disability in neurological status – it is necessary to check the level of consciousness of the youth. This status check is done by seeing if the youth responds to your voice, and if he/she is alert. Next, check for response to pain and unresponsiveness of the victim.

E = Exposure_- it is important to completely undress the youth at this time to evaluate the extent of possible injuries. These injuries may not be apparent on an initial evaluation.

Medical Response to Suicide Attempts

The next area of concern is the medical response to actual suicide attempts. In order to be prepared to make a response, it is important to identify the major ways youths might harm themselves in detention. Some of the main ways that youths might try to hurt themselves will be discussed in this section:

1. ***Choking/asphyxiation*** - if a teenager attempts to choke or hang him/herself the result could be hypoxia. Hypoxia is a decrease in the amount of oxygen available to the tissues and brain. This condition can cause permanent damage to the Central Nervous System. Any incident that might involve hypoxia necessitates that an accurate chronological record of all events including the onset, discovery, evaluation and follow-up of the incident is compiled. The following chart indicates how to do a neurological assessment following an episode where hypoxia is suspected or known to exist.

Hypoxia Assessment

		Score
Best Eye Response	Opens eyes spontaneously	4
	Opens eyes to speech	3
	Opens eyes to pain	2
	No response	1
Best Motor Response	Obeys commands	6
	Localizes pain	5
	Withdrawal from pain	4
	Flexion to pain	3
	Extension to pain	2
	No response	1
Best Verbal Response	Oriented	5
	Confused	4
	Inappropriate	3
	Incomprehensible	2
	No response	1

If total at least 14: Refer for evaluation by P.A. when available
If total 13-12: Call PA. or M.D. for advice
If total 11 or less: Immediate evaluation - call 911

2) ***Bleeding/cuts*** - the obvious danger from severe cuts is hemorrhage which can result in rapid death. A fully grown adolescent male can lose up to one and a half pints of blood before they are in danger of bleeding to death. An adolescent female is in grave danger with a loss of less than a pint and a half, and a smaller child can bleed out more quickly. A rapid loss of blood often results in shock, which can also be life threatening. The symptoms of severe shock are as follows:

a. blood pressure below 90 mm
b. increased pulse rate, can be weak and thready
c. skin pale and cold
d. breathing rate is rapid and shallow
e. mental state is anxious at first and then the victim falls into a coma

As the body loses blood, blood pressure may continue to drop. Low blood pressure can lead to shock and organ failure, particularly the kidneys and heart. Some indications of how low blood pressure has fallen are:

a. if you are able to feel a radial pulse (wrist) the pressure is likely more than 80
b. if you are unable to feel a radial pulse but can feel a femoral pulse (thigh) the pressure is likely more than 70
c. if you are unable to feel either a radial or a femoral pulse but can feel a carotid pulse (neck) then the pressure is likely more than 60

Bleeding Flow Sheet

Wound Management Flow Sheet

2. ***Poison Ingestion*** – Upon the discovery of a possible overdose or poisoning victim the first thing that a staff person should do is to contact the Poison Control Center. (see next page with 800 number). While one staff member is making this call, there are four steps that can be done to manage an overdose or the ingestion of a poisonous substance:

    a. if the substance taken is nearby the victim, remove the poison
    b. give the victim an antidote if available (the poison control people will instruct you as to what is the appropriate antidote for a known substance)
    c. promote the elimination of the substance – this is usually done by inducing vomiting by using Ipecac, however, if the victim has taken a poison which is corrosive in nature, such as lye, which can be found in certain cleaning supplies, like Drano or Liquid Plumber, vomiting can result in burning the esophagus. In this case, do not try to get the victim to throw up, but follow the instructions of the poison control people regarding coating the throat and stomach lining to prevent further damage.
    d. Provide support to the victim and monitor the vital functions

While the management priority will depend on the specific drug and the way it was administered, support of vital functions is the first concern.

3. ***Swallowed Poisons*** – A person who has swallowed poison may not show symptoms immediately. This can be because the amount ingested is less than noticeably toxic, or sufficient time may not have elapsed for full absorption. The average time from ingestion to symptoms is between a half hour and two hours, but this process can take up to six hours. If alcohol has been mixed with the substance this speeds up depressant intoxication and will often affect the vital signs in fifteen minutes.

4. ***Inhaled Poisons*** - If the poisonous substance has been inhaled, such as in carbon monoxide poisoning, inhaling gas fumes from an oven, or huffing, the individual should be exposed to fresh air immediately. He or she should be kept warm and lying down, and the vital signs should be monitored. If the person is not breathing, CPR may be necessary.

Poison Control Center

1-800-222-1222

Poisoning Event Flow Sheet

Types of Poisoning

While the management priority will depend on the specific drug and the route of administration, support of vital functions is the first concern. In the case of all swallowed poisons, the Poison Control Center should be contacted as soon as possible for advice.

In this next section I will try to list some common types of poisoning and describe the symptoms of each:

1. **Acetaminophen** : (Tylenol) – the symptoms of a overdose can occur within a few minutes or up to a few hours after ingestion. The immediate symptoms include:
    a. anorexia (loss of appetite)
    b. nausea and vomiting
    c. sweating

These symptoms can continue to improve over 48 hours, however serious damage can begin to occur inside the body. The major organ damage usually takes place in the kidneys, which in 3 to 5 days after a large ingestion, can result in jaundice, blood clots and kidney failure.

2. **Aspirin and other Salicylates**: (Bufferin/Excedrin)
    a. nausea and vomiting
    b. ringing in the ears
    c. fever
    d. dehydration
    e. lethargy or excitability
    f. disorientation
    g. convulsions
    h. coma
    i. respiratory problems

Ingestion of more than 150 mg is expected to cause toxicity with these substances, while ingestion of more than 300 to 500 mg is a serious situation, and ingestion of over 500 mg is potentially lethal.

3. **Anticholinergic Drugs** : (Atropine, Antihistamines, Tricyclics)
    a. dry mouth
    b. flushed (red) face
    c. retention of urine
    d. decreased bowel sounds
    e. fever
    f. rapid heart beat (tachycardia)
    g. hypertension (elevated blood pressure

h. restlessness
i. irritability
j. delirium or hallucinations
k. coma

4. **Alcohol**: (Ethanol, whiskey, brandy, and other liquors)
    a. initially excitement then depression
    b. delirium
    c. inebriation
    d. coma

Death generally results from respiratory failure.

5. **Amphetamines**: (Ritalin, Dexedrine, Adderall)
    a. increased body temperature (hyperthermia)
    b. rapid heart beat (tachycardia)
    c. shock
    d. hallucinations
    e. dilated pupils
    f. sweating
    g. convulsions
    h. elevated blood pressure
    i. irregular pulse
    j. coma (rare)

6. **Antidepressants**: (Prozac, Zoloft, Paxil)
    a. anxiety
    b. insomnia
    c. headache
    d. tremor
    e. fatigue
    f. nausea
    g. sweating
    h. diarrhea
    i. slowed respiration
    j. coma

These are some of the more common of many possible symptoms

7. **Barbiturates**: (Sleeping pills)
    a. similar to alcohol ingestion
    b. lethargy
    c. rapid changes in emotions
    d. impaired thinking
    e. poor coordination
    f. slurred speech

g. rapid movement of eyes

These symptoms occur in mild to moderate overdose, however, in larger doses the central nervous system (CNS) can be greatly depressed leading to extreme lethargy or profound coma. Heart dysfunction is possible and can lead to lowered blood pressure, dilation of the arteries and veins, and shock.

8. **Carbon Monoxide**: (Automobile exhaust, defective heater)
    a. headache
    b. dizziness
    c. vomiting
    d. bounding pulse
    e. dilated pupils
    f. dusky (gray colored) skin
    g. cherry red lips
    h. convulsions and twitching
    i. respiratory depression
    j. coma

9. **Hallucinogens:** (PCP, LSD, Ecstasy)
    a. agitation
    b. feeling of detachment
    c. fever
    d. sweating
    e. perceptual disorientation
    f. hypertension (elevated blood pressure)
    g. seizures
    h. kidney failure
    i. coma
    j. prolonged psychosis

10. **Hydrocarbons**: (Kerosene, gasoline, benzene, petroleum)
    a. choking and coughing
    b. rapid breathing (tachypnea)
    c. difficulty breathing
    d. retractions (sucking in of stomach in an effort to breathe)
    e. fever
    f. irritability
    g. drowsiness
    h. lethargy
    i. seizures
    j. coma

These are symptoms of inhalation of these substances. If they are swallowed the following symptoms may also occur:
    a. burning of the mouth and stomach

b. nausea and vomiting
c. cold skin
d. tremors
e. hypothermia (loss of body heat)
f. weak pulse
g. decreased blood pressure
h. seizures
i. loss of consciousness

Death from hydrocarbon overdose is usually due to pneumonia caused by aspiration (the inhalation of foreign material or vomit containing acid stomach contents).

Insecticides:

a. excessive saliva
b. tearing of the eyes
c. urination
d. vomiting
e. sweating
f. tremors
g. convulsions
h. coma
i. respiratory arrest

These substances are rapidly absorbed through the skin and mucous membranes (inside nose and mouth). Symptoms progress rapidly and can occur within minutes and almost before 12 hours of exposure.

11. **Narcotics**: (Morphine, heroin, opium)
a. stupor
b. coma
c. slow respiration
d. cyanosis (blue lips, skin, fingernails)
e. low blood pressure
f. shock
g. constricted pupils
h. flaccid (loose) muscles
i. difficulty breathing
j. fever
k. dizziness
l. delirium
m. respiratory failure

At first the intake of drugs acts like a stimulant, then it becomes a depressant, causing all body functions to slow down. Because of depressed breathing and heart rate, there is a danger of the brain not getting enough blood flow (asphyxia).

Diabetic Emergencies

An area of great concern to staff in detention is the medical treatment of diabetes. Because of the restrictions of being in a detention facility, the diabetic youth can present special problems. It is very important for these youth to receive the correct dosage of their medication and to get it at the proper time. This can present real monitoring problems. Improper timing and dosage of medication (insulin) can result in serious insulin reactions. The two main areas of medical difficulty presented by diabetes are insulin shock, and diabetic coma.

	Insulin Shock	Diabetic Coma
History: Skin Insulin Onset Sugar intake	Pale, moist Excessive Rapid (minutes) Decreased	Red, dry Insufficient Gradual Increased
Respirations: Rate Odor	Normal or shallow Acetone odor may be present	Air hunger Acetone odor usual (sweet, fruit smell)
Cardio-vascular: B.P. Pulse	Normal Normal, maybe rapid	Decreased Increased
G-I: Mouth Throat Hunger Vomiting Pain	Salivating Absent Intense Uncommon Absent	Dry mouth Intense Absent Common Frequent
Neuro: Headache, Tremor Mental Status Vision	Present Apathy to irritability to unconsciousness Double	Absent Restlessness, irritability to unconscious Dim
Improvement	Rapid with CHO administration	Gradual after administration of insulin (6-12 hours)

* Diabetic Emergencies are always treated on the premise of insulin shock. If the individual is fully conscious administer one of the following:

4 oz. apple or orange juice or ginger ale

3 oz. regular cola or soft drink

2 oz corn syrup or honey

2 oz. cake icing

5 pieces Life Savers or other roll candy

5 Jellybeans

This may be repeated in 10 minutes.

If symptoms decrease and the next meal is more than 1 hour away, give a protein and complex CHO snack (1 oz. cheese, slice of bread and glass of milk).

A diabetic youth can use his illness for self-harm. If any adolescent is not following his/her prescribed medical regimen, then it is necessary to notify not only the medical staff, but also the suicide prevention team.

Any time that a medical condition is felt to be being used for self harm, a Risk Level of 3 or 4 should be assigned, if this has not already been done.

Chapter 5 - Counseling of Depressed and Suicidal Youth

The provision of appropriate counseling services for detained youth can, at first glance, seem a daunting and complex task. It is difficult to gauge how much counseling anyone should have and who should be providing it. The expense of these services might run from minimal to unaffordable. These difficulties are exacerbated in the absence of a suitable understanding of why counseling services might be desirable or useful.

To address these questions in the context of juvenile detention it might help to think about what we do not wish to accomplish; this may facilitate a better understanding of what is desirable. Knowing what constitutes safety-detracting behaviors for automobile drivers can help to focus on positive, safety-enhancing behaviors. Understanding the potential hazards of poor mountaineering techniques can help to identify useful techniques. Similarly, if we are interested in responding well to the counseling challenges posed by suicidal youth, perhaps it might make sense to begin with considerations of ways we might help young people feel more suicidal or less stable. Can we describe a detention model that increases the risks of attempted and completed suicides?

The answer is both easy and affirmative. There are obvious ways to make suicide easier and more attractive in detention. For example, suicide can be structurally accommodated. Such accommodation can include unimpeded access to toxic cleaning materials and glues, the use of posts in bedrooms and private areas, the provision of unmovable clothing hooks in walls and on doors, removable spring assemblies on beds that can be turned into sharp weapons, available and accessible glass in windows, belts included with standard detention clothing, constant availability of shoelaces, unprotected electrical outlets, unmonitored use of razors and scissors for personal grooming and a host of other ingenious means of self-harm and death. Any program that aims to reduce or eliminate suicide in detention would be unwise if it failed to control or eliminate the means available to commit suicide.

More applicable to counseling is to know, as is well understood, that isolation increases the risk of suicide for at-risk persons, we might devise means to keep suicidal youths isolated. We might advocate the use of rooms that keep youths alone when they are most in crisis and unstable. We might understand that such youths are principally seeking attention and deny them that attention by keeping them unmonitored and out of contact with detention staff. Policies that force youths identified as especially at-risk for suicide can be designed to keep these youths even more isolated than youth who are not designated as at-risk. If suicide is made into purely a mental health issue, then policies may dictate that suicidal youth cannot talk to any persons except rarely available mental health specialists. This way suicidal youths will not interfere with ordinary detention programming. Essentially, corrections staff can ignore suicidal youths, because suicide poses mental health, not corrections issues; these youths pose problems for mental health professionals, not corrections staff.

With the understanding that many suicidal persons are also depressed, interventions with depressed youth can focus on psychotherapy offered only by fully qualified professionals who address primarily the core personality issues of depressed and delinquent youth. Once again, it may be helpful to label these young persons as mental health clients and thus separate them from most staff, who are unqualified to speak professionally with them. If possible, such youths should be segregated from staff and the rest of the detention population because they are so different. After all, they can contaminate the rest of the population unless they are contained, and they can drive other young people crazy.

Because tendencies toward suicide are elevated among delinquent youth, discipline methods can focus on targeting manipulation around the issue of suicide in an effort to address a fundamental delinquency issue: lying. Staff will discount the seriousness of suicide threats and grow confident in abilities to differentiate between actual and feigned suicide threats. Suicide will become viewed as a suspicious, usually empty threat by people who don't want to kill themselves, but who do want attention or some other benefit from acting suicidal. By no means should anyone merit special treatment by virtue of suicidal threats or gestures.

The proactive suicide intervention model developed in Lane County was designed to avoid some of the prominent pitfalls outlined above. The model includes several important principles to guide day-to-day, stabilization and counseling modes of the model at work. These principles inform the Lane County model:

1. Attention to risk for suicide is a constant part of safety consciousness and is taken seriously within the entire detention community;
2. Although isolation remains an intrinsic and unavoidable part of the detention experience, opportunities to reduce isolation will be afforded to youth identified as especially at-risk for suicide;
3. In addition to specialized staff, all staff can play roles in suicide counseling;
4. With regard to the issue of suicide, detention functions best as a community, not an amalgam of discrete persons and tasks. Suicide is everyone's concern.

What Does Counseling Mean in a Juvenile Detention Setting?

Leona Tyler, in her standard text, *The Work of the Counselor,* defines the purpose of counseling as assisting people to make choices, make changes and reduce personal confusion concerning work, relationships and aloneness. Note that Tyler's purpose does not include responsibility for changing behavior. Choices, changes and personal confusion are common issues for suicidal youth. Tyler's purpose of counseling can be realized in casual conversation with detained suicidal young people as they struggle with topics such as school and career questions, repair of damaged relationships, the loss of family, transitions to new homes or the construction of new relationships. Detained

youths may be breaking away from families, peer groups, or confronting the deaths or separation from persons who had been close to them. Many young people enter detention in crisis, even if they appear to be casual and unshaken. Counseling can be accomplished in a few minutes of structured conversation or within several hours of playing cards. Counseling may be an inadvertent outcome of the most innocuous of interactions with suicidal youth. Professional counselors often describe themselves as primarily listeners, suggesting the significance of silence in the counseling process. An effective counselor for a detained youth may be someone who keeps his or her mouth shut with a youth who believes that no one will listen. It may be taking the time to hear, question and reflect without giving advice, unless it is requested.

It is also fundamental to any counseling that it constitutes a relationship, not solitary persons in proximity to each other. The passage from mutual solitude to relationship is part of what differentiates counseling from persons who are just passing time in conversation. In effect, the counseling relationship may play a key role in bringing an individual who is alienated into a community, starting with just one person who becomes perceived as the first component of a support system. It could be said, in retort, that this description is strained, because the roles defined here might include simply friendly persons, welcoming persons, and even uneducated, warm-hearted persons. This is precisely the case: counseling itself need not be limited to a professional practitioner and no one else, especially when we are discussing services for a population whose risk is exacerbated by isolation. In effect, virtually any adult in a detention setting can act as a counselor with detained, suicidal youths. In this institution, some of the best counselors to suicidal youths have been housekeepers, cooks, medical personnel, regular line staff, on-call staff, volunteers and students. These persons have been identified by the youths themselves as effective resources. Virtually anyone who works or volunteers in detention can participate in counseling with suicidal youths.

At the same time not all efforts at counseling are appropriate, and not all persons who might wish to offer counseling services are effective counselors. Without going into great detail, the general guideline of the mental health professions is applicable: do no harm. What does this mean in practice? On a simple level, it means that any self-gratification from relationships with young people is secondary to the welfare of those persons. Sincere, mistaken efforts in this direction can be corrected, but the exploitation of relationships with vulnerable young people will not be tolerated or supported. Religious, political, sexual or economic agendas that make young people the instruments, rather than the beneficiaries of services have no parts in legitimate counseling.
Of course, there are obvious risks associated with growing close to persons who may be preoccupied with questions of life and death. One of the risks is that we ourselves might be drawn in too far, seduced by the same interests as the youths. This is a very real risk for anyone who might work with this population, but it is effectively mediated by the same basic tool we are trying to offer suicidal youth: conversation with an interested party, good counsel and connection with someone who can help us think more clearly. Suicidal thoughts are classically managed most poorly when they are kept secret, and when secrecy is enforced by isolation. The most dangerous things for young people to do are also the most dangerous things for us to do. While the work of counseling suicidal youths is unquestionably important, there is no doubt that it poses significant risks for

those who counsel. It is unwise to ignore or downplay such risks. Any counselor of suicidal youths must be prepared to understand the limitations of what he or she can offer, and seek help when it is needed.

Myths of Suicide

Within our culture are embedded significant beliefs that cripple, confound, complicate and obstruct the practice of counseling with suicidal persons. Frankly, it is impossible to provide effective and useful counseling if any or all of these myths have been internalized. Therefore, each of the major myths has been enumerated below and followed by rebuttal. Notice that there is something true to each of the myths, but that grain of truth has been distorted and twisted in each case, usually to the point that hand wringing becomes a seemingly rational response to the issue of suicide.

Myth #1: Talking about suicide can drive people to kill themselves. The very mention of suicide, therefore, is dangerous. By talking about suicide we somehow give tacit support to the idea of suicide and help people to consider it even more than they would if we talked about anything else. It would be better to talk about any topic other than suicide with a suicidal person.

The truth is that truly suicidal people are already concerned about the issue. To talk about suicide, then, is to take an interest in a suicidal person. That interest, of course, can be risky, but no one can make another person suicidal by showing an interest in that other person's welfare. Contrary to the expectation generated by the myth, most persons who have been considering suicide are relieved when another person asks about it. In fact, it is virtually impossible to offer effective counseling to a suicidal person while avoiding any mention of suicide. For a suicidal person there may be no other topic.

Myth #2: Most people identified as suicidal are just manipulative and do not really intend to kill themselves. A detained youth who talks about suicide is simply vying for attention, trying to achieve notoriety or manipulating for some other devious purpose. It is best not to play into the hands of such persons and realize that theirs are simply empty threats; the threats will disappear if they are ignored.

This is a common myth that, like a rumor, is not more credible because many people believe it**. The truth is that many detained youth are manipulative, just as non-detained youth and healthy adults might also be manipulative**. Being manipulative does not cancel out suicide, however; a person may be both suicidal and manipulative. Moreover, in a detention setting suicidal gestures, even if they are not intended to bring about death, can result in an unintended death. For example, a young person might tie something around his or her neck and begin to strangle after crying for help, but just as staff begin responding to that apparent emergency another even more tangible emergency diverts staff attention elsewhere. Someone could die in those few moments, even if the intent was rescue, not death. A young person who manipulates him or herself to death is just as dead as someone who intended death. Several recently completed suicides in Oregon were permitted to occur because staff were convinced that the persons threatening suicide were "only manipulative."

Myth #3: People who have attempted suicide will not try it again because the impulse to commit suicide is now "out of their systems." In effect, a suicide attempt

constitutes a life lesson that the suicide attempter has learned. Such a person has a respect for the gift of life that few of the rest of us can appreciate. Therefore, a past suicide attempt can lead to a confidence that suicide will not be attempted again.

In contrast to the myth, **what we know about suicide suggests that 80% of completed suicides are carried out by people who previously attempted suicide.** To even consider suicide seriously any person must overcome an inherent aversion to taking human life- especially one's own. Once that line has been crossed, it is easier to consider doing it again. A history of previous suicide attempts is not comforting, regardless of the argument to that effect. Previous suicide attempts are indicators of greater, not lower risk.

Myth #4: Suicidal people intend to die. Any program that intervenes to stop suicide is therefore only postponing the inevitable. It is not altogether possible to stop someone who fully intends to commit suicide. Suicide interventions programs are doomed to fail.

This myth stems from the erroneous belief that completed suicides are made by persons who are virtually compelled to die at their own hands, as if death is a source of ultimate satisfaction. While there may be such persons, **most suicidal people wonder about the wisdom and purpose of living; they are not necessarily intent on dying.** Ambivalence about the values of life and death can be productive topics of conversation and reason to consider the experiences of others. Death is not usually considered the only way out, but the fear is that it might be the only way out of a difficult set of choices or circumstances that seem to have no other solution. Suicide may be chosen as an option because alternative coping skills are unknown, have never been practiced or have never received support. Although as Albert Camus, among others, has argued, suicide may be a rational- even a wise choice- for adolescents, especially, suicide is often chosen as a solution to difficulties out of ignorance and lack of experience, not wisdom. Adolescent suicide is frequently tragic, not in the heroic sense, but because the solution- death- is so out of proportion to the problems it was chosen to solve.

Myth #5: All suicidal people are mentally ill. This means that suicidal persons are really within the province of mental health professionals, who are the only people who know what to do with such persons. It is naïve and foolish for anyone who does not have mental health training to work with such persons, and they should not be in juvenile detention homes. They belong in appropriate psychiatric institutions. Moreover, the problems of such persons are the result of mental illness, and it is foolish to believe that anything can be done short of effective treatment for mental illness.

It is true that some suicidal persons are mentally ill. It is also true that many detained youths have several psychiatric diagnoses. However, **suicides are attempted and completed by a broad range of people, from persons who appear to present no evidence of mental illness to those who are severely handicapped by their difficulties.** What is most apparent about suicidal persons is unhappiness, a quality of life issue that is not necessarily equated with mental illness. Any person can experience unhappiness, sadness, disappointment, loneliness or defeat. Each of these experiences,

and others like them, can fuel an interest in suicide. Effective counseling with suicidal persons targets ordinary human being issues and does not venture into psychotherapy or effective treatment of mental illnesses. Mental illness may be present in suicidal youths, but suicide and the more immediate issues surrounding it are really the focus of counseling, which is about relief of suffering rather than a cure for any malady.

Myth #6: People who make suicidal statements or threaten suicide don't follow through. The fact that a person talks about suicide indicates an actual desire to do something other than suicide. Really suicidal persons don't talk; they act. Therefore, doing something about threats of suicide plays into the hands of persons who really have something other than suicide in mind. Suicide intervention programs for such persons are therefore a waste of time, effort and money.

This myth may be based on the initial reactions of persons around many completed suicides: "I had no idea." In later reflection, however, many of those same persons have been able to realize that they were given indications of suicide, but they either discounted what they were told or did not understand the context at the time. We know from retrospective studies of completed suicides that **most people who completed suicide made either direct or indirect statements about intent to commit suicide.** It is therefore wise to understand suicidal threats, gestures and statements as reliable indicators of intent to commit suicide. Failure to accept this wisdom can bring about devastating consequences.

Myth #7: Suicide happens suddenly, without any warning. People who commit suicide are impulsive; they act quickly and do not carefully consider what they are doing. Very little can be done to intervene in or prevent suicide because it is such an impulsive act. To participate in a suicide intervention or prevention program is to pretend to do something about which nothing can be done.

Although some suicides may fit this model, by far **most suicidal acts and gestures were carefully considered as coping strategies long before they were carried out.** It is typical, not unusual, for people to contemplate suicide long before they take action to end life. The counselor has a definite role to play in helping people who are considering suicide as an option make an informed choice. **It has been said that suicide among adolescents is often a permanent solution to a temporary problem.**

Detention Stabilization

Description Of Duties Of A Stabilization Team Member

Each Monday the Suicide Stabilization Intern Coordinator compiles a list of all adolescents who are in either risk level 3 or 4, assigns each youth on this list to a member of the Stabilization Team and sends notice of these assignments out via email to interested parties. Individuals on "Special Behavior Plans" may also appear on this list and be monitored by the Suicide Stabilization Team.

The team member receiving the assignment(s) has an obligation to visit with that/those individuals twice weekly (minimum) for at least 30 minutes each visit. The objective for the team members is to stabilize the individual in the detention setting and to assist staff in maintaining a safe environment for these youth. This includes, but is not limited to, helping the adolescent transition to detention and to support the adolescent in finding appropriate avenues to express their despair or otherwise minimize the potential for self-harm in the detention setting.

Having the opportunity to work with the adolescents in Detention as a member of the Suicide Stabilization Team is not the same as having the opportunity to do therapy with these kids. It is important to remember that the goal is "stabilization", not "healing" or "psychotherapy". While these youth would frequently benefit from individual therapy the stabilization team is not the appropriate venue for this service. The goal is to "STABILIZE" the youth while "therapy" frequently includes a period of de-stabilization ("re-visiting" or "opening" old wounds"), actually creating vulnerability, as part of the therapeutic process. Among the many and varied reasons for this necessary distinction is that Stabilization Team Members most frequently work with youth for only a short time, are not readily "on call" if a psychological emergency developed, and are not necessarily trained in appropriate psychotherapy techniques and ethics.

Further, when working with youth it is vital to remember that you are usually only privy to the youth's perception of events and that other service providers (the probation officer, staff member, teacher, etc.) likely have different perspectives. Frequently, if not always (especially in the case of probation officers), these other professionals have access to a lot more information, from many more sources, than you do. It is wise to bear this in mind as the youth relay their version of the way their case is, or has been handled.

Another caveat to keep in mind is that the specific objectives selected to move any individual adolescent to a more stable emotional state can vary dramatically from youth to youth depending on their particular assumptions, situation and overall psychological profile.

Obvious, and commonly occurring, objectives are listed below with examples of specific practices that may be helpful to accomplish each objective. This is in no way a comprehensive listing of potential objectives or practices to be used by Stabilization Team Members. It is only a much-abbreviated listing of examples to give a 'flavor' of the role a Stabilization Team Member plays.

Center for Family Development Stabilization Protocol

Detention Stabilization Protocol

1. **Client** is assessed as needing stabilization work at Intake prior to being sent to Detention.

2. **Client's** name is placed on ***room chart.***
   - Updated twice daily by **Detention staff**
   - Chart is located in the pod control room office and copies also carried by **Detention Staff**

3. **Intern** will assign themselves a case:
   a. Go to Psych services office in detention and make a file with the following:
      a. Permission to Evaluate
      b. P-note
   b. Determine which youth to be seen.
      a. Go to detention and talk to detention staff to gather any information they have on risk level youth
      b. Look at Suicide stabilization tracker and room chart in pod. Assign them a youth using the following criteria.
         i. Unassigned Risk level (4s and 3s)
         ii. Detainees that have been without services the longest
         iii. Detention Staff recommendation
   c. Document assignment:
      a. Intern to make a sheet in the Suicide Stabilization Tracker for the client if needed and write their name on sheet.
4. Intern will prepare to see client:
   a. Talk to staff about client
   b. Read detention file outside of each pod
   c. Write client's name on the front of PET and the date on the back and put in Viriam's mailbox in the workroom.

5. Intern will see client: (Try to call detention staff first)

a. Try and see client during free periods they are as follows:
    i. One Pod will be available **M-F 3:30 pm – 5:00 pm** and both pods are available at **5:30 pm – 9:15 pm** (appointment must END by 9:15 pm), **EXCEPT Wednesday 6:00 pm – 8:15 pm** which is family visitation
    ii. **Lunch (12 noon – 12:45 pm)** is also a possibility but must be prearranged with client
    iii. **Sat and Sun** are basically open times, however, it is good to call and confirm.
    iv. If the **client** is still on **Orientation status** (first 2 days in Detention) they are available **any time**

b. Let client know that you will try and see them twice a week and let them know when that is.
c. If these times are unworkable then the Intern **can** see client during **post-lunch school period 12:45pm – 1:50pm M_F**. The Intern **does not** need to contact the teacher prior to taking the youth out, however, a brief check-in is advisable if possible.

6. After first meeting
    a. Fill out p-note and place in ***Client files*** will be **kept** in locked file cabinet in **Psych Services Detention office.** Will write up short progress note for Psych Services ***Client File***
        v. Length of session
        vi. Noted strengths of client
        vii. Status of client compared to last visit (same, improved, regressed)
        viii. If felt the need to contact Detention Staff due to regression
    b. Contact **Probation Counselor** by voice mail letting them know you have seen **client** and if **client** appears more, less, or equally as suicidal. If you feel that **client's risk level** should be **increased**:
        - Talk to **Detention Staff** member and state your reasons for wanting an increase in risk level.
        - **Document** reasons in ***Detention File***.
        - Notify **Megan** who will then notify **Mitch** and **John**.

7. Megan will report to detention three times a week to oversee Suicide stabilization assessment process and address any gaps in services.

Objectives of Stabilization

Objective 1:

Reduce distress due to "not knowing", even after youth has been through orientation. Orientation is very informative but youth may not have digested all, or even any, of the information at the time it was presented (for any number of reasons).

Practice: Inform youth of expected behaviors towards staff members. Discuss pros and cons of treating staff with respect. Remind them that staff can be a great resource to them and care very much about their well-being. Discuss the value of choosing several staff that they can develop a special rapport with - even if they are not willing to accept that all staff are potentially helpful.

Practice: Inform youth of the appropriate way to request services. Verbally instruct them and also take them physically through the process of filling out a request form to see their attorney, their probation officer, medical assistance, etc.

Practice: Inform Risk Level 4 youth about the process that occurs in order for them to have their Risk Level reduced. It may be helpful to clearly explain the difference between your role as Stabilization Member and the role of the Assessment Team Members.

Practice: Inform youth about visitation rules. Clarify, as possible, any misunderstandings (e.g. about expected contact visits, how the visitor list is compiled, etc.).

Practice: Normalize and validate the emotions they feel at this time; they are not the first to be distressed by "not knowing" while in detention.

Objective 2:

Reduce distress due to visitations (or lack of). Under the best of situations the visitations are stressful for youth in detention.

Practice: Debriefing the visitation can be enormously soothing for these youth. Allowing youth to express their feelings (e.g. apprehensions, hurt, anger, homesickness) after these contrived visits can be critical.

Practice: Assist youth to see the wider context of their visitors' behaviors during visitation. Youth may not realize the stress (e.g. anxiety, sadness, frustration) that their visitors may experience when visiting detention. They may not be able to see, without guidance, their visitor's perspective.

Practice: Assist youth to understand their immediate reactions to visitation. This includes normalizing and validating their experience and, again, assisting them to see the situation in a wider context.

Practice: Validate and normalize their emotions around visitations. They are not likely to be the first, or the only, youth to feel this way. Encourage them to discuss this with peers who are coping fairly well if this seems appropriate.

Objective 3:

Reduce distress due to youth's focus on negative past experiences.

Practice: Collaboratively assist youth to create a plan for short-term future goals that include clearly stating what they can do, personally and while in detention, to make those short-term goals a reality. The more detailed, personal, and realistic this list, or other documentation, the more likely it will be helpful. The idea is to help the youth see that they are capable of taking charge, and making changes, in certain aspects of their lives.
Ex.) If a youth expresses a great desire to get out (common) then:
* The short-term goal could be to convey to his or her probation officer, attorney, and ultimately the judge HOW they are willing to make things different when they are released.
*List behaviors that youth WILL take (e.g. attend school, report to PO as expected, etc.)
* Write letters to caretakers expressing desire to establish different relationship.

Practice: Listen to youth - really listen. This is where it can get tricky; this is not usually a time to dig deeper, not a time to interpret, not a time to assist youth to make connections from past experiences to present behaviors. Those actions could be therapeutic IF you had more time, and you were playing a different role in the youth's treatment plan. However, these actions would likely create vulnerability in the youth (even if only temporarily) that may not be consistent with the goal of stabilization.

Practice: Attempt to connect with youth in a way that allows them the confidence to confide and share their history and their feelings - then and now. Listening, remembering, and checking back in with them about their particular concerns will be stabilizing in itself.

Practice: It may be useful to normalize their experiences to some degree and will certainly be sensitive to validate their feelings about the experiences.

Objective 4:

Reduce distress due to conflicts with peer relations in detention.

Practice: Listen to youth's version of the conflict. Collaboratively discuss new ways of viewing the conflict and different responses if it is to occur again. Encourage youth to take responsibility for the part they played in the conflict.

Practice: Encourage them to take the "high road" and not become involved in other youth's struggles.

Practice: Talk about making the "hard choice" even if it not the "easy choice".

Practice: Validate and normalize the experience of difficult peer relations in this setting. Perhaps it will be useful to discuss how the commonly held emotions of frustration, fear, anger, and lack of social control in this setting contribute to creating a very challenging social environment.

Objective 5:

Reduce distress due to having to wear the smock.

Practice: Inform youth about safety concerns and convey desire to, above all, keep them alive.

Practice: Inform youth of process to get Risk Level reduced, and expectations for time-line for review to best of your knowledge (no promises, but realistic expectations).

Practice: Inform youth of any current behaviors that contribute to the concern that staff, and the Assessment Team, have for their well being. Explore appropriate alternative behaviors that might be satisfying (in some way) to the youth.

Practice: Normalize and validate this complaint. It is universal.

Objective 6:

Reduce distress due to upcoming court or disappointing court appearance.

Practice: Encourage youth to share their specific concerns and questions and frustrations. Share information, answer questions, and validate their frustrations when appropriate and as possible.

Practice: Encourage youth to role-play, with you, their appeal to the judge or to their lawyer or their next visit with their probation officer; help them put words to and clarify their desires for placement, services, etc.

Practice: Validate and normalize the level of distress felt and find constructive and concrete ways to minimize them (see above).

Objective 7:

Reduce distress due to "no shows" or "no follow-through" on part of probation officer, nurse, staff member, other professionals in psychological services, etc.

Practice: Encourage youth to gather information from the people who are believed to have "let them down". Frequently, the youth assume that this person did not take a certain action because the person "doesn't like" them. There may be quite understandable reasons for the actions, or failure to act. There could also be a misunderstanding about the commitment in the first place.

Practice: Role-play the information gathering described above emphasizing ways to gather information without being offensive, judgmental, or otherwise alienating or putting the service provider on the defense.

Practice: Remind of appropriate use of "Request Boxes".

Practice: To the best of your knowledge, clarify professional role of service providers in question if there seems to be a misunderstanding about services they have or have not provided.

Practice: If appropriate, encourage youth to consider alternative, or additional, actions they can personally take to get their needs or desires met rather than merely waiting for others to take a particular action.

Practice: Validate and normalize these commonly perceived "slightings". However, be cautious about siding with the youth and "condemning" accused staff or service provider. It may be useful to find constructive and concrete ways to minimize these perceptions (see above).

Pragmatics and Responsibilities of Stabilization Team Members:

Complete and comply to all instructions as provided in the orientation by the detention administrator of psychological services; this includes instructions on procedures with keys, time cards, ID badges, radios, ways to stay safe, etc.
Complete two shifts shadowing staff in detention.
Keep accurate and current records of time spent with youth in the "Risk Stabilization Notebook".
Attend regularly scheduled meetings with assigned personnel from Psychological Services.
Notify staff of any particular concerns with individual youth.
Adjust assigned risk level up if you have any reason to suspect that the youth is inappropriately assigned. Better to be safe than sorry.

Comply with “protected times” when visiting youth; staff is likely the best resource to establish when these times currently fall for your particular youth (e.g. groups, special activities, etc.).
On occasion, youth are placed on “Special Behavior Plans” and Stabilization Team Members coordinate that plan in tandem with a representative from the staff.

Things that are NOT the responsibility of Stabilization Team Members:

Adjust risk level down. This can only be done by a tandem assessment by members of the “Risk Assessment Team”.
Contact service providers (e.g. probation officers, nurse) at request of and on behalf of youth. It is best for youth to go through appropriate channels, via requests, and contact these individuals more directly.
Conduct psychological assessments for these youth. Interns who work stabilization as a part of their training will sometimes complete these assessments, but this is not “billable” as “Stabilization” time and is a separate matter.
Provide individual psychotherapy for these youth. If additional psychological services are requested, appropriate for you to provide, and the appropriate approval granted (via your supervisor*) they would be provided in a different role than as a member of the Stabilization Team.
Advocate for youth at CAP Committee meetings, court appearances, or other “staffing” that may take place. Involvement in these meetings may occur but will clearly occur only with the full involvement of your Supervisor(s) (clinical or administrative) and will not be initiated by the Stabilization Team Member themselves.

Chapter 6 - Detention Setting Risk Mitigation

Prevention of self-harm and/or suicide in a detention setting encompasses many issues. It is important to understand that it is impossible to totally prevent suicidal behavior from occurring in detention and it is impossible to make any facility totally suicide proof. Thus we adopt the language of risk management, we seek to reduce as much as possible the probability or risk of these behaviors and events from happening. We mitigate or reduce risk instead of eliminating risk.

This risk management stance is not a fatalistic exercise of accepting the "inevitable" completed suicide of a youth in detention. Instead it is an all encompassing review and physical intervention with all known factors, rendering them as harmless as possible. I have overheard detention and treatment managers saying their facility is "suicide proof" and I cringe, knowing they are not as safe as they purport to be and their sense of safety may be causing them to overlook some newly emergent problem.

The benefits of risk management are that it keeps the facility on its toes and the makes the suicide prevention processes a current activity rather than a problem that was "solved" at some point in the institutional past. Facilities, youth culture, creativity, individual needs, and other factors are in constant motion and change and suicide risk management must keep pace and even stay ahead of these curves to be effective.

As a side note to managers involved in risk reduction, the best sources of information on physical safety are:

1) The youth in your facility. Youth are incredibly inventive and many of them will be very honest with you about information on means to complete suicide in your setting. It is extremely useful to ask the youth to point out means. Some of these answers will, upon examination, prove fanciful and non-dangerous but others may illuminate new and undetected problems that need solution.
2) 2) The line staff in your facility. The staff that work with the youth are a prime source of information about risks that exist in your facility. They can tell you more about risk reduction than medical or psychiatric/psychological staff can. It is a good idea to have periodic check ins with these two groups and bluntly ask questions about existing risks in the facility.

Physical Environment

In the language and strategy of suicide prevention there are two main efforts, reducing the motivation to commit suicide and reducing the means to commit suicide. Reducing the motivation speaks to counseling and interactional interventions, spoken to elsewhere in this document. Reducing the means is physical intervention, environmental analysis and design, providing effective policy and procedure and the like. This section deals with reducing the means for suicide in detention.

Brief Analysis of Means/Method of Suicide

There is considerable research on the means that adolescents employ to end their lives. This information is presented in detail elsewhere in this document. It is useful, however, to look at this information from the vantage point of detention.

Methods of Suicide Ages 10-24

By order of decreasing percentage:

Method	% Male	% Female
Firearms	45	17
Hanging *Under age of 15	16 52	10 52
Carbon Monoxide	15	22
Ingestion	8	31
Jumping	6	12
Suffocation	1	1
Other	8	6

Most detention centers employ some form of physical screening of youth prior to admission to the facility. Lane County Youth Services does a complete skin search of any and all youth who come into contact with the non-detention environment. Youth are searched prior to admission and after family contact visits, court appearances, etc. Besides the stated function of eliminating weapons and drugs this search process also keeps means of self-harm out of the detention environment. Because of this search process, guns, knives, and other weapons that could be used against self are effectively screened from the facility. What this process does is greatly reduce the risk of a gun being used as a means for suicide in detention.

The other means from the above list that is greatly reduced in detention is carbon monoxide poisoning. Carbon Monoxide is a colorless, odorless gas typically produced by a combustion engine. Anytime you have such an engine present in the detention environment, which is usually only intermittently by maintenance, it is important to brief the people using the machine on the risks of carbon monoxide. Often the workers are well aware of this risk and have taken adequate precautions or can modify their normal procedures to greatly reduce risk. Obviously, youth should never be left unattended where such a machine is present.

The other main means, hanging, ingestion, jumping, and suffocation remain real risks in the detention setting and are discussed below.

Youth Rooms

One way of looking at risk is to analyze where youth spend their time while in detention. In general, the more time a youth spends in a particular area the greater the risk posed by that area. Compounding this is the reality that areas where youth are not directly

supervised and/or are more isolated are more dangerous areas than those where they are in the social presence of others.
From this vantage point, individual youth sleeping rooms pose one of the greatest risk areas in detention settings. Youth are typically in their rooms for varying amounts of time, and are often only periodically checked by staff. By Oregon statute youth are to be checked in detention settings every hour. We here at Lane County Youth Services check all youth in their rooms every 30 minutes. Youth who have been placed on a suicide risk level of 4 are checked at least every 15 minutes. It is important to realize that it only takes 4 minutes without air to die.
All detention sleeping rooms, group or individual, need to be closely examined for structural means to suicide. It is best to design the facility from the start with this in mind. Architects, even those whose business is designing and constructing juvenile detention facilities, do not often know the ins and outs of suicide prevention through design. It is critical to have detention staff present in the discussions on room design and then follow through and make sure sometimes costly or "unusual" design features are not value engineered out later in the construction process.
Some of the factors to pay attention to are:

Vents

Detention sleeping rooms typically have several vents in them. This allows for mandated airflow, fire prevention systems, HVAC and other functions. Vents are typically easily used for hanging, usually by youth who thread some item (like a shoelace) through one part of the vent and back out another part, providing a structure that will support their weight in hanging themselves, or the strength needed to loop something around their necks and then twisting until it shuts off their air supply.
All vents need to be covered with metal grating that is securely mounted to the wall and prevents youth from removing the grate under any circumstances. At the same time the holes in the vent should be very small, preventing a determined youth from threading string, clothing or any material in one vent hole and out another. In our experience grates with holes of 1/8 inch diameter or smaller is sufficient. The holes should be sufficiently spaced apart from each other to prevent this threading. Such vent design also prevents youth from hiding items for later retrieval in their rooms.

Hooks

Detention sleeping rooms are sometimes built with hooks for hanging clothes and/or other personal items. Fixed hooks in any area of detention provide convenient means for hanging and can be very dangerous.
There are hooks available on the market that will "give" under a minimal amount of weight. They can thus be used for clothing but not for anything even approaching a body. If it is not possible to procure this type of hook it is better to remove all hooks from the room. The inconvenience to the youth is far outweighed by the reduction of risk for self-harm.

Video Cameras

If at all possible, it is useful to install video cameras in the rooms that have been selected to house the youth with the highest risk for suicide. Color cameras, with wide lenses,

mounted in the upper corner of the room are best. Cameras should be tested to ensure the elimination or reduction of blind spots. High definition monitors are also strongly recommended. You can have a great video system but if the monitor is poor it will degrade the utility of the entire system.
Video camera observation does not substitute for physical sight checks and is provided only as a backup or redundant system. Numerous studies have shown that staff watching monitors habituate rapidly to video images and do not "see" what is on the monitors. Nonetheless, it is better to have video than not.
In terms of the numbers of room video cameras present within a given facility it really depends. The number of youth in need of video monitoring within detention tends to fluctuate, sometimes rapidly. As a general range, I would recommend 10% to 20% of individual rooms be video equipped. Here in Lane County we have 96 individual youth rooms, 12 of them have video monitors and we have at times been short on video rooms.
The main reason for including video systems in this section is to discuss making sure that your video system does not become part of the problem by providing an object in the room that youth can use to hang themselves. Any and all video cameras should be housed in security housings that are completely tamperproof. These housings need to be mounted in such a fashion that sheets, string, shoelaces etc. cannot be slipped around them in any way. Typically this means caulking the seams with tamper resistant materials. This caulking can lead to problems of accessing the camera for repair (the housings typically hinge in some fashion that is often obstructed by the caulk). It is better to re-caulk after repair and to purchase equipment that will be as maintenance free as possible. Detention staff in our facility has placed small pieces of paper covering the toilet part of the room on the monitors to provide some privacy for youth.

Beds

Beds, like vents, can present opportunities for looping, fastening, hanging or choking material. Wood, metal pipe or metal beam bed structures are not safe for detention settings. For this reason, most bunk bed structures pose risks that can be dangerous for suicidal youth.
Several decades ago Lane County had metal pipe beds that had cyclone fencing attached with metal hooks to the frame. I cannot think of a more dangerous design and indeed have had the experience of cutting several youth free who has used this type of structure to try and choke themselves.
The best beds are concrete single piece blocks with no lip or attachments. This type of bed is relatively inexpensive, easy to maintain, durable and most importantly safe for suicidal youth.

Toilets/Sinks

Like beds, toilets and sinks can present opportunities for looping or fastening hanging and choking material. The security industry has designed some pretty good products that reduce the ease of fastening anything to their product. Rounded edges, single piece construction, stainless steel, non-protruding buttons instead of handles all mitigate risk.
Although we have never encountered this type of suicide attempt, it is important to recognize that water can be used for drowning. In cases of extreme risk or youth who are verbalizing using the water in their room for suicide (or more commonly, for dousing

their room or plugging their toilet) each room should have an external chaise that allows the water to that room to be shut off.

Bedding

Bedding for risk level 4 youth needs to be of a particular type. We use felt blankets that cannot be torn along a seam. There are also suicide blankets made of the same quilted material as the anti-suicide smock but we do not use these, as they are poor at insulating youth from the cold.
We do not issue sheets, bedspreads, or pillowcases to acutely suicidal youth. These can typically be easily torn into long strips that are perfect for hanging or tying around a neck.
Mattresses also have to be very durable, and when torn open, do not present youth with material they can fashion into dangerous strips. We have several heavy-duty canvas mattresses that we have used on occasion. We typically use our normal detention mattress and pillow as the plastic from the covering cannot easily be used for self-harm and the innards are basically fluffing that cannot be made into a dangerous object.

Lighting/Fire Sprinklers

Any object that is fastened to the ceiling or walls and allows a youth to attach things to it is going to present a danger. Lighting fixtures can be dangerous installations. There are excellent security lighting products that are tamperproof and mount very flush to the ceiling or wall that can be used in youth detention rooms. These items all need to be inspected by detention staff for safe installation after they have been installed.
Current construction codes have sprinklers for fire control located in all rooms. Alone or sometimes mounted with a wire cage around them these can be very dangerous. Again, there exist breakaway models that do not support more than 50 pounds of weight that make them safer for use in detention rooms and other areas.

Youth Shower Area

Particular attention needs to be paid to the area where the youth shower. This is a high risk area because it typically combines lack of supervision due to privacy issues, towels and such that can be fashioned into nooses, strips etc. and protruding stationary items (showerheads).
Mitigation can intervene in all three areas of risk mentioned above. There should be some means of enabling staff to at least minimally physically check on youth in the shower area. This can be done via a small window in the shower door, translucent shower curtains (beware the curtain rod and any hooks), or having staff be present to monitor risk level 4 youth who are showering. It is good procedure to not allow high-risk youth into the shower with anything but their smock. They can ask for a towel when they are done. This reduces the time available to a youth for planning and action. Lastly it is best to design the shower from the start to have non-protruding heads, no stationary hooks (see rooms above), no easily available venting, no levers or knobs that can be used to fasten items to etc. Basically the more physical dangers exist in an area the more staff supervision is required. I prefer to act on the environment and reduce risk in that area

because over time staff loses sight of why they are monitoring youth and/or sometimes get called off supervision by other emergencies.

Other Youth Areas

Any area that youth have access to needs to be inspected for ways to reduce the access to life threatening means. Play yards, especially areas where youth are allowed alone and/or unsupervised need particular attention. It may be necessary to stipulate that high risk level youth cannot use that area unless accompanied by a staff.
The school and teachers need to be trained in suicide prevention and made aware of the potential problems that exist in their area(s). Such common items are paper cutters, scissors, rulers with a metal edge etc. All pose increased risk and should be eliminated when possible, or placed on a check out system and supervised closely when they are used. Risk level youth can also be prohibited from using such objects.
If youth work in the kitchen on KP they should be searched after their duty is complete. The kitchen should have all utensils under a lock system and security counts should be made on a periodic basis. Some common spices and herbs used in cooking can be toxic if taken in quantity. If youth have access to the kitchen these ingredients need to be identified and also locked up.

Youth Off Limits Areas

It is useful to have discussion with staff about denoting what areas in detention are completely off limits to youth under any circumstance and which areas are off limits unless accompanied by staff. These areas then need to be well marked with signage to that effect.
Simply prohibiting access to an area does not make it safe. Youth are often drawn to these types of areas simply because they are prohibited. Staff often become lax in supervision over time and may not observe the youth as closely as is needed. It often only takes a second for a youth to obtain something, which they can later use to end their life. Unfortunately, time is on their side. It is best to store a few lethal objects in detention as possible.

Youth Clothing/Suicide Smocks

Youth on suicide watch should not be given “normal” clothing to wear while in their room or in any area where they will be isolated for any period of time. This includes items such as pants, shirts, t-shirts, underwear, bras, and socks. Any of these and other clothing items can be used as is or ripped apart and “re-constructed” by youth to provide hanging or choking materials.
We here at Lane County Youth Services have used specially designed and commercially available “suicide smocks” as the only garment for risk level 4 youth when they are in their sleeping rooms. The suicide smocks are a tightly woven, quilted, single piece garment that cannot be torn, twisted or otherwise used for self-harm. These garments will not win any fashion contest but do provide adequate coverage for modesty, sufficient warmth during the winter and best of all safety. There are several types available, the one we use here at Lane County Youth Services is available through the Bob Barker Company at a pretty good price.

If a suicidal youth is going to be out of their room for any period of time they are allowed to change into “normal” clothing for the duration of their supervised activity. They then change back into the smock when they transition back in to their room.
Types of issues to aware of include the following situation. A youth on suicide watch was interviewed by detectives in our intake unit. The youth was changed into “normal” clothes for the interview. After the interview the detectives left the room and were escorted out of the building by the intake staff present at the time. When this staff returned to check on the youth and return him to detention he was found in the room almost unconscious from having a sock tied around his neck. Fortunately this attempt was not successful but the margin of safety was probably a minute or so. The lesson: The youth could have easily been interviewed in the smock. Alternately, no time in isolation with “normal clothing”. The staff should have taken the youth back to detention first and then dealt with the visitors later.
The “normal” clothing that a youth who is in a suicide smock uses needs to be stored somewhat away from their room. It is important to check the sleeping room doors in the facility to make sure youth cannot “snag” clothing or shoelaces from under their door. Staff also needs to be aware that youth do not attempt to secret or hide pieces of clothing under their smock for later use in their room.

Shoes

Shoes present a real problem for reducing suicide risk. There are many facets to this danger. Shoelaces provide one of the most dangerous and easily obtained means of hanging or choking. Youth committed to self-harm have gone so far as talking other non-suicidal youth into giving them their shoelaces. Detention staff needs to be aware of any shoes that are missing laces and quickly follow up on locating any missing lace. If the facility has the budget for it, you can purchase shoes that have Velcro fasteners instead of laces. Some of the high-end athletic shoes do not use laces anymore.
It is best if the youth’s personal shoes are stored in property and not made accessible to the youth at any time. Modern shoes have such intricate construction that there are myriad ways to hide items in the shoes that can escape even detailed staff inspection. Youth often have been in detention during previous stays and also often know they will be returning to detention. We have found, as well as heard about, both unsuccessful and successful attempts to smuggle contraband into the detention facility. Most of the time this is drug material, which can easily lead to an overdose, which could then lead to death, indirect suicide. The following true story sums up the problem: Youth is admitted to detention that is openly suicidal and is placed on a risk level 4 status. After several months in detention the youth obtains a staple and cuts his wrists in his room. Staff discovers this and intervenes; there is loss of blood but no short-term risk of loss of life. On the day of release from detention, as the youth is being given his own clothing, he hands the releasing staff a small razor blade he had hidden in his shoe. He tells the staff he does not feel safe outside of detention having this means to suicide on his person. He has had this razor during his entire detention stay but did not use it. But for conflicted motivation and relationship to the detention staff this youth could have easily killed themselves at almost anytime during their 3-month stay.

Youth Access to Dangerous Objects

MSDS Sheets

All chemical cleaning supplies, sprays, solutions etc. that are used in detention need to have a material data safety sheet (MSDS) for them. These sheets should be available to all staff via a binder that is kept in the detention pod office.
It is important that the detention manager, medical staff, and procurement person go over all MSDS sheets for the facility on a regularly scheduled basis.
It is also important to firmly seek out materials that are non-poisonous for use in the detention environment. As a general rule of thumb I would allow no poisonous substances to be stored on the unit at all, even if they are in "no youth" areas. As the Russians say "Even an unloaded gun will eventually go off".
Fortunately there are now many great cleaning products etc that are non-toxic and at the most cause a case of the runs. We have had several cases in my tenure here of youth drinking cleaning soap, fortunately a non-life threatening event.
We not allow youth access to any spray. Youth can use a wide variety of canned sprays for huffing and most sprays contain aerosols that produce a high, sometimes in conjunction with the poisonous contents of the spray. We use hand pump spray bottles only.

String/Cloth

If a youth is on a suicide watch it is important to limit and restrict their access to anything that can used for strangulation or hanging.
The following incident illustrates this point. We, like most facilities, have regular times when youth participate in cleaning their rooms. We use rags (mostly) for this purpose. Youth are given rags to clean with and then give the rags back to staff when they are done. A risk level youth was given rags for cleaning and the staff that gave them the rags was called away on other matters. Another staff stepped in to finish the cleaning process and the youth gave that staff back some rags. What was unknown was that the youth had secreted some of the rags on his person and later ripped them up, fashioning a strong string, which they then used to try and strangle him/herself. Fortunately, staff discovered the youth before they died. We now use only sponges for risk level 4 cleaning. This does not mean that a risk level 4 youth could not possibly obtain rags from another youth; it just lessens the probability and ease of use in using a rag to kill themselves.

Pencils/Pens

It is important to have a security count/check out system for pencils and pens as well as restrict the use of these items in any unsupervised manner by suicidal youth.
Security counts are part of any safe detention setting but this takes on additional value in reducing risk for self-harm. Here at youth services we do not allow risk level 4 youth to have pencils alone in the room. If they are using a pencil they come out into the common area where they can be observed and receive staff supervision.

We recently have gone to using a non-toxic crayon for risk level 4 youth that are assigned therapeutic art by the stabilization team. Thus far there has been good success with this program.
It is important that you explain security procedures to the myriad of visitors who come in to see youth in detention. Most of these people have no understanding of the risk posed by a pencil or such object. As a result, without briefing, it is common for them to leave this type of object behind or to inadvertently give them to youth and not ask for them back.

Staples/Paperclips

Innocuous items like staples and paperclips need to be controlled as much as possible. Both present potential problems for use as hand fashioned cuff keys but they are more dangerous when used for self-harm.
Groupwork staff and teachers in the detention setting should not use paperclips as part of their office supplies. It is so easy for these to fall off. Because of their tensile strength paperclips can be successfully used to quickly produce life-threatening cuts. Visitors to detention need to be trained to not give youth materials with paper clips attached. As a backup, the detention line staff needs to inspect materials coming in for paperclips and remove them when found.
Staples present more of a problem for control but less of a risk. So many items contain staples in them including paperwork given to the youth, magazines (staples are often hidden in the binding), brochures, some books, etc. Fortunately, the use of a staple (depending on the size) to kill oneself is actually pretty difficult. Staples can produce loss of blood and horrendous scars but are much less effective for self-harm than a knife type object or a stabbing type effort.
I recommend controlling staples as much as is possible. Make the detention staff aware and on the lookout to reduce exposure to staples where possible. In our facility this includes having staples removed from manuals youth have present in their rooms. Currently it does not include taking apart magazines to remove staples, although risk level 4 youth cannot have such objects in their rooms.

Other Objects

Eye Glasses

Youth on risk level 4 should not be given eye glasses in their rooms. Such eyewear is dangerous as they contain glass or plastic that can be broken and then used to cut on oneself. Eye glasses can be stored by detention line staff in an easy to access for staff area and given to the youth when they are under direct supervision, and then retrieved when youth return to their room.

Hair Ties

Hair ties should not be given to suicidal youth. These ties have a variety of construction but often involve elastic and cloth that can be fashioned easily into something to be used for strangulation.

Eating Utensils

Risk level youth should not be given metal or plastic eating utensils if they are eating in their room unsupervised. There are some very light weight plastic utensils that are so bendable they pose much reduced risk. Alternately, risk level 4 youth can have prepared meals that do not require the use of utensils (finger food).

Medical Wraps/Prosthesis/Etc

These items need to be stored outside the detention sleeping room and used only when a suicidal resident is under direct staff supervision. Often hospitals, when dealing with injuries sustained by a youth in cutting on themselves, will dress wounds in material that can then be used for strangulation. Fortunately, medical centers have a wide array of possible types of bandages. Safety concerns need to be communicated to the physician by the attending line staff.

Youth Isolation

Youth who are suicidal often have other social problems as well. This tends to place them in the category of youth in detention who fail in normal programming. Some suicidal youth are very withdrawn, they can want to "hole up" in their room and/or lack the energy or skills necessary for normal daily activities. Some suicidal youth can be anti-social, violent, or not focused on daily activities to the extent they end up either in their rooms or on special restrictions that increase their isolation from other youth and detention staff. It is important that detention staff recognize these patterns and actively work to decrease isolation in detention. Special programming, increased staff contact, one on one time and groups focusing on depression and suicide can help minimize youth isolation.

Programming Issues

It is important that the detention suicide intervention program recognize possible "secondary gain" for youth on suicide status. These youth tend to have increased staff contact, attend special groups, and other benefits that can be appealing to manipulative youth. It is useful to balance the "perks" of a suicide status with natural consequences. Some of these "natural consequences" can include having the light stay on at night to aid staff in the checks, wearing a suicide smock in their rooms, not being eligible for roommates, not having pencils in their rooms, not being eligible for razors on the unit etc. These measures tend to produce a situation in which youth rarely manipulate to get on a suicide watch for ulterior motives.

Youth will sometimes act out with suicidal-like behaviors in the hope of being transferred to mental health or hospital type settings. Over time, Lane County detention has stopped referring youth to mental health for suicide. We are acknowledged locally as having a superior setting for suicidal adolescents than the local psychiatric facility. We let youth know they will not be transferred and that we deal with this type of issue internally with our own resources.

Suicide Checks

Detention suicide watch checks are often part of the State's detention statutes. Sometimes they can be found in Administrative rules. In any case it is important to recognize that these are minimums and can be improved upon by the facility to reduce risk. Although our "standard" suicide check is every 15 minutes we can (and have) instituted more frequent checks or even 24 hour watch procedures if that is what it takes to keep a youth safe.

Whatever the standard, the detention facility needs to have some form of accountability for documenting these checks. The documentation needs to include the time and date of the check, the area checked, and the staff who performed the check. It is best if this documentation exists in a way that cannot be altered or "fudged" by staff. Again, technology provides several excellent solutions via card readers, centralized computer records and the like.

Setting up a Contact Schedule

The member of the detention suicide stabilization team assigned to a particular youth has latitude to set up special contacts with the youth. The normal expectation is that the stabilization member will contact and talk with the youth at least twice a week but this can be increased to daily contact.

The detention supervisor also often contact the youth's probation/parole officer to set up increased counselor visits. Again the normal expectation of twice weekly visits can be increased as needed.

In extreme cases, members of the suicide panel can be "on-call" for a particular youth as resources and be brought in on an emergency basis. Also in extreme cases, detention management can assign short term one on one care to the youth by bringing in an additional staff to stay with the youth, connect with them and keep them safe.

Family as Resource

Sometimes the family can be a support for the depressed/suicidal youth. The counselor/detention administration or stabilization members can set up special visits for the youth with their family. The family needs to be briefed as to the reason for these visits and their role in stabilization of the youth.

Release of Suicidal Youth from Detention

When youth who are suicidal are released from detention special precautions must be made to ensure continuity of care and safety for the youth. Obviously a controlled environment like detention can be a safer place than their "normal" environment.

If the youth is being released to another facility, the receiving staff and facility must be made aware of the youth's suicidal intent as well as the care they received in detention. One can go as far as having a form that the receiving staff signs saying they were briefed and acknowledge the presence of suicidal risk in the youth.

If the youth is being released to parents or guardians the same approach must be taken, by briefing the parents on the suicide risk. Parents will also often want to know what

resources they can connect with. It is useful to have a handout with local mental health providers who work with suicidal issues.

The most critical release is when the suicidal youth is being released to self or their own recognizance. Fortunately this is a rare event but it does happen. In these cases it is necessary to either contact the psychologist to clear the release or release the youth through a local mental health hospital setting. It is not safe to release a youth to their own resources if they are suicidal.

Appendix #1 - Practice Cases

David

David, just prior to going outside for PE, balked saying he didn't have to participate as he was on a "no PE" status. In checking with the nurse David was eligible to go outside and participate in PE. David was encouraged to at least try. David eventually went outside but when the class was asked to jog the track David opted to slowly walk the track. After several requests from the teacher to jog with no response from David, the teacher asked David to go inside. David became upset, flipped off the teacher and started yelling obscenities. He also threatened the teacher with physical harm.

David was escorted inside by several detention staff. Upon entering the facility David continued his obscenities and also kicked a chair across the dayroom. Staff spent some time defusing David in the dayroom. David made several comments to staff that he would break his own leg, stick his head in the toilet, smash his head against a wall, or even hang himself in his room with a sheet.

David expressed that he would rather go to the local psychiatric hospital or even the County Jail than remain at Skipworth. David was reticent in talking with staff about suicide but offered that "it would be no big loss" if he were dead. He also made the statement that if he went to the hospital he would not be back.

Suicide Risk Questionnaire

Ginny

Approximately nine months ago Ginny reports that she had three episodes of suicidal behavior.
The initial attempt followed an argument with the mother and her feeling that she couldn't do anything right. She decided to cut her left wrist and made a shallow horizontal cut which has left a fine scar. She states that she did not cut herself enough to bleed very much and that the cut did not need medical attention. She decided it was stupid and stopped herself.
The second attempt came when a fried decided to kill herself. Ginny responded by saying "You want to see someone die? well watch!". She then was going to cut her arm along the vessels with a razor. Her friend told her to stop and she did before she cut herself deeply enough to need any care.
The third time followed a lot of drinking at a party and an argument with her old boyfriend. She was going to cut herself using a broken glass but did not need any medical attention for the cuts she made.
All the above episodes took place within a period on one month. She states that she currently has no thoughts of suicide, and expressed a feeling of safety while here at Skipworth. At the same time she appears flat in affect and depressed. She expresses that she prefers to be a loner and would rather spend time in her room than be out in the community. She readily signed a suicide contract, but would not identify staff that she felt comfortable talking with if she became depressed.

Suicide Risk Questionnaire

Jim

Jim states that he has been going with his girl friend for approximately six months and is deeply in love. The girl's parents told him that they did not want him seeing their daughter and that he was no longer welcome. Jim states that he decided to kill himself by cutting his wrists two weeks ago. After making two extremely shallow scratches he made a deeper slice. During the time that this took, Jim decided that suicide was not the answer and aborted the attempt. His mother was home at the time and he went and told her what he had done. They spent some time talking about the situation and he decided that he wants to live. Jim was able to identify some of the negative consequences to killing himself and knows that his parents would be hurt if he died. He states he has never used drugs (other than alcohol) in his life.
Jim was able to commit himself to being safe while he is here at Skipworth, but as this is his first stay, does not know any of the kids or staff.

Suicide Risk Questionnaire

John

John reports a couple of attempts at suicide over a year ago. These followed feelings of being rejected by his family members, including his mother and mother's boyfriend, his brother, and father. (He states even the family dog rejected him). In speaking of them John states "I lost my...." None of these individuals are dead, just lost to him.
John is currently using drugs (marijuana) about once a week. He states he used to use much more often.
Although John thinks of suicide he states he does not have a plan to harm himself. He has a new family that he likes and identifies with and that he says loves him and he loves them. He is quite fatalistic about his stay here in detention, saying he refuses to live with his father. He was able to identify staff and kids that he could talk to if he were having difficulties, especially staff Becky Watts and Dan Cole. John has a court hearing tomorrow where his living situation will be decided.

Suicide Risk Questionnaire

Viriam

Viriam was detained this afternoon. He explained during the intake that his wrist had been cut more than a year ago by a friend when they were both intoxicated. He said he and the friend did not intend death to be the result of their actions.
Viriam is not happy about being here but denies any suicidal intentions or ideation. He plans to be out of here before long and reports plans for future employment after returning home.
There are indications that Viriam is depressed. He refuses to complete his orientation materials and plans to stay in his room as long as he can. He states he fears for his safety in detention because of the presence of several other youth currently in detention. Viriam ignored this staff's suggestions of how to deal with the situation. Viriam also shows some signs of drug use, (tattoos, slightly disoriented) but claims not to have used in the past three months. He also has some pronounced cigarette burns on his hands and wrists.

Suicide Risk Questionnaire

Martin

Martin was detained after wrecking the car he was driving. He was on his way from the Dalles to San Diego with a female friend. The female friend is badly injured as a result of the crash and is in ICU in the hospital. Alejandro has some bruises from the accident but was cleared after his medical exam.
Martin speaks very little English. He is an indigenous Mexican and speaks a blend of Mexican Spanish and Indian dialects. We had the help of an interpreter for the intake process. Martin was very teary during the intake and appeared depressed to the staff doing the intake. He often had his head in his hands sobbing.
Martin reports that his mother and father are dead and that he has been on his own for the past two years. Police found drugs in the car after the crash and that is why he was brought to detention.
Martin is unwilling to tell us the names of any relatives or family in the area. He strongly distrusts “Federales”. He says the drugs were a plant by the police and he knows nothing about them. He said he is going to "go crazy" if he is kept locked up, and that he has to see his girlfriend right now.
Martin states he attempted suicide when his parents died and that he needed to go the hospital to have his stomach pumped at that time. He has not had any other episodes of ideation.

Suicide Risk Questionnaire

Staff Safety Pledge

(raise right hand, left hand on heart)

I, your name, having been trained in suicide prevention, do hereby accept responsibility for the safety of the youth under my care in facilities name. I pledge to be the staff who makes a difference and keeps the youth safe. I pledge to follow my hunches, use good my judgment and caring concern in keeping the youth under my care safe from self harm.

Appendix # 2 – Oregon Research Institute Study

Psychological Patterns of Depression and Suicidal Behavior of Adolescents in a Juvenile Detention Facility

David E. Mace, Paul Rohde, and Virginia Gnau

Abstract

555 detained youths were tested, 80 of which had extensive diagnostic interviews, to attempt to understand the social and psychological relationship between depression, suicidal behavior and misconduct. Implications for screening high risk adolescents, the comorbidity of other mental health issues, and their relevance to treatment planning is discussed.

Although the prevalence of suicide attempts among high school students ranges from 3.5 percent to 9 percent (Velez & Cohen, 1988; Andrews & Lewinsohn, 1992) actual deaths due to suicide in juvenile detention facilities have been estimated to be 4.6 times higher (Memory, 1989). Suicide prevention programs are designed for the general population of adolescents and do not take into account the dynamics that are seen in juvenile offenders. Depressive symptoms are common with teenagers that are incarcerated, however, there is little research to support detention staff decisions when they are presented with a combination of depression and suicidal behavior exhibited by their wards. Incarcerated teenagers are a particularly relevant group for empirical study because they are at high risk for both suicide attempts and completed suicide. Proactive suicide prevention programs have been specifically designed for detention facilities based on the practical experience of the staff. The need for more empirical information on which to base identification, stabilization, and treatment has had little response due to the complexity of adapting research design methods to a detention center (Mace, Crumbley, Gnau, Leppard, Khalsa, 1 994).

The purpose of this article is to present relevant findings from research by the Oregon Research Institute which collected data between November 1992 and July 1995 at the Skipworth juvenile Home, a 36 bed detention center in Lane County, Oregon (Rohde, Mace, Seeley, submitted for publication; and Rohde, Seeley, & Mace, in press). Also included are results that were not found to be statistically significant, but provide practical implications for program development. The research was broken into two

studies, one to determine correlates about the demographics and dynamics, and the second to assess comorbidity with other psychiatric disorders.

Method

Within the first few days in which an adolescent was detained a 188 item questionnaire was administered. This took approximately 25 minutes to complete. One thousand and thirty-five questionnaires were completed by 555 teenagers, or approximately 59 percent of youths admitted (81 percent of youths detained for more than four days) to the center during the period of data collection. The mean age of participants was 15.3 years. Two hundred and forty of the participants completed the questionnaire at least twice due to recidivism. This questionnaire was used to form the first part of the research to determine suicidal ideations and behavior correlates in terms of demographic characteristics, current suicidal ideation, life time thoughts of death and suicide, life time suicide attempts, current depression, exposure to suicide events, anger, substance use, conduct problems, borderline personality features, coping skills, major life events, loneliness, social support, impulsivity, parental supervision, and social desirability.

Sixty of the above subjects completed a diagnostic interview based on a version of the Schedule for Affective Disorders and Schizophrenia for School Age Children (K-SADS, K-SAD~E and SADS-P) and included additional items to facilitate diagnosis under DSM-III R criteria (American Psychiatric Association, l 987). Additional measures, including the Beck Depression Inventory (BDI), Hamilton Rating Scale for Depression (HRSD), and the Personality Disorder Examination (PDE) were included. Interviews were conducted by two interviewers, each with advanced degrees in Psychology. The selection of subjects for the second study were not randomly made from the first group. Those with depressive symptoms, a disproportionate number of girls and those with longer stays were targeted for interview. The second study subjects' average age was 14.9 years.

Results

Of the 555 subjects taking the questionnaire 82.5 percent were male, 17.5 percent were female. Seventy-six and a half percent were self identified as

being Caucasian, with the remaining subjects, Native American, 8.4 percent, Hispanic, 5.8 percent, African American, 4.0 percent, Asian and Pacific Islanders, 2.7 percent, and others, 2.5 percent. The Native American category is higher than what this population represents in that there was a tendency for teens with any distant Native American relative to so list themselves. Prior to entering detention, 56.7 percent of these teens had been in school,40.4 percent dropped out, and 2.9 percent graduated. Their residence had 36.6 percent living with non-relatives, and 3.1 per- *h¢:* cent living alone. There were 31.9 percent living in households with their mother as the sole parent, 15.2 percent were living

with their mother and stepfather, and 13.2 percent lived with their biological mother and father. Research findings with the general adolescent population showed that when both biological parents are at home there is less likelihood of a suicide attempt (Andrews & Lewinsohn, 1992) this was not found to be a positive variable with delinquent youths and presents the question of the degree of dysfunction of even intact families.

Within this sample 14.2 percent were currently having suicidal ideations. This number increases to 23.8 percent when reviewing incarcerated teens over a seven day period. 19.4 percent of those in detention had one or more previous suicide attempts, with more than half of those having two or more attempts. These numbers are particularly alarming considering the mean age of 15.3 years of the participants, when in the general adolescent population no study has shown more than 9 percent by the completion of high school. The Beck Depression Inventory indicated 34.0 percent with scores greater than 16, or a current significant clinical level of depression.

There were significant gender differences in terms of suicidal ideations and attempts. The boys showed 12.7 percent of current suicidal ideations as opposed to 21.6 percent for girls. 15.1 percent of the males had one or more suicide attempts as compared to 39.8 percent of the females. Of those attempts, 35.7 percent of males and 32.4 percent of females required medical treatment. In terms of the method of attempts, 52.8 percent of the girls used ingestion and 33.3 percent used cutting. With the boys, 21.1 percent used ingestion, with 24.6 percent cutting, but had an increase in other methods, 15.8 percent by hanging, and 21.1 percent used a gun. The impulsivity of this group in jumping from ideation to attempt had 48.2 percent of the boys, and 45.9 percent of the girls carrying out the act within a few hours of premeditation. The need for screening teens on entering detention is emphasized in that only 32.7 percent of the boys and 43.2 percent of the girls talked to someone prior to making an attempt. Although delinquent youth can use suicidal behavior in a manipulative manner, 72.5 percent of the boys and 8 1 percent of the girls who made attempts reported that they were either unsure or really wanted to die. 69.5 percent of the males and 64.8 percent of females were either unsure or thought that their method of attempt was lethal.

Racial classifications were not significantly associated with either current ideation or lifetime history of attempts. For boys, nine variables were significantly more associated with suicidal ideations than with suicide attempts: Current depression, anger, borderline personality features, major life events, loneliness, number of close friends, self esteem, impulsivity, and social desirability, and one variable, older age, was significantly more associated with suicide attempts than ideation. For girls, four variables were significantly more associated with ideation than with attempts: Younger age, suicide attempts, and suicide by family member, and low self esteem. Suicide attempt by a friend was significantly more associated with suicide attempts than ideations. Multiple Logistic Regression (MLR) analysis was conducted to provide for a predictive model of current suicidal ideations. 76.8 percent of males were optimally screened when measures of greater current depression, history of suicide attempts, greater number of life events, more loneliness, and fewer close relatives were factored. Correct classification of 74.8

percent of the females was identified with measures of younger age, greater current depression and impulsivity.

Similar MLR analysis was made in the attempt to find factors to identify past suicide attempts. Correct classification of 62.4 percent of the boys was made through current suicidal ideation, use of ineffective coping behavior, and not residing with at least one biological parent prior to entering detention. Correct classification of girls occurred 76.4 percent by using measures for greater number of major life events, impulsivity, and not residing with at least one biological parent.

Table I - Suicidal Ideations and Attempts by Gender

Variable	Males	Females
Current Suicidal Ideation (%)	12.7	21.6*
Current depression, BDI mean	12.5	16.3***
Lifetime Thoughts of Death (%)	58.9	74.7**
Lifetime wishes to be dead (%)	34.9	53.1***
Lifetime suicidal ideation (%)	31.6	51.1***
Suicide Attempts		
%0	84.9	60.2***
%1	7.8	15.1
%2 or more	7.3	24.7
Method of Attempt		
% ingestion	21.1	52.8***
% cutting	24.6	33.3
% hanging	15.8	2.8
% jumping	7.0	5.6
% gun	21.1	2.8
% other	10.5	2.8
Received Medical Treatment (%)	35.7	32.4
Length of Premeditation		
% few hours	48.2	45.9
% a day	10.7	10.8
% several days to a week	19.6	18.9
% more than a week	21.4	24.3
Told someone before attempt (%)	32.7	43.2
Told someone after attempt (%)	75.9	89.2
Intention		
% wanted to live	17.5	18.9
% unsure	31.6	40.5
% wanted to die	40.9	40.5
Subjective lethality		
% thought I'd live	30.5	35.1

% unsure	30.5	37.8
% thought I'd die	39.0	27.0

**p<.01, ***p<.001
Significant level of gender differences

Regardless of whether risk factors were found to be significant or not, their accumulation increased the likelihood of current suicidal ideations or past suicide attempt with both genders. As Table 2 indicates, teenagers inside detention arrive with an interaction of factors that place them at high risk for suicide attempts. No one in the sample attempted suicide during the course of the data collection. When the diagnostic interview was conducted with multiple psychiatric diagnoses. Delinquents 60 subjects, as expected, 73.3 percent qualified for a who have alcohol and drug abuse/dependency with Conduct Disorder both currently and in terms of out a mood disturbance have lower likelihood of a lifetime occurrence. In the process of screening for suicide attempt than those with a mood disorder and detention, non drug related thought disturbances and intellectual incompetence are virtually eliminated and cognitive and learning disorders were not examined. The rates of psychiatric disorder within this Given Diagnostic Interviews group are presented in Table 3 for both current symptom patterns as well as patterns that have occurred throughout the individual's lifetime.

When past suicide attempts are reviewed as a function of psychiatric diagnoses within detention there was a significant increase in its likelihood with mood disturbances. The factor of Attention Deficit Hyperactivity Disorder associated with suicide attempts appears to be reflective of impulsivity. It is important to note that in this study the diagnosis of ADHD is based on a symptom pattern and not etiology and does not differentiate between symptoms based on chemical imbalance, anxiety, or personality style.

Table 2 – Current Suicidal Ideations while in Detention and Suicide Attempts Prior to Detention with a Cummulation of Risk Factors

Current Suicidal Ideation	Number of Risk Factors	0	1	2	3	4	5
Males	% ideation	0.0	0.0	3.0	9.0	20.5	44.5
	Number Subjects	22	75	99	89	78	43
Females	% ideation	0.0	16.7	29.7	33.3		
	Number subjects	16	36	37	6		

Past Suicide Attempts	Number of Risk Factors	0	1	2	3	4	5
Males	% attempts	1.7	8.8	16.0	25.0	34.6	100.0
	Number subjects	60	114	131	88	26	3
Females	% attempts	0.0	13.6	43.3	65.0	83.3	
	Number subjects	11	22	30	20	6	

Perhaps the most interesting finding did not have sufficient sample size to show significance. Table 5 shows the rate of suicide attempts when associated with multiple psychiatric diagnoses. Delinquents who have alcohol and drug abuse/dependency without a mood disturbance have lower likelihood of a suicide attempt than those with a mood disorder and substance abuse.

Table 3 - Rates of Psychiatric Disorder from Subjects Given Diagnostic Interview

% with Disorder	Current	Lifetime
Major depression	23.3	40.0
Dysthymia	8.3	8.3
Anxiety disorders	10.0	18.3
Conduct disorder	73.3	73.3
ADHD	13.3	16.7
Oppositional	1.7	16.7
Alcohol abuse	1.7	6.7
Alcohol dependence	18.7	41.7
Cannabis abuse	3.3	5.0
Cannabis dependence	23.3	43.3
Hard drug abuse	1.7	6.7
Hard drug dependence	16.7	33.3

Table 4 - Frequency of Suicide Attempt as a Function of Current Psychiatric Disorders

Disorder	Percent with past suicide attempt
Major depression	50.0
Dysthymia	80.0
Anxiety	66.7
Conduct	38.6
ADHD	62.5
Alcohol abuse/dep.	50.0
Cannabis abuse/dep.	31.1
Hard drug abuse/dep	60.0

Note: It was common for youths to have multiple diagnoses especially with Conduct Disorder.

When depression and anxiety are viewed without substance abuse, there is the highest possibility for a suicide attempt. Substance use, at least in this sample, reduces the likelihood of a suicide attempt with mood disordered teens. Conduct disorder appears to provide the same pattern of diversion in reducing suicide attempts with mood disordered adolescents.

Table 5 - Impact of Comorbidity

Disorder	Rate of Suicide Attempt
Depression without A & D	66.7%
Depression/Substance abuse	52.6%
Substance abuse w/o Depression	15.0%
Anxiety w/o A & D	100%
Anxiety/Substance abuse	42.9%
Substance w/o anxiety	31.3%
Depression w/o conduct disorder	75.0%
Depression/conduct disorder	41.7%
Conduct disorder w/o Depression	18.2%

Discussion

When the percentages of lifetime suicidal ideations of 31.6 percent for males and 51.1 percent for females is reviewed with the previous history of suicide attempts of 15.1 percent for males and 39.8 for females, it is easy to surmise that adolescents in a juvenile detention facility are at high risk for self destructive behavior. This is particularly true considering the mean age of 15.3 years of subjects reviewed for this study. The fact of being in a juvenile detention facility, in and of itself, is likely a more sensitive indicator for the potential of suicide than standardized screening devices used in the general community. It is therefore necessary to develop screening instruments that are particular to the dynamics of this population of youths.

Factors that are discriminatory in a general population, such as dysfunctional family patterns, substance abuse, separation from the family, etc., can be applied to most, if not all of the detainees, and therefore have little utility in screening. Triaging of high risk teenagers is still necessary within detention in order to provide a practical method of identifying and stabilizing those at highest risk prior to an incident.

The gender differences were the most pronounced variance, especially in terms of twice the likelihood that a girl will have a previous suicide attempt than a boy. Considering that a previous suicide attempt is the best predictor for a future attempt or suicide, the importance of further research to best differentiate gender factors is critical. It is our

belief that identifying current suicidal ideations as well as the potential for an attempt within detention is necessary for a proactive approach to this problem. Individual cases inside detention have been reviewed where there had not been any current suicidal ideations before the act. This shows that although current suicidal ideations are highly related to the prediction of an attempt other factors need to be accounted for when the individual is evaluated. An understanding of the dynamics of this group from research must be combined with the experience of the staff in order to deal with suicide prevention on an individual basis.

The factors presented in the Results section were able to correctly screen for current suicidal ideations in approximately three fourths of the subjects, as well as three fourths of the girls and 62.4 percent of boys for previous suicide attempts. Although this is a significant increase in identifying those at particularly high risk, when the end result can be permanent damage or death, further research is obviously needed. Larger samples would allow for identifying other variables like gender and age that provide for variance in clusters of factors that can determine the likelihood of a suicide attempt while in detention. There does not appear to be a specific set of factors that would apply to all youths under the jurisdiction of the courts. Screening should eventually be based on a subtyping model that first classifies by sub groupings based on age, gender, personality style, etc., and then reviews for the more specific dynamics within that sub grouping which can better triage the severity of risk.

The degree to which these youths have additional mental health issues is also illustrated in the research. 73.3 percent had behavior that was sufficiently pervasive for a Conduct Disorder, however, approximately one fourth were incarcerated for more specific crimes or sex offenses. Because the histories were self reported the extent of their substance use both past and current may have been understated, especially considering that many of them lacked current use because they had been incarcerated for a few months. Mood disorders are common as is a Borderline symptom pattern, but it is rare to expect a thought disturbance or a level of moodiness/histrionics that would be clinically Bipolar. From a standpoint of program design, it was the manner in which disorders interacted that was the most interesting. To reiterate, there was not sufficient data for these results to be statistically significant. It does appear that the types of activities involved with Conduct Disorder and substance abuse provide for a dysfunctional coping strategy that reduces the likelihood of past suicide attempts. As we are taking away these dysfunctional strategies, we must understand that they are nonetheless effective, for many youths, in reducing the stressors that can lead to a suicide. The implication is that in designing programs specifically treating misconduct and/or substance use, that including a component of applicable coping strategies is imperative.

There continue to be obstacles in attempts to better understand the problems presented by depression and suicidal behavior within closed custody. Research designs and mental health grants prefer a more controlled environment than the practical and often political atmosphere that a juvenile detention facility provides. The use of a control group that would receive less than adequate care is not possible. Methods of stabilization and coping skill development need to vary and be flexible based on the needs of each individual

child within the resources of each center. The variance between both detention facilities and staff vary even within common geographical locations. In the 7 years that Lane County has run a proactive suicide prevention program, we have significantly reduced attempts within detention and it has been more cost effective than our previous, reactive approach. Suicide prevention programs cannot wait for more research. They need to be based on the information currently available and applied through the experience of the staff at each facility but should be updated as research results develop. Regardless, each child is unique, and the decisions for care need to be made on a case by case basis.

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David E. Mace, Ed D. was the contract psychologist for the Lane County (Oregon) Department of Youth Services (DYS) and a consultant with Oregon Research Institute (ORI) Paul Rohde, Ph.D., is a research scientist and psychologist with ORI. Virginia Gnau, MS, ANP, was a Nurse Practitioner who provided medical care at the Skipworth Juvenile Detention Facility in Lane County. She and Dr. Mace developed the Suicide Prevention Program - Lane County Model

This work was supported by National Institute of Mental Health Grant MH49441. For a more technical review of the research design and some of the data presented in this paper, see Rohde, et al. Statistical analysis was done by John R. Seeley of ORI. This study could not have been completed without the support and cooperation of the staff of ORI and DYS, and of course, the young people at Skipworth. For further information regarding this research, suicide prevention programs, and training, contact Dr. Mace, at the Lane County Department of Youth Services, 2727 Centennial Blvd., Eugene, OR 97401, or call him at (541) 343-7317.

Appendix # 3 - Adolescent Suicide Bibliography

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Appendix # 4 - Web Resources

Web resources change rapidly. The authors suggest setting your search engine (google.com) to find: adolescent, suicide, and detention. Other modifiers can also be used.

http://www.med.uio.no/iasp/ - International Association for Suicide Prevention (IASP)

http://www.who.int/mental_health/Topic_Suicide/suicide1.html - World Health Organization Suicide Prevention Homepage

http://www.ohd.hr.state.or.us/ipe/2000plan/sectn2-8.htm - Oregon Health Division Suicide Prevention Initiative

http://www.mentalhealth.org/publications/allpubs/SMA01-3517/appendixc.htm - National Strategy for Suicide Prevention homepage

http://www.nimh.nih.gov/publicat/depsuicidemenu.cfm - National Institute of Mental Health Suicide Website

http://www.mentalhealth.com/mag1/p51-dp01.html - Site about adolescent depression/suicide prevention

http://www.cdc.gov/nccdphp/dash/yrbs/natsum97/susu97.htm - Centers for Desease Control Suicide Prevention for Adolescents

http://www.cdc.gov/nccdphp/dash/yrbs/natsum97/susu97.htm - National Mental Health Association website on Teen Suicide

http://www.aacap.org/web/aacap/publications/factsfam/suicide.htm American Academy of Child and Adolescent Psychiatry fact sheet on Teen Suicide

http://depts.washington.edu/ysp/ - Washington State Teen Suicide Prevention Initiative

http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000024/p0000024.asp - Centers for disease Control Youth Suicide Prevention Programs Summary

http://www.safeyouth.org/topics/suicide.htm - Safe Youth Project web site.

http://www.nmha.org/ccd/support/screening.cfm Depression/Suicide screening site

http://www.mentalhealth.org/suicideprevention/default.asp National Strategy for Suicide prevention website.

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

http://www.nopcas.com/ National Organization of People of Color Against Suicide

http://www.spanusa.org/ Suicide prevention Awareness Network website

http://cebmh.warne.ox.ac.uk/csr/ Centre for Suicide Research Oxford University

http://www.fmhi.usf.edu/amh/homicide-suicide/ Violence and Suicide prevention website

http://www.teenanswer.org/ Adolescents Never Suicide when Everyone Answers – teen suicide prevention site.